RECOMMENDATIONS BY THE NATIONAL HEALTH LAW PROGRAM FOR MODERNIZATION OF THE MEDICAID MANAGED CARE REGULATIONS (42 C.F.R. PART 438)

Recommended new language in bold font, recommended deleted language in strikethrough font.

Subpart A—General Provisions

§438.1 Basis and scope.

(a) *Statutory basis.* This part is based on sections 1902(a)(4), 1903(m), 1905(t), and 1932 of the Act.

(1) Section 1902(a)(4) requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operation of the State plan. The application of the requirements of this part to PIHPs and PAHPs that do not meet the statutory definition of an MCO or a PCCM is under the authority in section 1902(a)(4).

(2) Section 1903(m) contains requirements that apply to comprehensive risk contracts.

(3) Section 1903(m)(2)(H) provides that an enrollee who loses Medicaid eligibility for not more than 2 months may be enrolled in the succeeding month in the same MCO or PCCM if that MCO or PCCM still has a contract with the State.

(4) Section 1905(t) contains requirements that apply to PCCMs.

(5) Section 1932—

(i) Provides that, with specified exceptions, a State may require Medicaid beneficiaries to enroll in MCOs or PCCMs;

(ii) Establishes the rules that MCOs, PCCMs, the State, and the contracts between the State and those entities must meet, including compliance with requirements in sections 1903(m) and 1905(t) of the Act that are implemented in this part;

(iii) Establishes protections for enrollees of MCOs and PCCMs;

(iv) Requires States to develop a quality assessment and performance improvement strategy;

(v) Specifies certain prohibitions aimed at the prevention of fraud and abuse;

(vi) Provides that a State may not enter into contracts with MCOs unless it has established intermediate sanctions that it may impose on an MCO that fails to comply with specified requirements; and

(vii) Makes other minor changes in the Medicaid program.

(b) *Scope.* This part sets forth requirements, prohibitions, and procedures for the provision of Medicaid services through MCOs, PIHPs, PAHPs, and PCCMs. Requirements vary depending on the type of entity and on the authority under which the State contracts with the entity. Provisions that apply only when the contract is under a mandatory managed care program authorized by section 1932(a)(1)(A) of the Act are identified as such.

§438.2 Definitions.

As used in this part—

Capitation payment means a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan.

The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Comprehensive risk contract means a risk contract 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) Rural health clinic services.

(3) FQHC services.

(4) Other laboratory and X-ray services.

(5) Nursing facility (NF) services.

(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.

(7) Family planning services.

(8) Physician services.

(9) Home health services.

Federally qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Health care professional means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, **licensed nurse midwife,** and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health insuring organization (*HIO*) means 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(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

***LEP* means Limited English Proficiency, as defined by the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003).**

Managed care organization (*MCO*) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, 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 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 §438.116.

Nonrisk contract means a contract 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 §447.362 of this chapter; 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.

Prepaid ambulatory health plan (PAHP) means an entity that—

(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary care case management means a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to Medicaid beneficiaries.

Primary care case manager (PCCM) means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

(1) A physician assistant.

(2) A nurse practitioner.

(3) A certified nurse-midwife.

Risk contract means a contract 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.

§438.6 Contract requirements.

(a) *Regional office review.* The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in §438.806.

(b) *Entities eligible for comprehensive risk contracts.* A State agency may enter into a comprehensive risk contract only with the following:

(1) An MCO.

(2) The entities identified in section 1903(m)(2)(B)(i), (ii), and (iii) of the Act.

(3) Community, Migrant, and Appalachian Health Centers identified in section 1903(m)(2)(G) of the Act. Unless they qualify for a total exemption under section 1903(m)(2)(B) of the Act, these entities are subject to the regulations governing MCOs under this part.

(4) An HIO that arranges for services and became operational before January 1986.

(5) An HIO described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990).

(c) *Payments under risk contracts—*

(1) *Terminology.* As used in this paragraph, the following terms have the indicated meanings:

(i) *Actuarially sound capitation rates* means capitation rates that—

(A) Have been developed in accordance with generally accepted actuarial principles and practices;

(B) Are appropriate for the populations to be covered, and the services to be furnished under the contract;

~~And(~~**(C)** Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board**; and**

(D) Are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that care and services are available to the extent that such care and services are available to the general population in the geographic area.

(ii) *Adjustments to smooth data* means adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

(iii) *Cost neutral* means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

(iv) *Incentive arrangement* means any payment mechanism under which a contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

(v) *Risk corridor* means a risk sharing mechanism in which States and contractors share in both profits and losses under the contract outside of predetermined threshold amount, so that after an initial corridor in which the contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.

(2) *Basic requirements.*

(i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.

(ii) The contract must specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

(3) *Requirements for actuarially sound rates.* In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

(ii) Adjustments made to smooth data and adjustments to account for factors such as medical trend inflation, incomplete data, MCO, PIHP, or PAHP administration (subject to the limits in paragraph (c)(4)(ii) of this section), and utilization;

(iii) Rate cells specific to the enrolled population, by—

(A) Eligibility category;

(B) Age;

(C) Gender;

(D) Locality/region; and

(E) Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

(v) For rates covering CYs 2013 and 2014, complying with minimum payment for physician services under paragraph (c)(5)(vi) of this section, and part 447, subpart G, of this chapter.

(4) *Documentation.* The State must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—

(A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

(iii) The State's projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.

(iv) An explanation of any incentive arrangements, or stop-loss, reinsurance, or any other risk-sharing methodologies under the contract.

(v) Documentation showing the actuary's methodology and assumptions and the data on which the actuarial determination of rates was made, sufficient to enable a reviewing actuary to verify the soundness of the rates.

(5) *Special contract provisions.*

(i) Contract provisions for reinsurance, stop-loss limits or other risk-sharing methodologies must be computed on an actuarially sound basis.

(ii) If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for MCO, PIHP, or PAHP administrative costs directly related to the provision of these services.

(iii) Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound.

(iv) For all incentive arrangements, the contract must provide that the arrangement is—

(A) For a fixed period of time;

(B) Not to be renewed automatically;

(C) Made available to both public and private contractors;

(D) Not conditioned on intergovernmental transfer agreements; and

(E) Necessary for the specified activities and targets.

(v) If a State makes payments to providers for graduate medical education (GME) costs under an approved State plan, the State must adjust the actuarially sound capitation rates to account for the GME payments to be made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State plan for FFS. States must first establish actuarially sound capitation rates prior to making adjustments for GME.

(vi) For CYs 2013 and 2014, and payments to an MCO, PIHP or PAHP for primary care services furnished to enrollees under part 447, subpart G, of this chapter, the contract must require that the MCO, PIHP or PAHP meet the following requirements:

(A) Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under part 447, subpart G, of this chapter.

(B) Provide documentation to the State, sufficient to enable the State and CMS to ensure that provider payments increase as required by paragraph (c)(5)(vi)(A) of this section.

(d) *Enrollment discrimination prohibited.* Contracts with MCOs, PIHPs, PAHPs, and PCCMs must provide as follows:

(1) The MCO, PIHP, PAHP, or PCCM accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by the Regional Administrator), up to the limits set under the contract.

(2) Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in §438.50(a).

(3) The MCO, PIHP, PAHP, or PCCM will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

(4) The MCO, PIHP, PAHP, or PCCM will not discriminate against individuals eligible to enroll on the basis of race, color, ~~or~~ national origin, **language, disability, age, sex, sexual orientation, or gender identity,** and will not use any policy or practice that has the effect of discriminating on the basis of race, color, ~~or~~ national origin**, language, disability, age, sex, sexual orientation, or gender identity**. **The MCO, PIHP, PAHP, or PCCM will comply with the requirements of section 1557 of the Affordable Care Act.**

(e) *Services that may be covered.* An MCO, PIHP, or PAHP contract may cover, for enrollees, services that are in addition to those covered under the State plan, although the cost of these services cannot be included when determining the payment rates under §438.6(c).

(f) *Compliance with contracting rules.* All contracts must meet the following provisions:

(1) Comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; **section 1557 of the Affordable Care Act,** and the Americans with Disabilities Act of 1990 as amended.

(2) Provide for the following:

(i) Compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in §434.6(a)(12) and §447.26 of this subchapter.

(ii) Reporting all identified provider-preventable conditions in a form or frequency as may be specified by the State.

(3) Meet all the requirements of this section.

(g) *Inspection and audit of financial records.* Risk contracts must provide that the State agency and the Department may inspect and audit any financial records of the entity or its subcontractors.

(h) *Physician incentive plans.* (1) MCO, PIHP, and PAHP contracts must provide for compliance with the requirements set forth in §§422.208 and 422.210 of this chapter.

(2) In applying the provisions of §§422.208 and 422.210 of this chapter, references to “M+C organization”, “CMS”, and “Medicare beneficiaries” must be read as references to “MCO, PIHP, or PAHP”, “State agency” and “Medicaid beneficiaries”, respectively.

(i) *Advance directives.* (1) All MCO and PIHP contracts must provide for compliance with the requirements of §422.128 of this chapter for maintaining written policies and procedures for advance directives.

(2) All PAHP contracts must provide for compliance with the requirements of §422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in §489.102(a) of this chapter.

(3) The MCO, PIHP, or PAHP subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law.

(4) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

(j) *Special rules for certain HIOs.* Contracts with HIOs that began operating on or after January 1, 1986, and that the statute does not explicitly exempt from requirements in section 1903(m) of the Act, are subject to all the requirements of this part that apply to MCOs and contracts with MCOs. These HIOs may enter into comprehensive risk contracts only if they meet the criteria of paragraph (a) of this section.

(k) *Additional rules for contracts with PCCMs.* A PCCM contract must meet the following requirements:

(1) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(2) Restrict enrollment to beneficiaries who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(3) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(4) Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the beneficiary's health status or need for health care services.

(5) Provide that enrollees have the right to disenroll from their PCCM in accordance with §438.56(c).

(l) *Subcontracts.* All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

(m) *Choice of health professional.* The contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

[67 FR 41095, June 14, 2002, as amended at 76 FR 32837, June 6, 2011; 77 FR 66699, Nov. 6, 2012]

§438.8 Provisions that apply to PIHPs and PAHPs.

(a) The following requirements and options apply to PIHPs **and PAHPs**, PIHP **and PAHP** contracts, and States with respect to PIHPs **and PAHPs**, to the same extent that they apply to MCOs, MCO contracts, and States for MCOs.

(1) The contract requirements of §438.6, except for requirements that pertain to HIOs **and, in the case of PAHPs that do not include any of the providers listed in §489.102 of this chapters except for advanced directives**.

(2) The information requirements in §438.10.

(3) The provision against provider discrimination in §438.12.

(4) The State responsibility provisions of subpart B of this part ~~except §438.50.~~

(5) The enrollee rights and protection provisions in subpart C of this part.

(6) The quality assessment and performance improvement provisions in subpart D of this part to the extent that they are applicable to services furnished by the PIHP **or PAHP**.

(7) The grievance system provisions in subpart F of this part.

(8) The certification and program integrity protection provisions set forth in subpart H of this part.

~~(b) The following requirements and options for PAHPs apply to PAHPs, PAHP contracts, and States.~~

~~(1) The contract requirements of §438.6, except requirements for—~~

~~(i) HIOs.~~

~~(ii) Advance directives (unless the PAHP includes any of the providers listed in §489.102) of this chapter.~~

~~(2) All applicable portions of the information requirements in §438.10.~~

~~(3) The provision against provider discrimination in §438.12.~~

~~(4) The State responsibility provisions of subpart B of this part except §438.50.~~

~~(5) The provisions on enrollee rights and protections in subpart C of this part.~~

~~(6) Designated portions of subpart D of this part.~~

~~(7) An enrollee's right to a State fair hearing under subpart E of part 431 of this chapter.~~

(~~8~~**9**) Prohibitions against affiliations with individuals debarred by Federal agencies in §438.610.

[67 FR 41095, June 14, 2002, as amended at 67 FR 65505, Oct. 25, 2002]

§438.10 Information requirements.

(a) *Terminology.* As used in this section, the following terms have the indicated meanings:

Enrollee means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

Potential enrollee means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(b) *Basic rules.*

(1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all **information to enrollees and potential enrollees, including** enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees, in a manner and format that may be easily understood.

(2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.

(3) Each MCO, PIHP, **PAHP, and PCCM** must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(c) *Language.* The State must do the following:

(1) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State **and in each service MCO, PIHP, PAHP, and PCCM's area**. "Prevalent" means a non-English language spoken by ~~a significant number or percentage~~ **500 or 5%** of potential enrollees and enrollees in the State.

(2) Make available **competent translation of** written information in each prevalent non-English language. **Written information can be created in each non-English language or translated from English.**

(3) Require each MCO, PIHP, PAHP, and PCCM to make its written information available in the prevalent non-English languages in its particular service area. **All written information and notices must include taglines in at least 15 languages and large print informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.**

(4) Make **competent** oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.

(5) Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—

(i) That oral interpretation is available for any language and written information is available in prevalent languages; and

(ii) How to access those services.

(6) Make all information available in alternative formats accessible for people with disabilities. All notices and written information must include a large print tagline and information on how to request the notice in alternative formats.

(7) Require each MCO, PIHP, PAHP, and PCCM to include a large print tagline and information on how to request the notice in alternative formats.

(8) For the purpose of this section, competence is defined by the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003).

(d) *Format.*

(1) Written material must—

(i) Use easily understood language and format; and

(ii) **Comply with the standards set forth in § 438.70.**

~~(ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.~~

(2) **The State must inform** ~~All~~ enrollees and potential enrollees **that information is available in alternative formats and how to obtain information in the appropriate format. It must also** ~~must be informed~~ **require each MCO, PIHP, PAHP, and PCCM to provide notice to its enrollees and potential enrollees** that information is available in alternative formats and how to ~~access those~~ **obtain information in the appropriate** formats.

(e) *Information for potential enrollees.*

(1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:

(i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program;

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHPs, PAHPs, or PCCMs; **and**

(iii) By making the information available through a website that is accessible to the public.

(2) The information for potential enrollees must include the following:

(i) General information about—

(A) The basic features of managed care;

(B) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; ~~and~~

(C) MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care;

(D) The State's standards for access to care that must be developed pursuant to 42 U.S.C. § 1396u-2(c)(1)(A);

(E) Information related to external quality review, as required by § 438.364(b);

(ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area **including:** ~~A summary of the following information is sufficient, but the State must provide more detailed information upon request:~~

(A) Benefits covered.

(B) Cost sharing, if any.

(C) Service area.

(D) **Provider information including:**

(i) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers **and**

(ii) ~~, and including i~~**I**dentification of **current contracted** providers **and indication of whether they are** accepting new patients.

For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals.

(E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service. **The MCO, PIHP, PAHP, or PCCM must inform potential enrollees where and how to obtain this information from the State.**

(F) The State's strategy for assessing, reviewing, and improving the quality of managed care services offered by MCOs and PIHPs as set forth in § 438.202(a).

(f) *General information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs.* Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows:

(1) The State must notify all enrollees of their disenrollment rights **at the time a potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program**, and, at a minimum, annually **thereafter**. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.

(2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must **furnish to** ~~notify~~ all enrollees ~~of their right to request and obtain~~ the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year.

(3) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the beneficiary's enrollment.

(4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change**.**

(5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(6) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees:

(i) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes, at a minimum, information on primary care physicians, specialists, and hospitals.

(ii) Any restrictions on the enrollee's freedom of choice among network providers.

(iii) Enrollee rights and protections, as specified in §438.100.

(iv) Information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in §438.10(g)(1), and for PAHP enrollees, the information specified in §438.10(h)(1).

(v) 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**, including prescription drugs, mental health and substance use services, and long term services and supports**.

(vi) Procedures for obtaining benefits, including authorization requirements **and factors such as physical accessibility and non-English languages spoken.**

(vii) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.

(viii) The extent to which, and how, after-hours and emergency coverage are provided, including:

(A) What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in §438.114(a).

(B) The fact that prior authorization is not required for emergency services.

(C) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.

(D) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the contract.

(E) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.

(ix) The post-stabilization care services rules set forth at §422.113(c) of this chapter.

(x) Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

(xi) Cost sharing, if any.

(xii) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, **the MCO, PIHP, PAHP, or PCCM must inform enrollees that the services are not covered. T**he State must provide information on how and where to obtain the service and the **MCO, PIHP, PAHP, or PCCM must inform enrollees how they can to obtain information from the State about how to access those services.**

(xiii) Information on how to obtain continued services during a transition, as provided in § 438.62.

(xiv) Information related to external quality review, as set forth in § 438.364(b).

(xv) The State's standards for access to care that must be developed pursuant to 42 U.S.C. § 1396u-2(c)(1)(A).

(xvi) Information related to utilization review, including clinical coverage guidelines.

(xvii) How to request information in non-English languages or alternative formats.

(xviii) How to request auxiliary aids and services.

(xiv) Additional information that is available upon request and how to request that information.

(7) In all cases, If the State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM knows or has reason to know that an enrollee is LEP, the notice must be provided in the enrollee's non-English language. If the State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM knows or has reason to know that the enrollee has a disability that requires an alternative format for notices, an overview of the information must be provided in that alternate format.

(8) In addition to furnishing the information described in this subsection directly to enrollees, the State, its contracted representative, and the MCO, PIHP, PAHP, or PCCM (as applicable) must post the information on a website that is accessible to the public.

(g) *Specific information requirements for enrollees of MCOs, PIHPs, **and PAHPs**.* In addition to the requirements in §438.10(f), the State, its contracted representative, or the MCO, PIHP, ***and PAHPs*** must provide the following information to their enrollees **at least annually and make the information available by posting on a website that is accessible to the public**:

(1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§438.400 through 438.424, in a State-developed or State-approved description, that must include the following:

(i) For State fair hearing—

(A) The right to hearing;

(B) The method for obtaining a hearing; and

(C) The rules that govern representation at the hearing.

(ii) The right to file grievances and appeals.

(iii) The requirements and timeframes for filing a grievance or appeal.

(iv) The availability of assistance in the filing process.

(v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.

(vi) The fact that, when requested by the enrollee—

(A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and

(B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

(vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

(2) Advance directives, as set forth in §438.6(i)(2). **This provision shall apply to a PAHP to the extent that the PAHP includes any of the providers listed in §489.102(a) of this chapter.**

(3) Additional information that is available upon request, including the following:

(i) Information on the structure**,** ~~and~~ operation**, licensure, certification, and accreditation standards** of the MCO, PIHP, **or PAHPs**.

(ii) **Information about contracted health care professionals, including but not limited to education, licensure, and Board certification or recertification.**

(iii) Physician incentive plans as set forth in §438.6(h) of this chapter.

(iv) Summary description of the method of compensation for physicians.

(v) The procedures MCOs, PIHPs, or PAHPs use to control utilization of services or expenditures including all clinical coverage standards.

(vi) Information on the financial condition of MCOs, PIHPs, or PAHPs, including the most recently audited information.

(vii) Information related to external quality review, as set forth in § 438.364(b)

(viii) The State's standards for access to care that must be developed pursuant to 42 U.S.C. § 1396u-2(c)(1)(A).

(ix) The State's strategy for assessing, reviewing, and improving the quality of managed care services offered by MCOs, PAHPs, and PIHPs as set forth in § 438.202(a).

(x) Any element of information specified in paragraphs (f), (g), (h), or (i).

(4) Additional information for individuals who are LEP or have disabilities.

(i) If the State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM knows or has reason to know that the enrollee is LEP, an overview of the information must be provided in the enrollee's non-English language and information on how to access all of the information in the enrollee's language. Otherwise, the information must comply with § 438.70.

(ii) If the State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM knows or has reason to know that the enrollee has a disability that requires an alternative format for notices, an overview of the information must be provided in that alternate format. Otherwise, the information must comply with § 438.70.

~~(h) *Specific information for PAHPs.* The State, its contracted representative, or the PAHP must provide the following information to their enrollees **annually and by posting on a website.**:~~

~~(1) The right to a State fair hearing, including the following:~~

~~(i) The right to a hearing.~~

~~(ii) The method for obtaining a hearing.~~

~~(iii) The rules that govern representation.~~

~~(2) Advance directives, as set forth in §438.6(i)(2), to the extent that the PAHP includes any of the providers listed in §489.102(a) of this chapter.~~

~~(3) Upon request, physician incentive plans as set forth in §438.6(h).~~

(~~i~~**h**) *Special rules: States with mandatory enrollment under State plan authority*.

(1) *Basic rule.* If the State plan provides for mandatory enrollment under § 438.50, the State or its contracted representative must provide information on MCOs**, PIHPs, PAHPs,** and PCCMs (as specified in paragraph (i)(3) of this section), either directly or through the MCO**, PIHPs, PAHPs,** or PCCM.

(2) *When and how the information must be furnished.* The information must be furnished as follows:

(i) For potential enrollees, within the timeframe specified in § 438.10(e)(1).

(ii) For enrollees, **upon enrollment,** annually and upon request.

(iii) In a comparative, chart-like format.

(iv) By posting on a website that is accessible to the public.

(3) *Required information.* Some of the information is the same as the information required for potential enrollees under paragraph (e) of this section and for enrollees under paragraph (f) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (i)(2) of this section, and includes the following for each contracting MCO or PCCM in the potential enrollees and enrollee's service area:

(i) The MCO's or PCCM's service area.

(ii) The benefits covered under the contract.

(iii) Any cost sharing imposed by the MCO or PCCM.

(iv) To the extent available, quality and performance indicators, including enrollee satisfaction.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§438.12 Provider discrimination prohibited.

(a) *General rules.*

(1) An MCO, PIHP, or PAHP may not discriminate for the participation, reimbursement, or indemnification of any provider 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. If an MCO, PIHP, or PAHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with health care professionals, an MCO, PIHP, or PAHP must comply with the requirements specified in §438.214.

(b) *Construction.* Paragraph (a) of this section may not be construed to—

(1) Require the MCO, PIHP, or PAHP to contract with providers beyond the number necessary to meet the needs of its enrollees;

(2) Preclude the MCO, PIHP, or PAHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(3) Preclude the MCO, PIHP, or PAHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

Subpart B—State Responsibilities

§ 438.50 State Plan requirements.

(a) General rule. A State plan that requires Medicaid beneficiaries to enroll in managed care entities must comply with the provisions of this section, except when the State imposes the requirement—

(1) As part of a demonstration project under section 1115 of the Act; or

(2) Under a waiver granted under section 1915(b) of the Act.

(b) State plan information. The plan must specify—

(1) The types of entities with which the State contracts;

(2) The payment method it uses (for example, whether fee-for-service or capitation);

(3) Whether it contracts on a comprehensive risk basis; and

(4) The process the State uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the State plan has been implemented.

(c) State plan assurances. The plan must provide assurances that the State meets applicable requirements of the following statute and regulations:

(1) Section 1903(m) of the Act, for MCOs and MCO contracts.

(2) Section 1905(t) of the Act, for PCCMs and PCCM contracts.

(3) Section 1932(a)(1)(A) of the Act, for the State's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities.

(4) This part, for MCOs**, PIHPs, PAHPs,** and PCCMs.

(5) Part 434 of this chapter, for all contracts.

(6) Section 438.6(c), for payments under any risk contracts, and § 447.362 of this chapter for payments under any nonrisk contracts.

(d) Limitations on enrollment. The State must provide assurances that, in implementing the State plan managed care option, it will not require the following groups to enroll in an MCO, **PIHP, PAHP,** or PCCM:

(1) Beneficiaries who are also eligible for Medicare.

(2) Indians who are members of Federally recognized tribes, except when the MCO **PIHP, PAHP,** or PCCM is—

(i) The Indian Health Service; or

(ii) An Indian health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

(3) Children under 19 years of age who are—

(i) Eligible for SSI under title XVI;

(ii) Eligible under section 1902(e)(3) of the Act;

(iii) In foster care or other out-of-home placement;

(iv) Receiving foster care or adoption assistance; or

(v) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms of either program participation or special health care needs.

(e) Priority for enrollment. The State must have an enrollment system under which beneficiaries already enrolled in an MCO **PIHP, PAHP,** or PCCM are given priority to continue that enrollment if the MCO **PIHP, PAHP,** or PCCM does not have the capacity to accept all those seeking enrollment under the program.

(f) Enrollment by default.

(1) For beneficiaries who do not choose an MCO **PIHP, PAHP,** or PCCM during their enrollment period, the State must have a default enrollment process for assigning those beneficiaries to contracting MCOs **PIHPs, PAHPs,** and PCCMs.

(2) The process must seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid beneficiaries. **If the recipient has more than one existing provider of Medicaid services, the process should seek to preserve existing relationships to the greatest extent possible.** If that is not possible, the State must distribute the beneficiaries equitably among qualified MCOs **PIHPs, PAHPs,** and PCCMs available to enroll them, excluding those that are subject to the intermediate sanction described in § 438.702(a)(4).

(3) An "existing provider-recipient relationship" is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

(4) A provider is considered to have "traditionally served" Medicaid beneficiaries if it has experience in serving the Medicaid population.

(5) A recipient shall not be enrolled by default into an MCO or PCCM that refuses to cover all Medicaid services in the State plan.

§438.52 Choice of MCOs, PIHPs, PAHPs, and PCCMs.

(a) *General rule.* Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities. **At least one of those entities must cover the full range of reproductive health services covered in the State plan, to the extent that reproductive health services fall within the scope of services for which the entity is responsible.**

(b) *Exception for rural area residents.*

(1) Under any of the following programs, and subject to the requirements of paragraph (b)(2) of this section, a State may limit a rural area resident to a single MCO, PIHP, PAHP, or PCCM system:

(i) A program authorized by a plan amendment under section 1932(a) of the Act.

(ii) A waiver under section 1115 of the Act.

(iii) A waiver under section 1915(b) of the Act.

(2) A State that elects the option provided under paragraph (b)(1) of this section, must permit the beneficiary—

~~(i) T~~ **to** choose from at least two physicians or case managers~~.; and~~

~~(ii) To obtain services from any other provider under any of the following circumstances:~~

~~(A) The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, PAHP, or PCCM network.~~

~~(B) The provider is not part of the network, but is the main source of a service to the beneficiary, provided that—~~

~~(*1*) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO, PIHP, PAHP, or PCCM network as other network providers of that type.~~

~~(*2*) If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 days (after being given an opportunity to select a provider who participates).~~

~~(C) The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks.~~

~~(D) The beneficiary's primary care provider or other provider determines that the beneficiary needs related services that would subject the beneficiary to unnecessary risk~~

~~if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.~~

~~(E) The State determines that other circumstances warrant out-of-network treatment.~~

(3) As used in this paragraph, "rural area" is any area other than an "urban area" as defined in §412.62(f)(1)(ii) of this chapter.

(c) *Exception for certain health insuring organizations (HIOs).* The State may limit beneficiaries to a single HIO if—

(1) The HIO is one of those described in section 1932(a)(3)(C) of the Act; and

(2) The beneficiary who enrolls in the HIO has a choice of at least two primary care providers within the entity.

(d) *Limitations on changes between primary care providers.* For an enrollee of a single MCO, PIHP, PAHP, or HIO under paragraph (b) or (c) of this section, any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under §438.56(c).

(e) *Time allotted for choice of* MCO, PIHP, PAHP, and PCCM*. When enrollees are given a choice of plans in which to enroll and will be automatically enrolled if they make no selection, they must be allowed at least 45 days to make a plan selection.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§ 438.56 Disenrollment: Requirements and limitations.

(a) *Applicability*. The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) *Disenrollment requested by the MCO, PIHP, PAHP, or PCCM.* All MCO, PIHP, PAHP, and PCCM contracts must—

(1) Specify the reasons for which the MCO, PIHP, PAHP, or PCCM may request disenrollment of an enrollee;

(2) Provide that the MCO, PIHP, PAHP, or PCCM may not request disenrollment for any of the following reasons: (1) an adverse change in the enrollee's health status; (ii) the enrollee's utilization of medical services; (iii) diminished mental capacity; or (iv) uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); ~~and~~

(3) Provide that the MCO, PIHP, PAHP, or PCCM may not request disenrollment because of an enrollee's race, color, national origin, disability, age, sex, gender identity, or sexual orientation; and

(4) Specify the methods by which the MCO, PIHP, PAHP, or PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(c) *Reasons for disenrollment*.

(1) The State agency or MCO, PIHP, PAHP, or PCCM shall disenroll any enrollee from a plan when one of the following conditions is met:

(i) An enrollee's Medicaid eligibility is terminated.

(ii) The State agency (or agent) incorrectly enrolled or assigned an enrollee to a plan not of his/her choosing, as indicated on the enrollment request form completed by beneficiary.

(iii) An enrollee was enrolled in the plan due to incorrect information provided by the State agency or due to prohibited marketing practices by the plan.

(iv) An enrollee's request for disenrollment is due to plan merger or reorganization.

(v) There is a change of an enrollee's place of residence to outside the plan's service area.

(vi) An enrollee requests the disenrollment for any reason and the request is not made during any restricted disenrollment period for that enrollee.

(vii) An enrollee requests disenrollment for good cause, as specified in paragraph (e)(2) below, when the request is made during any restricted disenrollment period for the enrollee.

(viii) An enrollee requests disenrollment for one of the reasons specified for exemption from plan enrollment in § 438.57 and meets the criteria specified in that section.

(ix) An enrollee meets the criteria for expedited disenrollment in accordance with subsection (c).

(x) An enrollee becomes enrolled in other health coverage, except that dual enrollment is permitted if a recipient is enrolled in other coverage in an MCO and

(A) The Medicaid plan in which the eligible recipient is enrolling is the same as the MCO in which the recipient is enrolled, and

(B) Such enrollment is allowed in the contract between the plan and the department.

(2) In a system in which enrollment in a plan is mandatory, the State shall provide enrollees with the information necessary to change their enrollment to another plan. An enrollee who does not select the competing plan shall be assigned another plan, in accordance with § 438.57. If a competing plan is at enrollment capacity, fee-for-service Medicaid shall be made available to the eligible recipient. Enrollees may disenroll from their plans into fee-for-service Medicaid when they: (i) meet the criteria in § 438.57 for exemption from plan enrollment or (ii) are eligible for voluntary enrollment.

(**d) *Limits on disenrollment* - If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, and PCCM contracts must provide that a recipient may request disenrollment as follows:**

(1) For good cause, at any time, as described in (e)(2) below.

(2) Without good cause, at the following times:

(i) At any time during the 90 days following the date of the recipient's initial enrollment with the MCO, PIHP, PAHP, or PCCM, or the date the State sends the recipient notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment under paragraph (h) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

(iv) When the State imposes the intermediate sanction specified in § 438.702(a)(3).

(e) ***Procedures for disenrollment***—(1) Request for disenrollment. The recipient (or his or her representative) must submit an oral or written request **either —**

(i) To the State agency (or its agent); or

(ii) To the MCO, PIHP, PAHP, or PCCM, if the State permits MCOs, PIHP, PAHPs, and PCCMs to process disenrollment requests.

(iii) Expedited disenrollment requests may also be submitted by facsimile, via a dedicated website, or over the telephone to the State agency (or its agent).

(2) ***Good** Cause for disenrollment*. The following are **good** cause for disenrollment:

(i) The enrollee moves out of the MCO's, PIHP's, PAHP's, or PCCM's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) The enrollee requires Medicaid services that are excluded under the terms of the plan's contract and which can be obtained only if the member disenrolls from the plan.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers or specialists experienced in dealing with the enrollee's health care needs.

(v) The enrollee requests the disenrollment because of an irreconcilable breakdown in the physician-patient relationship and has used the plan's problem resolution process. Documentation of the irreconcilable breakdown in the patient-physician relationship, including the use of the plan's problem resolution process, must be submitted with the disenrollment request by the recipient, the recipient's authorized representative or the plan.

(vi) The enrollee meets the criteria in § 438.57 for exemption from plan enrollment.

(vii) The enrollee or plan requests the disenrollment for any other reasons determined by the State agency to constitute good cause.

(3) *MCO, PIHP, PAHP, or PCCM action on request.*

(i) An MCO, PIHP, PAHP, or PCCM **must** either approve a request for disenrollment or refer the request to the State**, including expedited disenrollment requests, within two working days of receipt if such requests meet the conditions for plan disenrollment specified in subsection (c) above.**

(ii) If the MCO, PIHP, PAHP, PCCM, or State agency (whichever is responsible) fails to make a disenrollment determination so that the recipient can be disenrolled within the timeframes specified in paragraph (f)(1) of this section, the disenrollment is considered approved.

(4) *State agency action on request*. For a request received directly from the recipient, or one referred by the MCO, PIHP, PAHP, or PCCM, the State agency must take action to approve or disapprove the request based on the following:

(i) Reasons cited in the request.

(ii) Information provided by the MCO, PIHP, PAHP, or PCCM at the agency's request.

(iii) Any of the reasons specified in paragraph (e)(2) of this section.

(5) Use of the MCO, PIHP, PAHP, or PCCM grievance procedures.

(i) The State agency may require that the enrollee seek redress through the MCO, PIHP, PAHP, or PCCM's grievance system before making a determination on the enrollee's request.

(ii) The grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in § 438.56(f)(1).

(iii) If, as a result of the grievance process, the MCO, PIHP, PAHP, or PCCM approves the disenrollment, the State agency is not required to make a determination.

(6) *Enrollment and disenrollment forms*

(i) The State agency shall make an enrollment/disenrollment form available in information packets mailed to mandatory eligible beneficiaries, at the enrollment presentations, by posting on a website that is accessible to the public, and at agency approved sites. The State agency or MCO, PIHP, PAHP, or PCCM shall mail the enrollment/disenrollment form to a recipient within three working days of receiving a telephone or written request for a form.

(ii) Plans shall make an enrollment/disenrollment form available at member services departments, by posting on a website that is accessible to the public, and shall mail the form to a recipient within three working days of receiving a telephone or written request for a form.

(f) *Timeframe for disenrollment determinations.*

(1) Regardless of the procedures followed, 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 or the MCO, PIHP, PAHP, or PCCM files the request**, unless there the disenrollment request is urgent and meets the criteria for an "expedited" disenrollment under paragraph (g) .**

(2) If the MCO, PIHP, PAHP, or PCCM or the State agency (whichever is responsible) fails to make the determination within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(3) The MCO, PIHP, PAHP, or PCCM shall notify beneficiaries in writing of the approval or disapproval of enrollment and disenrollment requests, including expedited disenrollment requests, within seven working days of receipt of the request. This notice shall include the effective date of the enrollment and/or disenrollment.

(g) *Expedited disenrollment*. Expedited disenrollment requests shall be effective on the first day of the month in which the request is processed. The State agency shall process all completed disenrollment requests as expedited disenrollments if they meet the following criteria and any required supporting documentation is provided:

(1) The recipient is an American Indian, a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from the Indian Health Service facility for care on a fee-for-service basis.

(2) The recipient is receiving services under a federal foster care or adoption assistance program or has been placed in the care of a child protective services agency. The disenrollment request must be submitted by the authorized foster parent, the authorized adoptive parent, or the licensed agency providing protective services.

(3) The beneficiary has a complex medical condition, specified in § 438.57, and the disenrollment request is submitted with verification of the medical condition, treatment plan, and duration of treatment by the Medi-Cal fee-for-service physician.

(4) The recipient is enrolled in a Medicaid home and community-based waiver program under 1915(c) or State plan option under 1915(i). Verification of participation in the waiver program must be submitted with the disenrollment request by the recipient or the recipient's authorized representative as specified in (h).

(5) The State agency incorrectly enrolled or assigned the eligible recipient to a plan not chosen by the recipient, as determined by the State agency, the recipient or the plan and verified by the State agency. An explanation of the incorrect enrollment or assignment must be submitted with the disenrollment request by the recipient or the recipient's authorized representative.

(6) The recipient submitted a non-expedited disenrollment request that meets the requirements for disenrollment or a request for exemption from plan enrollment based upon a qualifying complex medical condition that was not timely processed by the State agency. An explanation of the lack of timely processing must be submitted with the disenrollment request by the recipient or the recipient's authorized representative.

(7) The recipient has moved or been placed outside of the plan service area and has notified his or her caseworker of the new address. If the recipient's new address is not yet shown in the Medicaid Eligibility Data System, the recipient is responsible for requesting that the caseworker provide verification of the new address to the State agency by telephone, facsimile, or in writing.

(8) The recipient or plan has experienced an irreconcilable breakdown in the patient-physician relationship, has used the plan's internal grievance procedure, and the State agency has approved the disenrollment. Documentation of the irreconcilable breakdown in the patient-physician relationship, including the use of the plan's problem resolution process, must be submitted with the disenrollment request by the recipient, the recipient's authorized representative as specified in (h), or the plan. Use of the plan's problem resolution process shall not be required in situations where a recipient's behavior presents physical risk to plan staff, a provider, or staff at a provider site, and the plan or provider has filed a police report regarding the physical risk.

(9) The recipient was enrolled in the plan due to incorrect information provided by the State agency or due to prohibited marketing practices by the plan, as determined by the State agency, the recipient or the plan and verified by the State agency. Explanation of the incorrect information or the prohibited marketing practices must be submitted with the disenrollment request by the recipient or the recipient's authorized representative.

(10) The recipient requires nursing facility services, other than enrollees requesting hospice services, has been admitted to a long-term care facility and will remain in long-term care for more than two consecutive months. The name of the long-term care facility and the date of admission must be submitted with the disenrollment request by the recipient or the recipient's authorized representative.

(11) The recipient is deceased, and the death is not yet reflected in the Medicaid Eligibility Data System. A copy of the death certificate must be submitted with the disenrollment request by the recipient's authorized representative.

(~~g~~**h**) *Notice and appeals*. A State that restricts disenrollment under this section must take the following actions:

(1) Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period.

(2) Ensure access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment.

(~~h~~**i**) *Automatic reenrollment*: *Contract requirement*. If the State plan so specifies, the contract must provide for automatic reenrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of ~~2 months~~ **30 days** or less.

§ 438.57 Exemption from Plan Enrollment (*new section*)

(a) *General requirements.* In such States where mandatory enrollment in Medicaid managed care exists, an eligible recipient, who satisfies the requirements in (1), (2), or (3) below, may request fee-for-service Medicaid for up to 12 months as an alternative to plan enrollment, by submitting a request for exemption from plan enrollment to the State agency as specified in (b) below.

(1) An eligible recipient who is an American Indian as specified in §438.56(g), a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis.

(2) An eligible recipient who is receiving fee-for-service Medicaid treatment or services for a complex medical condition, from any provider who is participating in the Medicaid program but is not a contracting provider of a plan in the eligible recipient's county of residence, may request a medical exemption to continue fee-for-service Medicaid for purposes of continuity of care.

(i) *Complex medical conditions.* For purposes of this section, conditions meeting the criteria for a complex medical condition include, but are not limited to, the following:

(A) An eligible recipient is pregnant.

(B) An eligible recipient is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this section.

(C) An eligible recipient is receiving chronic renal dialysis treatment.

(D) An eligible recipient has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS).

(E) An eligible recipient has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy.

(F) An eligible recipient has been approved for a major surgical procedure by the fee-for-service Medicaid program and is awaiting surgery or is immediately post-operative.

(G) An eligible recipient has a complex neurological disorder, such as multiple sclerosis, a complex hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in (A) through (D) above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be interrupted.

(H) The recipient is enrolled in a Medicaid home and community-based waiver program under 1915(c) or a State plan option under 1915(i) and enrollment in a plan would jeopardize the recipient's ability to live in the community). Verification of participation in the waiver program or State plan option must be submitted with the disenrollment request by the recipient or the recipient's authorized representative as specified in (h).

(i) A request for exemption from plan enrollment based on complex medical conditions shall not be approved for an eligible recipient who has: (i) Been a enrollee of either plan on a combined basis for more than 180 consecutive calendar days, (ii) A current Medicaid provider that the recipient is seeking to continue care with and was a main source of Medicaid services for the recipient during any time in the previous year who is contracting with another plan available to the recipient, or (iii) Has already begun treatment after the date of plan enrollment.

(3) Except for pregnancy, any eligible recipient granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and begin receiving care from a plan provider without deleterious medical effects, as determined by a recipient's treating physician in the Medicaid fee-for-service program, up to 12 months from the date the medical exemption is first approved by the State agency. A recipient granted a medical exemption due to pregnancy may remain with the fee-for-service Medicaid provider through delivery and the end of the month in which 90 days post-partum occurs.

(4) Any extension to the 12-month medical exemption time limit shall be requested through the State agency no earlier than 11 months after the starting date of the exemption currently in effect. The State agency will notify the recipient 45 days before the expiration of an approved medical exemption and will inform the recipient how to request an extension. An extension to the medical exemption shall be approved if the eligible recipient continues to meet the requirements of subsection (a)(2).

(b) *Process.*

(1) A request for exemption from plan enrollment or extension of an approved exemption due to a complex medical condition, as specified in (a)(2)(A), shall be submitted to the the State agency by the Medicaid fee-for-service provider or the Indian Health Service facility treating the recipient and shall be submitted by mail or facsimile. Request for exemption from plan enrollment or extension of an approved exemption shall not be submitted by the plan.

(2) The State agency (or its agent), shall approve each request for exemption from plan enrollment that meets the requirements of this section. At any time, the State agency may, at its discretion, verify the complexity, validity, and status of the medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with a plan. State agency may deny a request for exemption from plan enrollment or revoke an approved request for exemption if a provider fails to fully cooperate with this verification. The State agency must accept the Statement of the treating physician or other qualified provider as true and valid and may not administratively overturn such a determination without evidence that it is not a valid medical exemption request.

(3) Approval of requests for exemption from plan enrollment is subject to the same processing times and effective dates specified in section 438.56(f) for the processing of enrollment and disenrollment requests.

(4) The State agency may revoke an approved request for exemption from plan enrollment at any time if the agency determines that the approval was based on false or misleading

information, the medical condition was not complex, treatment has been completed, or the requesting provider is not or has not been providing services to the recipient. The State agency shall provide written notice to the recipient that the approved request for exemption from plan enrollment has been revoked and shall advise the recipient that he or she must enroll in a Medicaid plan and how that enrollment will occur, as specified in §438.56 (f)(3). The revocation of an approved request for exemption from plan enrollment shall not otherwise affect an eligible recipient's eligibility or ability to receive covered services as a plan enrollee.

§438.58 Conflict of interest safeguards.

(a) As a condition for contracting with MCOs, PIHPs, or PAHPs, a State must have in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or the default enrollment process specified in §438.50(f).

(b) These safeguards must be at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) **with adjustments to titles and amounts to be appropriate to individual States.**

(c) A State must ensure that a MCO, PHIP, or PAHP has sufficient conflict of interest safeguards to address conflicts in identifying, requesting, and authorizing of services; care coordination; and grievance systems.

(d) At a minimum, the conflict of interest safeguards must provide for

(1) Disclosure of relevant financial interests;

(2) A procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise

(3) Remedial action for failure to comply with the conflict of interest safeguards.

§438.60 Limit on payment to other providers.

The State agency must ensure that no payment is made to a provider other than the MCO, PIHP, or PAHP for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract, in accordance with §438.6(c)(5)(v), to make payments for graduate medical education.

§438.62 Continued services to beneficiaries.

(a) The State agency must arrange for Medicaid services to be provided **out-of-network** without delay to any Medicaid enrollee of an MCO, PIHP, PAHP, or PCCM **when the enrollee moves from fee-for-service to an MCO, PIHP, PAHP, or PCCM; from one MCO, PIHP, PAHP, or PCCM to another; from another insurance affordability program into Medicaid; or from an MCO, PIHP, PAHP or PCCM to fee-for-service, and—** ~~whose contract is terminated and for any Medicaid enrollee who is disenrolled from an MCO, PIHP, PAHP, or PCCM for any reason other than ineligibility for Medicaid.~~

(1) The service or type of provider (including training, experience, specialization, and linguistic and cultural competency) is not available within the MCO, PIHP, PAHP, or PCCM network;

(2) The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks;

(3) The enrollee's primary care provider or other provider determines that the enrollee needs related services that would subject the enrollee to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network;

(4) For up to 12 months after enrolling into a MCO, PIHP, PAHP, or PCCM, the enrollee is completing covered services that, at the time of enrollment into the MCO, PIHP, PAHP, or PCCM,

the enrollee was receiving from an out-of-network provider, as long as the conditions in (b) are met;

(5) For the duration of a terminal illness when enrollee is completing covered services that, at the time of enrollment into the MCO, PIHP, PAHP, or PCCM, the enrollee was receiving from an out-of-network provider, for a terminal illness. A terminal illness is any incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the effective date of coverage for a new enrollee; or

(6) The State determines that other circumstances warrant out-of-network treatment.

(b) An enrollee shall be entitled to complete covered services with an out-of-network provider as described in (a)(4) and (a)(5) above as long as—

(1) The MCO, PIHP, PAHP, or PCCM is determines that the enrollee has seen the provider at least once in the 12 month period immediately preceding the enrollee's enrollment in the MCO, PIHP, PAHP, or PCCM;

(2) The provider is willing to accept the higher of contract rates of the MCO, PIHP, PAHP, or PCCM, or the State agency's FFS rates; and

(3) The provider meets the applicable professional standards of the MCO, PIHP, PAHP, or PCCM such that the provider would qualify to participate in the network of the MCO, PIHP, PAHP, or PCCM.

§ 438.63 Third party liability where the resource is another managed care plan (*new section*).

(a) If the enrollee is enrolled in another prepaid managed care plan through employment or some other means, the enrollee's Medicaid MCE may be considered the secondary resource. However, the prepaid managed care plan shall not be considered an available resource if it is not available to the enrollee, including but not limited to the following situations:

(1) If the prepaid managed care plan requires the enrollee to pay a deductible or copayment for utilization of a services under that plan, that plan service is not an available third party resource unless the State agency or other third party (other than the enrollee) pays the deductible or copayment on behalf of the enrollee, or the deductible or copayment is waived by the plan.

(2) The prepaid managed care plan is not geographically accessible, as measured by that plan's enrollment area or when geographic distance (as determined used the standards set forth in § 438.206 and including lack of a means of transportation) prevents the enrollee from reasonably availing the services offered through that plan.

(3) The services needed by the enrollee are not covered under the prepaid managed care plan's scope of benefits.

(b) In the case of prenatal or preventive pediatric care (including early and periodic screening and diagnostic services under EPSDT), the MCE shall provide such services in accordance with the usual schedule without regard to the liability of a third party, including another prepaid managed care plans and thereafter seek reimbursement from the third party resource.

(c) A provider who is participating in the enrollee's Medicaid MCE may not refuse to furnish services to an enrollee because of another prepaid managed care plan's potential liability for the service.

(d) The information provided to enrollees and prospective enrollees, under § 438.10, shall include the following:

(i) That an enrollee may obtain Medicaid services from their Medicaid MCE provider who is not enrolled in the enrollee's third party insurance plan if the third party insurance plan does not cover the services.

(ii) That an enrollee may obtain Medicaid services from the Medicaid MCE if the enrollee's third party insurance providers (including both primary and specialized services) are not geographically available.

(iii) That an enrollee has the right to request an administrative hearing if the Medicaid MCE or the State denies a request for coverage on the basis of available third party resources.

§438.66 Monitoring procedures.

The State agency must have in effect procedures for monitoring the MCO's, PIHP's, or PAHP's operations, including, at a minimum, operations related to the following:

(a) Beneficiary enrollment and disenrollment.

(b) Processing **and analysis** of grievances and appeals.

(c) Quality assessment and performance improvement, as set forth in subpart D of this part.

(c) Violations subject to intermediate sanctions, as set forth in subpart I of this part.

(d) Violations of the conditions for FFP, as set forth in subpart J of this part.

(e) All other provisions of the contract, as appropriate.

§438.70 Language Access and Disability Access (*new section*).

(a) *General rule.* A State that requires Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM shall ensure that the MCO, PIHP, PAHP or PCCM complies with the requirements in subparagraph (b) regarding assistance for individuals who are LEP and subparagraph (c) ensuring access for individuals with disabilities.

(b) *Standards for Ensuring Access to Individuals who are Limited English Proficient*. The following standards shall apply to ensure that information provided to any potential enrollee or enrollee is culturally and linguistically appropriate to the needs of the population being served, including individuals who are LEP such that an MCO, PIHP, PAHP and PCCM must:

(1) Develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group's diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs;

(2) Collect and maintain updated information to help understand the composition of the communities in the service area, including the primary languages spoken;

(3) In compliance with §438.10(c) and (f), provide enrollees and potential enrollees with information and assistance in the consumer's preferred language, at no cost to the enrollee or potential enrollee, including the provision of oral interpretation of non-English languages and the translation of written documents in non-English languages when necessary or when requested by the enrollee to ensure effective communication. Use of an enrollee's family or friends as oral interpreters can satisfy the requirement to provide linguistically appropriate services only when requested by the enrollee as the preferred alternative to an offer of other interpretive services and the MCO, PIHP, PAHP or PCCM evaluates the competency of the family member to serve as an interpreter;

(4) Provide oral and written notice to enrollees with LEP, in their preferred language, informing them of their right to receive language assistance services and how to obtain them;

(5) Provide staff ongoing education and training in culturally and linguistically appropriate service delivery; and

(6) Implement strategies to recruit, support, and promote a staff that is representative of the demographic characteristics, including primary languages spoken, of the communities in their service area.

(c) *Standards ensuring access by persons with disabilities.* The following standards will apply to ensure that information provided to any potential enrollee or enrollee is culturally and linguistically appropriate to the needs of the population being served, including individuals with disabilities. An MCO, PIHP, PAHP or PCCM must:

(1) Ensure that any consumer education materials, Web sites, or other tools utilized for consumer assistance purposes, are accessible to people with disabilities, including those with

sensory impairments, such as visual or hearing impairments, and those with mental illness, addiction, and physical, intellectual, and developmental disabilities;

(2) Ensure that notices are provided in alternative formats or communicated using auxiliary aids and services when needed to ensure effective communication of information with individuals with disabilities;

(3) Provide assistance to enrollees or potential enrollees in a location and in a manner that is physically and otherwise accessible to individuals with disabilities;

(4) Provide effective communication to covered companions with communication disabilities;

(5) Ensure that authorized representatives are permitted to assist an individual with a disability to make informed decisions;

(6) Acquire sufficient knowledge to refer people with disabilities to local, State, and federal long-term services and supports programs when appropriate;

(7) Be able to work with all individuals regardless of age, disability, or culture, and seek advice or experts when needed; and

(8) Provide auxiliary aids and services for individuals with disabilities, at no cost, when necessary or when requested by the enrollee or potential enrollee to ensure effective communication. Use of an enrollee or potential enrollee's adult family or friends as interpreters can satisfy the requirement to provide auxiliary aids and services only when requested by the enrollee or potential enrollee as the preferred alternative to an offer of other auxiliary aids and services, the accompanying adult agrees, and reliance on the accompanying adult is appropriate under the circumstances.

(a) An accompanying adult may not be relied upon when there is reason to doubt the person's impartiality or effectiveness.

(b) An adult or minor child may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available in an emergency involving an imminent threat to the safety or welfare of an individual or the public.

(d) *Monitoring.* Any MCO, PIHP, PAHP or PCCM during the exercise of its authority will monitor compliance with the standards in this section.

Subpart C—Enrollee Rights and Protections

§438.100 Enrollee rights.

(a) *General rule.* The State must ensure that—

(1) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and

(2) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers ~~take those rights into account when~~ furnish~~ing~~ services to enrollees **in accordance with those rights.**

(b) *Specific rights*.

(1) *Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.

(2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to—

(i) Receive information in accordance with §438.10.

(ii) Be treated with respect and with due consideration for his or her dignity and privacy.

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(f)(6)(xii).)

(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment. If an enrollee has a guardian or legal representative, the health care decision should be driven by the individual.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(vi) Not to be discriminated against on the basis of race, color, ~~or~~ national origin, language, disability, age, sex, gender identity or sexual orientation.

(vi**i**) 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.

(**viii) File grievances, appeal, or file complaints with or against the MCO, PIHP, or PAHP.**

(3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§438.206 through 438.210.

(c) *Free exercise of rights.* The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.

(d) *Compliance with other Federal and State laws.* The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; **§ 1557 of the Patient Protection and Affordable Care Act;** and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§438.102 Provider-enrollee communications.

(a) *General rules.*

(1) An MCO, PIHP, or PAHP may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

(i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(ii) Any information the enrollee needs in order to decide among all relevant treatment options.

(iii) The risks, benefits, and consequences of treatment or nontreatment.

(iv) 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.

(2) Subject to the information requirements of paragraph (b) of this section, an MCO, PIHP, or PAHP that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section is not required to do so if the MCO, PIHP, or PAHP objects to the service on moral or religious grounds.

(b) *Information requirements: MCO, PIHP, and PAHP responsibility.* (1) An MCO, PIHP, or PAHP that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows:

(i) To the State—

(A) With its application for a Medicaid contract; and

(B) Whenever it adopts the policy during the term of the contract.

(ii) Consistent with the provisions of §438.10—

(A) To potential enrollees, before and during enrollment; and

(B) To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle the MCO, PIHP, or PAHP to the option provided in paragraph (a)(2) of this section, the overriding rule in §438.10(f)(4) requires the State, its contracted representative, or MCO, PIHP, or PAHP to furnish the information at least 30 days before the effective date of the policy.)

(2) As specified in §438.10, paragraphs (e) and (f), the information that MCOs, PIHPs, and PAHPs must furnish to enrollees and potential enrollees does not include how and where to obtain the service excluded under paragraph (a)(2) of this section, **but must include how and where to obtain information from the State about how to obtain the service.**

(c) *Information requirements: State responsibility.* For each service excluded by an MCO, PIHP, or PAHP under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in §438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii).

(d) *Sanction.* An MCO that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§438.104 Marketing activities.

(a) *Terminology.* As used in this section, the following terms have the indicated meanings:

(1) *Cold-call marketing* means any unsolicited personal contact by the MCO, PIHP, PAHP, or PCCM with a potential enrollee for the purpose of marketing as defined in this paragraph.

(2) *Marketing* means any communication, from an MCO, PIHP, PAHP, or PCCM 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, or PCCM's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's, PIHP's, PAHP's, or PCCM's Medicaid product.

(3) *Marketing materials* means materials that—

(i) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, or PCCM; and

(ii) Can reasonably be interpreted as intended to market to potential **or current** enrollees.

MCO, PIHP, PAHP, or PCCM include any of the entity's employees, affiliated providers, agents, or contractors.

(b) *Contract requirements.* Each contract with an MCO, PIHP, PAHP, or PCCM must comply with the following requirements:

(1) Provide that the entity—

(i) Does not distribute any marketing materials without first obtaining State approval **of the materials**;

(ii) Distributes the materials to its entire service area as indicated in the contract;

(iii) Complies with the information requirements of §438.10 to ensure that, before enrolling, the beneficiary receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll;

(iv) Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and

(v) Does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

(2) Specify the methods by which the entity assures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the State agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or Statement (whether written or oral) that—

(i) The beneficiary must enroll in the MCO, PIHP, PAHP, or PCCM in order to obtain benefits or in order to not lose benefits;

(ii) The MCO, PIHP, PAHP, or PCCM is endorsed by CMS, the Federal or State government, or similar entity;

(iii) information that would be misleading in context to a person not possessing special knowledge regarding health care coverage as to the benefits, costs, provider networks or availability or services provided by the plan

(c) *State agency review.*

(1) In reviewing the marketing materials submitted by the entity, the State must consult with the Medical Care Advisory Committee established under §431.12 of this chapter or an advisory committee with similar membership.

(2) The State must review all marketing materials and informing practices for accuracy of information, language, reading level, comprehensibility, cultural sensitivity and diversity. Marketing materials must conform to the requirements in § 438.10(c) and (f), and 438.70.

(3) The State must review all marketing materials and informing practices to ensure that the MCO, PHIP, PAHP, or PCCM does not target or avoid populations based on their perceived health status, cost or for other discriminatory reasons.

§438.106 Liability for payment.

Each MCO, PIHP, and PAHP must provide that its Medicaid enrollees are not held liable for any of the following:

(a) The MCO's, PIHP's, or PAHP's debts, in the event of the entity's insolvency **or any other reason**.

(b) Covered services provided to the enrollee, for which—

(1) The State does not pay the MCO, PIHP, or PAHP; or

(2) The State, or the MCO, PIHP, or PAHP does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

(c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or PAHP provided the services directly.

§438.108 Cost sharing.

The contract must provide that any cost sharing imposed on Medicaid enrollees is in accordance with §§447.50 through 447.57 of this chapter **with the following additional restrictions:**

(1) For Federal FY 2015, any deductible an MCO, PIHP, or PAHP imposes does not exceed $2.65 per month per family for each period of Medicaid eligibility. Thereafter, any deductible should not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher 5-cent increment.

(2) The contract must clearly delineate the respective responsibilities of the State and the MCO, PIHP, or PAHP with regard to tracking and aggregating all Medicaid cost sharing and premiums in each beneficiary's household in accordance with 42 C.F.R. § 447.56(f). This includes but is not limited to how the aggregating methodology will account for expenses related to Medicaid services not offered by the managed care plan but available to one or more individuals in the beneficiary's household. Beneficiaries must be informed of the aggregating methodology and how to obtain ongoing access to their cost-sharing data.

(3) An MCO, PIHP, or PAHP may not impose cost sharing on any service that is higher than the cost sharing the State agency imposes for the same service for a comparable population under its State plan.

(4) Cost sharing for any Medicaid enrollee in an MCO, PIHP, or PAHP , regardless of his or her household income, must not exceed the maximum limits for individuals below 100% FPL as defined in 42 C.F.R. §§ 447.52(b), .53(b) and .54(b).

(5) The State agency may not permit a provider, including a pharmacy or hospital, to require an individual enrolled an MCO, PIHP, or PAHP to pay cost sharing as a condition for receiving the item or service.

(6) The State agency may not target cost sharing to specified groups of individuals enrolled in MCOs, PIHPs, PAHPs.

§438.114 Emergency and poststabilization services.

(a) *Definitions.* As used in this section—

(1) *Emergency medical condition* means 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:

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

(2) *Emergency services* means covered inpatient and outpatient services that are as follows:

(i) Furnished by a provider that is qualified to furnish these services under this title.

(ii) Needed to evaluate or stabilize an emergency medical condition.

(3) *Poststabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.

(b) Information requirements. To enrollees and potential enrollees upon request, and to enrollees during enrollment and at least annually thereafter, each State (or at State option, each MCO, PIHP, PAHP, and PCCM) must provide, in clear, accurate, and standardized form, information that describes or explains at least the following—

(1) What constitutes an emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in paragraph (a) of this section;

(2) The fact that prior authorization is not required for emergency services;

(3) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent;

(4) The locations of any emergency settings and other locations at which MCO, PIHP, PAHP, and PCCM providers and hospitals furnish emergency services and post-stabilization services covered under the contract;

(5) The enrollee's right to use any hospital or other setting for emergency care, subject to the provisions of this section;

(6) The availability of post-stabilization care services rules set forth at § 422.113(c) of this chapter; and

(7) The amount of cost sharing imposed, if any, for non-emergency services provided in an emergency department and the right to be notified of available non-emergency services providers, as set forth at 42 U.S.C. § 1396o-1.

(~~b~~**c**) *Coverage and payment: General rule.* The following entities are responsible for coverage and payment of emergency services and poststabilization care services.

(1) The MCO, PIHP, or PAHP.

(2) The PCCM that has a risk contract that covers these services.

(3) The State, in the case of a PCCM that has a fee-for-service contract.

(**d**) *Coverage and payment: Emergency services*—

(1) The entities identified in paragraph (b) of this section—

(i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, or PCCM; and

(ii) May not deny payment for treatment obtained under either of the following circumstances:

(A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of *emergency medical condition* in paragraph (a) of this section.

(B) A representative of the MCO, PIHP, PAHP, or PCCM instructs the enrollee to seek emergency services.

(C) An enrollee has not been able to obtain non-emergency services from the MCO, PIHP, PAHP, or PCCM in a timely or accessible manner.

(2) A PCCM must—

(i) Allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services; and

(ii) Pay for the services if the manager's contract is a risk contract that covers those services.

(**e**) *Additional rules for emergency services.*

(1) The entities specified in paragraph (b) of this section may not—

(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and

(ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

(2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.

(**f**) *Coverage and payment: Poststabilization care services.* Poststabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those provisions, reference to "M+C organization" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section.

(**g**) *Applicability to PIHPs and PAHPs.* To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.

§438.116 Solvency standards.

(a) *Requirement for assurances*

(1) Each MCO, PIHP, and PAHP that is not a Federally qualified HMO (as defined in section 1310 of the Public Health Service Act) must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the MCO's, PIHP's, or PAHP's debts if the entity becomes insolvent.

(2) Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement.

(b) *Other requirements*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, an MCO or PIHP, must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.

(2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP, that meets any of the following conditions:

(i) Does not provide both inpatient hospital services and physician services.

(ii) Is a public entity.

(iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers.

(iv) Has its solvency guaranteed by the State.

Subpart D—Quality Assessment and Performance Improvement

§438.200 Scope.

This subpart implements section 1932(c)(1) of the Act and sets forth specifications for quality assessment and performance improvement strategies that States must implement to ensure the delivery of quality health care by all MCOs, PIHPs, and PAHPs. It also establishes standards that States, MCOs, PIHPs, and PAHPs must meet.

§438.202 State responsibilities.

Each State contracting with an MCO, **PAHP,** or PIHP must do the following:

(a) Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs , **PAHPs,** and PIHPs.

(b) Obtain the input of beneficiaries and other stakeholders in the development of the strategy and make the strategy **widely** available for public comment before adopting it in final, **including but not limited to posting drafts of the strategy and important deadlines on a website that is accessible to the public**

(c) Ensure that MCOs, PIHPs, and PAHPs comply with standards established by the State, consistent with this subpart.

(d) Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically, as needed.

(e) Submit to CMS **and make available by posting on a website that is accessible to the public** the following **information**:

(1) A copy of the initial strategy, and a copy of the revised strategy whenever significant changes are made.

(2) Regular reports on the implementation and effectiveness of the strategy.

§438.204 Elements of State quality strategies.

At a minimum, State strategies must include the following:

(a) The MCO, **PAHP,** and PIHP contract provisions that incorporate the standards specified in this subpart.

(b) Procedures that—

(1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.

(2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO, **PAHP,** and PIHP for each Medicaid enrollee at the time of enrollment **and, for each enrollee who is a minor or incapacitated, the primary language of the enrollee's parent(s) and guardian(s)**..

(3) Regularly monitor and evaluate the MCO, **PAHP,** and PIHP compliance with the standards.

(c) For MCOs, **PAHP,** and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.

(d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO, **PAHP,** and PIHP contract.

(e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.

(f) An information system that supports initial and ongoing operation and review of the State's quality strategy.

(g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

§438.206 Availability of services.

(a) Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs.

~~(b) *Delivery network.* The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements:~~

(b) An MCO, PIHP, or PAHP may specify the networks of providers from whom enrollees may obtain services if the State and the MCO, PIHP, or PAHP ensure that all covered services are available and accessible under the plan. To accomplish this, the State shall ensure that each contracting MCOs, PIHPs, and PAHPs meets the following requirements:

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. **These providers shall include providers of all categories of services listed in §§ 440.10 – 440.140, 440.155, 440.165-167, 440.169-440.185, to the extent those services are covered by the State plan and the MCO, PIHP, or PAHP contract. Networks must also include a sufficient number and geographic distribution of Essential Community Providers, where available, to ensure reasonable and timely access to a broad range of such providers in the plan's service area. Essential Community Providers are providers that serve predominantly low-income, medically underserved individuals, including providers defined in section 340B(a)(4) of the Public Health Services Act and § 1927(c)(1)(D)(i)(IV) of the Social Security Act.**

(2) In establishing and maintaining the network, each MCO, PIHP, and PAHP must **account for** the following:

(i) The anticipated Medicaid enrollment.

(ii) The expected utilization of services, taking into consideration the characteristics and health care needs**, including accessibility needs**, of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP.

(iii) The numbers of network providers who are not accepting new Medicaid patients.

(iv) The numbers of network providers who provide a full range of covered reproductive health services including high risk pregnancy care, family planning services and supplies, and abortion.

(v) The needs of enrollees for long-term services and supports, mental health, and substance use services.

(3) Provides or arranges for necessary specialty care, including community-based long-term services and supports, including by offering access to such care out-of-network when required by subsection (7) below.

(4) If an MCO, PIHP, or PAHP contracts with institutions or individual providers who refuse to provide a full range of reproductive health services, the MCO, PIHP, or PAHP must also:

(i) Contract with at least one institutional provider and one professional provider within the same geographic area that provides covered services in-network providers refuse to provide;

(ii) If there is no provider in the geographic area that offers the covered services, contract with additional providers in nearby regions and provide transportation services; and

(iii) Ensure a protocol is in place to allow enrollees to obtain covered services when a primary care provider refuses or is unable to make a referral to needed services.

(5) Establish written standards for the following:

(i) Timeliness of access to care and enrollee services. Each MCO, PIHP, and PAHP must demonstrate that its written standards ensure that its contracted provider network has

adequate capacity and availability of licensed health care providers to offer enrollees appointments as follows:

(A) Urgent care appointments for medical or dental services shall be available within 48 hours of the request for appointment, except as provided in (F);

(B) Non-urgent appointments for primary and specialty care shall be available within 15 business days of the request for appointment, except as provided in (F) and (G);

(C) Non-urgent appointments with a non-physician mental health care provider shall be available within 10 business days of the request for appointment, except as provided in (F) and (G);

(D) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition shall be available within 15 business days of the request for appointment, except as provided in (F) and (G);

(E) Non-urgent dental appointments shall be offered within 30 business days of the request for appointment, except as provided in (F); and

(F) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

(G) The applicable waiting time for a particular appointment must be shortened if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined that it is medically necessary for the enrollee to receive care more quickly; and

(H) The network providers shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

(I) Services included in the contract shall be available 24 hours a day, 7 days a week, when medically necessary.

(J) The MCO, PIHP, and PAHP shall establish mechanisms to ensure compliance by providers.

(K The MCO, PIHP, and PAHP shall monitor providers regularly to determine compliance.

(L) The MCO, PIHP, and PAHP shall take corrective action if there is a failure to comply.

(ii) Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations.

(iii) Provider consideration of beneficiary input into the provider's proposed treatment plan.

(~~iii~~**iv**) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services **that meet or exceed standards established by CMS**.

(v) The geographic location of providers and Medicaid enrollees considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities. **Except as provide in subsection (E) below, the MCO, PIHP, or PAHP shall ensure that:**

(A) 90% of enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and

distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.

(B) 90% enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.

(C) 90% enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated laboratory, pharmacy and similar ancillary facilities that dispense services and goods by order or prescription on the primary care provider.

(D) All contracting providers certify that their facilities and services are accessible to all enrollees, and fully compliant with the Americans with Disabilities Act (ADA) and any other applicable State and federal disability and civil rights laws.

(E) The State will establish alternative primary, specialty, and ancillary access standards for MCOs, PIHPs, or PAHPs operating in rural areas, service areas within a State with a population of 500,000 or fewer, other areas within a State that are sparsely populated, or in other circumstances in which the standards are unreasonably restrictive.

(~~2~~**6**) Provides female enrollees including adolescents with direct access to a women's health specialist within the network for covered women's health services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

(~~3~~**7**) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

(~~4~~**8**) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP is unable to provide them **in accordance with § 438.62**.

(~~5~~**9**) Requires out-of-network providers to coordinate with the MCO or PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

(~~6~~**10**) Demonstrates that its providers are credentialed as required by §438.214.

(c) *Furnishing of services.* The State must ensure that each MCO, PIHP, and PAHP contract complies with the requirements of this paragraph.

(1) **Ambulance services, emergency and urgently needed services, and post-stabilization care services coverage. Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services in accordance with § 422.114.** ~~*Timely access.* Each MCO, PIHP, and PAHP must do the following:~~

~~(i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.~~

~~(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.~~

~~(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.~~

~~(iv) Establish mechanisms to ensure compliance by providers.~~

~~(v) Monitor providers regularly to determine compliance.~~

~~(vi) Take corrective action if there is a failure to comply.~~

(2) *Cultural considerations.* Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with

LEP and diverse cultural and ethnic backgrounds. **Each MCO, PIHP and PAHP must ensure that services related to language access and disability access are provided to all potential enrollees and enrollees who are LEP or have disabilities, as required by § 438.70. Each MCO, PIHP and PAHP must pay for the costs of the language access and disability access and not require its network providers to pay for these costs.**

(3) Plans shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(5).

(i) Plans shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(ii) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services; telephone medical advice services; the plan's contracted primary care and mental health care provider network; or other method that provides triage or screening services consistent with the requirements of this subsection.

(4) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative who is knowledgeable about and competent to respond to an enrollee's questions and concerns shall not exceed ten minutes.

§438.207 Assurances of adequate capacity and services.

(a) *Basic rule.* The State must **monitor and** ensure~~, through its contracts,~~ that each MCO, PIHP, and PAHP gives assurances to the State and provides**—at least annually—**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 to care under this subpart **and the standards set forth in §438.10(c) and (f) and §438.70**..

(b) *Nature of supporting documentation.* Each MCO, PIHP, and PAHP must submit documentation to the State **certifying that it complies with the requirements of § 438.206, as follows:** ~~, in a format specified by the State to demonstrate that it complies with the following requirements:~~

(1) Each MCO, PIHP, and PAHP shall submit a narrative description of its service area and the geographic area in which its enrollees (actual and/or projected) live and work and list all U.S. Postal ZIP Code numbers included in the service areas. To the extent possible, service areas should be delineated by political or natural boundaries. ~~**Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.**~~

(2) Each MCO, PIHP, and PAHP shall submit a map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) employed should be of convenient size and of the largest scale sufficient to include the applicant's entire service area and the surrounding area in which the actual or projected enrollees live or work. The use of good-quality city street maps or the street and highway maps available for various metropolitan areas, and regions of the State, such as are commonly available from automobile associations or retail service stations or from an internet or computer based program is preferred. The map or maps should show the following information:

(i) Such geographic detail, including highways and major streets, as is generally portrayed on the kinds of maps referred to above.

(ii) The boundaries of applicant's service area.

(iii) The location of any contracting or plan-operated hospital and, if separate, each contracting or plan operated emergency health care facility. Hospitals are to be designated by an "H" and emergency care facilities by an "E."

(iv) The location of primary care providers, designated by a "P." For convenience, the primary care providers within any mile-square area may be considered as being at one location within that area.

(v) The location of all other contracting or plan-operated health care providers including the following: Dental, designated by a "D." Pharmacy, designated by an "Rx." Laboratory, designated by an "L." Eye Care, designated by an "O." Specialists and ancillary health care providers, designated by an "S."

(vi) The location of all subscriber groups which have submitted letters of intent or interest to join the applicant's plan designated by a "G." (See Item CC-3.)

(3) Each MCO, PIHP, and PAHP shall attach an index to the map or maps described in subsection (2) which shows, for each symbol placed on the map for a hospital, emergency care facility, primary care provider or ancillary provider, the following information:

(i) For each hospital, its total beds and the number of beds available to enrollees of the plan.

(ii) For each symbol for primary care providers, the number of full-time equivalent primary care providers represented by that symbol.

(iii) For each interested subscriber group, the name of the group and the projected number of enrollees from that group. ~~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.~~

(4) Has policies in place to ensure disability access and language access as required in § 438.10(c) and (f) and §438.70.

(c) *Timing of documentation.* Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section 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) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect adequate capacity and services, including—

(i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area or payments; or

(ii) Enrollment of a new population in the MCO, PIHP, or PAHP.

(d) *State review and certification to CMS.* After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must certify to CMS that the MCO, PIHP, or PAHP has complied with the CMS and the State's requirements for availability of services, as set forth in §438.206.

(e) *CMS' right to inspect documentation.* The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.

§438.208 Coordination ~~and continuity~~ of care.

(a) *Basic requirement*.

(1) *General rule.* Except as specified in paragraph~~s~~ (a)(2) ~~and (a)(3)~~ of this section, the State must ensure ~~through its contracts,~~ that each MCO, PIHP, and PAHP complies with the requirements of this section.

(2) *PIHP and PAHP exception.* For PIHPs and PAHPs **that do not provide primary care**, 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

~~(i) Meet the primary care requirement of paragraph (b)(1) of this section; and~~

~~(ii)~~ ~~l~~implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section.

~~(3)~~ *Exception for MCOs that serve dually eligible enrollees.*

(i) For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the State determines to what extent the MCO must meet the primary care coordination, identification, assessment, and treatment planning provisions of paragraphs (b) and (c) of this section with respect to dually eligible individuals.

(ii) The State bases its determination on the services it requires the MCO to furnish to dually eligible enrollees.

(b) *Primary care and coordination of health care services for all MCO, PIHP, and PAHP enrollees.* Each MCO, PIHP, and PAHP must implement procedures to deliver primary care to and coordinate health care service for all MCO, PIHP, and PAHP enrollees. These procedures must meet State requirements and must do the following:

(1) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.

(3) Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(4) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable, **including by ensuring each enrollee is able to request that health care service plan communications containing medical information be communicated to him or her at a specific mail or email address or specific telephone number, as designated by that enrollee.**

(c) *Additional services for enrollees with special health care needs*.

(1) *Identification.* The State must implement mechanisms to identify persons with special health care needs to MCOs, PIHPs and PAHPs, ~~as those persons are defined by the State~~. These identification mechanisms—

(i) Must be specified in the State's quality improvement strategy in §438.202; and

(ii) May use State staff, the State's enrollment broker, or the State's MCOs,

PIHPs and PAHPs.

(2) *Assessment.* Each MCO, PIHP, and PAHP must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

(3) *Treatment plans.* ~~If the State requires~~ **The State must require** MCOs, PIHPs, and PAHPs to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. **Such**~~, the~~ treatment plan must be—

(i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

(ii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP; and

(iii) In accord with any applicable State quality assurance and utilization review standards.

(4) *Direct access to specialists.* For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with §438.208(c)(2)) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

§438.210 Coverage and authorization of services.

(a) *Coverage.* Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in §440.230.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service—

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes "medically necessary services" in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) ~~Addresses the extent to which the~~ **Requires the** MCO, PIHP, or PAHP ~~is responsible for~~ **to** cover~~ing~~ services **as needed for**~~related to the following~~:

(A) The prevention, diagnosis, and treatment of health impairments **or conditions.**

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

(ii) **take into account the needs of people with special health care needs and chronic conditions when determining authorization periods,** and

(iii) Consult with the requesting provider when appropriate.

(3) That the MCO, PIHP, or PAHP shall not require prior authorization for family planning services and supplies and for family planning related services.

(~~3~~4) 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 a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

(c) *Notice of adverse action.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. ~~For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.~~

(d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.*

(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function**, or the enrollee is in need of time sensitive services,** the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(e) *Compensation for utilization management activities.* Each contract must provide that, consistent with §438.6(h), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

STRUCTURE AND OPERATION STANDARDS

§438.214 Provider selection.

(a) *General rules.* The State must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of this section.

(b) *Credentialing and recredentialing requirements.*

(1) Each State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow.

(2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO, PIHP, or PAHP.

(c) *Nondiscrimination.* MCO, PIHP, and PAHP provider selection policies and procedures, consistent with §438.12, must not:

(1) discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(2) discriminate against particular providers on the basis of their race, color, ~~or~~ national origin, language, disability, age, sex, gender identity, or sexual orientation.

(d) *Excluded providers.* MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

(e) *State requirements.* Each MCO, PIHP, and PAHP must comply with any additional requirements established by the State.

[67 FR 41095, June 14, 2002; 67 FR 54532, Aug. 22, 2002]

§438.218 Enrollee information.

The requirements that States must meet under §438.10 constitute part of the State's quality strategy at §438.204.

§438.224 Confidentiality.

The State must ensure, through its contracts, that (consistent with subpart F of part 431 of this chapter), for medical records and any other health and enrollment information that identifies a particular

enrollee, each MCO, PIHP, and PAHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

§438.226 Enrollment and disenrollment.

The State must ensure that each MCO, PIHP, and PAHP contract complies with the enrollment and disenrollment requirements and limitations set forth in §438.56.

§438.228 Grievance systems.

(a) The State must ensure, through its contracts, that each MCO, **PAHP,** and PIHP has in effect a grievance system that meets the requirements of subpart F of this part.

(b) If the State delegates to the MCO, **PAHP,** or PIHP responsibility for notice of action under subpart E of part 431 of this chapter, the State must **approve the MCO**, **PAHP, or PIHP' notice of action and must** conduct random reviews of each delegated MCO or PIHP and its providers and subcontractors to ensure that they are **utilizing the notice and** notifying enrollees in a timely manner.

§438.230 Subcontractual relationships and delegation.

(a) *General rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP—

(1) **Monitors,** ~~o~~versees and ~~is accountable for~~ **ensures performance of** any functions and **compliance with all** responsibilities that it delegates to any subcontractor; and

(2) Meets the conditions of paragraph (b) of this section.

(b) *Specific conditions.* (1) Before any delegation, each MCO, PIHP, and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.

(2) **Each MCO, PIHP, and PAHP must ensure that t**~~T~~here is a written agreement that—

(i) Specifies the activities and report responsibilities delegated to the subcontractor;

(**ii) Provides that the subcontractor agrees to fulfill the activities and report responsibilities delegated to it under the agreement;**

(iii) **Provides for the State and MCO, PIHP, and PAHP to have timely access to all subcontractor records related to the performance of delegated activities;**

(iv) Provides for ~~revoking delegation~~ **termination of the agreement** or imposing other sanctions if the subcontractor's performance ~~is inadequate~~ **does not satisfy the standards set forth in the agreement**.

(3) The MCO, PIHP, or PAHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.

(4) If any MCO, PIHP, or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP, or PAHP and the subcontractor take corrective action **and reports those identified deficiencies, areas for improvement, or corrective action measures to the State Medicaid agency and any other regulatory agency responsible under State or Federal law**.

MEASUREMENT AND IMPROVEMENT STANDARDS

§438.236 Practice guidelines.

(a) *Basic rule:* The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) *Adoption of practice guidelines.* Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals, **enrollees, consumer representatives, and other stakeholders**.

(4) Are reviewed and updated periodically as appropriate.

(c) *Dissemination of guidelines.* Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and~~, upon request,~~ to enrollees and potential enrollees**, and will post the guidelines and periodic review reports on a website that is accessible to the public, and make the guidelines available upon request.**

(d) *Application of guidelines.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

§438.240 Quality assessment and performance improvement program.

(a) *General rules.*

(1) The State must require, through its contracts, that each MCO, PIHP**, and PAHP** have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(2) CMS, in consultation with States and other stakeholders, **shall** ~~may~~ specify performance measures **to be required by States in their contracts with MCOs, PIHPs, and PAHPs.**

(3) CMS, in consultation with States and other stakeholders, ~~and~~ **may specify** topics for performance improvement projects to be required by States in their contracts with MCOs **PIHPs, and PAHPs**.

(4) the State and MCO shall post its quality assessment and performance improvement program information, status reports, and performance measurement data on a website that is accessible to the public and shall update the information on no less than a quarterly basis.

(b) *Basic elements of MCO, PIHP, and PAHP quality assessment and performance improvement programs.* At a minimum, the State must require that each MCO, PIHP, and **PAHP** comply with the following requirements:

(1) Achieve required minimum performance levels on quality measures.

(2) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(3) Submit performance measurement data as described in paragraph (c) of this section. **The State shall require at least the full adult and child core set of quality measures established by 42 U.S.C. § 1320b-9a and 42 U.S.C. § 1320b-9b.**

(4) Have in effect mechanisms to detect both underutilization and overutilization of services **and take corrective action.**

(5) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees, **including those** with special health care needs.

(c) ***Minimum*** *performance measurement.* E~~Annually a~~ch MCO, PIHP, and **PAHP** must—

(1) **Achieve required minimum performance levels on quality measures.**

(2) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of §§438.204(c) and 438.240(a)(2); **and**

(3) Submit to the State, data specified by the State, that enables the State to measure the MCO's, PIHPs, or **PAHP'**s performance **and post the data on a website that is accessible to the public**~~(3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.~~

(d) *Performance improvement projects.*

(1) **The State must ensure that each MCO, PIHP, and PAHP initiates each year one or more projects among the required clinical and non-clinical areas specified in paragraphs (d)(3) and (d)(4) of this section. To ensure that the projects are representative of the entire spectrum of**

clinical and non-clinical areas associated with MCOs, PIHPs, and PAHPs, the State must specify the appropriate distribution of projects. MCOs, PIHPs, **PAHPs** must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of system interventions to achieve improvement in quality.

(iii) Evaluation of the effectiveness of the interventions.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

(2) Each MCO, PIHP, and **PAHP** must report the status and results of each project to the State as requested, including those that incorporate the requirements of §438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

(3) Clinical areas include—

(i) Prevention and care of acute and chronic conditions;

(ii) High-volume services;

(iii) High-risk services; and

(iv) Continuity and coordination of care.

(4) Non-clinical areas include—

(i) Grievances and appeals;

(ii) Access to, and availability of, services, including specialty care and long term services and supports; and

(iii) Cultural competence.

(5) The State and each MCO, PIHP, and PAHP must post its Performance Improvement Projects and status reports to its website that is accessible to the public, and must make information available to enrollees and potential enrollees at the time of plan selection and renewal.

(6) In addition to requiring each MCO, PIHP, and PAHP to initiate its own performance improvement projects, the State may require that an MCO, PIHP, or PAHP—

(i) Conduct particular performance improvement projects on a topic specified by the State; and

(ii) Participate annually in at least one Statewide performance improvement project.

(7) For each project, each MCO, PIHP, and PAHP must assess its performance using quality indicators that are—

(i) Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research; and

(ii) Capable of measuring outcomes such as changes in health status, functional status, and enrollee satisfaction, or valid proxies of these outcomes.

(8) Performance assessment on the selected indicators must be based on systematic ongoing collection and analysis of valid and reliable data.

(e) *Program review by the State.*

(1) The State must review, at least annually, the impact and effectiveness of each MCO's, **PIHP, and PAHP**'s quality assessment and performance improvement program. The review must include—

(i) The MCO's, **PIHP's, and PAHP**'s performance on the standard measures on which it is required to report; and

(ii) The results of each MCO's, **PIHP's, and PAHP**'s performance improvement projects.

(2) The State may require that an MCO, **PIHP's, and PAHP**'s have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

§438.242 Health information systems.

(a) *General rule.* The State must ensure, through its contracts, that each MCO, **PIHP, and PAHP** maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(b) *Basic elements of a health information system.* The State must require, at a minimum, that each MCO, **PIHP, and PAHP** comply with the following:

(1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.

(2) Ensure that data received from providers is accurate and complete by—

(i) Verifying the accuracy and timeliness of reported data;

(ii) Screening the data for completeness, logic, and consistency; and

(iii) Collecting service information in standardized formats to the extent feasible and appropriate.

(3) Make all collected data available to the State and upon request to CMS, as required in this subpart. **All collected data, including encounter data, grievances and appeals, and utilization, must also be made available to the public by posting the data and analyses on the publicly accessible website of the MCO, PIHP, and PAHP and the State. The MCO, PIHP, PAHP, and the State must maintain the public posting of such information for no less than three years to track progress and identify ongoing deficiencies.**

Subpart E—External Quality Review

SOURCE: 68 FR 3635, Jan. 24, 2003, unless otherwise noted.

§438.310 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart is based on sections 1932(c)(2), 1903(a)(3)(C)(ii), and 1902(a)(4) of the Act.

(b) *Scope.* This subpart sets forth requirements for annual external quality reviews of each contracting managed care organization (MCO), ~~and~~ prepaid ~~i~~npatient health plan (PIHP), **and prepaid ambulatory health plan (PAHP)** including—

(1) Criteria that States must use in selecting entities to perform the **reviews and ensuring the independence of such entities;**

(2) Specifications for the activities related to external quality review;

(3) Circumstances under which external quality review may use the results of Medicare quality reviews or private accreditation reviews; and

(4) Standards for making available the results of the reviews.

(c) *Applicability.* The provisions of this subpart apply to MCOs, PIHP**s, and PAHP**s, and to health insuring organizations (HIOs) that began on or after January 1, 1986 that the statute does not explicitly exempt from requirements in section 1903(m) of the Act.

§438.320 Definitions.

As used in this subpart—

EQR stands for external quality review.

EQRO stands for external quality review organization.

External quality review means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO, PIHP, **and PAHP**, or their contractors furnish to Medicaid beneficiaries.

External quality review organization means an organization that meets the competence and independence requirements set forth in §438.354, and performs external quality review, other EQR-related activities as set forth in §438.358, or both.

Financial relationship means—

(1) 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

(2) A compensation arrangement with an entity.

Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, **and PAHP**, increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services ~~that are~~ consistent with current professional knowledge.

Validation means 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.

§438.350 State responsibilities.

Each State that contracts with MCOs, PIHPs, **and PAHPs**, must ensure that—

(a) Except as provided in §438.362, a qualified EQRO performs an annual EQR for each contracting MCO, PIHPs, **and PAHPs**;

(b) The EQRO has sufficient **valid and reliable** information to use in performing the review;

(c) The information used to carry out the review must be obtained from the EQR-related activities described in §438.358.

(d) For each EQR-related activity, the information must include the elements described in §438.364(a)(1)(i) through (a)(1)(iv);

(e) The information provided to the EQRO in accordance with paragraph (c) of this section is obtained through methods consistent with the protocols established under §438.352; and

(f) The results of the reviews are made available as specified in §438.364.

§438.352 External quality review protocols.

Each protocol must specify—

(a) The data to be gathered;

(b) The sources of the data;

(c) The activities and steps to be followed in collecting the data to ~~promote~~**ensure** its accuracy, validity, and reliability;

(d) The proposed method or methods for validly analyzing and interpreting the data once obtained; and

(e) Instructions, guidelines, worksheets, and other documents or tools necessary for implementing the protocol.

§438.354 Qualifications of external quality review organizations.

(a) *General rule.* The State must ensure that an EQRO meets the requirements of this section.

(b) *Competence.* The EQRO must have at a minimum the following:

(1) Staff with demonstrated experience and knowledge of—

(i) Medicaid beneficiaries, policies, data systems, and processes;

(ii) Managed care delivery systems, organizations, and financing;

(iii) Quality assessment and improvement methods; and

(iv) Research design and methodology, including statistical analysis.

(2) Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.

(3) Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

(c) *Independence.* The EQRO and its subcontractors are independent from the State Medicaid agency and from the MCOs, PIHPs, **and PAHPs** that they review. To qualify as "independent"—

(1) A State agency, department, university, or other State entity may not have Medicaid purchasing or managed care licensing authority; and

(2) A State agency, department, university, or other State entity must be governed by a Board or similar body the majority of whose members are not government employees.

(3) An EQRO may not—

(i) **Review a particular MCO, PIHP, or PAHP, nor review any other MCO, PIHP, or PAHP operating in the same service area as such particular MCO, PIHP, or PAHP, if either the EQRO or the MCO, PIHP, or PAHP exerts control over the other through-**

(A) Stock ownership;

(B) Stock options and convertible debentures;

(C) Voting trusts;

(D) Common management, including interlocking management; and

(E) Contractual relationships.

(ii) Deliver any health care services to Medicaid beneficiaries;

(iii) Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PIHP**, or PAHP** services, except for the related activities specified in §438.358; or

(iv) Have a present, or known **or expected** future, direct or indirect financial relationship with an MCO, PIHP, **or PAHP** that it will review as an EQRO.

(4) As used in this paragraph, "control" has the meaning given the term in 48 C.F.R. §19.101.

§438.356 State contract options.

(a) The State—

(1) Must contract with one EQRO to conduct either EQR alone or EQR and other EQR-related activities; and

(2) May contract with additional EQROs to conduct EQR-related activities as set forth in §438.358.

(b) Each EQRO must meet the competence requirements as specified in §438.354(b).

(c) Each EQRO is permitted to use subcontractors. The EQRO is accountable for, and must oversee, all subcontractor functions.

(d) Each EQRO and its subcontractors performing EQR or EQR-related activities must meet the requirements for independence, as specified in §438.354(c).

(e) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services. **Notwithstanding State law, the State agency shall post its Request for Proposals (RFP) on a website that is accessible to the public and provide a reasonable public comment period prior to beginning the bidding process**.

§438.358 Activities related to external quality review.

(a) *General rule.* The State, its agent that is not an MCO, PIHP, or **PAHP**, or an EQRO may perform the mandatory and optional EQR-related activities in this section.

(b) *Mandatory activities.* ~~For~~ each MCO, PIHP, or **PAHP**, **must provide access to and the entity must utilize sufficient reliable data to complete**~~must use information from~~ the following activities:

(1) Validation of performance improvement projects required by the State to comply with requirements set forth in §438.240(b)(1) and that were underway during the preceding 12 months.

(2) Validation of MCO, PIHP, or **PAHP** performance measures reported (as required by the State) or MCO or ~~PIHP~~**PHP** performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in §438.240(b)(2).

(3) A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or **PAHP's** compliance with standards (except with respect to standards under §§438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of §438.204(g).

(**4) Validation of encounter data reported by an MCO, PIHP, or PAHP within the preceding 12 months.**

(5) Administration of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time during the preceding 12 months

(6) Administration or validation of quantitative and qualitative research with enrollees, such as consumer surveys and focus groups, conducted during the preceding 12 months examining consumer experience and care quality.

(7) A review and analysis of complaints, grievances, and appeals filed in the preceding 12 months with each MCO or PHP, including their outcomes, to identify systemic problems and recommend potential remedies.

(c) *Optional activities.* The **entity performing the** EQR may also use information derived during the preceding 12 months ~~from the following~~ **to complete the following** optional activities:

~~(1) Validation of encounter data reported by an MCO or PIHP.~~

(2) Administration or validation ~~of consumer or~~ provider surveys of quality of care.

(3) Calculation of performance measures in addition to those reported by an MCO, PIHP, **or PAHP** and validated by an EQRO.

(4) ~~Conduct~~ **Administration** of performance improvement projects in addition to those conducted by MCO, PIHP, **or PAHP** and validated by an EQRO.

~~(5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.~~

(d) *Technical assistance.* The EQRO may, at the State's direction, provide technical guidance to groups of MCOs, PIHPs, **or PAHPs** to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

§438.360 Nonduplication of mandatory activities.

(a) *General rule.* To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO, PIHP, **or PAHP** obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities specified in §438.358 if the conditions of paragraph (b) or paragraph (c) of this section are met.

(b) *MCOs, PIHP, **or PAHPs** reviewed by Medicare or private accrediting organizations.* For information about an MCO's, PIHP's, **or PAHP's** or ~~PIHP~~ compliance with one or more standards required under §438.204(g), (except with respect to standards under §§438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) the following conditions must be met:

(1) The MCO, PIHP, **or PAHP** is in compliance with standards established by CMS for Medicare+Choice or a national accrediting organization. The CMS or national accreditation standards are comparable to standards established by the State to comply with §438.204(g) and the EQR-related activity under §438.358(b)(3).

(2) Compliance with the standards is determined either by—

(i) CMS or its contractor for Medicare; or

(ii) A private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in §422.158.

(3) The MCO, PIHP, **or PAHP** provides to the State all the reports, findings, and other results of the Medicare or private accreditation review applicable to the standards provided for in §438.204(g); and the State provides the information to the EQRO.

(4) In its quality strategy, the State identifies the standards for which the EQR will use information from Medicare or private accreditation reviews, and explains its rationale for why the standards are duplicative.

(c) *Additional provisions for MCOs, PIHPs, **or PAHPs** serving only dually eligibles.* The State may use information obtained from the Medicare program in place of information produced by the State, its agent, or EQRO with respect to the mandatory activities specified in §438.358 (b)(1) and (b)(2) if the following conditions are met:

(1) The MCO, PIHP, **or PAHP** serves only individuals who receive both Medicare and Medicaid benefits.

(2) The Medicare review activities are substantially comparable to the State-specified mandatory activities in §438.358(b)(1) and (b)(2).

(3) The MCO, PIHP, **or PAHP** provides to the State all the reports, findings, and other results of the Medicare review from the activities specified under §438.358(b)(1) and (b)(2) and the State provides the information to the EQRO.

(4) In its quality strategy, the State identifies the mandatory activities for which it has exercised this option and explains its rationale for why these activities are duplicative.

§438.362 Exemption from external quality review.

(a) *Basis for exemption.* The State may exempt an MCO, PIHP, **or PAHP** from EQR if the following conditions are met:

(1) The MCO, PIHP, **or PAHP** has a current Medicare contract under part C of title XVIII or under section 1876 of the Act, and a current Medicaid contract under section 1903(m) of the Act.

(2) The two contracts cover all or part of the same geographic area within the State.

(3) The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO, PIHP, **or PAHP** has been subject to EQR under this part, and found to be performing acceptably with respect to the quality, timeliness, and access to health care services it provides to Medicaid beneficiaries.

(b) *Information on exempted MCOs, PIHP**, or PAHPs**.* When the State exercises this option, the State must obtain either of the following:

(1) *Information on Medicare review findings.* Each year, the State must obtain from each MCO, PIHP, **or PAHP** that it exempts from EQR the most recent Medicare review findings reported on the MCO, PIHP, **or PAHP** including—

(i) All data, correspondence, information, and findings pertaining to the MCO's, PIHP's, **or PAHP's** compliance with Medicare standards for access, quality assessment and performance improvement, health services, or delegation of these activities;

(ii) All measures of the MCO's, PIHP's, **or PAHP's** performance; and

(iii) The findings and results of all performance improvement projects pertaining to Medicare enrollees.

(2) *Medicare information from a private, national accrediting organization that CMS approves and recognizes for Medicare+Choice deeming.*

(i) If an exempted MCO, PIHP, **or PAHP** has been reviewed by a private accrediting organization, the State must require the MCO, PIHP, **or PAHP** to provide the State with a copy of all findings pertaining to its most recent accreditation review if that review has been used for either of the following purposes:

(A) To fulfill certain requirements for Medicare external review under subpart D of part 422 of this chapter.

(B) To deem compliance with Medicare requirements, as provided in §422.156 of this chapter.

(ii) These findings must include, but need not be limited to, accreditation review results of evaluation of compliance with individual accreditation standards, noted deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

§438.364 External quality review results.

(a) *Information that must be produced.* The State must ensure that the EQR produces at least the following information:

(1) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, **or PAHP**. The report must also include the following for each activity conducted in accordance with §438.358:

(i) **A Statement disclosing the EQRO's officers, directors, trustees and key employees, as well as affiliates and chapters.**

(ii) Objectives.

(ii**i**) Technical methods of data collection and analysis.

(**iv**~~ii~~) Description of data obtained, **including an analysis of the gaps and shortcomings of the data collection methodology that may inhibit its accuracy, validity and reliability**

(~~i~~v) Conclusions drawn from the data.

(2) An assessment of each MCO's, PIHP's, **or PAHP's** strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

(3) Recommendations for improving the quality of health care services furnished by each MCO, PIHP, **or PAHP**.

(4) As the State determines, methodologically appropriate, comparative information about all MCOs, PIHPs, **or PAHPs**.

(5) An assessment of the degree to which each MCO, PIHP, **or PAHP** has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

(b) *Availability of information**.***

(1) The State must ~~provide~~**post** copies of the information specified in paragraph (a) of this section **on a website accessible to the general public.**~~upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, beneficiary advocacy groups, and members of the general public.~~ The State must make this information available in alternative formats for persons with **LEP or disabilities, in accordance with § 438.10(c) and (f) and § 438.70**, when requested.

(2) The State must post information specified in paragraph (a) within one week after receiving it.

(3) The information specified in paragraph (a) must remain posted and accessible for at least 5 years.

(c) *Safeguarding patient identity.* The information released under paragraph (b) of this section may not disclose the identity of any patient.

§438.370 Federal financial participation.

(a) FFP at the 75 percent rate is available in expenditures for EQR (including the production of EQR results) and EQR-related activities set forth in §438.358 conducted by EQROs and their subcontractors.

(b) FFP at the 50 percent rate is available in expenditures for EQR-related activities conducted by any entity that does not qualify as an EQRO.

Subpart F—Grievance System

§438.400 Statutory basis and definitions.

(a) *Statutory basis.* This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

Action means—

In the case of an MCO, **PAHP, or** PIHP—

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the State;

(5) Denial of disenrollment or enrollment exemption requests;

(6) The failure of an MCO, **PAHP, or** or PIHP to act within the timeframes provided in §438.408(b);

(7) A decision of the total budget for enrollees' services;

(8) Determination of a cost sharing amount; or

(9) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

Appeal means a request for review of an action, as "action" is defined in this section.

Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of ~~care or~~ services **or continuity of care** provided, **the number and type of providers in the network, the amount of time required to travel to a provider, failure to provide information as required by § 438.10,** and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

§438.402 General requirements.

(a) *The grievance system.* Each MCO, **PAHP, or** and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.

(b) *Filing requirements*.

(1) *Authority to file.*

(i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing.

(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.

(2) *Timing.* The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's, **PAHP's, or** PIHP's notice of action. Within that timeframe—

(i) The enrollee or the provider may file an appeal; and

(ii) In a State that does not require exhaustion of MCO, **PAHP, or** and PIHP level appeals, the enrollee may request a State fair hearing.

(3) *Procedures.*

(i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO, **PAHP, or** PIHP.

(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

§438.404 Notice of action.

(a) *Language and format requirements.*

(1) The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d), **and § 438.70** to ensure ease of understanding.

(2) If the State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM has information that the recipient has LEP, the notice must be provided in the recipient's non-English language and information on how to access all of the information in the recipient's language. For all other beneficiaries, an overview must include taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.

(3) If the State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM has information that the recipient has a disability that requires an alternative format for notices, the notice must be provided in that alternate format and must include a large print tagline and information on how to request the notice in alternative formats.

(b) *Content of notice.* The notice must explain the following:

(1) The action the MCO**, PAHP,** or PIHP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO**, PAHP,** or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO**, PAHP,** or PIHP level appeal procedures, the enrollee's right to request a State fair hearing **or if the State does require exhaustion, that the enrollee retains the right to request a fair hearing;**

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) *Timing of notice.* The MCO**, PAHP,** or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).

(4) If the MCO**, PAHP,** or PIHP extends the timeframe in accordance with §438.210(d)(1), it must—

(i) Give the enrollee written notice 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; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d).

§438.406 Handling of grievances and appeals.

(a) *General requirements.* In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability **, as well as ensuring that forms and notices are available in alternative formats, in compliance with § 438.70.**

(2) Acknowledge receipt of each grievance and appeal **within 3 calendar days**.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's **specific** condition or disease **and the specific services requested by the recipient.**

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(4) Provide for submission of grievances and appeals in a non-English language or alternate format to accommodate the needs of individuals with LEP or individuals with disabilities.

(b) *Special requirements for appeals.* The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing **by the MCO, PAHP, or PIHP**, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's eState.

(5) Provide that enrollees who have LEP are provided language services throughout the appeals process including translated notices, oral language services at the appeal.

(6) Provide that enrollees who have disabilities and need written information in alternative formats or augmentative or auxiliary aids for communication are provided those aids throughout the appeals process including notices in alternative format, assistance at the appeal.

§438.408 Resolution and notification: Grievances and appeals.

(a) *Basic rule.* The MCO**, PAHP,** or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) *Specific timeframes*.

(1) *Standard disposition of grievances.* For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed ~~90~~**30** days from the day the MCO or PIHP receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than **30**~~45~~ days from the day the MCO**, PAHP,** or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO**, PAHP,** or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) *Extension of timeframes*.

(1) The MCO**, PAHP,** or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days, **or 3 calendar days in the case of an expedited appeal**, if—

(i) The enrollee requests the extension; or

(ii) **Only in the case of a standard resolution under (b)(2),** the MCO**, PAHP,** or PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. **In the case of an expedited appeal under (b)(3), MCO, PAHP, or PIHP must shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and that the delay is in the enrollee's interest and will not jeopardize the enrollees' life or health or ability to attain, maintain or regain maximum functions.**

(2) *Requirements following extension.* If the MCO**, PAHP,** or PIHP extends the timeframes, it must—for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

(d) *Format of notice*.

(1) *Grievances.* The State must establish the method MCOs**, PAHPs,** and PIHPs will use to notify an enrollee of the disposition of a grievance.

(2) *Appeals.*

(i) For all appeals, the MCO**, PAHP,** or PIHP must provide written notice of disposition.

(ii) For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice **within 24 hours and a written notice no longer than 2 calendar days after the disposition**.

(3) For individuals who have LEP, the notice must be:

(i) translated into the enrollee's language if the enrollee's language is prevalent (as described in §438.10(c) and (f) and §438.70; or

(ii) include a tagline in the enrollee's language informing the enrollee how to obtain the information contained in the notice in the enrollee's language.

(4) For individuals with disabilities who need written materials in an alternate format, the notice must be provided in that format.

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so;

(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.

(f) *Requirements for State fair hearings*.

(1) *Availability.* The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than ~~20~~**60** or in excess of 90 days from whichever of the following dates applies—

(i) If the State requires exhaustion of the MCO**, PAHP,** or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or

(ii) If the State does not require exhaustion of the MCO**, PAHP,** or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, **within 90 days** from the date on the MCO's**, PAHP's,** or PIHP's notice of action.

(2) *Parties.* The parties to the State fair hearing include the MCO**, PAHP,** or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's eState.

(3) *Language Access and Disability Access.*

(i) For individuals who have LEP, the State must provide language services including translated notices, oral language services at the appeal.

(ii) For individuals who have disabilities and need written information in alternative formats or augmentative or auxiliary aids for communication, the State must provide those aids throughout the appeals process including notices in alternative format, assistance at the appeal.

§438.410 Expedited resolution of appeals.

(a) *General rule.* Each MCO, PIHP, **or PAHP** must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or 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 or health or ability to attain, maintain, or regain maximum function**.**

(b) *Punitive action.* The MCO, PIHP, **or PAHP** must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) *Action following denial of a request for expedited resolution.* If the MCO, PIHP, **or PAHP** denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2);

(2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

§438.414 Information about the grievance system to providers and subcontractors.

The MCO, PIHP, **or PAHP** must provide the information specified at §438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

§438.416 Recordkeeping and reporting requirements.

The State must require MCOs, PIHPs, **or PAHPs** to maintain records of grievances and appeals and must review the information as part of the State quality strategy.

§438.420 Continuation of benefits while the MCO, PAHPs, or PIHP appeal and the State fair hearing are pending.

(a) *Terminology.* As used in this section, "timely" filing means filing on or before the later of the following:

(1) Within ten days of the MCO, PIHP, **or PAHP** mailing the notice of action.

(2) The intended effective date of the MCO's**, PAHP's,** or PIHP's proposed action.

(b) *Continuation of benefits.* The MCO, PIHP, **or PAHP** must continue the enrollee's benefits if—

(1) The enrollee or the provider files the appeal timely;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

~~(4) The original period covered by the original authorization has not expired~~ and

(~~5~~**4**) The enrollee requests extension of benefits.

(c) *Duration of continued or reinStated benefits.* If, at the enrollee's request, the MCO, PIHP, **or PAHP** continues or reinStates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal.

(2) Ten days pass after the MCO, PIHP, **or PAHP** mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached **after receiving timely notice of such right to seek a fair hearing pursuant to Section 431.210.**

(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.

~~(4) The time period or service limits of a previously authorized service has been met.~~

(d) *Enrollee responsibility for services furnished while the appeal is pending.* If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in §431.230(b) of this chapter. **To recover costs from an enrollee who has LEP or has a disability that requires information provided in alternate formats, the MCO, PIHP**, **or PAHP may only recover the cost of the services furnished to the enrollee while the appeal is pending if the MCO, PIHP, or PAHP can document that it provided the enrollee with information about recovery in the enrollee's language or in an alternate format to meet the needs of an individual with a disability.**

NOTE ON ALTERNATIVES:

We strongly recommend simply deleting the language in § 438.420 (b)(4) and (c)(4).

There are other options for ensuring that utilization review policies do not trump constitutional protections or create illegal obstacles to the implementation of the constitutional protections. In the alternative to deleting § 438.420(b)(4) and (c)(4),we suggest adding a new subsection, § 438.420(e), which could take one of the following forms:

Alternative 1 (based on legislation recently enacted in New York):

When a non-governmental entity is authorized by the State agency pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of long term services and supports, a beneficiary may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to 42 C.F.R. § 431.230, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of a prior service authorization.

Alternative 2 (based on assumption that managed care plans are selecting and enrolling high quality providers):

MCEs shall provide that when an in-plan prescribing clinician orders any item or service of long term services and supports, if that item of service is, in the opinion of the in-plan clinician prescribed to meet an ongoing need, the item or service will not be disrupted pending further medical review and modification of the prescription or, as appropriate, plan of care.

Alternative 3 (based on Minnesota policies):

If the enrollee timely appeals the reduction or termination of previously authorized items or services and the treating physician or another in-plan prescribing clinician orders the items or services to be continued at the previously authorized level, the State agency must (directly or through its contractors) must continue to provide services at the level equal to the level ordered by the physician until the State agency renders its final decision.

§438.424 Effectuation of reversed appeal resolutions.

(a) *Services not furnished while the appeal is pending.* If the MCO, PIHP, **or PAHP**, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) *Services furnished while the appeal is pending.* If the MCO, PIHP, **or PAHP**, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.

Subpart G [Reserved]

Subpart H—Certifications and Program Integrity

§438.600 Statutory basis.

This subpart is based on sections 1902(a)(4), 1902(a)(19), 1903(m), and 1932(d)(1) of the Act.

(a) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(b) Section 1902(a)(19) requires that the State plan provide the safeguards necessary to ensure that eligibility is determined and services are provided in a manner consistent with simplicity of administration and the best interests of the beneficiaries.

(c) Section 1903(m) establishes conditions for payments to the State with respect to contracts with MCOs.

(d) Section 1932(d)(1) prohibits MCOs and PCCMs from knowingly having certain types of relationships with individuals excluded under Federal regulations from participating in specified activities, or with affiliates of those individuals.

§438.602 Basic rule.

As a condition for receiving payment under the Medicaid managed care program, an MCO, PCCM, PIHP, or PAHP must comply with the applicable certification, program integrity and prohibited affiliation requirements of this subpart.

§438.604 Data that must be certified.

(a) *Data certifications.* When State payments to an MCO, PIHP, **or PAHP** are based on data submitted by the MCO, PIHP, **or PAHP**, the State must require certification of the data as provided in §438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals, and related documents.

(b) *Additional certifications.* Certification is required, as provided in §438.606, for all documents specified by the State.

§438.606 Source, content, and timing of certification.

(a) *Source of certification.* For the data specified in §438.604, the data the MCO, PIHP, **or PAHP** submits to the State must be certified by one of the following:

(1) The MCO's, PIHP's, **or PAHP's** Chief Executive Officer.

(2) The MCO's, PIHP's, **or PAHP**'s Chief Financial Officer.

(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's, PIHP's, **or PAHP**'s Chief Executive Officer or Chief Financial Officer.

(b) *Content of certification.* The certification must attest, based on best knowledge, information, and belief, as follows:

(1) To the accuracy, completeness and truthfulness of the data.

(2) To the accuracy, completeness and truthfulness of the documents specified by the State.

(c) *Timing of certification.* The MCO, PIHP, **or PAHP** must submit the certification concurrently with the certified data.

§438.608 Program integrity requirements.

(a) *General requirement.* The MCO, PIHP, **or PAHP** must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

(b) *Specific requirements.* The arrangements or procedures must include the following:

(1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.

(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.

(3) Effective training and education for the compliance officer and the organization's employees.

(4) Effective lines of communication between the compliance officer and the organization's employees.

(5) Enforcement of standards through well-publicized disciplinary guidelines.

(6) Provision for internal monitoring and auditing.

(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

§438.610 Prohibited affiliations with individuals debarred by Federal agencies.

(a) *General requirement.* An MCO, PCCM, PIHP, or PAHP may not knowingly have a relationship of the type described in paragraph (b) of this section with the following:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) *Specific requirements.* The relationships described in this paragraph are as follow:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP.

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity.

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

(c) *Effect of Noncompliance.* If a State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance with paragraphs (a) and (b) of this section, the State:

(1) Must notify the Secretary of the noncompliance.

(2) May continue an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary directs otherwise.

(3) May not renew or otherwise extend the duration of an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary provides to the State and to Congress a written Statement describing compelling reasons that exist for renewing or extending the agreement.

(d) *Consultation with the Inspector General.* Any action by the Secretary described in paragraphs (c)(2) or (c)(3) of this section is taken in consultation with the Inspector General.

Subpart I—Sanctions

§438.700 Basis for imposition of sanctions.

(a) Each State that contracts with an MCO**, PIHP, or PAHP** must, and each State that contracts with a PCCM may, establish intermediate sanctions, as specified in §438.702, that it may impose if it makes any of the determinations specified in paragraphs (b) through (d) of this section. The State may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) A State determines whether an MCO, **PIHP, or PAHP** acts or fails to act as follows:

(1) Fails substantially to provide medically necessary services that the MCO, **PIHP, or PAHP** is required to provide, under law or under its contract with the State, to an enrollee covered under the contract

(**2) ~~Restricts~~Fails or substantially fails to comply with enrollee rights under 438.100(b), information requirements under 438.10, or Subpart F (Grievance System).**

(**3**) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

(**4**) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes**, but is not limited to,** 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

(**5**) Misrepresents or falsifies information that it furnishes to CMS or to the State.

(**6)** Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

(**7**) Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§422.208 and 422.210 of this chapter.

(c) A State determines whether an MCO, PIHP, PAHP or PCCM has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

(d) A State determines whether—

(1) An MCO, **PIHP, or PAHP** has violated any of the other **applicable** requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations;

(2) A PCCM has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations;

(3) For any of the violations under paragraphs (d)(1) and (d)(2) of this section, only the sanctions specified in §438.702, paragraphs (a)(3), (a)(4), and (a)(5) may be imposed.

§438.702 Types of intermediate sanctions.

(a) The types of intermediate sanctions that a State may impose under this subpart include the following:

(1) Civil money penalties in the amounts specified in §438.704.

(2) Appointment of temporary management for an MCO as provided in §438.706.

(3) Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.

(4) Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.

(5) Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

(b) State agencies retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in §438.700, as well as additional areas of noncompliance. Nothing in this subpart prevents State agencies from exercising that authority.

§438.704 Amounts of civil money penalties.

(a) *General rule.* The limit on, or the maximum civil money penalty the State may impose varies depending on the nature of the MCO's or PCCM's action or failure to act, as provided in this section. **For an action or failure to act involving an enrollee, the State may impose a separate and distinct penalty per event and per enrollee affected**.

(b) *Specific limits.*

(1) The limit is $**45**~~25~~,000 for each determination under the following paragraphs of §438.700:

(i) Paragraph (b)(1) (Failure to provide services).

(ii) Paragraph (b)(2) (Failure to comply with enrollee rights under 438.100(b) or Subpart F)

(ii) Paragraph (b)(5) (Misrepresentation or false Statements to enrollees, potential enrollees, or health care providers).

(iii) Paragraph (b)(6) (Failure to comply with physician incentive plan requirements).

(iv) Paragraph (b)(7)

(v) Paragraph (c) (Marketing violations).

(2) The limit is $100,000 for each determination under paragraph (b)(3) (discrimination) or (b)(4) (Misrepresentation or false Statements to CMS or the State) of §438.700.

(3) The limit is $~~1~~**2**5,000 for each beneficiary the State determines was not enrolled because of a discriminatory practice under paragraph (b)(3) of §438.700. (This is subject to the overall limit of $100,000 under paragraph (b)(2) of this section).

(c) *Specific amount.* For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $~~2~~**4**5,000 or double the amount of the excess charges, whichever is greater. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollees.

§438.706 Special rules for temporary management.

(a) *Optional imposition of sanction.* The State may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that—

(1) There is continued egregious behavior by the MCO, including but not limited to behavior that is described in §438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

(2) There is substantial risk to enrollees' health **or rights**; or

(3) The sanction is necessary to ensure the health **or rights** of the MCO's enrollees—

(i) While improvements are made to remedy violations under §438.700; or

(ii) Until there is an orderly termination or reorganization of the MCO.

(b) *Required imposition of sanction.* The State must impose temporary management (regardless of any other sanction that may be imposed) if it finds that an MCO has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Act, or this subpart. The State must also grant enrollees the right to terminate enrollment without cause, as described in §438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment.

(c) *Hearing.* The State may not delay imposition of temporary management to provide a hearing before imposing this sanction.

(d) *Duration of sanction.* The State may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur.

§438.708 Termination of an MCO or PCCM contract.

A State has the authority to terminate an MCO or PCCM contract and enroll that entity's enrollees in other MCOs or PCCMs, or provide their Medicaid benefits through other options included in the State plan, if the State determines that the MCO or PCCM has failed to do either of the following:

(a) Carry out the substantive terms of its contract; or

(b) Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.

§438.710 Due process: Notice of sanction and pre-termination hearing.

(a) *Notice of sanction.* Except as provided in §438.706(c), before imposing any of the intermediate sanctions specified in this subpart, the State must give the affected entity timely written notice that explains the following:

(1) The basis and nature of the sanction.

(2) Any other due process protections that the State elects to provide.

(b) *Pre-termination hearing*.

(1) *General rule.* Before terminating an MCO or PCCM contract under §438.708, the State must provide the entity a pre-termination hearing.

(2) *Procedures.* The State must do the following:

(i) Give the MCO or PCCM written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

(ii) After the hearing, give the entity written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and

(iii) For an affirming decision, give enrollees of the MCO or PCCM notice of the termination and information, consistent with §438.10, on their options for receiving Medicaid services following the effective date of termination.

§438.722 Disenrollment during termination hearing process.

After a State notifies an MCO or PCCM that it intends to terminate the contract, the State may do the following:

(a) Give the entity's enrollees written notice of the State's intent to terminate the contract.

(b) Allow enrollees to disenroll immediately without cause.

(1) If the State allows enrollees to disenroll immediately without cause, it must inform enrollees in a written notice of intent to terminate the contract

§438.724 Notice to CMS.

(a) The State must give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in §438.700.

(b) The notice must—

(1) Be given no later than 30 days after the State imposes or lifts a sanction; and

(2) Specify the affected MCO, the kind of sanction, and the reason for the State's decision to impose or lift a sanction.

(3) be made available to the public at least by issuing a press release and posting prominent notice on the State Agency's website.

§438.726 State plan requirement.

(a) The State plan must include a plan to monitor for violations that involve the actions and failures to act specified in this part and to implement the provisions of this part.

(b) A contract with an MCO must provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under section 438.730(e).

§438.730 Sanction by CMS: Special rules for MCOs

(a) Basis for sanction.

(1) A State agency may recommend that CMS impose the denial of payment sanction specified in paragraph (e) of this section on an MCO with a contract under this part if the agency determines that the MCO acts or fails to act as specified in §438.700(b)(1) through (b)(6).

(b) *Effect of an Agency Determination.*

(1) The State agency's determination becomes CMS's determination for purposes of section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days.

(2) When the agency decides to recommend imposing the sanction described in paragraph (e) of this section, this recommendation becomes CMS's decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days.

(c) *Notice of sanction.* If the State agency's determination becomes CMS's determination under section (b)(2), the State agency takes the following actions:

(1) Gives the MCO written notice of the nature and basis of the proposed sanction;

(2) Allows the MCO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction;

(3) May extend the initial 15-day period for an additional 15 days if—

(i) the MCO submits a written request that includes a credible explanation of why it needs additional time;

(ii) the request is received by CMS before the end of the initial period; and

(iii) CMS has not determined that the MCO's conduct poses a threat to an enrollee's health or safety.

(d) *Informal reconsideration.*

(1) If the MCO submits a timely response to the notice of sanction, the State agency—

(i) Conducts an informal reconsideration that includes review of the evidence by a State agency official who did not participate in the original recommendation;

(ii) Gives the MCO a concise written decision setting forth the factual and legal basis for the decision; and

(iii) Forwards the decision to CMS.

(2) The agency decision under paragraph (d)(1)(ii) of this section becomes CMS's decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS.

(3) If CMS reverses or modifies the State agency decision, the agency sends the MCO a copy of CMS's decision.

(e) *Denial of payment.*

(1) CMS, based upon the recommendation of the agency, may deny payment to the State for new enrollees of the HMO under section 1903(m)(5)(B)(ii) of the Act in the following situations:

(i) If a CMS determination that an MCO has acted or failed to act, as described in paragraphs (b)(1) through (b)(6) of §438.700, is affirmed on review under paragraph (d) of this section.

(ii) If the CMS determination is not timely contested by the MCO under paragraph (c) of this section.

(2) Under §438.726(b), CMS's denial of payment for new enrollees automatically results in a denial of agency payments to the HMO for the same enrollees. (A new enrollee is an enrollee that applies for enrollment after the effective date in paragraph (f)(1) of this section.)

(f) *Effective date of sanction.*

(1) If the MCO does not seek reconsideration, a sanction is effective 15 days after the date the MCO is notified under paragraph (b) of this section of the decision to impose the sanction.

(2) If the MCO seeks reconsideration, the following rules apply:

(i) Except as specified in paragraph (d)(2)(ii) of this section, the sanction is effective on the date specified in CMS's reconsideration notice.

(ii) If CMS, in consultation with the State agency, determines that the MCO's conduct poses a serious threat to an enrollee's health or safety, the sanction may be made effective earlier than the date of the agency's reconsideration decision under paragraph (c)(1)(ii) of this section.

(g) *CMS's role.*

(1) CMS retains the right to independently perform the functions assigned to the State agency under paragraphs (a) through (d) of this section.

(2) At the same time that the agency sends notice to the MCO under paragraph (c)(1)(i) of this section, CMS forwards a copy of the notice to the OIG.

(3) CMS conveys the determination described in paragraph (b) of this section to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and part 1003 of this title. In accordance with the provisions of part 1003, the OIG may impose civil money penalties on the MCO in addition to, or in place of, the sanctions that may be imposed under this section.

Subpart J—Conditions for Federal Financial Participation

§438.802 Basic requirements.

FFP is available in expenditures for payments under an MCO contract only for the periods during which the contract—

(a) Meets the requirements of this part; and

(b) Is in effect.

§438.804 Primary care provider payment increases.

(a) For MCO, PIHP or PAHP contracts that cover calendar years 2013 and 2014, FFP is available at an enhanced rate of 100 percent for the portion of the expenditures for capitation payments made under those contracts to comply with the contractual requirement under §438.6(c)(5)(vi) only if the following requirements are met:

(1) The State must submit to CMS the following methodologies for review and approval.

(i) The State develops a reasonable methodology, based on rational and documented data and assumptions, for identifying the provider payments that would have been made by MCO, PIHP or PAHP for specified primary care services furnished as of July 1, 2009. This methodology can take into consideration the availability of data, and the costs and burden of administering the method, but should produce a reliable and accurate result to the fullest extent possible.

(ii) The State develops a reasonable methodology, based on rational and documented data and assumptions, for identifying the differential in payment between the provider payments that would have been made by the MCO, PIHP or PAHP on July 1, 2009 and the amount needed to comply with the contractual requirement under §438.6(c)(5)(vi). This methodology can take into consideration the availability of data, and the costs and burden of administering the method, but should produce a reliable and accurate result to the fullest extent possible.

(2) The State must submit the methodologies in paragraphs (a)(1)(i) and (ii) of this section to CMS for review no later than the end of the first quarter of CY 2013.

(3) CMS will use the approved methodologies required under this section in the review and approval of MCO, PIHP or PAHP contracts and rates consistent with §438.6(a).

(b) [Reserved]

[77 FR 66699, Nov. 6, 2012]

§438.806 Prior approval.

(a) *Comprehensive risk contracts.* FFP is available under a comprehensive risk contract only if—

(1) The Regional Office has confirmed that the contractor meets the definition of an MCO or is one of the entities described in paragraphs (b)(2) through (b)(5) of §438.6; and

(2) The contract meets all the requirements of section 1903(m)(2)(A) of the Act, the applicable requirements of section 1932 of the Act, and the implementing regulations in this part.

(b) *MCO contracts.* Prior approval by CMS is a condition for FFP under any MCO contract that extends for less than one full year or that has a value equal to, or greater than, the following threshold amounts:

(1) For 1998, the threshold is $1,000,000.

(2) For subsequent years, the amount is increased by the percentage increase in the consumer price index for all urban consumers.

(c) FFP is not available in an MCO contract that does not have prior approval from CMS under paragraph (b) of this section.

§438.808 Exclusion of entities.

(a) *General rule.* FFP is available in payments under MCO contracts only if the State excludes from the contracts any entities described in paragraph (b) of this section.

(b) *Entities that must be excluded.*

(1) An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

(2) An entity that has a substantial contractual relationship as defined in §431.55(h)(3) of this chapter, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act.

(3) An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

(i) Any individual or entity excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

(ii) Any entity that would provide those services through an excluded individual or entity.

§438.810 Expenditures for enrollment broker services.

(a) *Terminology.* As used in this section—

Choice counseling means activities such as answering questions and providing information (in an unbiased manner) on available MCO, PIHP, PAHP, or PCCM delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider;

Enrollment activities means activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone or in person;

Enrollment broker means an individual or entity that performs choice counseling or enrollment activities, or both, and;

Enrollment services means choice counseling, or enrollment activities, or both.

(b) *Conditions that enrollment brokers must meet.* State expenditures for the use of enrollment brokers are considered necessary for the proper and efficient operation of the State plan and thus eligible for FFP only if the broker and its subcontractors meet the following conditions:

(1) *Independence.* The broker and its subcontractors are independent of any MCO, PIHP, PAHP, PCCM, or other health care provider in the State in which they provide enrollment services. A broker or subcontractor is not considered "independent" if it—

(i) Is an MCO, PIHP, PAHP, PCCM or other health care provider in the State;

(ii) Is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the State; or

(iii) Owns or controls an MCO, PIHP, PAHP, PCCM or other health care provider in the State.

(2) *Freedom from conflict of interest.* The broker and its subcontractor are free from conflict of interest. A broker or subcontractor is not considered free from conflict of interest if any person who is the owner, employee, or consultant of the broker or subcontractor or has any contract with them—

(i) Has any direct or indirect financial interest in any entity or health care provider that furnishes services in the State in which the broker or subcontractor provides enrollment services;

(ii) Has been excluded from participation under title XVIII or XIX of the Act;

(iii) Has been debarred by any Federal agency; or

(iv) Has been, or is now, subject to civil money penalties under the Act.

(3) *Approval.* The initial contract or memorandum of agreement (MOA) for services performed by the broker has been reviewed and approved by CMS.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§438.812 Costs under risk and nonrisk contracts.

(a) Under a risk contract, the total amount the State agency pays for carrying out the contract provisions is a medical assistance cost.

(b) Under a nonrisk contract—

(1) The amount the State agency pays for the furnishing of medical services to eligible beneficiaries is a medical assistance cost; and

(2) The amount the State agency pays for the contractor's performance of other functions is an administrative cost.