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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 433, 438, 440, 457 and 495

[CMS-2390-P]

RIN 0938-AS25

Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The proposed rule would align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implement statutory provisions; strengthen actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promote the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It would also ensure appropriate beneficiary protections and enhance policies related to program integrity. This proposed rule would also require states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries. This proposed rule would also implement provisions of the Children's Health Insurance Program

Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 27, 2015.

ADDRESSES: In commenting, please refer to file code CMS-2390-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.
2. By regular mail. You may mail written comments to the following address **ONLY**:
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2390-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address **ONLY**:
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2390-P,
Mail Stop C4-26-05,

7500 Security Boulevard,
Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier

delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Nicole Kaufman, (410) 786-6604, Medicaid Managed Care Operations.

Kristin Younger, (410) 786-3869, Medicaid Managed Care Quality.

Meg Barry, (410) 786-1536, CHIP.

Nancy Dieter, (410) 786-7219, Third Party Liability.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments.

Comments received timely would also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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Acronyms

Because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

[the] Act Social Security Act

Affordable Care Act The Affordable Care Act of 2010 (which is the collective term for the
 Patient Protection and Affordable Care Act (Pub. L. 111-148) and the
 Health Care Education Reconciliation Act (Pub. L. 111-152))

ARRA American Recovery and Reinvestment Act of 2009

BBA Balanced Budget Act of 1997

BIA Bureau of Indian Affairs

CDIB Certificate of Degree of Indian Blood

CPE	Certified Public Expenditure
CFR	Code of Federal Regulations
CBE	Community Benefit Expenditures
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
DUR	Drug Utilization Review [program]
EQR	External Quality Review
EQRO	External Quality Review Organization
FFM	Federally-Facilitated Marketplaces
FFP	Federal Financial Participation
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HHS	[U.S. Department of] Health and Human Services
HIO	Health Insuring Organization
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD	International Classification of Diseases
IGT	Intergovernmental Transfer
IHCP	Indian Health Care Provider
LEP	Limited English Proficiency
LTSS	Long-Term Services and Supports

MA	Medicare Advantage
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MHPA	Mental Health Parity Act of 1996
MHPAEA	Mental Health Parity and Addiction Equity Act MHPAEA
MLTSS	Managed Long-Term Services and Supports
MLR	Medical Loss Ratio
MSIS	Medicaid Statistical Information System
MH/SUD	Mental Health/Substance Use Disorder Services
NAMD	National Association of Medicaid Directors
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
OMB	Office of Management and Budget
PCCM	Primary Care Case Manager
PHS	Public Health Service Act
PIP	Performance Improvement Project
PMPM	Per-member Per-month
PAHP	Pre-paid Ambulatory Health Plan
PIHP	Pre-paid Inpatient Health Plan
QHP	Qualified Health Plans
SHO	State Health Official Letter
SBC	Summary of Benefits and Coverage

SFH	State Fair Hearing
SBM	State-Based Marketplaces
SIU	Special Investigation Unit
SMDL	State Medicaid Director Letter
T-MSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability

I. Medicaid Managed Care

A. Background

In 1965, amendments to the Social Security Act (the Act) established the Medicaid program as a joint federal and state program to provide medical assistance to individuals with low incomes. Under the Medicaid program, each state that chooses to participate in the program and receive federal financial participation for program expenditures establishes eligibility standards, benefits packages, and payment rates, and undertakes program administration in accordance with federal statutory and regulatory standards. The provisions of each state's Medicaid program are described in the state's Medicaid “state plan.” Among other responsibilities, we approve state plans and monitor activities and expenditures for compliance with federal Medicaid laws to ensure that beneficiaries receive access to quality health care. (Throughout this preamble, we use the term “beneficiaries” to mean “individuals eligible for and receiving Medicaid benefits.”)

Until the early 1990s, most Medicaid beneficiaries received Medicaid coverage through fee-for-service (FFS) arrangements. However, over time that practice has shifted and states are increasingly utilizing managed care arrangements to provide Medicaid coverage to beneficiaries. Under managed care, beneficiaries receive part or all of their Medicaid services from health care providers who are paid by an organization that is under contract with the state; the organization

receives a monthly capitated payment for a specified benefit package. In 1992, 2.4 million Medicaid beneficiaries (or 8 percent of all Medicaid beneficiaries) accessed part or all of their Medicaid benefits through capitated health plans; by 1998, that number had increased fivefold to 12.6 million (or 41 percent of all Medicaid beneficiaries). In fiscal year (FY) 2011, at least 39 million (or 58 percent of all Medicaid beneficiaries) in 39 states and the District of Columbia accessed part or all of their Medicaid benefits through such capitated health plans.¹

In a Medicaid managed care delivery system, through contracts with health plans, states require that the plan provide or arrange for a specified package of Medicaid services for enrolled beneficiaries. Under these contracts, the organization offering the health plan is paid a fixed, prospective, monthly payment for each enrolled beneficiary. This payment approach is referred to as “capitation.” Beneficiaries enrolled in capitated managed care organizations (MCOs) must access the Medicaid services covered under the state plan through the health plan. States may contract with managed care entities that offer comprehensive benefits, referred to as MCOs. Alternatively, managed care plans can receive a capitated payment for a limited array of services, such as behavioral health or dental services. Such entities that receive a capitated payment for a limited array of services are referred to as “prepaid inpatient health plans” (PIHPs) or “prepaid ambulatory health plans” (PAHPs) depending on the scope of services the health plan provides. Finally, applicable federal statute recognizes primary care case management as a type of managed care entity subject to some of the same standards as MCOs. States that do not pursue capitated arrangements but want to promote coordination and care management may contract with primary care providers or care management entities to support better health outcomes and increase the quality of care delivered to beneficiaries, but continue to pay for covered benefits on a FFS basis

¹ MACPAC, [Report to Congress on Medicaid and CHIP](https://www.macpac.gov/wp-content/uploads/2015/01/2014-06-13_MACPAC_Report.pdf) (June 2014), tables 11 and 14 at pgs. 106 and 120, available at https://www.macpac.gov/wp-content/uploads/2015/01/2014-06-13_MACPAC_Report.pdf.

directly to the health care provider.

As Medicaid managed care grew in the 1990's, the Congress enacted specific standards for Medicaid managed care programs in sections 4701 through 4709 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33, enacted on August 5, 1997). The BBA represented the first comprehensive revision to federal statutes governing Medicaid managed care since the early 1980s. In general, the BBA modified the federal statute to: (1) Allow states to mandate the enrollment of certain Medicaid beneficiaries into MCOs without having to first seek a waiver of federal statutory standards; (2) eliminate standards on the composition of enrollment in MCOs that had not proven to be effective (the 75/25 rule limiting Medicare and Medicaid enrollment to 75 percent of total enrollment); (3) apply consumer protections that were becoming widespread in the private sector and Medicare markets to Medicaid beneficiaries (for example, consumer information standards and standards for access to services); and (4) apply certain advances and developments in health care quality improvement that were then widely used in the private sector to Medicaid managed care programs. These standards are codified in sections 1903 and 1932 of the Act and implemented in regulations at 42 CFR part 438 published June 14, 2002 (67 FR 40989), with an effective date of August 13, 2002.

Since the publication of the Medicaid managed care regulations in 2002, the landscape for health care delivery has continued to change, both within the Medicaid program and outside (in Medicare and the private sector market). States have continued to expand the use of managed care over the past decade, serving both new geographic areas and broader groups of Medicaid beneficiaries. In particular, states have expanded managed care delivery systems to include seniors and persons with disabilities, as well as those who need long-term services and supports (LTSS). In 2004, eight states (AZ, FL, MA, MI, MN, NY, TX, and WI) had implemented Medicaid

managed long-term services and supports (MLTSS) programs. By January 2014, 12 additional states had implemented MLTSS programs (CA, DE, IL, KS, NC, NM, OH, PA, RI, TN, VA, WA).

The predominant form of managed care in Medicaid is capitated risk-based arrangements – virtually identical in structure and payment to arrangements in the commercial marketplace. Notably, in FY 2011, at least 58 percent of all Medicaid beneficiaries (about 39 million individuals) in 39 states and the District of Columbia accessed part or all of their Medicaid benefits through such capitated health plans, accounting for approximately 24 percent of all Medicaid spending. These figures are based on the Medicaid and CHIP Payment and Access Commission (MACPAC) Report to Congress on Medicaid and CHIP (June 2014).² Some states carve out behavioral health or dental services from the comprehensive acute care MCO and manage such services under a risk-based PIHP or PAHP. Additional states have added or expanded managed care programs since 2012.

States may implement a managed care delivery system using four types of federal authorities. Under the authority of section 1915(a) of the Act, states can implement a voluntary managed care program by executing a contract with organizations that the state has procured using a competitive procurement process. To require beneficiaries to enroll in managed care to receive services, a state must obtain approval from CMS under two primary authorities:

(1) Through a state plan amendment that meets standards set forth in section 1932 of the Act, states can implement a mandatory managed care delivery system. This authority does not allow states to require beneficiaries who are dually eligible for Medicare and Medicaid (dually eligible), American Indians/Alaska Natives, or children with special health care needs to enroll in a

²MACPAC, *Report to Congress on Medicaid and CHIP* (June 2014) at pgs. 106, 119, and 120, available at https://www.macpac.gov/wp-content/uploads/2015/01/2014-06-13_MACPAC_Report.pdf.

managed care program. State plans, once approved, remain in effect until modified by the state.

(2) CMS may grant a waiver under section 1915(b) of the Act, permitting a state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including dually eligible beneficiaries, American Indians/Alaska Natives, or children with special health care needs. After approval, a state may operate a section 1915(b) waiver for a 2-year period (certain waivers can be operated for up to 5 years if they include dually eligible beneficiaries) before requesting a renewal for an additional 2 (or 5) year period.

CMS may also authorize managed care programs as part of demonstration projects under section 1115(a) of the Act that includes waivers permitting the state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including dually eligible beneficiaries, American Indians/Alaska Natives, and children with special health care needs. Under this authority, states may seek additional flexibility to demonstrate and evaluate innovative policy approaches for delivering Medicaid benefits, as well as the option to provide services not typically covered by Medicaid. Such flexibility is approvable only if the objectives of the Medicaid statute are likely to be met, and is subject to evaluation.

These authorities may permit states to operate their programs without complying with the following standards of Medicaid law outlined in section of 1902 of the Act:

- Statewideness [section 1902(a)(1) of the Act]: States may implement a managed care delivery system in specific areas of the State (generally counties/parishes) rather than the whole state;
- Comparability of Services [section 1902(a)(10) of the Act]: States may provide different benefits to people enrolled in a managed care delivery system; and
- Freedom of Choice [section 1902(a)(23)(A) of the Act]: States may require people to

receive their Medicaid services only from a managed care plan or primary care provider.

Laws passed since the Medicaid managed care regulations were promulgated in 2002 have altered the Medicaid program to such a degree that we believe our current regulatory framework for managed care is no longer the most appropriate. Such legislation includes the Medicare Improvement for Patients and Providers Act (MIPPA) (Pub. L. 110-275, enacted on July 15, 2008), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008) (MHPAEA) (Division C of Pub. L. 110-343, enacted on October 3, 2008), the Children's Health Insurance Program Reauthorization Act (CHIPRA) (Pub. L. 111-3, enacted on February 4, 2009), and the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (Pub. L. 111-148, enacted March 23, 2010). We note, in particular, that the Affordable Care Act provided states the option to expand Medicaid eligibility to most low-income adults, bringing millions of new beneficiaries into the Medicaid program, most of whom are likely to receive coverage through capitated managed care. In addition, the coverage provided under the Affordable Care Act has also made issues of coordination and alignment with the private insurance market increasingly important to improve operational efficiencies for health plans that operate in both public and private markets, and improve the experience of care for individuals moving between sources of health care coverage. Specifically, Medicaid beneficiaries who experience increases in income may move to receiving health insurance coverage through qualified health plans in the Marketplace. Greater alignment between Medicaid managed care plans and qualified health plans will help these individuals transition between sources of coverage.

Because the health care delivery landscape has changed substantially, both within the Medicaid program and outside of it, and reflecting the significant role that managed care plays in

the Medicaid program, this rule proposes to modernize the Medicaid managed care regulatory structure to facilitate and support delivery system reform initiatives to improve health care outcomes and the beneficiary experience while effectively managing costs. To that end, the proposed rule includes provisions that would strengthen the ability of states to use managed care to promote innovative and cost effective methods of delivering care to Medicaid and CHIP beneficiaries, to incent managed care plans to engage in state activities that promote certain performance targets, and to identify strategies for value-based purchasing models for provider reimbursement. The rule also includes provisions that strengthen the quality of care provided to Medicaid beneficiaries, including measuring and managing quality and improving coordination of care. The rule also promotes more effective use of data in overseeing managed care and promotes advances in health information exchange.

This proposed rule would revise the Medicaid managed care regulations to align with other statutory and regulatory provisions that pertain to other sources of coverage, strengthen actuarial soundness and other payment regulations to improve accountability of rates paid in the Medicaid managed care program, ensure beneficiary protections, and incorporate statutory provisions affecting Medicaid managed care passed since 2002. In addition, the rule promotes beneficiary access to care by strengthening provider networks. This proposed rule also recognizes that through managed care plans, state and federal taxpayer dollars are used to purchase covered services from providers on behalf of Medicaid enrollees, thus ensuring accountability and strengthening program integrity safeguards are necessary to ensure the appropriate stewardship of those funds.

We recognize that in addition to the changes the Affordable Care Act brought to the Medicaid program, it also included significant changes for private insurance and group health plans. Among the reforms of the private health care coverage market are the creation of minimum

standards for the treatment of appeals by covered individuals, minimum medical loss ratios for health insurance, and certain minimum coverage standards for essential health benefits and preventive services. The Affordable Care Act created the Marketplaces (also known as “Exchanges”) and qualified health plans (QHPs), which are private health plans that are certified as meeting minimum standards. See 45 CFR 155.20. Only QHPs can be offered through Marketplaces and they are the only plans for which federal premium tax credits and cost-sharing reductions are available to assist many consumers with the cost of health care coverage. In developing these Medicaid managed care proposed regulations, we considered the market reforms, the standards established for QHPs, and our Medicare Advantage (MA) experience, which is the managed care component of the Medicare program that has also grown significantly since 2002.

Therefore, this proposed rule seeks to align Medicaid managed care rules with Marketplace or MA standards, where appropriate and feasible, to support administrative simplicity for states and health plans to manage health care delivery across different product lines, as well as to enhance beneficiary protections. In general, we believe that adopting standards for Medicaid managed care that parallel or align with those in the private health care and MA context where appropriate will benefit Medicaid programs and enrollees, both because those minimum standards would provide an appropriate level of protection for enrollees and because alignment would ease the administrative burden on issuers and regulators that work in all of those contexts and markets. By aligning Medicaid managed care with other programs when possible, we believe enrollees will experience smoother transitions and have fewer disruptions to care when they transition among sources of health care coverage. Improving beneficiary experience and alignment are important goals of this proposed rule, and the proposed changes would enable states and health plans to more successfully achieve these goals.

B. Provisions of the Proposed Regulations

We have restated the entirety of part 438 and incorporated our proposed changes into the regulation text due to the extensive nature of our proposal. However, for many sections within part 438, we are not proposing substantive changes. This preamble discusses our proposed changes with discussion of the current law where appropriate.

Throughout this document, the term “PAHP” is used to mean a prepaid ambulatory health plan that does not exclusively provide non-emergency medical transportation services. Whenever this document is referencing a PAHP that exclusively provides non-emergency medical transportation services, it will be specifically addressed as a “Non-Emergency Medical Transportation (NEMT) PAHP.” In addition, many of our proposals incorporate “PCCM entities” into existing regulatory provisions and the proposed amendments. Our proposal on this topic is discussed in section I.B.6.e. of this proposed rule.

In general, we have organized the subjects in this proposed rule according to one of the goals described above, but many of the subjects could be attributed to more than one goal.

1. Alignment with Other Health Coverage Programs

a. Marketing (§438.104)

Current regulation at §438.104 imposes certain limits on MCOs, PIHPs, PAHPs, and PCCMs in connection with marketing activities; our 2002 final rule based these limits on those set forth in section 1932(d)(2) of the Act for MCOs and PCCMs and extended them to PIHPs and PAHPs based on our authority at section 1902(a)(4) of the Act. The creation of qualified health plans (QHPs) by the Affordable Care Act and changes in managed care delivery systems since the adoption of the 2002 rule are the principle reasons behind our proposal to revise the marketing standards applicable to Medicaid managed care programs. QHPs are defined in 45 CFR 155.20.

We propose to revise §438.104(a) as follows: to (1) to amend the definition of “marketing” in §438.104 to specifically exclude communications from a QHP to Medicaid beneficiaries even if the issuer of the QHP is also the entity providing Medicaid managed care; (2) to amend the definition of “marketing materials;” and (3) to add a definition for “private insurance” to clarify that QHPs certified for participation in the FFM or an SBM are excluded from the term “private insurance” as it is used in this regulation. In recognition of the wide array of services PCCM entities provide in some markets, we also propose to include PCCM entities in §438.104 as we believe it is important to extend the beneficiary protections afforded by this section to enrollees of PCCM entity enrollees by proposing to revise paragraphs (a) and (b) to include “or PCCM entity” wherever the phrase “MCO, PIHP, PAHP or PCCM” appears. We are not proposing changes to paragraph (b), except for one clarifying change to (b)(1)(v) as noted below.

We have received several questions from Medicaid managed care plans about the implications of current Medicaid marketing rules in §438.104 for their operation of QHPs. Specifically, stakeholders have asked whether the provisions of §438.104(b)(1)(iv) would prohibit a carrier that offers both a qualified health plan (QHP) and a managed care organization (MCO) from marketing both products. The provision in the regulations implements section 1932(d)(2)(C) of the Act, titled “Prohibition of Tie-Ins.” In issuing regulations implementing this provision in 2002, we clarified that we interpreted it as intended to preclude tying enrollment in the Medicaid plan to purchasing other types of private insurance (67 FR 41027). Therefore, it would not apply to the issue of a possible alternative to the Medicaid plan, which a QHP could be if the consumer is determined as not Medicaid eligible or loses Medicaid eligibility. Section 438.104(b)(1)(iv) only prohibits insurance policies that would be sold “in conjunction with” enrollment in the Medicaid plan.

We recognize that a single legal entity could be operating separate lines of business, that is, a Medicaid MCO (or PIHP or PAHP) and a QHP. Issuers of QHPs may also contract with states to provide Medicaid managed care plans; in some cases the issuer might be the MCO, PIHP, or PAHP, or the entity offering the Medicaid managed care plan, thus providing coverage to Medicaid beneficiaries. Many Medicaid health plan contracts with states executed prior to 2014 did not anticipate this situation and may contain broad language that could unintentionally result in the application of Medicaid standards to the non-Medicaid lines of business offered by the single legal entity. For example, if a state defines the entity subject to the contract through reference to something shared across lines of business, such as licensure as an insurer, both the Medicaid MCO and QHP could be subject to the terms of the contract with the state. To prevent ambiguity and overly broad restrictions, contracts should contain specific language to clearly define the state's intent that the contract is specific to the Medicaid plan being offered by the entity. This becomes critically important in the case of a single legal entity operating Medicaid and non-Medicaid lines of business. We strongly recommend that states and Medicaid health plans review their contracts to ensure that it clearly defines each party's rights and responsibilities.

As consumers may experience periodic transitions between Medicaid and QHP eligibility, and families may have members who are divided between Medicaid and QHP coverage, selecting a carrier that offers both types of products may be the most effective way for some consumers to manage their health care needs. Improving coordination of care and minimizing disruption to care is best achieved when the consumer has sufficient information about coverage options when making a plan selection. We believe that our proposed regulatory revisions would enable more complete and effective information sharing and consumer education while still upholding the intent of the Medicaid beneficiary protections detailed in the Act. Section 438.104 alone does not

prohibit a managed care plan from providing information on a qualified health plan (QHP) to enrollees who could potentially enroll in a QHP as an alternative to the Medicaid plan due to a loss of eligibility or to potential enrollees who may consider the benefits of selecting an MCO, PIHP, PAHP, or PCCM that has a related QHP in the event of future eligibility changes. Our proposal would set minimum marketing standards that a state may build on as part of its contracts with entities providing Medicaid managed care.

Finally, we have also received inquiries about the use of social media outlets for dissemination of marketing information about Medicaid managed care. The definition of “marketing” in §438.104 includes “any communication from” an entity that provides Medicaid managed care (including MCOs, PIHPs, PAHPs, etc.) and “marketing materials” include “materials that ... are produced in any medium.” These definitions are sufficiently broad to include social media and we intend to interpret and apply §438.104 as applicable to communication via social media and electronic means. To address these inquiries and to make this interpretation clear, we also propose to clarify the regulation text by adding unsolicited contact by e-mail and texting as prohibited cold-call marketing activities in paragraph (b)(1)(v).

We believe these proposed revisions would clarify, for states and issuers, the scope of the marketing provisions in §438.104, which generally are more detailed and restrictive than those imposed on QHPs under 45 CFR 156.225. While we continue to believe that the Medicaid managed care regulation correctly provides significant protections for Medicaid beneficiaries, we recognize that the increased prevalence in some markets of carriers offering both QHP and Medicaid products and seek to provide clearer and more targeted Medicaid managed care standards with our proposed changes.

b. Appeals and Grievances (§438.400, §438.402, §438.404, §438.406, §438.408, §438.410,

§438.414, §438.416, §438.424, §431.200, §431.220 and §431.244)

We propose several modifications to the current regulations governing the grievance and appeals system for Medicaid managed care to further align and increase uniformity between rules for Medicaid managed care and rules for MA managed care plans and rules applicable to private health insurance and group health plans. The existing differences between the rules applicable to Medicaid managed care and those applicable to the MA and private insurance and group health plans concerning grievance and appeals processes inhibit the efficiencies that could be gained with a streamlined grievance and appeals process that applies across the market. A streamlined process would make navigating the appeals system more manageable for consumers in an increasingly fluid health care market. Our proposed changes in subpart F of part 438 would adopt new definitions, update appeal timeframes, and align certain processes for appeals and grievances. We also propose modifying §§431.200, 431.220 and 431.244 to effectuate the changes proposed to subpart F of part 438.

We are concerned that the different appeal and grievance processes for the respective programs and health coverage causes: (1) confusion for beneficiaries who are transitioning between private health care coverage, MA coverage, and Medicaid managed care; and (2) inefficiencies for health insurance issuers that participate in both the public and commercial sectors. Aligning appeal and grievance procedures across these areas will provide consumers with a more manageable and consumer friendly appeals process and allow health insurers to adopt more consistent protocols across product lines.

The grievance, organization determination, and appeal regulations in 42 CFR part 422, subpart M, govern grievance, organization determinations, and appeals procedures for MA members. The internal claims and appeals, and external review processes for private insurance

and group health plans are found in 45 CFR 147.136. We referred to both sets of standards in reviewing current Medicaid managed care regulations regarding appeals and grievances.

(1) Subpart F, part 438

Two of our proposals concerning the grievance and appeals system for Medicaid managed care affect the entire subpart. First, we propose to add PAHPs to the types of entities subject to the standards of subpart F and propose to revise text throughout this subpart accordingly. Currently, subpart F only applies to MCOs and PIHPs. Unlike MCOs which provide comprehensive benefits, PIHPs and PAHPs provide a narrower benefit package. While PIHPs were included in the standards for a grievance system, PAHPs were excluded. In 2002 most PAHPs were, in actuality, capitated PCCM programs managed by individual physicians or small group practices and, therefore, should not be expected to have the administrative structure to support a grievance process. However, since then, PAHPs have evolved into arrangements under which entities – private companies or government subdivisions - manage a smaller subset of Medicaid covered services such as dental, behavioral health, and home and community-based services. Because some PAHPs may provide those medical services which typically are subject to medical management techniques such as prior authorization, we believe PAHPs should be expected to manage a grievance process, and therefore, propose that they be subject to the grievance and appeals standards of this subpart. In adding PAHPs to subpart F, our proposal would also change the current process under which enrollees in a PAHP may seek a State Fair Hearing (SFH) immediately following an action to deny, terminate, suspend, or reduce Medicaid covered services in favor of having the PAHP conduct the first level of review of such actions. We rely on our authority at sections 1902(a)(3) and 1902(a)(4) of the Act to propose extending these appeal and grievance provisions to PAHPs.

We note that some PAHPs receive a capitated payment to provide non-emergency medical transportation (NEMT) services to Medicaid beneficiaries; for these NEMT PAHPs, an internal grievance and appeal system does not seem appropriate. The reasons for requiring PAHPs that cover medical services to adhere to the grievance and appeals processes in this subpart are not present for a PAHP solely responsible for NEMT. We propose to distinguish NEMT PAHPs from PAHPs providing medical services covered under the state plan. Consequently, NEMT PAHPs will not be subject to these internal grievance and appeal standards. Beneficiaries receiving services from NEMT PAHPs will continue to have direct access to the SFH process to appeal adverse benefit determinations, as outlined in §431.220. We request comment on this approach.

As a result of our proposal to have PAHPs generally follow the provisions of subpart F of part 438, we also propose corresponding amendments to §§431.220 and 431.244 regarding SFH, and changes to §431.244 regarding hearing decisions. In §431.220(a)(5), we propose to add PAHP enrollees to the list of enrollees that have access to a SFH after an appeal has been decided in a manner adverse to the enrollee; and in §431.220(a)(6), we propose that beneficiaries receiving services from NEMT PAHPs will continue to have direct access to the SFH process. We propose no additional changes to §431.220. In §431.244, as in part 438 subpart F generally, in each instance where MCO or PIHP is referenced, we propose to add a reference to PAHPs.

Second, throughout subpart F, we propose to insert “calendar” before any reference to “day” to remove any ambiguity as to the duration of timeframes. This approach is consistent with the timeframes specified in regulations for the MA program at 42 CFR part 422, subpart M.

(2) Statutory basis and definitions (§438.400)

In general, the proposed changes for §438.400 are to revise the definitions to provide greater clarity and to achieve alignment and uniformity for health care coverage offered through

Medicaid managed care, private insurance and group health plans, and MA plans. We are not proposing to change the substance of the description of the authority and applicable statutes in §438.400(a) but propose a more concise statement of the statutory authority.

In §438.400(b), we propose a few changes to the defined terms. First, we propose to replace the term “action” with “adverse benefit determination.” The proposed definition for “adverse benefit determination” would include the existing definition of “action” and revisions to include determinations based on medical necessity, appropriateness, health care setting, or effectiveness of a covered benefit in revised paragraph (b)(1). We believe this would conform to the term used for private insurance and group health plans and lays the foundation for MCOs, PIHPs, or PAHPs to consolidate processes across Medicaid and private health care coverage sectors. We considered the term “adverse determination” but that is already used in §431.202 to describe a nursing home level of care determination. Further, the term “adverse benefit determination” is used in 45 CFR 147.136 and 29 CFR. 2560.503-1, which are provisions governing internal grievance and appeals processes for private insurance (the group and individual insurance markets) and group health plans (fully-insured and self-insured plans). By adopting a uniform term for MCO, PIHP, or PAHP enrollees and enrollees in private insurance and group health plans, we hope consumers will be able to identify similar processes between lines of business, and be better able to navigate different health care coverage options more easily. Our proposal would also update cross-references to other regulations affected by this proposed rule, delete the term “Medicaid” before the word “enrollee,” and consistently replace the term “action” in the current regulations in subpart F with the term “adverse benefit determination” throughout this subpart.

In addition to using the new term “adverse benefit determination,” we propose to revise the definition of “appeal” to add accuracy by stating that an appeal is a review by the MCO, PIHP, or PAHP, as opposed to the current definition which defines it as a request for a review. In the definition of “grievance,” we propose a conforming change to delete the reference to “action,” to delete the part of the existing definition that references the term being used to mean an overall system, and to add text to clarify the scope of grievances.

For clarity, we propose to separately define “grievance system” as the processes the MCO, PIHP, or PAHP implements to handle appeals and grievances and collect and track information about them. By proposing a definition for “grievance system,” we intend to clarify that a MCO, PIHP, or PAHP must have a formal structure of policies and procedures to appropriately address both appeals and grievances. We also propose to remove the reference to the state’s fair hearing process from this definition as it is addressed in part 431, subpart E. This continued to be a significant source of confusion, even after the changes were made in the 2002 final rule, and we hope these proposed changes add clarity.

(3) General Requirements (§438.402)

We propose in paragraph (a) to add “grievance” in front of “system” and to delete existing language that defines a system in deference to the proposed new definition added in §438.400. We also propose to add text to clarify that subpart F does not apply to NEMT PAHPs.

In paragraph (b), we propose to revise the paragraph heading to “Level of appeals” and limit MCOs, PIHP, and PAHPs to only one level of appeal for enrollees before beneficiaries exhaust the managed care plan’s internal appeal process. Once this single level appeal process is exhausted, the enrollee would be able to request a SFH under subpart E of part 431. In conjunction with this proposal, we are also proposing to amend §438.402(c)(1)(i) and §438.408(f)

with corresponding text that would have enrollees exhaust their MCO, PIHP, or PAHP appeal rights before seeking a SFH. Our proposal is designed to ensure that the MCO, PIHP, or PAHP process would not be unnecessarily extended by having more than one level of internal review. This proposal is consistent with the limit imposed on issuers of individual market insurance under 45 CFR 147.136(b)(3)(ii)(G) and MA organizations at §422.578, although we acknowledge that issuers of group market insurance and group health plans are not similarly limited under 45 CFR 147.136(b)(2) and 29 CFR 2560.503-1(c)(3). We believe that this proposal would not impair the administrative alignment we seek in this context and ensures that enrollees can reach the SFH process within an appropriate time. We request comment on this proposal.

In paragraph (c)(1)(i), we propose to revise this section to permit an enrollee to request a SFH after receiving notice from the MCO, PIHP, or PAHP upholding the adverse benefit determination. We propose in paragraph (c)(1)(ii) to remove the standard for the enrollee's written consent for the provider to file an appeal on an enrollee's behalf. The current standard is not specified in section 1932(b)(4) of the Act and is inconsistent with similar MA standards for who may request an organization determination or a reconsideration at §422.566(c)(1)(ii) and §422.578, so we believe it is not necessary.

We propose in paragraph (c)(2) to delete the state's option to select a timeframe between 20 and 90 days for enrollees to file an appeal and propose to revise paragraphs (c)(2)(i) and (ii) to set the timing standards for filing grievances (at any time) and appeals (60 calendar days), respectively. For grievances, we do not believe that grievances need a filing limit as they do not progress to a SFH and thus do not need to be constrained by the coordination of timeframes. For appeals, proposed paragraph (c)(2)(ii) would permit an enrollee or provider to file an appeal within 60 calendar days of receipt of the notice of an adverse benefit determination. Medicare

beneficiaries in a MA plan and enrollees in private health care coverage each have 60 calendar days to request an appeal under regulations governing MA plans (§422.582) and private insurance and group health plans (45 CFR 147.136(b)(2) and (b)(3) and 29 CFR 2560.503-1(h)(2)). By adjusting the timeframe for MCO, PIHP, or PAHP enrollees to file appeals to 60 calendar days from the date of notice of the adverse decision, our proposal would achieve alignment and uniformity across Medicaid managed care plans, MA organizations, and private insurance and group health plans, while ensuring adequate opportunity for beneficiaries to appeal. We note that the existing provisions of §438.402 (b)(2)(i) are subsumed into the proposed paragraph (c)(1)(i) and (ii) while the existing provisions of paragraph (b)(2)(ii) would be deleted consistent with our proposal in §438.408(f)(1) concerning exhaustion of the MCO's, PIHP's, or PAHP's appeal process.

In paragraph (c)(3), we propose to add headings to paragraphs (c)(3)(i) and (c)(3)(ii) and to make non-substantive changes to the text setting forth the procedures by which grievances or appeals are filed. Under our proposal, as under current law, a standard grievance or appeal may be requested orally or in writing (which includes online), and standard appeal requests made orally must be followed up in writing. Expedited appeal requests may be requested either way, and if done orally, the consumer does not need to follow up in writing.

We request comment on the extent to which states and managed care plans are currently using or plan to implement an online system that can be accessed by enrollees for filing and/or status updates of grievances and appeals. If such systems are not in use or in development, we request comment on the issues influencing the decision not to implement such a system and whether an online system for tracking the status of grievances and appeals should be required at the managed care plan level

(4) Timely and adequate notice of adverse benefit determination (§438.404)

In §438.404, we propose to revise the section heading to a more accurate and descriptive title, “Timely and adequate notice of adverse benefit determination.” In paragraph (a), we propose a non-substantive wording revision to more accurately reflect the intent that notices must be timely and meet the information standards detailed in proposed §438.10.

In paragraph (b), describing the minimum content of the notice, we propose to delete paragraph (b)(4) (about the state option for exhaustion) to correspond to our proposal in §438.408(f) and redesignate the remaining paragraphs accordingly. In paragraph (b)(2), we propose to clarify that the reason for the adverse benefit determination includes the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee’s claim for benefits. This additional documentation would include information regarding medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. In new paragraph (b)(5), we propose to replace expedited “resolution” with expedited “appeal process” to add consistency with wording throughout this subpart. We further propose to add the phrase “consistent with State policy” in paragraph (b)(6) to be consistent with a proposed change in §438.420(d) regarding the MCO’s, PIHP’s, or PAHP’s ability to recoup from the enrollee under a final adverse decision be addressed in the contract and that such practices be consistent across both FFS and managed care delivery systems within the state. While notice of the possibility of recoupment under a final adverse decision is an important beneficiary protection, we recognize that such notice may deter an enrollee from exercising the right to appeal. We would issue guidance following publication of the rule regarding the model language and content of such notice to avoid dissuading enrollees from pursuing appeals.

In paragraph (c), we propose to revise paragraph (c)(4) to replace “extends the timeframe in accordance with...” with “meets the criteria set forth ...” to more clearly state that MCOs, PIHPs, and PAHPs cannot extend the timeframes without meeting the specific standards of §438.210(d)(1)(ii). Lastly, in paragraph (c)(6), we propose to update the cross reference from §438.210(d) to §438.210(d)(2).

(5) Handling of Grievances and Appeals (§438.406)

In addition to language consistent with our overall proposal to make PAHPs subject to the grievance and appeals standards for MCOs and PIHPs, we are proposing to reorganize §438.406 to be simpler and easier to follow and to revise certain procedural standards for appeals. Existing paragraph (a) is revised by adding the existing provision in paragraph (a)(1) to paragraph (a), which specifies that each MCO, PIHP, and PAHP must give enrollees any reasonable assistance, including auxiliary aids and services upon request, in completing forms and taking other procedural steps.

In paragraph (b), we propose to revise the paragraph heading and redesignate existing provisions in paragraphs (a)(2) and (a)(3) as (b)(1) and (b)(2), respectively; we also propose to add grievances to the provisions of both. MCOs, PIHPs, or PAHPs would have to send an acknowledgment receipt for each appeal and grievance and follow the limitations on individuals making decisions on grievances and appeals in paragraphs (b)(2)(i) and (ii). In new (b)(2)(i), we propose to add that individuals who are subordinates of individuals involved in any previous level of review are, like the individuals who were involved in any previous level of review, excluded from making decisions on the grievance or appeal. This proposed revision adds another level of beneficiary protection that we believe is appropriate and is consistent with standards under the commercial rules in 45 CFR 147.136 that incorporate 29 CFR 2560.503-1(h)(3)(ii). Redesignated

paragraph (b)(2)(ii) remains unchanged from its current form. Consistent with the standards under the commercial rules in 45 CFR 147.136 that incorporate 29 CFR 2560.503-1(h)(2)(iv), we propose to add a new paragraph (b)(2)(iii) to specify that individuals that make decisions on appeals and grievances take all comments, documents, records, and other information submitted by the enrollee into account regardless of whether the information had been considered in the initial review. We propose to redesignate current paragraph (b)(2) as (b)(4) and add “testimony” in addition to evidence and legal and factual arguments. We also propose to use the phrase “legal and factual arguments” to replace the phrase “allegations of fact or law” in the current text for greater clarity.

We note that, currently, in paragraph (b)(3) the enrollee must have the opportunity before and during the appeal process to examine the case file, medical record and any documents or records considered during the appeal process. We propose to redesignate this paragraph as paragraph (b)(5) and to replace “before and during” with “sufficiently in advance” of resolution, to add specificity. We also propose to add “new or additional evidence” to the list including case file, medical records, and any other documents or records that must be available to the enrollee. This language in paragraph (b)(5) would align with the disclosure standards applicable to private insurance and group health plans in 45 CFR 147.136(b)(2)(ii)(C)(1). Existing paragraph (b)(4) would be redesignated as paragraph (b)(6) without change.

(6) Resolution and notification: Grievances and appeals (§438.408 and §431.244(f))

We propose to make significant modifications to §438.408 to further align Medicaid managed care standards with MA and private insurance and group health plan standards. We are proposing several significant modifications as explained in more detail below: (1) Changes in the timeframes to decide appeals and expedited appeals, (2) strengthen notice standards for extensions,

and (3) change the processes for receiving a SFH for enrollees of MCOs, PIHPs, and PAHPs. In addition, we propose to reorganize the regulation for greater clarity and to add the phrase “consistent with state policy” to paragraph (e)(2)(iii) to be consistent with our proposal in §438.420(d).

In §438.408(b)(2), we propose to adjust the timeframes in which MCOs, PIHPs, and PAHPs would have to make a decision about an enrollee appeal to align with the standards applicable to a MA organization. Currently, MCOs and PIHPs may have up to 45 days to make a decision about a standard (non-expedited) appeal. In §422.564(e), MA plans must make a decision about first level appeals in 30 days, while Part D plans must provide a decision in 7 days under §423.590(a)(1). Federal regulations on the commercial insurance market permit up to 60 days for a standard decision on an internal appeal (see §147.136(b)(2)(i) and (b)(3), incorporating 29 CFR 2560.503-1(b)(1) for individual health insurance issuers and group health insurance issuers and plans). We are proposing to shorten the timeframe for MCO, PIHP, and PAHP appeal decisions from 45 days to 30 calendar days, which would achieve alignment with MA standards while still allowing adequate time for decision-making and response.

In paragraph (b)(3), we propose to adjust the Medicaid managed care timeframes for expedited appeals to align with standards applicable to MA and the commercial insurance market. Currently under subpart F, MCOs and PIHPs have 3 working days from receipt of a request to make a decision in an expedited review. The MA (§422.572(a)) and commercial insurance regulations (29 CFR 2590.715-2719(c)(2)(xiii)) stipulate that a health plan must make a decision within 72 hours of receiving a request for expedited review. We propose to modify our expedited appeal decision timeframes from 3 working days to 72 hours. The change would improve the speed with which enrollees would receive a MCO, PIHP, or PAHP decision on critical issues, and

align Medicaid managed care with Medicare and private insurance and group health plans. Again, this change would enable insurance companies that operate multiple product lines to have consistent regulatory standards governing its operations.

We also propose to strengthen the notification responsibilities on the MCO, PIHP, or PAHP following an extension of the timeframe for resolution of a grievance or appeal, when the extension is not requested by the enrollee. In addition, we propose to add existing text from paragraph (c)(2)(i) regarding timeframe extensions that are not requested by the enrollee to paragraph (c)(2). We also propose to add a standard for the MCO, PIHP, or PAHP to make reasonable efforts to give the enrollee prompt oral notice of the delay in paragraph (c)(2)(i). We propose to add the current standards in §438.404(c)(4)(i) and (ii) to §438.408(c)(ii) and (iii), which describe the standards on the MCO, PIHP, or PAHP for an extension of the timeframe for standard or expedited appeals for clarity and consistency.

In §438.408(d)(1) and (2), we propose to add a provision requiring that grievance notices (as established by the state) and appeal notices (as directed in the regulation) from a MCO, PIHP, or PAHP ensure meaningful access for people with disabilities and people with limited English proficiency by, at a minimum, meeting the standards described at §438.10 .

In §438.408(e), we propose to add “consistent with state policy” in paragraph (e)(2)(iii). This is added here to be consistent with a proposed change in §438.420(d) which stipulates that the MCO’s, PIHP’s, or PAHP’s ability to recoup from the enrollee under a final adverse decision must be addressed in the contract and that such practices be consistent across both FFS and managed care delivery systems within the state. For example, if the state does not exercise the authority for recoupment under §431.230(b) for FFS, the same practice must be followed by the state’s contracted MCOs, PIHPs, and PAHPs.

In §438.408(f), we are proposing to modify the Medicaid managed care appeals process such that an enrollee must exhaust the MCO, PIHP, or PAHP appeal process prior to requesting a SFH. This would eliminate a bifurcated appeals process while aligning with Medicare and the private market regulations. Under current Medicaid rules, states have the discretion to decide if enrollees must complete the MCO, PIHP, or PAHP appeal process before requesting a SFH or whether they can request a SFH while the MCO, PIHP, or PAHP appeal process is still underway. Depending on the state's decision in this regard, this discretion has led to duplicate efforts by the MCO, PIHP, or PAHP and the state to address an enrollee's appeal. Both MA rules and regulations governing private insurance and group health plans have a member complete the health plan's internal appeal process before seeking a second—that is, external—level review. Our proposed change would be consistent with both those processes.

Specifically, under the proposed change in paragraph (f)(1), a MCO, PIHP, or PAHP enrollee would have to complete the MCO, PIHP, or PAHP appeal process before requesting a SFH. Maintaining two processes at the same time can be confusing and cumbersome to all parties involved. With the proposed change, consumers would still be able to take advantage of the SFH process, but in a consecutive manner which would lead to less confusion and effort on the enrollee's part. Moreover, our proposed reduction in the timeframes that a MCO, PIHP, or PAHP would have to take action on an appeal (from 45 to 30 calendar days) in §438.408(b)(2) would permit enrollees to reach the SFH process more quickly. Further, a federal standard would eliminate variations across the country and lead to administrative efficiencies at the MCO, PIHP, and PAHP level. We believe that our proposal achieves the appropriate balance between alignment, beneficiary protections, and administrative simplicity. For consistency, this change is also reflected in proposed revisions to §438.402(b) and §438.404(b)(4) as noted previously.

We propose in new paragraph (f)(2) to revise the timeframe enrollees have to request a SFH to align with filing timeframes applicable to group health plans and private insurance. Currently in §438.408(f)(1), a state may set the timeframe for an enrollee to request a SFH within the range of 20 to 90 days from the date of notice of the MCO's, PIHP's, or PAHP's resolution. By adjusting the timeframe for enrollees to file SFH requests to 120 calendar days, we give enrollees more time to gather the necessary information, seek assistance for the SFH process and make the request for a SFH.

We also propose a number of changes to §431.244, Hearing Decisions, that correspond to these proposed amendments to §438.408. In §431.244, we propose to remove paragraph (f)(1)(ii) which references direct access to a SFH when permitted by the state. As that option is proposed to be deleted in §438.408(f)(1), it should also be deleted in §431.244(f)(1). In §431.244(f)(2), we considered whether to modify the 3 working day timeframe on the State to conduct an expedited SFH. In the interest of alignment, we examined the independent and external review timeframes in both MA and QHPs and found no analogous standard or consistency for final administrative action regarding expedited hearings. We believe that SFHs are different than a review by an Independent Review Organization (IRO) or Independent Review Entity (IRE). We have therefore decided to keep the SFH expedited timeframe at 3 working days. We propose to delete current paragraph (f)(3) as it is no longer relevant given the deletion of direct access to SFH proposed revision to §438.408(f)(1). We propose no additional changes to §431.244.

(7) Expedited resolution of appeals (§438.410)

In addition to the revisions to add PAHPs to the scope of this regulation, we propose to revise §438.410(c)(2) to replace the current general language on oral and written notification with a cross reference to §438.408(c)(2), which as proposed, provides more specificity on the

responsibilities of the MCO, PIHP, or PAHP when extending timeframes for resolution. We also propose a grammatical correction to paragraph (b) to replace the word “neither” with “not.” We propose no other changes to this section.

(8) Information about the grievance system to providers and subcontractors (§438.414)

In addition to the change proposed throughout this subpart in connection with PAHPs, we propose to update the cross reference from §438.10(g)(1) to §438.10(g)(2)(xi) to be consistent with our proposed revisions to §438.10, discussed in more detail below in section I.B.6.d.

(9) Recordkeeping requirements (§438.416)

In §438.416, we propose to modify the recordkeeping standards under subpart F to achieve consistency across states by specifying the recordkeeping elements. The current recordkeeping provisions do not set standards for the type of appeals and grievance information to be collected, and only stipulate that states must review that information as part of an overall quality strategy. The proposed recordkeeping language here would set minimum standards for the types of information that must be collected to create consistency across states. Under the proposed updates to the recordkeeping section, states would have to review information about appeals and grievances as part of its ongoing monitoring, which would allow for better tracking of issues and promote faster interventions.

Specifically, we propose to redesignate the existing provisions of §438.416 as a new paragraph (a), adding that the state must review the information as part of its monitoring of managed care programs and to update and revise its comprehensive quality strategy. We are proposing to add a new paragraph (b) to specifically list the information that must be contained in the record of each grievance and appeal: a description of the reason for the appeal or grievance, the date received, the date of each review or review meeting if applicable, the resolution at each

level, the date of resolution, and the name of the enrollee involved. Finally, we are proposing to add a new paragraph (c) to stipulate that the record be accurately maintained and made accessible to the state and available to CMS upon request.

(10) Effectuation of reversed appeal resolutions (§438.424)

In addition to adding PAHPs to §438.424 as discussed earlier in this preamble, we propose to revise the current rule in paragraph (a) so that the MCO, PIHP, or PAHP must effectuate a reversal of an adverse benefit determination and authorize or provide such services no later than 72 hours from the date it receives notice of the adverse benefit determination being overturned. This is consistent with the timeframes for reversals by MA organizations and independent review entities in the MA program, as specified in §422.619 for expedited reconsidered determinations, when the reversal is by the MA organization or the independent review entity. In addition to providing consistency across these different managed care programs, and the increases in efficiency that we predict as a result of this alignment, we believe that 72 hours is sufficient time for an MCO, PIHP, or PAHP to authorize or provide services that an enrollee has successfully demonstrated are covered services. We solicit comment on this proposal and on our assumptions as to the amount of time that is necessary for an MCO, PIHP, or PAHP to authorize or provide services.

c. Medical Loss Ratio (§438.4, §438.5, §438.8, and §438.74)

The Affordable Care Act includes standards for a minimum medical loss ratio (MLR) in the private health insurance and MA markets. A standardized MLR calculation allows regulators the ability to conduct a retrospective analysis of premiums paid compared to overall expenditures to ensure a fair and equitable arrangement is maintained; additionally, the outcomes of the MLR calculation may be considered by issuers and managed care plans in future rate development or

decision making. We believe that MLR calculation and reporting are important tools to ensure that capitation rates set for Medicaid managed care programs are actuarially sound and adequately based on reasonable expenditures on covered medical services for enrollees.

As of 2015, Medicaid and CHIP are the only health benefit coverage programs to not utilize a minimum MLR for managed care plans. We understand some states require a minimum MLR or some similar calculation, but these standards vary widely depending on state defined characteristics and have differing levels of enforcement. In keeping with our goals of alignment with the health insurance market whenever reasonable and appropriate and to ensure that capitation rates are actuarially sound, we propose that the MLR for MCOs, PIHPs, and PAHPs be calculated, reported, and used in the development of actuarially sound capitation rates. Under sections 1903(m)(2) and regulations based on our authority under section 1902(a)(4) of the Act, actuarially sound capitation rates must be utilized for MCOs, PIHPs, and PAHPs; actuarial soundness requires that capitation payments cover reasonable, appropriate and attainable costs in providing covered services to enrollees in Medicaid managed care programs. Medical loss ratios are one tool that could be used to assess whether capitation rates are appropriately set by generally illustrating how those funds are spent on claims and quality improvement activities as compared to administrative expenses, demonstrating that adequate amounts under the capitation payments are spent on services for enrollees. In addition, MLR calculation and reporting would result in responsible fiscal stewardship of total Medicaid expenditures by ensuring that states have sufficient information to understand how the capitation payments made for enrollees in managed care programs are expended.

A national standard for Medicaid managed care plans that aligns with the methodologies for health insurance issuers found in 45 CFR 158 et seq. and the rules for MA and Part D plans

found in §422.2400 et seq. and §423.2400 et seq. would provide the most consistent approach to calculating and reporting MLR. A consistent methodology across multiple markets (private, Medicare, and Medicaid) would allow for administrative efficiency for the states in their roles regulating insurance and Medicaid and for issuers and managed care entities to collect and measure data necessary to calculate an MLR and provide reports. In addition, a consistent standard would allow comparison of MLR outcomes consistently from state to state and among commercial, Medicare, and Medicaid managed care plans.

To establish the standard that MLR be calculated, reported and used in the Medicaid managed care rate setting context, we propose to incorporate these standards in the actuarial soundness standards proposed in §438.4 and §438.5, and to add new §438.8 and §438.74, which would establish, respectively, the substantive standards for how MLR is calculated and reported by MCOs, PIHPs, and PAHPs and state responsibilities in oversight of the MLR standards.

(1) Medical Loss Ratio as a component of Actuarial Soundness (§438.4 and §438.5)

First, we propose standards for how MLR calculations and reporting must be considered in both a prospective and retrospective manner in the rate setting process to ensure that capitation rates are actuarially sound.

In §438.4(b)(8), we propose that rates for MCOs, PIHPs, and PAHPs must be set such that, using the projected revenues and costs for the rate year, the MCO, PIHP, or PAHP would achieve an MLR of at least 85 percent, but not exceed a reasonable maximum threshold that would account for reasonable administrative costs. We believe that 85 percent is the appropriate minimum threshold and is the industry standard for MA and large employers in the private health insurance market. We believe that considering the MLR as part of the rate setting process would be an effective mechanism to ensure that program dollars are being spent on health care services,

covered benefits, and quality improvement efforts rather than on potentially unnecessary administrative activities. Additionally, our proposed use of the MLR and 85 percent threshold is very similar to the use of the MLR in the proposed and final rules entitled “Rate Increase Disclosure and Review” (75 FR 81012 and 76 FR 29973) that implemented 45 CFR 154.205 for that provision considers whether a rate increase that would be subject to CMS’ Center for Consumer Information and Insurance Oversight’s (CCIIO) review would result in a projected MLR below the 85 percent MLR standard. In addition, as issuers may participate in multiple product lines, we believe that there would be administrative efficiencies from using consistent standards and methods for calculating MLR. We also believe that issuers, states, and CMS would benefit from an MLR that can be compared to other similar measures.

We also believe that it is appropriate to consider the MLR in rate setting to protect against the potential for an extremely high MLR (for example, an MLR greater than 100 percent). When an MLR is too high, it means there is a possibility that the capitation rates were set too low. Capitation rates that are too low raise concerns about enrollees’ access to services, the quality of care, provider participation, and the continued viability of the Medicaid managed care plans in that market. Additionally, extremely high MLRs may indicate that the capitation rates do not account for reasonable administrative costs, which could result in poor client and provider experiences. We are hesitant to set a specific upper bound for the MLR that represents a maximum upper threshold that is analogous to 85 percent as a minimum threshold. States are better positioned to establish and justify a maximum MLR threshold, which accounts for the type of services being delivered, the state’s administrative requirements, the maturity of the program and the managed care plans. Nonetheless, states should consider an appropriate maximum threshold to ensure that the capitation rates are adequate for necessary and reasonable administrative costs and we have

proposed such a standard, rather than a specific percentage, for an upper bound on MLR experience.

In §438.5(b)(5), we propose that states must use the annual MLR calculation and reporting from MCOs, PIHPs, or PAHPs as part of developing rates for future years. While the projected MLR measurement proposed in §438.4(b)(8) appears to be most closely tied to the actuarial soundness of the rates, we believe that knowing the actual MLR experienced by an MCO, PIHP, or PAHP each year will provide important information necessary for rate setting for future years. We propose that states must take the information about past MLR experience into account as part of the rate setting process. If an MCO, PIHP, or PAHP has not met the 85 percent MLR in prior years, the state would use that information in the development of future capitation rates. If the MCO's, PIHP's, or PAHP's reported MLR calculation continues to reflect that the actual experience varies from those projections used in the rate development process, the state, and its actuary, would use that information during the development of the capitation rates for future rating periods. The information and process, in turn, assist in setting a rate where the MCO, PIHP, or PAHP would reasonably be expected to achieve at least an 85 percent MLR in future contract years.

(2) Standards for calculating and reporting Medical Loss Ratio (§438.8)

Second, we propose minimum standards for how the MLR must be calculated and the associated reports submitted to the state so that the MLR information used in the rate setting process is available and consistent. Our goal in developing the MLR standards is to be as consistent as possible with the NAIC model and the regulations on health insurers in the private market and MA, while taking into consideration the unique aspects of delivering services through Medicaid managed care. While we considered both the commercial market and MA standards

when developing this proposed rule, we more closely aligned with the commercial rules as we believe the need for consistency is greater between plans on the Marketplace and in Medicaid. We did incorporate MA standards for the calculation of the MLR when we believed the needs of incorporating standards of a public program outweighed our desire to create efficiency between the calculations from the Marketplace to Medicaid.

In paragraph (a), we propose that states ensure through their contracts with any risk based MCO, PIHP, or PAHP that starts on or after January 1, 2017, the MCO, PIHP, or PAHP would meet the standards proposed in §438.8. Non-risk PIHP or PAHP contracts by their nature do not need to calculate a MLR standard since contractors are paid an amount equal to their incurred service costs plus an amount for administrative activities. Through this proposed paragraph, we propose that MLR reporting years would start with contracts beginning on or after January 1, 2017. We believe that most states use 1 year contract periods with MCOs, PIHPs, and PAHPs, but for those states that do not, we propose that the state have its MCOs, PIHPs, and PAHPs calculate and report the MLR for the rating period beginning in 2017. This means if a state has a contract running from October 2017 through September 2018 and the state wishes to align their MLR reporting year with the contract year, the first MLR reporting year would be October 2017 through September 2018. We believe that starting the MLR calculation and reporting standards with contract years starting in 2017 will allow enough time for states, MCOs, PIHPs, and PAHPs to take any necessary measures to prepare for application of the MLR after this proposed rule is finalized. We request comment on this timeframe and whether we should consider a start date that is some specific time after the final rule becomes effective.

Paragraph (b) proposes to define terms used in this proposed section, including the terms MLR reporting year and non-claims cost; several terms that are relevant for purposes of credibility

adjustments are also proposed but are discussed with proposed §438.8(h). We discuss the definition of non-claims cost below in connection with the proposal at §438.5(d)(2)(v)(A) and how such costs are excluded from incurred claims. The private market and MA both calculate the MLR on a calendar year basis. While we expect some states to use a calendar year as the basis for the calculation of the MLR, other states may choose to use a different time period. States vary their contract years and we propose to give states the option of aligning their MLR reporting year with the contract year if they so choose so long as the MLR reporting year is the same as the rating period, although states will not be permitted to have a MLR reporting year that is more than 12 months. We considered allowing an MLR calculation consistent with any rating period even if the rating period was more than 12 months, but were concerned that allowing varying lengths of time in the MLR reporting year could create inconsistencies with how the credibility factors are applied to the MLR calculation. In addition, the 12 month period is consistent with how the commercial and MA MLR is calculated. In the event the state changes the time period, for example, transitions from paying capitation rates on a state fiscal year to a calendar year, the state could choose if the MLR calculation would be done for two 12 month periods with some period of overlap. Whichever methodology the state elects, the state will need to clarify the decision in the actuarial certification and take this overlap into account when determining the penalties or remittances (if any) on the MCO, PIHP, or PAHP for not meeting the standards developed by the state.

Proposed paragraph (c) addresses certain minimum standards for the use of an MLR if a state elects to mandate a minimum MLR for an MCO, PIHP, or PAHP. We know that some states have imposed MLR percentages on certain plans that equal or exceed 85 percent and we do not want to prevent states from continuing those practices if they believe a higher MLR percentage is appropriate. Therefore, our proposed regulation permits each state, through its law, regulation, or

contract with the MCO, PIHP, or PAHP to establish a minimum MLR that may be higher than 85 percent, although the method of calculating the MLR would still be consistent with the standards in proposed §438.8. The parameters on state flexibility, to set an MLR requirement that is no lower than 85 percent but that is calculated consistent with the requirements in proposed §438.8, are based on our authority under section 1902(a)(4) of the Act and recognizes that for some managed care programs, for example, MLTSS programs, states may find it appropriate to establish an MLR standard that is higher than 85 percent. If a state were to set an MLR standard below 85 percent that was calculated in a different manner than the proposals in §438.8, it would be inconsistent with our approach of assuming an MLR of at least 85 percent in the development of actuarially sound capitation rates, as described in §438.4(b)(7). We understand that some states use their existing MLR standard as a general rule or guidepost for health plan evaluation as opposed to recouping funds from the MCO, PIHP, or PAHP if its MLR falls below the state-defined threshold. While states would not have to collect remittances from the MCOs, PIHPs, or PAHPs through this proposed rule (see discussion of §438.8(j)), we strongly encourage states to implement the types of financial contract provisions that would drive MCO, PIHP, and PAHP performance in accordance with the MLR standard. In section I.B.1.c.(3) of this proposed rule, we address the treatment of any federal share of potential remittances.

Proposed paragraphs (d), (e) and (f) propose the basic methodology and components that make up the calculation of the MLR. The calculation of the MLR proposed for Medicaid managed care is the sum of the MCO's, PIHP's, or PAHP's incurred claims, expenditures on activities that improve health care quality, and activities specified under proposed §438.608(a)(1) through (5), (7), (8) and (b) (subject to the cap in §438.8(e)(4)), divided by the adjusted premium revenue collected, taking into consideration any adjustments for MCO, PIHP, or PAHP enrollment (known

as a credibility adjustment). Our proposal uses the same general calculation as the one established in 45 CFR 158.221 (private plan MLR) with proposed differences as to what is included in the numerator and the denominator to account for differences in the Medicaid program. The proposal also calculates the MLR over a 12-month period rather than a 3-year period.

The total amount of the numerator is proposed in paragraph (e) which, as noted above, is equal to the sum of the incurred claims, expenditures on activities that improve health care quality, and, subject to the cap in paragraph (e)(4), activities related to proposed standards in §438.608(a)(1) through (5), (7), (8) and (b) of this proposed rule. As proposed, there are certain amounts that would need to be included or deducted from incurred claims for this MLR calculation. Generally, the proposed definition of incurred claims comports with the private market and MA standards, with Medicaid differing in several ways, such as:

- We propose that amounts the MCO, PIHP, or PAHP receives from the state for purposes of stop-loss payments, risk-corridor payments, or retrospective risk adjustment are deducted from incurred claims. MCOs, PIHPs, and PAHPs should not include those payments as incurred claims (proposed §438.8(e)(2)(ii)(C) and (e)(2)(iv)(A)).
- Likewise, if a MCO, PIHP, or PAHP must make payments to the state because of a risk-corridor or risk adjustment calculation, this proposed rule would include those amounts in incurred claims (proposed §438.8(e)(2)(iv)(A)).
- A state may operate Medicaid-specific solvency funds for its managed care program. If MCOs, PIHPs, or PAHPs must pay into those funds, this proposed rule would consider those payments incurred claims (proposed §438.8(e)(2)(iii)(A)).
- Due to proposed changes in subpart H, we believe there is a possibility that the adjustment to claims in the MLR numerator of Medicaid MCOs, PIHPs, or PAHPs could have

fewer recoveries from fraudulent or excluded providers because of enhanced fraud prevention and monitoring measures. We want to encourage Medicaid MCOs, PIHPs, and PAHPs to build and sustain a program integrity infrastructure that has strong prevention activities as well as robust processes for the detection, referral and recovery of improper payments, including potential fraud, waste and abuse. Therefore, we propose that expenditures related to fraud prevention activities, as set forth in §438.608(a)(1) through (5), (7), (8) and (b), may be attributed to the numerator but would be limited to 0.5 percent of MCO's, PIHP's, or PAHP's premium revenues. Section I.B.4.c.(4) of this proposed rule provides a discussion of the proposed revisions to §438.608. We also propose to make clear in the regulatory text that the expenses for fraud prevention activities described in §438.8(e)(4) would not duplicate expenses for fraud reduction efforts for purposes of accounting for recoveries in the numerator pursuant to §438.8(e)(2)(iii)(C), and the same would be true in the converse. While many employees of a managed care plan may conduct activities that support fraud, waste, and abuse prevention through the normal course of duties, the expenditures related to the proposed fraud, waste, and abuse activities attributable to the numerator, as proposed in §438.8(e)(4), are associated with the work of employees that directly carry out those functions and associated data analytics and technological infrastructure to conduct these ongoing fraud prevention activities. Successful technology and analytics to conduct fraud, waste, and abuse prevention and detection will have some of the following characteristics: a process for incorporating field intelligence, policy knowledge and clinical expertise (or other expertise relevant to the industry) into the development of the predictive or other sophisticated algorithms to ensure that the results are actionable; a method for tracking, measuring, and evaluating the actions taken based on the information produced, and the presence of an analytical environment for data exploration that includes the historic information necessary for predictive modeling and an

operational environment that quickly displays results and visualization (graphics, maps) that assists the end user in taking action.

We believe that this proposed limit on expenditures for fraud prevention is a reasonable amount to encourage MCOs, PIHPs, and PAHPs to build and maintain robust and dynamic fraud prevention programs. In addition, we assert that the 0.5 percent figure is appropriate as a limitation because fraud prevention and monitoring costs should not yield a one-to-one ratio relative to recoveries due to fraud, waste, or abuse. In other words, one dollar spent on fraud prevention and monitoring activities should render more than one dollar in recoveries. We request comment on the approach to incorporating fraud prevention activities and the proportion of such expenditures in the numerator for the MLR calculation, as this proposal is unique to Medicaid managed care. We also request general comments on the proposal, as well as other methodologies. Specifically, we request comment on alternative options that only account for increased investments in fraud prevention activities relative to prior-year levels, so as to prevent incorporation in the numerator of fraud prevention activities plans currently undertake.

Non-claims costs would be considered the same in Medicaid as they are in the commercial market and MA rules. We propose in §438.8(e)(2)(v)(A)(3) that certain amounts paid to a health care professional are not included as incurred claims; we intend to use the illustrative list in the similar provisions at §422.2420(b)(4)(i)(C) and §158.140(b)(3)(iii) to interpret and administer this aspect of our proposal. Incurred claims would not include non-claims costs and remittances paid to the state from a previous year's MLR experience. In paragraph (e)(2)(iii)(A), we propose that payments made by an MCO, PIHP, or PAHP to mandated solvency funds must be included as incurred claims, which is consistent with the commercial market regulations on market stabilization funds at 45 CFR 158.140(b)(2)(i). Paragraph (e)(2)(iv) would take a consistent

approach with the commercial rules at 45 CFR 158.140(b)(4)(ii) that amounts that must either be included in or deducted from incurred claims are net payments related to risk adjustment and risk corridor programs. We propose in paragraph (e)(2)(v) that the following non-claims costs are excluded from incurred claims: amounts paid to third party vendors for secondary network savings, network development, administrative fees, claims processing, and utilization management; and amounts paid for professional or administrative services. This approach is consistent with the expenditures that must be excluded from incurred claims under the commercial rules at 45 CFR 158.140(b)(3). Proposed paragraph (e)(2)(vi) would incorporate the provision in MA regulations at 42 CFR 422.2420(b)(5) for the reporting of incurred claims for a MCO, PIHP, or PAHP that is later assumed by another entity to avoid duplicative reporting in instances where one MCO, PIHP, or PAHP is assumed by another.

Through these proposed rules in §438.8(e)(3), an activity that improves health care quality can be included in the numerator as long as it meets one of three standards: (1) it meets the definition in 45 CFR 158.150(b) (the private insurance market MLR rule) of an activity that improves health care quality and is not excluded under 45 CFR 158.150(c); (2) it is an activity specific to Medicaid managed care External Quality Review activities (described in subpart E); or (3) it is an activity related to Health Information Technology and meaningful use, as defined in 45 CFR 158.151 and excluding any costs that are deducted or excluded from incurred claims under paragraph (e)(2). Regarding activities related to Health Information Technology and meaningful use, we encourage states to support the adoption of certified technology that enables interoperability across providers and supports seamless care coordination for enrollees. In addition, we refer MCOs, PIHPs, and PAHPs to the Office of the National Coordinator for Health Information Technology's draft of the "2015 Interoperability Standards Advisory" published for

public comment (available at <http://www.healthit.gov/standards-advisory>), which proposes a set of best available standards and implementation specifications enabling priority health information exchange use cases.

We understand that some managed care plans cover more complex populations in their Medicaid line of business than in their commercial line of business; therefore, the case management/care coordination standards are more intensive and costly for Medicaid health plans than in a typical private market group health plan. Consistent with the use of the term in the private market, we believe the definition of activities that improve health care quality in 45 CFR 158.150 is broad enough to encompass MCO, PIHP, and PAHP activities related to service coordination, case management, and activities supporting state goals for community integration of individuals with more complex needs such as individuals using LTSS. For that reason, we are not specifically identifying these activities separately in this rule, but expect MCOs, PIHPs, and PAHPs would include the cost of appropriate outreach, engagement, and service coordination in this category. We request comment on this approach.

Paragraph (f) proposes what would be included in the denominator for calculation of the MLR. Generally, the denominator is the MCO's, PIHP's, or PAHP's premium revenue less any expenditure for federal or state taxes and licensing or regulatory fees. In proposed §438.8(f)(2), we specify what must be included in premium revenue. We expect that a state will have adjusted capitation payments appropriately for every population enrolled in the MCO, PIHP, or PAHP so that the capitated payment reasonably reflects the costs of providing the services covered under the contract for those populations and meets the actuarial soundness standards in §438.4 through §438.7. Additionally, because many states make payments to MCOs, PIHPs, or PAHPs for one-time, specific life events of enrollees – events that do not receive separate payments in the private

market or MA- these payments need to be included as premium revenue in the denominator.

Typical examples of these are maternity “kick-payments” where a payment to the MCO is made at the time of delivery for to offset the costs of prenatal, postnatal and labor and delivery costs for an enrollee.

As proposed in paragraph (f)(3), we would treat taxes, licensing and regulatory fees in the same way as they are treated in the private market and MA; they would be deducted from premium revenue. Similar to the private market in 45 CFR 158.161(b), fines or penalties imposed on the MCO, PIHP, or PAHP would not be deducted from premium revenue and must be considered non-claims costs (proposed §438.8(e)(2)(v)(A)(4)). Consistent with MA, we propose in paragraph (f)(3)(v) to allow Community Benefit Expenditures (CBEs), as defined in 45 CFR 158.162(c) (which is analogous to the definition in §422.2420(c)(2)(iv)(A)), to be deducted up to the greater of 3 percent of earned premiums or the highest premium tax rate in the applicable state multiplied by the earned premium for the MCO, PIHP, or PAHP. We request comment on this proposal. Paragraph (f)(4) incorporates the provision for MLR under MA regulations at §422.2420(c)(4) for the reporting of the denominator for a MCO, PIHP, or PAHP that is later assumed by another entity to avoid duplicative reporting in instances where one MCO, PIHP, or PAHP is assumed by another.

Paragraph (g) proposes our standards for allocation of expenses. MCOs, PIHPs, and PAHPs would use a generally accepted accounting method to allocate expenses to only one category, or if they are associated with multiple categories, pro-rate the amounts so the expenses are only counted once.

Section 2718(c) of the Public Health Service Act charges the National Association of Insurance Commissioners (NAIC) with developing uniform methodologies for calculating

measures of the expenditures that make up the MLR calculation, and provides that “such methodologies must be designed to take into account the special circumstances of small plans, different types of plans, and newer plans.” To address the special circumstances of smaller plans, the NAIC model regulation allows smaller plans to adjust their MLR calculations by applying a “credibility adjustment.” In paragraph (h), we propose to adopt this method of credibility adjustment for MCOs, PIHPs, and PAHPs. To the extent possible, we propose to follow the approach used in both the private market (45 CFR 158.230) and MA and Medicare Part D MLR rules (§§422.2440, 423.2440).

A credibility adjustment is a method to address the impact of claims variability on the experience of smaller plans due to random statistical variation and we propose to define a credibility adjustment in this manner in §438.8(b). All issuers experience some random claims variability, where actual claims experience deviates from expected claims experience. In a health plan with a large number of enrollees the impact of such random deviations is less than in plans with fewer enrollees. One source of variability is the impact of large claims, which are infrequent but have a greater impact on financial experience than average or typical claims. Large claims have a disproportionate impact on small plans because the higher claim cost is spread across a smaller premium base. These random variations in the claims experience for enrollees in a smaller plan may cause an issuer’s reported MLR to be below or above a particular standard in any particular year, even though the state or the issuer estimated in good faith that the combination of the projected premiums and claims would produce an MLR that meets the specific standard. It is important to emphasize that health insurance rates are the product of assumptions, estimates, and projections. For example, when an actuary projects that the rate he or she has calculated will produce an 85 percent MLR, whether in fact it will produce an 85 percent MLR, depends on

whether the assumptions the actuary has made—such as those concerning the characteristics and health status of the enrollees covered by the plan, the intensity and frequency with which its enrollees will use health care services, and unit costs—turn out to be correct. All things being equal, it is more likely that those assumptions will turn out to be correct when an issuer insures a large number of enrollees rather than a small number, and differences between the assumptions and actual experience would likewise be smaller when an issuer covers a larger number of enrollees.

After extensive analysis and public discussion, the NAIC adopted a credibility adjustment table designed to result in an issuer that charges premiums intended to produce an 80 percent MLR to pay a rebate less than 25 percent of the time. We propose to adopt this approach of less than 25 percent in paragraph (h)(4)(ii). Toward the conclusion of its public proceedings on these issues, the NAIC gave some consideration to setting the base credibility factors so that such an issuer would have to pay a rebate less than 10 percent of the time. The credibility factors in that case would have been roughly twice as large as the factors the NAIC adopted. The case made in favor of making this change is that it would reduce the likelihood of requiring a plan to pay a rebate simply because of chance variation in claims experience. However, it would also have increased the likelihood that a plan setting premiums to achieve an MLR that is less than the applicable MLR standard would avoid paying a rebate, and it would have reduced the size of the rebates that plans pricing below the MLR standard would have to pay. The NAIC concluded that the credibility factors it adopted more equitably balance the consumers' interest in requiring plans that should pay rebates to pay rebates against the issuers' interest in minimizing the risk of paying rebates as a result of chance variations.

We propose to adopt a credibility adjustment methodology in paragraph (h)(4). The NAIC

recommends that the credibility factors be monitored and reevaluated in light of developing experience as the Affordable Care Act reforms are implemented over the next several years. We concur with this recommendation and we intend both to monitor the effects of the credibility adjustment and, as appropriate, to update the credibility adjustment method within the parameters of the methodology proposed in this rule.

The NAIC developed a standard for the minimum number of life-years for the plan's MLR to be determined at least partially credible. The NAIC selected the standard in part to avoid having credibility adjustments that would exceed 10 percent (credibility adjustments are described later in this section). The standards for the private market and MA and Part D were selected using similar criteria. We propose in paragraph (h)(4)(iii) setting the minimum number of member months (that is, the sum of the number of months that each individual was enrolled in the plan over the period that the MLR is measured) to determine at least partial credibility such that the maximum credibility adjustment is equal to or less than 10 percent. Using member months would be consistent with the approach taken for MA and Part D, and we believe the use of member months is more consistent with Medicaid data and reports. We would also recommend that states that collect remittances from plans based on the MLR, would not collect remittances from any plan that is determined to be non-credible on the basis of the number of member months of enrollment in the plan.

In paragraph (h)(4)(iv), we propose to follow the NAIC's assumption that variations of less than approximately 1 percent are reasonably to be expected based on ordinary variation in claims experience of very large plans. We propose to consider the experience of such plans to be fully credible, and would recommend that such a plan should have to pay a remittance based on its reported MLR, to the extent that a state chooses to collect a remittance as described in paragraph

(j) of this section.

The NAIC designated a minimum number of life-years that would be needed to assign full credibility to a plan's MLR and a minimum number of life-years that would be needed to assign at least partial credibility to a plan's MLR. For the MLR of plans that are assigned partial but not full credibility, the NAIC developed a credibility adjustment to apply to the MLR. We propose to adopt a similar approach based on the variability of Medicaid expenditures in paragraph (h)(4)(v). For purposes of the credibility adjustment for Medicaid MCOs, PIHPs, and PAHPs we use the term "member months", and propose to define the term in §438.8(b) as the "number of months an enrollee or group of enrollees is covered by an MCO, PIHP, or PAHP over a specified time period, such as a year."

The Office of the Actuary modeled the distribution of the MLR using the following statistical formula by applying the Central Limit Theorem:

$$MLR_n = \frac{\sum_{i=1}^n X_i}{n\mu / 0.85} \xrightarrow{d} N\left(0.85, \frac{0.85^2 \sigma^2}{n\mu^2}\right)$$

where X_i is the annual claim amount with mean (μ) and variance (σ^2) for an individual. X_i is assumed to be independently and identically distributed for each individual.

n is the number of individuals in the group; and

$$N\left(0.85, \frac{0.85^2 \sigma^2}{n\mu^2}\right) \text{ denotes the Normal distribution with mean, } 0.85, \text{ and variance, } \frac{0.85^2 \sigma^2}{n\mu^2}.$$

The numerator of the formula represents the aggregate claims (a variable), and the denominator represents the aggregate premium. The denominator is modeled as a single point equal to the expected premium because we are not evaluating the variability in the denominator.

The credibility adjustment equals the expected value of the MLR less the 25th percentile (25 percent target failure rate). This difference can be calculated by multiplying the z -score for the standard normal distribution by the standard deviation for the MLR. The credibility adjustment

equals:

$$\left| -0.6745 \frac{0.85\sigma}{\sqrt{n\mu}} \right|$$

where -0.6745 is the z -score for the 25th percentile of the standard normal distribution.

We propose that, in addition to calculating the number of member-months needed to determine the minimum number of member-months for a MLR to be partially credible and for a MLR to be fully credible, the credibility adjustment would also be determined at several other numbers of member-months in between those levels and published. For a MLR that is determined to be partially credible, the credibility adjustment would be calculated by interpolating between the credibility adjustments at the nearest member-month levels published. For example, if a MLR for a plan with 5,000 member-months would receive a credibility adjustment of 2.0 percent and a plan with 10,000 member-months would receive a credibility adjustment of 1.0 percent, then we would determine that a plan with 6,000 member-months would receive a credibility adjustment of 1.8 percent using linear interpolation, as demonstrated in the equation below:

$$1\% + [(10,000 - 6,000) / (10,000 - 5,000)] \times (2\% - 1\%) = 1.8\%$$

More generally:

$$\text{Credibility Adjustment} = CA_b + \left[\frac{(MM_b - MM)}{(MM_b - MM_a)} \right] \times (CA_a - CA_b)$$

where MM is the number of member-months for a specific plan for which the MLR is measured; CA_a and CA_b are the credibility adjustments for the published member-month levels below and above the number of member-months MM for a specific plan; and MM_a and MM_b are the member-month levels below and above the number of member-months MM for a specific plan (for which the credibility adjustments would be CA_a and CA_b).

As proposed in §438.8(h)(4)(vi), the number of member-months required for full and

partial credibility for the MLR may be rounded for the purposes of administrative simplicity. We believe the standards would be clearer and easier to implement if they were rounded rather than unrounded. We intend that, under our proposal, we would round the member-month standards to the nearest 1,000, but depending on the results of the calculations of the number of member-months we may choose a different degree of rounding to ensure that the credibility thresholds are consistent with the objectives of this regulation.

In paragraph (i)(1), the minimum MLR would be calculated and reported for the entire population enrolled in the MCO, PIHP, or PAHP under the contract with the state unless the state directs otherwise. We expect that most states would have the MCO, PIHP, or PAHP calculate the MLR on a contract-wide basis, but we propose to permit flexibility for states that may choose to separate the MLR calculation by Medicaid eligibility group based on differences driven by the federal medical assistance percentage (FMAP) (to simplify accounting with the federal government), by capitation rates, or for legislative tracking purposes. However, while states could divide eligibility groups for MLR calculation purposes, states may not apply different standards of review or different MLR minimums to different eligibility groups. The state may choose any aggregation method described, but proposed paragraph (k)(1)(xii) stipulates that the MCO, PIHP, and PAHP must clearly show in their report to the state which method it used.

Paragraph (j) proposes that an MCO, PIHP, or PAHP pay a remittance to the state if the state elects to impose a remittance standard on a MCO, PIHP, or PAHP that does not meet the minimum MLR standard set by the state as described in proposed in §438.8(c). We strongly encourage states to incent MCO, PIHP, and PAHP performance consistent with their authority under state law.

We propose that MCOs, PIHPs, and PAHPs would submit a report meeting specific content

standards and in the time and manner established by the state (so long as the deadline is within 12 months of the end of the MLR reporting year). We believe this will be enough time after the end of the MLR reporting year for the state to reconcile any incentive or withhold arrangements they have with the MCOs, PIHPs, and PAHPs and for the managed care plans to calculate the MLR accurately. The specified contents of the report in paragraph (k) are considered the minimum information necessary for the state to monitor and confirm compliance with the standards for the calculation of the MLR as specified in this section. We request comment on whether this is an appropriate timeframe.

Because there is always some uncertainty when health plans enter a new market, we propose in paragraph (l) that MCOs, PIHPs, and PAHPs need not calculate or report their MLR in the first year they contract with the state to provide Medicaid services if the state chooses to exclude that MCO, PIHP, or PAHP from the MLR calculation in that year. If the state chose that option, the first MLR reporting year the MCO, PIHP, or PAHP would be the next MLR reporting year and only the experience of the MCO, PIHP, or PAHP for that MLR reporting year would be included. We considered whether to provide similar flexibility for situations where a Medicaid MCO, PIHP, or PAHP covers a new population (that is, the state decides to cover a new population of Medicaid beneficiaries in managed care). While we agree it is possible that there may be unknown risk to the plans for new populations, we do not believe any additional considerations need to be factored in for these cases because capitation payments and any risk mitigation strategy employed by the state would already be considered in the numerator and denominator. Moreover, if we were to allow those newly added populations to be carved out of the MLR calculation, we would create an unnecessary misalignment between Medicaid and the rules governing the private market and MA MLR. We request comment on this proposal and

whether we should further define when a health plan newly contracts with the state.

We anticipate that states may make retroactive changes to capitation rates that could affect the MLR calculation for a given MLR reporting year. Permissible retroactive adjustments to the final capitation rate are discussed in section I.B.3.e. of this proposed rule. We propose in paragraph (m) that in any case where a state makes a retroactive adjustment to the rates that affect a MLR calculation for a reporting year, the MCO, PIHP, or PAHP would need to recalculate the MLR and provide a new report with the updated figures.

In paragraph (n) we propose that the MCO, PIHP, or PAHP provide an attestation when submitting the report specified under proposed paragraph (k) that gives an assurance that the MLR was calculated in accordance with the standards in this proposed section.

(3) State Requirements (§438.74)

We propose minimum standards for state oversight of the MLR standards in §438.74. Specifically, we propose two key standards related to oversight for states when implementing the MLR for contracted MCOs, PIHPs, and PAHPs: (1) report to CMS a summary description of the outcomes of the MLR calculations for each MLR reporting year; and (2) re-pay the federal share of any remittances the state chooses to collect from the MCOs, PIHPs, or PAHPs. The proposed report in paragraph (a) is a summary description of the MLR calculations for each of the MCOs, PIHPs, and PAHPs in the state, and must be included with the rate certification that would be submitted under §438.7 of this proposed rule. In proposed paragraph (b), if the state chooses to collect any remittances from the MCOs, PIHPs, or PAHPs for not meeting the minimum MLR standard, then the state would also need to determine a methodology for how the state will return the federal share of that remittance. With much of the Medicaid expansion population included in managed care and the possibility of the FMAP changing within the MLR reporting year, a MLR

calculated on a contract basis may have varying levels of federal match within the MLR remittance. If a state has decided not to segregate MLR reporting by population, the state will need to submit to CMS the methodology of how the federal share of the remittance was calculated that would be reviewed and approved in the normal CMS-64 claiming protocol.

2. Standard Contract Provisions (§438.3, §438.6)

Our existing regulations at §438.6 stipulate that MCO, PIHP, and PAHP capitation rates must be set on an actuarially sound basis, based on section 1903(m)(2)(A)(iii) of the Act (for MCOs) and section 1902(a)(4) of the Act (for PIHPs and PAHPs). Section 438.6 currently also includes standards related to contracting and contract terms for MCOs, PIHPs, and PAHPs. Based on our experience with the changing Medicaid managed care environment, we are proposing several updates to these standards for contract terms and actuarial soundness. In addition, the current language also includes provisions that are better organized by specific topic. To that end, we propose to restructure the standards currently codified in §438.6 at the same time as we propose several substantive changes in these areas. Our proposal would divide the content into the following five new sections, four of which specifically address setting actuarially sound capitation rates.

- §438.3 – Standard Contract Provisions
- §438.4 – Actuarial Soundness
- §438.5 – Rate Development Standards
- §438.6 – Special Contract Provisions Related to Payment
- §438.7 – Rate Certification Submission

We discuss in section I.B.3., the substance of our proposal concerning setting actuarially sound capitation rates, and focus in this section I.B.2. on our proposal for the standard contract

provisions for MCO, PIHP, and PAHP contracts. Where we propose to reorganize or recodify existing provisions into new sections, they are so noted in this preamble discussion. Likewise, where we have proposed additional specificity, those are clearly delineated. We welcome comments on both the approach and content of this portion of the proposed rule.

We propose to add a new §438.3 to contain the standard provisions for MCO, PIHP, and PAHP contracts that are distinguishable from the rate setting process. As proposed, these provisions generally set forth specific elements that states must include as performance standards in their managed care contracts. As published in 2002, §438.6 contained contract standards from part 434 that were carried over from that section and updated as necessary when part 438 was created to contain all standards for Medicaid managed care programs, including the standards for actuarially sound capitation payments and for risk-sharing and related payment mechanisms. To improve the clarity and readability of part 438, we propose that §438.3 would include the standard contract provisions from current §438.6 that are unrelated to payment. We recognize that additional contract standards that direct aspects of the MCO's, PIHP's, or PAHP's operations appear elsewhere in this part; however, to preserve the continuity of and familiarity with part 438 over the past decade, we do not believe it is necessary or appropriate to completely consolidate all contract standards into one section.

We are proposing that the provisions currently codified in §438.6 as paragraphs (a) through (m) be redesignated respectively as §438.3(a) through (l), (p) and (q), with some revisions as described below. These proposed paragraphs address standards for our review and approval of contracts, entities eligible for comprehensive risk contracts, payment, prohibition of enrollment discrimination, services covered under the contract, compliance with applicable laws and conflict of interest safeguards, provider-preventable conditions, inspection and audit of financial records,

physician incentive plans, advance directives, subcontracts, choice of health care professional, additional rules for contracts with PCCMs, and special rules for certain HIOs.

First, in §438.3(a) related to our review and approval of contracts, we propose to add the regulatory flexibility for us to set forth procedural rules—namely timeframes and detailed processes for the submission of contracts for review and approval—in sub-regulatory materials, and add a new standard for states seeking contract approval prior to a specific effective date that proposed final contracts must be submitted to us for review no later than 90 days before the planned effective date of the contract. Under our proposal, the same timeframe standard would also apply to rate certifications, as proposed §438.7(a) incorporates the review and approval process of §438.3(a). To the extent that the final contract submission is complete and satisfactory responses to questions are exchanged in a timely manner, we believe that 90 days is a reasonable and appropriate timeframe for us to conduct the necessary level of review of these documents to verify compliance with federal standards and thereby authorize FFP concurrent with the health plan's initiation of performance under the contract. We acknowledge a state's interest in receiving approval prior to the planned effective date and propose that states provide us with adequate time to conduct our review to ensure compliance with applicable rules. In addition, for purposes of consistency throughout part 438, we are removing specific references to the CMS Regional Offices and replacing it with a general reference to CMS. This proposed change does not represent a modification in the role of the Regional Offices.

We propose for §438.3(b) and (d) to merely redesignate the existing provisions at §438.6(b) and (d), with the addition of PCCM entities to paragraph (d) consistent with our proposal discussed in section I.B.6.e. of this proposed rule about PCCM entities. Wherever there is a reference to PCCM in existing regulatory text being moved or amended as part of our proposal

for §438.3, we propose to add PCCM entities.

In proposed §438.3(c), we propose to restate our longstanding standard currently in §438.6(c)(2)(ii) that the final capitation rates for each MCO, PIHP, or PAHP must be specifically identified in the applicable contract submitted for our review and approval. We also propose to clarify in this paragraph that the final capitation rates must be based only upon services covered under the state plan and that the capitation rates represent a payment amount that is adequate to allow the MCO, PIHP, or PAHP to efficiently deliver covered services in a manner compliant with contractual standards.³

We propose to redesignate the provisions prohibiting enrollment discrimination currently at §438.6(d) as new §438.3(d) and propose to replace the reference to the Regional Administrator with CMS for consistency with other proposals to refer uniformly to CMS in the regulation text. We also propose to add sex as a protected category as discussed in the proposed changes in §438.3(f) below.

The current regulation at §438.6(e) addresses the services that may be covered by the MCO, PIHP, or PAHP contract. We propose to move that provision to §438.3(e). The existing provision also prohibits services that are in addition to those in the Medicaid state plan from being included in the capitation rate and we have proposed to address that standard in proposed §438.3(c) above.

We also propose to redesignate the existing standard for compliance with applicable laws and conflict of interest standards from existing §438.6(f) to §438.3(f)(1) with the addition of a

³ We note that in “Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care,” published April 10, 2015 [CMS-2333-P], we proposed that certain additional costs could also be used to develop capitation rates. We anticipate that if that proposal is finalized, that provision would be codified as part of §438.6(e) and redesignated through this proposed rule as §438.3(e).

reference to section 1557 of the Affordable Care Act, which prohibits discrimination in health programs that receive federal financial assistance. Similarly, we propose to add sex as a protected category for purposes of MCO, PIHP, PAHP, or PCCM enrollment practices in the enrollment provisions proposed to be moved to §438.3(d)(4). We also propose a new standard, at proposed §438.3(f)(2), to state more clearly the existing standard that all contracts comply with conflict of interest safeguards (described in §438.58) and section 1902(a)(4)(C) of the Act.

We propose to redesignate the standards related to provider reporting of provider-preventable conditions currently codified in §438.6(f)(2)(i) to the new §438.3(g). With this redesignation, we propose to limit these standards to MCOs, PIHPs, and PAHPs, because those are the entities for which these standards are applicable.

We propose to move the inspection and audit rights for the state and federal government from §438.6(g) to new §438.3(h) and to expand the existing standard to include access to the premises, physical facilities and equipment of contractors and subcontractors where Medicaid-related activities or work is conducted. In addition, we propose to clarify that the State, CMS, and the Office of the Inspector General may conduct such inspections or audits at any time.

As part of our proposal to redesignate the provisions related to physician incentive plans from §438.6(h) to new §438.3(i), we propose to correct the outdated references to Medicare+Choice organizations to MA organizations. We propose to redesignate the provisions for advance directives currently in §438.6(i) as §438.3(j). We propose to redesignate the provisions for subcontracts currently at §438.6(l) as §438.3(k) and also propose to add a cross-reference to §438.230 that specifies standards for subcontractors and delegation. We propose to redesignate the standards for choice of health care professional currently at §438.6(m) at §438.3(l).

In proposed §438.3(m), we propose to add a new standard that MCOs, PIHPs, and PAHPs

submit audited financial reports annually. We believe this standard is appropriate and necessary for these managed care plans because such information is a source of base data that must be used for rate setting purposes in proposed §438.5(c). We propose that the audits are conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. We propose to reserve §438.3(n).

In proposed §438.3(o), we propose that contracts covering long-term services and supports provide that services that could be authorized through a waiver under section 1915(c) of the Act or a state plan amendment through section 1915(i) or 1915(k) be delivered consistent with the settings standards in §441.301(c)(4).

We propose to redesignate existing §438.6(j) (special rules for certain HIOs) and (k) (additional rules for contracts with PCCMs) as §438.3(p) and (q). As part of our proposed redesignation of the HIO-specific provisions from existing §438.6(j) to new §438.3(p), we also propose to correct a cross-reference in that paragraph. The existing language cross-references §438.6(a) to determine whether certain HIOs may enter into risk contracts. This cross-reference first appeared in the 1998 proposed rule when §438.6(a) contained the contract review standards for risk-bearing entities. In the final rule for part 438, those standards were moved to §438.6(b) and the reference in §438.6(j) was not updated. We propose to correct that oversight by using a cross reference to paragraph (a) of this proposed section, where we have proposed to designate the contract review standard. We propose to redesignate the additional contract standards specific to PCCM contracts from existing §438.6(k) to new §438.3(q) so that all contract standards for MCOs, PIHPs, and PAHPs are separated from any special rules for PCCMs. We believe this restructuring adds clarity to our rules.

In proposed §438.3(r), we propose to set standards for contracts with PCCM entities, in

addition to those standards specified for PCCM contracts in proposed §438.3(q), including the submission of such contracts for our review and approval to ensure compliance with §438.10 (information standards). If the PCCM entity contract provides for shared savings, incentive payments or other financial reward for improved quality outcomes, §438.330 (performance measurement), §§438.340 (managed care elements of comprehensive quality strategy), and 438.350 (external quality review) would be applicable.

In proposed §438.3(s), we propose to add standards for contracts with MCOs, PIHPs, or PAHPs that are contractually obligated to provide coverage of covered outpatient drugs. The proposed MCO standards are based primarily on section 1903(m)(2)(A)(xiii) of the Act and we rely on our authority under section 1902(a)(4) to extend them to PIHPs and PAHPs that are contractually obligated to provide covered outpatient drugs. In addition, we rely on section 1902(a)(4) of the Act to address, for all managed care plans within the scope of this proposal, requirements that are outside the scope of section 1903(m)(2)(A)(xiii) of the Act, namely the proposal at §438.3(s)(1), (4) and (6).

Section 2501(c)(1)(C) of the Affordable Care Act amended section 1903(m)(2)(A) of the Act to add clause (xiii) to add certain standards applicable to contracts with MCOs. In the February 2, 2012 **Federal Register**, we published the “Medicaid Program; Covered Outpatient Drugs” proposed rule that included the addition of a definition for covered outpatient drugs in §447.502 (77 FR 5318). We propose here to incorporate appropriate definitions related to covered outpatient drugs in part 438 should such definitions be implemented and have used the phrase “as defined in section 1927(k)” in our proposed regulation text as a placeholder for that in §438.3(s).

In paragraph (s)(1), we propose that the MCO, PIHP, or PAHP must provide coverage of covered outpatient drugs (as defined in section 1927(k)(2) of the Act) as specified in the contract

and in a manner that meets the standards for coverage of such drugs imposed by section 1927 of the Act as if such standards applied directly to the MCO, PIHP, or PAHP. This is intended to clarify that when the MCO, PIHP, or PAHP provides prescription drug coverage, the coverage of such drugs must meet the standards set forth in the definition of covered outpatient drugs at section 1927(k)(2) of the Act. The MCO, PIHP, or PAHP may be permitted to maintain its own formularies for covered outpatient drugs that are under the contract, but when there is a medical need for a covered outpatient drug that is not included in their formulary but that is within the scope of the contract, the MCO, PIHP, or PAHP must cover the covered outpatient drug under a prior authorization process. This proposal is based on our authority under section 1902(a)(4) of the Act to mandate methods of administration that are necessary for the efficient operation of the state plan. Furthermore, if an MCO, PIHP, or PAHP is not contractually obligated to provide coverage of a particular covered outpatient drug, or class of drugs, the state is required to provide the covered outpatient drug through FFS in a manner that is consistent with the standards set forth in its state plan and the requirements in section 1927 of the Act.

In paragraph (s)(2), we propose to implement section 1903(m)(2)(A)(xiii)(III), specifically, we propose that MCOs, PIHPs, and PAHPs report drug utilization data necessary for the state to bill for rebates under section 1927(b)(1)(A) to the state within 45 calendar days after the end of each quarterly rebate period to ensure that MCO, PIHP, or PAHP data is included with the FFS invoicing of manufacturers for rebates for the state in the same rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed or covered by the MCO, PIHP, or PAHP.

As amended, section 1927(b)(1)(A) of the Act provides in part that states must bill

manufacturers for rebates for drugs dispensed to enrollees with a Medicaid managed care plan and the proposed standard in paragraph (s)(2) will help facilitate state compliance with the statutory directive. In paragraph (s)(3), we propose that the MCO, PIHP, or PAHP must have procedures in place to exclude utilization data for drugs subject to discounts under the 340B Drug Pricing Program from the utilization reports submitted under proposed paragraph (s)(2). Section 2501(c) of the Affordable Care Act modified section 1927(j)(1) of the Act to specify that covered outpatient drugs are not subject to the rebate standards if such drugs are both subject to discounts under section 340B of the PHS Act and dispensed by MCOs. Section 340B of the PHS Act prohibits covered entities from billing Medicaid for covered outpatient drugs purchased at discounted 340B prices if the drugs are subject to a Medicaid rebate. Section 1903(m)(2)(A)(xiii)(III) of the Act provides that the reporting standard for MCOs does not include information about drugs that are not subject to the rebates under section 1927 of the Act. As we propose in paragraph (s)(2), that MCOs, PIHPs, and PAHPs must report utilization data, it would follow that covered outpatient drugs purchased at 340B prices need to be excluded from the utilization reports to the state to avoid duplicate discounts for rebates paid by manufacturers. To ensure that drug manufacturers will not be billed for rebates for drugs purchased and dispensed under the 340B Drug Pricing Program, MCOs, PIHPs, or PAHPs must have mechanisms in place to identify these drugs and exclude the reporting of this utilization data to the state as to avoid the manufacturer from incurring a duplicate discount on these products.

In paragraph (s)(4), we propose that MCOs, PIHPs, or PAHPs that provide coverage of covered outpatient drugs also operate a drug utilization review (DUR) program that is consistent with the standards in section 1927(g) of the Act; this standard means that the DUR program operated by the MCO, PIHP, or PAHP would be compliant with section 1927(g) of the Act if it

were operated by the state in fulfilling its obligations under section 1927 of the Act. This does not mean that the DUR program operated by the MCO, PIHP, or PAHP must be the same as that operated by the state, but that the MCO's, PIHP's, or PAHP's DUR program meets the requirements in section 1927(g) of the Act. This proposal is based on our authority under section 1902(a)(4) of the Act. We recognize that MCOs, PIHPs, and PAHPs that are contractually responsible for covered outpatient drugs generally conduct utilization review activities as these activities promote the delivery of quality care in a cost effective and programmatically responsible manner. We believe that because the MCO, PIHP, or PAHP is providing coverage for covered outpatient drugs as part of the state plan instead of the state providing that coverage through FFS, it is appropriate to extend the DUR responsibilities associated with such coverage to the MCO, PIHP, or PAHP. Section 1927(g)(1)(A) of the Act provides, in part, that states must provide a DUR program for covered outpatient drugs to assure that prescriptions: (1) are appropriate; (2) are medically necessary; and (3) are not likely to result in adverse medical results. We intend that our proposal in paragraph (s)(4) be met when the DUR program operated by an MCO, PIHP, or PAHP meets these standards. We recommend that the state's DUR Board coordinate with the MCOs, PIHPs, and PAHPs to coordinate review activities. In paragraph (s)(5), we propose that the MCO, PIHP, or PAHP would have to provide a detailed description of its DUR program activities to the state on an annual basis. The purpose of the report is to ensure that the parameters of section 1927(g) of the Act are being met by the MCO's, PIHP's, or PAHP's DUR program, as proposed under paragraph (s)(4).

Finally, in paragraph (s)(6), we propose that the state stipulate that the MCO, PIHP, or PAHP conduct the prior authorization process for covered outpatient drugs in accordance with section 1927(d)(5); we rely again on our authority under section 1902(a)(4) of the Act for this

proposal. We believe that because the MCO, PIHP, or PAHP is providing coverage for covered outpatient drugs as part of the state plan instead of the state providing that coverage through FFS, it is appropriate to extend the prior authorization standards associated with such coverage to the MCO, PIHP, or PAHP. Therefore, we propose that the MCO, PIHP, or PAHP would provide a response to a request for prior authorization for a covered outpatient drug by telephone or other telecommunication device within 24 hours of the request and dispense a 72 hour supply of a covered outpatient drug in an emergency situation. We request comment on the proposals for MCO, PIHP, or PAHP coverage of covered outpatient drugs.

In proposed §438.3(t), we propose a new contract provision for MCO, PIHP, or PAHP contracts that cover Medicare-Medicaid dually eligible enrollees and delegate the state's responsibility for coordination of benefits to the health plan. Under our proposal, in states that use the automated crossover process for FFS claims, the contract would need to provide that the MCO, PIHP, or PAHP sign a Coordination of Benefits Agreement and participate in the automated crossover process administered by Medicare. In FFS, states are responsible for dually eligible beneficiaries' Medicare cost-sharing and use Medicare's automated crossover process to reduce burden on providers. Under this crossover process, a Medicare provider—who may not be part of the managed care plan's network—submits a claim to Medicare and there is an automatic crossover to the state for whatever Medicaid payment would be due. As more MCOs, PIHPs, or PAHPs plans are contractually responsible for Medicare deductibles and co-insurance, providers face a much more complex set of processes. If an MCO, PIHP, or PAHP does not enter into a Coordination of Benefits Agreement with Medicare, providers may have to submit separate bills in electronic or paper format. Each health plan has its own process, and often, a single provider may have patients in two or three different health plans. Contract provisions requiring an MCO, PIHP,

or PAHP serving dually eligible enrollees to enter into a Coordination of Benefits Agreement with Medicare and participate in automated crossover would encourage providers to serve dually eligible beneficiaries. Further, such a standard would also reduce administrative burden for the relevant entities, ensuring more efficient provision of benefits to enrollees.

We propose to add a new paragraph (u) to permit MCOs and PIHPs to receive a capitation payment from the state for an enrollee aged 21 to 64 that spends a portion of the month for which the capitation is made as a patient in an institution for mental disease (IMD) so long as the facility is a hospital providing psychiatric or substance use disorder (SUD) inpatient care or sub-acute facility providing psychiatric or SUD crisis residential services and the stay in the IMD is for less than 15 days in that month. As background, paragraph (B) following section 1905(a)(29) provides that federal financial participation is not available for any medical assistance under title XIX for services provided to an individual ages 21 to 64 who is a patient in an IMD facility. Under this broad exclusion, no FFP is available for the cost of services provided either inside or outside the IMD while the individual is a patient in the facility. In light of the flexibility that managed care plans have had historically to furnish care in alternate settings that meet an enrollee's needs, we propose to clarify that managed care plans have had flexibility under risk contracts to provide alternative services or services in alternative settings in lieu of covered services or settings if cost-effective, on an optional basis, and to the extent the managed care plan and the enrollee agree that such setting or service would provide medically appropriate care.

We aim to propose rules on substitute providers under Medicaid managed care programs for CMS's "in lieu of" policy in particular. For reasons set forth later in this section, we believe that addressing managed care plan flexibility in the context of short inpatient or sub-acute IMD stays is necessary because of what we believe are access issues for short-term inpatient psychiatric

and SUD treatment. We propose to include sub-acute facilities in our proposal as an option to address access issues for inpatient services. Our proposed clarification of policy aims to ensure that the use of IMD settings in lieu of covered settings for this care is sufficiently limited so as to not contravene the Medicaid coverage exclusion in section 1905(a)(29)(B) of the Act. Our proposal recognizes that managed care plans have flexibility in ensuring access and availability of covered services while ensuring that use of an appropriate alternate setting does not endanger beneficiaries' overall access to Medicaid benefits for the entire month during which a brief stay occurs. We welcome comment on these proposals, as well as other recommendations for addressing the IMD payment exclusion in managed care delivery systems.

Managed care programs may achieve efficiency and economic savings compared to Medicaid FFS programs by managing care through numerous means, including networks of providers, care coordination and case management. We have previously acknowledged such increased efficiencies and savings, see 67 FR 41005, and current §438.6(e) (proposed to be redesignated as §438.3(e)) permit managed care plans to provide additional services not covered in the state plan, but such services cannot be included when determining payment rates. We believe that to implement the IMD exclusion in the managed care plan context by prohibiting or limiting the payment through the capitation rate for services when an enrollee is a patient in an IMD is contrary to the flexibilities managed care plans have had in the delivery of services. We could take a narrow view of section 1905(a)(29)(B) of the Act and prohibit the payment, either entirely or in part, of the capitation rate for any month during which a beneficiary is a patient in any IMD for any part of the month, or to require mid-month changes in capitation payments and enrollment status. Either of these alternatives would have the potential to disrupt the coordination and management of care for such beneficiaries that managed care plans otherwise use. We also

acknowledge that inherent in transferring the risk for Medicaid coverage during a period means that capitation payments may be made for months during which no Medicaid services are used by a particular beneficiary who is enrolled with the plan. Thus, we believe that it is appropriate to permit states to make a monthly capitation payment that covers the risk of services that are eligible for FFP rendered during that month when the enrollee is not a patient in an IMD, even though the enrollee may also be a patient in an IMD during a portion of that same period. A corollary of our proposal is that capitation payments may not be made if the specified conditions outlined in this section are not met and that a state would have to ensure that covered Medicaid services are provided on a FFS basis or make other arrangements to assure compliance. We seek comment on our proposed approach to providing this flexibility under managed care and alternative permissible options under the statute.

We clarify here that services rendered to a patient in an IMD may be considered “in lieu of services” covered under the state plan, as described in this proposed rule. “In lieu of services” are alternative services or services in a setting that are not included in the state plan or otherwise covered by the contract but are medically appropriate, cost effective substitutes for state plan services included within the contract (for example, a service provided in an ambulatory surgical center or sub-acute care facilities, rather than an inpatient hospital). However, an MCO, PIHP or PAHP may not require an enrollee to use an “in lieu of” arrangement as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner. Accordingly, the contract may not explicitly require the MCO or PIHP to use IMD facilities, and must make clear that the managed care plan may not make the enrollee receive services at an IMD facility versus the setting covered under state plan. However, the contract could include, in its list of Medicaid-covered services to

be provided under the contract, services such as inpatient psychiatric hospital services. The MCO or PIHP could then purchase these services from an IMD rather than an inpatient hospital if it so chooses in order to make the covered services available. This is consistent with the ability of managed care plans to select providers for their network to provide covered services.

We propose to limit payment of capitation rates for enrollees that are provided services while in an IMD (to stays of less than 15 days per month and so long as the IMD is a certain type of facility) for two reasons. First, our proposal seeks to address the specific concerns about ensuring access to and availability of inpatient psychiatric and SUD services that are covered by Medicaid; these concerns have focused on short-term stays. The expansion of the Medicaid program coupled with the overall increase in health care coverage in managed care plans in the Marketplace leads us to expect greater demand on the limited inpatient resources available to provide mental health and SUD services. An estimated 7.1 percent of those aged 18-64 currently meet the criteria for a serious mental illness⁴ and an estimated 14.9 percent are currently experiencing serious psychological distress.⁵ Further, an estimated 13.6 percent of uninsured individuals aged 18-64 within the Medicaid expansion population currently have a substance use

⁴ Serious Mental Illness: Respondents to the NSDUH meet the criteria for SMI in the past year if they have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) that has resulted in serious functional impairment that substantially interferes with or limits one or more major life activities. Adult NSDUH respondents' mental illness is determined based on modeling their responses to questions on distress (Kessler-6 [K6] scale) and impairment (truncated version of the World Health Organization Disability Assessment Schedule [WHODAS]).

⁵ Serious Psychological Distress (SPD): Respondents are determined to have SPD if they have a score of 13 or higher on the Kessler-6 (K6) scale. The Kessler-6 (K6) scale consists of six questions that gather information on how frequently adult respondents experienced symptoms of psychological distress during the past month or during the one month in the past year when they were at their worst emotionally. These questions ask about the frequency of feeling (1) nervous, (2) hopeless, (3) restless or fidgety, (4) sad or depressed, (5) that everything was an effort, and (6) no good or worthless. The NSDUH measure of serious psychological distress results in larger prevalence estimates than the SMI.

disorder.⁶ Similarly, within the Marketplace eligible population, 6.1 percent currently have a serious mental illness, 13.5 percent are experiencing serious psychological distress, and 14.3 percent have a substance use disorder.⁷ However, over the past several years the number of beds in freestanding inpatient psychiatric facilities declined by 5 percent with freestanding inpatient psychiatric facilities in urban areas accounting for the majority of the decrease (5.7 percent). In addition, psychiatric beds have decreased significantly over the past 25 years⁸ in urban hospitals and distinct part psychiatric units have declined by 9 percent from 2010 to 2013. In addition, newer diversionary services such as crisis residential services have been effective in diverting individuals with psychiatric and substance use disorders experiencing a crisis from emergency departments or inpatient services. We have heard concerns from states and other stakeholders that access to and availability of short-term inpatient psychiatric and SUD services has been compromised and that delays in the provision of care may occur. Managed care plans have an obligation to ensure access to and availability of services under Medicaid regulations for services not prohibited by statute and covered under the contract. To meet that obligation, managed care plans have used alternate settings, including short term crisis residential services, to provide appropriate medical services in lieu of Medicaid-covered settings, they are also dealing with the gap between the need for and the capacity to provide inpatient and sub-acute psychiatric services.

The second reason we are limiting the payment of capitation rates for enrollees that are

⁶ Substance Use Disorder (SUD): An adult is defined as having a SUD if they meet the criteria for abuse or dependence for illicit drugs or alcohol. Abuse of illicit drugs or alcohol is defined as meeting one or more of the four criteria for abuse included in the DSM-IV. Dependence on illicit drugs or alcohol is defined as meeting three out of seven dependence criteria (for substances that included questions to measure a withdrawal criterion) or three out of six dependence criteria (for substances that did not include withdrawal questions) for that substance, based on criteria included in DSM-IV. Additional criteria for alcohol and marijuana dependence since 2000 included the use of these substances on 6 or more days in the past 12 months.

⁷ Substance Abuse and Mental Health Services Administration (SAMHSA), *Behavioral Health Treatment Needs Assessment Toolkit for States*, available at <http://store.samhsa.gov/shin/content//SMA13-4757/SMA13-4757.pdf>.

⁸ New Freedom Commission on Mental Health, *Subcommittee on Acute Care: Background Paper*. DHHS Pub. No. SMA-04-3876. Rockville, MD: 2004.

provided services while in an IMD is that we believe that section 1905(a)(29)(B) of the Act is applicable to the managed care context. Managed care plans should not be used to provide Medicaid coverage for services not authorized in statute, such as services provided to individuals in an IMD that are not furnished in lieu of a covered service authorized in statute. If an enrollee were a patient in an IMD for an extended period of time, the likelihood that the enrollee would otherwise be incurring authorized Medicaid-covered expenses—and with it, the risk compensated by the capitation payment—decreases. We believe that permitting capitation payments when an enrollee has a short-term stay in an IMD is a means of securing compliance with the statute by delineating parameters for these payments, which we would otherwise exclude or prohibit to achieve compliance with the statute.

Therefore, we propose that capitation payments may be made for a month in which an enrollee receives inpatient services in an IMD for a period of 15 days or less. This 15-day parameter is based on evidence of lengths of stay in an IMD based on data from the Medicaid Emergency Psychiatric Demonstration. This evidence suggests that the average length of stay is 8.2 days.⁹ We propose to define a short-term stay as 15 days or less to account for the variability in the length of stay often experienced by individuals who need acute inpatient psychiatric or SUD services. We would expect practice patterns for the same services, whether delivered in an inpatient hospital or an IMD facility would be similar and that such patterns would be monitored by the state. Note that under this proposal, an enrollee could have a length of stay longer than 15 days that covers two consecutive months where the length of stay within each month is less than 15 days, and the MCO or PIHP would be eligible to receive a capitation payment for that enrollee for both months. We considered other alternatives to this approach, including whether to remain

⁹ http://innovation.cms.gov/Files/reports/MEPD_RTC.pdf, page 12.

silent on a numerical definition associated with a short-term acute stay, or utilizing a number associated with an average length of stay, such as data available under the Medicaid Emergency Psychiatric Demonstration. We request comment on this provision, general approach and methodology, or any other comments. We also request comment on the proposed definition of a short-term acute stay in this context, including the cost of IMD services in FFS or managed care, the wisdom of reflecting a number as either a hard cap on the amount of time for which FFP would be available via the capitation payment, or as an articulation of the average length of stay across a managed care plan's enrollees that would legitimize FFP. We also request comment on ways to operationalize use of an average length of stay in terms of capitation payment development and oversight. In addition, we request comment on the percentage of enrollees that have a length of stay of less than 15 days for inpatient or sub-acute psychiatric services.

For purposes of rate setting, the state and its actuaries may use the utilization of services provided to an enrollee while they have a short term stay as a patient in an IMD to determine an estimate of the utilization of state plan services, that is, inpatient psychiatric services, covered for the enrolled population in future rate setting periods. However, the costs associated with the services to patients in an IMD may not be used when pricing covered inpatient psychiatric services. The IMD utilization must be priced consistent with the cost of the same services through providers included under the state plan. We note that this guidance for accounting for service utilization to patients in an IMD differs from rate setting guidance issued in December 2009 for in lieu of services in the context of home and community based services, see CMS, [Providing Long-Term Services and Supports in a Managed Care Delivery System: Enrollment Authorities and Rate Setting Techniques](#) (December 2009), at page 15, available at <http://www.pasrrassist.org/sites/default/files/attachments/10-07-23/ManagedLTSS.pdf>. In that

guidance, we provided that the state may modify the rate-setting process to account for the expected cost as well as utilization of in lieu of services as a proxy for the cost of approved state plan services in a contract. In the context of services rendered to patients in an IMD, we believe such proxy pricing is not consistent with the statutory prohibition of FFP referenced above. As noted earlier, we welcome comment on this proposal.

In proposed paragraph (v), we establish minimum recordkeeping requirements for MCOs, PIHPs, PAHPs, and subcontractors, as applicable, of at least 6 years for data, documentation and information specified in this part. Specifically, we propose that MCOs, PIHPs, PAHPs, and subcontractors retain enrollee grievance and appeal records as specified in §438.416, base data as specified in §438.5(c), MLR reports as specified in §438.8(k), and the documentation specified in §438.604, §438.606, §438.608, and §438.610. We make this proposal under our authority under section 1902(a)(4) of the Act to mandate methods of administration that are necessary for the efficient operation of the state plan. The retention of these records will aid in monitoring, oversight, and audit activities at the state and federal levels. We request comment on the proposed length of record retention; specifically, whether 6 years is consistent with existing state requirements on managed care plans for record retention and whether we should adopt a different timeframe. We note that MA requires MA organizations to retain records for a period of 10 years at §422.504(d).

3. Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs (§438.2, §438.4, §438.5, §438.6, and §438.7)

Building on a decade of experience with states, we are proposing to improve the effectiveness of the regulatory structure to better assure the fiscal integrity, transparency and beneficiary access to care under the Medicaid program and to promote innovation and

improvement in the delivery of services through a comprehensive review of Medicaid managed care capitation rates. The existing regulatory framework is process-based, rather than focused on a substantive review and assessment of the actuarial assumptions and methodologies underlying the development of the rates. Our proposal would strengthen that approach. The overarching goal behind our proposed revisions to the rate-setting framework (proposed in §438.4 through §438.7) is to reach the appropriate balance of regulation and transparency that accommodates the federal interests as payer and regulator, the state interests as payer and contracting entity, the actuary's interest in preserving professional judgment and autonomy, and the overarching programmatic goals—shared by states and the federal government—of promoting beneficiary access to quality care, efficient expenditure of funds and innovation in the delivery of care. In addition, we believe that requiring more consistent and transparent documentation of the rate setting process will allow us to conduct more efficient reviews of the rate certification submissions, which is a benefit to all parties.

Section 1903(m)(2)(A)(iii) of the Act permits federal matching dollars for state expenditures to a risk bearing entity for Medicaid services when “such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the state and the entity under which the prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts [meeting certain value thresholds].” Existing §438.6(c)(i) elaborates upon the statutory standard to define actuarially sound rates as rates that: (1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered and the services to be furnished under the contract; and (3) have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows

the practice standards established by the Actuarial Standards Board. In its Actuarial Standard of Practice No. 49, “Medicaid Managed Care Capitation Rate Development and Certification” issued in March 2015, the American Academy of Actuaries states that Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. Other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. Costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes. See Actuarial Standard of Practice No. 49 (March 2015), available at http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf. Our proposal to revise the Medicaid managed care rate setting framework expands upon these basic and generally accepted definitions of actuarial soundness to ensure that Medicaid rates are developed in a transparent and consistent manner across Medicaid managed care programs.

We relied on the following principles of actuarial soundness to inform the modernized rate setting framework in this proposed rule. First, capitation rates should be sufficient and appropriate for the anticipated service utilization of the populations and services covered under the contract and provide appropriate compensation to the health plans for reasonable non-benefit costs. Built into that principle is the concept that an actuarially sound rate should result in appropriate payments for both payers (the state and the federal government) and that the rate should promote program goals such as quality of care, improved health, community integration of enrollees and cost containment, where feasible. Second, an actuarial rate certification underlying the capitation

rates should provide sufficient detail, documentation, and transparency of the rate setting components set forth in this regulation to enable another actuary to assess the reasonableness of the methodology and the assumptions supporting the development of the final capitation rate. Third, a transparent and uniformly applied rate review and approval process based on actuarial practices should ensure that both the state and the federal government act effectively as fiscal stewards and in the interests of beneficiary access to care.

a. Definitions (§438.2)

We propose to define “actuary” to incorporate standards for an actuary who is able to provide the certification under current law at §438.6(c); that is, that the individual meets the qualification standards set by the American Academy of Actuaries as an actuary and follows the practice standards established by the Actuarial Standards Board. We also propose that where the regulation text refers to the development and certification of the capitation rates, and not the review or approval of those rates by CMS, the term actuary refers to the qualified individual acting on behalf of the state. We intend that an actuary who is either a member of the state’s staff or a contractor of the state could fulfill this role so long as the qualification and practice standards are also met.

We propose to modify the existing definition of “capitation payment” by removing references to “medical” services in recognition of the fact that states are contracting with MCOs, PIHPs, and PAHPs for LTSS, which are not adequately captured in the existing definition of capitation payments that refers only to medical services.

We propose to define a “material adjustment” as one that, in the objective exercise of an actuary’s judgment, has a significant impact on the development of the capitation rate. We note that material adjustments may be large in magnitude, or be developed or applied in a complex

manner. The actuary developing the rates should use reasonable actuarial judgment based on generally accepted actuarial principles when assessing the materiality of an adjustment. Further discussion of material adjustments is provided in the discussion on documentation of adjustments in §438.7 and section I.B.3.c. of this proposed rule.

We also propose to add a definition for “rate cells.” The use of rate cells is intended to group people with more similar characteristics and expected health care costs together to set capitation rates more accurately. The rate cells should be developed in a manner to ensure that an enrollee is assigned to one and only one rate cell. That is, each enrollee should be categorized in one of the rate cells and no enrollee should be categorized in more than one rate cell.

b. Actuarial soundness standards (§438.4)

Consistent with the principles of actuarial soundness described herein, we propose to add a new §438.4 that builds upon the definition of actuarially sound capitation rates currently at §438.6(c)(i) and establishes standards for states and their actuaries. In §438.4(a), we propose to define actuarially sound capitation rates as rates that are projected to provide for all reasonable, appropriate, and attainable costs under the terms of the contract and for the time period and population covered under the contract. Further, we state that the rate development process should be conducted and rates developed in accordance with the proposed standards for approval of rates in §438.4(b).

Under this provision, costs that are not reasonable, appropriate, or attainable should not be included in the development of capitated rates. Thus, for instance, costs related to improper payments that an MCO, PIHP, or PAHP recovers are not reasonable costs and should not be included as part of the base data used to develop the capitation rate. This is because, consistent with proposed standards in §438.608(a)(2) and (d)(1) described in section I.B.4.(c) of this

proposed rule, MCOs, PIHPs, and PAHPs must report improper payments and recover overpayments they identify from network providers. States must take such recoveries into account when developing capitation rates. Therefore, capitation rates that include the amount of improper payments recovered by an MCO, PIHP, or PAHP as projected costs would not be considered actuarially sound.

In §438.4(b), we propose to set forth the standards that capitation rates must meet and that we will apply in the review and approval of actuarially sound capitation rates. In §438.4(b)(1), we propose to redesignate the standard currently in §438.6(c)(1)(i)(A) that capitation rates have been developed in accordance with generally accepted actuarial principles and practices. We also propose in §438.4(b)(1) that capitation rates must meet the standards described in proposed §438.5 dedicated to rate development standards. We acknowledge that states may desire to establish minimum provider payment rates in the contract with the managed care plan. Because actuarially sound capitation rates must be based on the reasonable, appropriate, and attainable costs under the contract, minimum provider payment expectations included in the contract would necessarily be built into the relevant service components of the rate. However, we propose in paragraph (b)(1) to prohibit different capitation rates based on the FFP associated with a particular population. We believe that such practices represent cost-shifting from the state to the federal government and are not based on generally accepted actuarial principles and practices.

In §438.4(b)(2), we propose to redesignate the provision currently at §438.6(c)(1)(i)(B). We have restated the standard but the substance is the same: the capitation rates must be appropriate for the population(s) to be covered and the services provided under the managed care contract.

In §438.4(b)(3), we propose that capitation rates be adequate to meet the requirements on

MCOs, PIHPs, and PAHPs in §§438.206, 438.207, and 438.208. These sections contain the requirements for MCOs, PIHPs, and PAHPs to ensure availability and timely access to services, adequate networks, and coordination and continuity of care, respectively. The definition of actuarially sound capitation rates in proposed §438.4(a) provides that the rates must provide for all reasonable, appropriate, and attainable costs that are required under the contract. The maintenance of an adequate network that provides timely access to services and ensures coordination and continuity of care is an obligation on the managed care plans for ensuring access to services under the contract. In the event concerns in these areas arise, the review of the rate certification would explore whether the provider rates are sufficient to support the MCO's, PIHP's, or PAHP's obligations. We solicit comments on this proposal.

In §438.4(b)(4), we propose that capitation rates be specific to the payment attributable to each rate cell under the contract. The rates must appropriately account for the expected benefit costs for enrollees in each rate cell, and for a reasonable amount of the non-benefit costs of the plan. Payments from any rate cell must not be expected to cross-subsidize or be cross-subsidized by payments for any other rate cell. In accordance with the existing rule in §438.6(c)(2)(i), we propose that all payments under risk contracts be actuarially sound and that the rate for each rate cell be developed and assessed according to generally accepted actuarial principles and practices. See 67 FR 40989, 40998. We now propose to make this a more explicit standard in the regulation text in paragraph (b)(3) to eliminate any potential ambiguity on this point and to be consistent with our goal to make the rate-setting and rate approval process more transparent. Some states use rate ranges as a tool that allows the submission of one actuarial certification but permits further negotiation with each of the MCOs, PIHPs, and PAHPs within the rate range. Historically, we have permitted that any rate paid to any managed care plan within the certified range will be

determined to be actuarially sound regardless of where it fell in the range. However, the rate ranges may be quite large. States have not had to submit additional documentation to CMS as long as the final payment rate was within the certified rate range. Additionally, states have used rate ranges to increase or decrease rates paid to the managed care plans without providing further notification to CMS or the public of the change or certification that the change was based on actual experience incurred by the MCOs, PIHPs, or PAHPs that differed in a material way from the actuarial assumptions and methodologies initially used to develop the capitation rates. In this rule, we propose to alter past practices moving forward such that:

- Each individual rate paid to each MCO, PIHP, or PAHP be certified as actuarially sound with enough detail to understand the specific data, assumptions, and methodologies behind that rate.
- States may still use rate ranges to gauge an appropriate range of payments on which to base negotiations but states will have to ultimately provide certification to CMS of a specific rate for each rate cell, rather than a rate range. While we understand that this will impact some states that rely heavily on rate ranges, we believe that requiring the details, including the specific data, assumptions, and methodologies, behind each contracted rate strengthens program integrity and transparency in the rate setting process. We request comment on this approach.

This proposed change and the impact on our review of the rate-setting process would give CMS, the states, and taxpayers more confidence that Medicaid capitation payments are proper for the services and populations covered, are supportive of beneficiary access to quality care, and are an efficient use of Medicaid funds.

In proposed §438.4(b)(5), we propose to redesignate the standard in current §438.6(c)(1)(i)(C) that an actuary certify that the rate methodology and the final capitation rates

are consistent with the standards of this part and generally applicable standards of actuarial practice. This would require that all components and adjustments of the rate be certified by the actuary. In addition, the actuary would certify the rate for each rate cell under the contract. Under our proposal, a rate certification of a general rate range would not be sufficient. Also, we reiterate that for this standard to be met, the individual providing the certification must be within our proposed definition of “actuary” in §438.2.

As proposed, §438.4(b)(6) would incorporate the special contract provisions related to payment proposed in §438.6 if such provisions were applied under the contract. As discussed in this rule, we propose to codify in §438.6 the rules for risk-sharing mechanisms, incentive arrangements, withhold arrangements, and delivery system and provider payment initiatives under MCO, PIHP, or PAHP contracts.

Proposed §438.4(b)(7) incorporates the documentation standards proposed in §438.7. We believe that for us to assess the actuarial soundness of capitation rates the data, methodologies, and assumptions applied by the actuary must be sufficiently and transparently documented. Clear documentation will support the goal of instituting a meaningful and uniformly applied rate review and approval process and will streamline the process for both states and CMS. Again, we believe that the elements of actuarial soundness specified in proposed §438.4 – and the more detailed standards in proposed §§438.5, 438.6 and 438.7 – are consistent with the prevailing and generally accepted actuarial practices for Medicaid rate setting.

In proposed §438.4(b)(8), we propose to include a new standard that actuarially sound capitation rates for MCOs, PIHPs, and PAHPs must be developed so that MCOs, PIHPs, and PAHPs can reasonably achieve a minimum MLR of at least 85 percent, and if higher, a MLR calculation that provides for reasonable administration costs when using the calculation defined in

proposed §438.8. See section I.B.1.c.(1) of this proposed rule for additional discussion of this proposal. States could establish higher MLR standards, either for rate development purposes or to measure actual performance of the managed care plan, or both. We believe this minimum standard, which is consistent with MLR standards for both commercial and MA organizations, balances the goal of ensuring enrollees are provided appropriate services while also ensuring a cost effective delivery system. As a result of this standard, the reports from MCOs, PIHPs, and PAHPs on the MLR would be integral sources of data for rate setting. For instance, states that discover, through the MLR reporting under proposed §438.8(k), that an MCO, PIHP, or PAHP has not met an MLR standard of at least 85 percent would need to take this into account and include adjustments in future year rate development. We believe that such adjustments to account for a lower MLR ensure ongoing actuarial soundness. All such adjustments would need to comply with all standards around adjustments discussed in section I.B.3.c. of this proposed rule.

Through this proposed rule, as we codify and revise standards for states and their actuaries for the development of Medicaid capitation rates our aim is to offer flexibility in setting rates to foster efficiency, quality and innovation. We solicit comment whether these standards are adequate for this purpose and the goals discussed in this proposed rule. Also, we request comment on methods, measures, and data sources that the states and their actuaries can use to assess whether capitation rates are adequate to support provider reimbursement levels that result in managed care plan provider networks that satisfy the network adequacy and timely access standards in proposed §§438.68 and 438.206.

c. Rate Development Standards (§438.5)

In §438.5(a), we propose to establish definitions for terms of significance to the standards for rate development and documentation in the rate certification as proposed in §438.7(b). We

propose to add definitions for “budget neutral,” “prospective risk adjustment,” “retroactive risk adjustment,” and “risk adjustment.”

We propose to define “budget neutral” in accordance with the generally accepted usage of the term as applied to risk sharing mechanisms, as meaning no aggregate gain or loss across the total payments made to all managed care plans under contract with the state. We propose to define “risk adjustment” as a methodology to account for health status of enrollees covered under the managed care contract. We propose that the definitions for “prospective risk adjustment” and “retrospective risk adjustment” clarify when the risk adjustment methodology is applied to the capitation rates under the contract.

In §438.5(b), we set forth the steps a state, acting through its actuary, would have to follow when establishing Medicaid managed care capitation rates. These proposed standards are based on furthering the goals of transparency, fiscal stewardship, and beneficiary access to care. We believe setting clear standards and expectations for rate development, which are to be documented in the rate certification as described in proposed §438.7(b), would—without restricting appropriate flexibility for states to drive program improvements through managed care contracting—support managed care systems that can operate efficiently, effectively, and with a high degree of fiscal integrity. These goals would underlie our interpretation and guidance on the rules adopted to govern rate-setting for MCOs, PIHPs, and PAHPs.

Paragraph (b) of this section generally proposes the steps that would be necessary for developing actuarially sound capitation rates with specific standards for the steps outlined in proposed paragraphs (c) through (g). We based these steps on our understanding of how actuaries approach rate setting with modifications to accommodate our proposal as to what actuarial soundness should include in the context of Medicaid managed care. We solicit comment on

whether additional or alternative steps are more appropriate to meet the stated goals for establishing standards for rate setting. We do not intend for these steps to be followed in the order listed in this proposed rule, but we would stipulate that the rate setting process include each step and follow the standards for each step. In reviewing and approving rates under this proposal, we would evaluate each step and states would have to explain why any one of the steps was not followed or was not applicable. The six steps include:

- Collect or develop appropriate base data from historical experience;
- Develop and apply appropriate and reasonable trends to project benefit costs in the rating period, including trends in utilization and prices of benefits;
- Develop appropriate and reasonable projected costs for non-benefit costs in the rating period as part of the capitation rate;
- Make appropriate and reasonable adjustments to the historical data, projected trends, or other rate components as necessary to establish actuarially sound rates;
- Consider historical and projected MLR of the MCO, PIHP, or PAHP; and
- For programs that use a risk adjustment process, select an appropriate risk adjustment methodology, apply it in a budget neutral manner, and calculate adjustments to plan payments as necessary.

In §438.5(c), we propose standards for selection of appropriate base data. In paragraph (c)(1), we propose that, for purposes of rate setting, states provide to the actuary Medicaid-specific data such as validated encounter data, FFS data (if applicable), and audited financial reports for the 3 most recent years completed prior to the rating period under development. In proposed §438.5(c)(2), we propose that the actuary exercise professional judgment to determine which data is appropriate after examination of all data sources provided by the state, setting a minimum

parameter that such data be derived from the Medicaid population or derived from a similar population and adjusted as necessary to make the utilization and cost data comparable to the Medicaid population for which the rates are being developed. We propose that the data that the actuary uses must be from the 3 most recent years that have been completed prior to the rating period for which rates are being developed. For example, for rate setting activities in 2016 for calendar year 2017, the data used must at least include data from calendar year 2013. We understand that claims may not be finalized for 2015 and we would expect the actuary to make appropriate and reasonable judgments as to whether 2013 or 2014 data, which would be complete, must account for a greater percentage of the base data set. We use a calendar year for ease of reference in the example, but a calendar year is interchangeable with the state's contracting cycle period (for example, state fiscal year). We understand that there may be reasons why older data are necessary to inform certain trends or historical experience containing data anomalies, but the primary source of utilization and price data should be no older than the most recently completed 3 years. Noting that states may not be able to meet the standard in proposed paragraph (c)(2) for reasons such as a need to transition into these new standards or for an unforeseen circumstance where data meeting the proposed standard is not available, we propose an exception in the regulation to accommodate such circumstances. Under our proposal in §438.5(c)(3)(i) and (ii), the state may request an exception to the provision in paragraph (c)(2) that the basis of the data be no older than from the three most recent and complete years prior to the rating period provided that the state submits a description of why an exception is needed and a corrective action plan with the exception request that details how the problems will be resolved in no more than 2 years after the rating period in which the deficiency was discovered, as proposed in §438.5(c)(3)(ii). We believe that 2 years is enough time for states to work with their contracted managed care plans or repair

internal systems to correct any issues that impede the collection and analysis of recent data. We request comment on this proposed standard and our assumption about the length of time to address data concerns that would prevent a state from complying with our proposed standard.

Proposed §438.5(d) addresses standards for trend factors in setting rates. Specifically, we propose that trend factors be reasonable and developed in accordance with generally accepted actuarial principles and practices. We also stipulate that trend factors be developed based on actual experience from the same or similar populations. We propose specific standards for the documentation of trend factors in proposed §438.7(b)(2). We request comment on whether we should establish additional parameters and standards in this area.

Proposed paragraph (e) would establish standards for developing the non-benefit component of the capitation rate, which includes expenses related to administration, taxes, licensing and regulatory fees, reserve contributions, profit margin, cost of capital, and other operational costs. The only non-benefit costs that may be recognized and used for this purpose are those associated with the MCO's, PIHP's, or PAHP's provision of state plan services to Medicaid enrollees; this proposal is consistent with our proposal at §438.3(c) that capitation rates be based only on services covered under the state plan.

In paragraph (f), we propose to address adjustments. Adjustments are important for rate development and may be applied at almost any point in the rate development process. For purposes of this proposed rule, we have separated risk adjustment from all other adjustments, and specific standards for risk adjustment are proposed in paragraph (g) of this section. Proposed standards for adjustments are set forth in §438.5(f). We believe that most adjustments applied to Medicaid capitation rate development would reasonably support the development of accurate data sets for purposes of rate setting, address appropriate programmatic changes, the health status of the

enrolled population, or reflect non-benefit costs. For additional discussion on acuity adjustments to account for the health status of the enrolled population, refer to the content on risk adjustment in section I.B.3.e of the preamble. We considered identifying specific adjustments we find permissible in the regulations instead of requiring additional justification, but believe that such an approach might foreclose the use of reasonable adjustments. We request comment on this approach.

In proposed paragraph (g), we propose to set forth standards for risk adjustment. In general, risk adjustment is a methodology to account for the health status of enrollees when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.

States currently apply the concept of “risk adjustment” in multiple ways and for multiple purposes. In some cases, states may use risk adjustment as the process of determining and adjusting for the differing risk between managed care plans. In other cases, states may use risk adjustment as the process of determining the relative risk of the total enrolled population compared to a standard population (for example, the enrolled population from a prior rating period.) For purposes of this regulation, we consider the first case to be the concept of risk adjustment as described in §438.5(a) and §438.5(g). We consider the second case to be an acuity adjustment subject to the proposed standards for adjustments in §438.5(f). Risk adjustment may be conducted in one of two ways. First, a state may use historical data to adjust future capitation payments. This is risk adjustment conducted on a prospective basis. Second, a state may perform a reconciliation and redistribution of funds based on the actual experience in the rating period. This is risk adjustment conducted on a retrospective basis. In §438.5(g), we propose that prospective or retrospective risk adjustment be budget neutral. This is a proposed redesignation and renaming of

the standard that such mechanisms be cost neutral in the current §438.6(c)(1)(iii). The proposed documentation standards in the certification would depend on the type of risk adjustment chosen and are discussed in proposed §438.7(b)(4).

d. Special Contract Provisions Related to Payment (§438.6)

We propose, at §438.6, contract standards related to payments to MCOs, PIHPs, and PAHPs, specifically, risk-sharing mechanisms, incentive arrangements, and withhold arrangements. This section builds upon, and proposes minor modifications to the special contract provisions that are currently codified at §438.6(c)(5). We propose, at paragraph (a), three definitions applicable to this section. The definition for an “incentive arrangement” is unchanged from the definition that is currently codified in §438.6(c)(1)(iv). We propose a definition for “risk corridor” with a slight modification from the existing definition at §438.6(c)(1)(v). The current definition specifies that the state and the contractor share in both profits and losses outside a predetermined threshold amount. Experience has shown that states employ risk corridors that may apply to only profits or losses. We therefore propose to revise the definition to provide flexibility that reflects that practice. We also propose to add a definition for “withhold arrangements,” which would be defined as a payment mechanism under which a portion of the capitation rate is paid after the MCO, PIHP, or PAHP meets targets specified in the contract. Our current regulation is silent on this increasingly popular payment mechanism and we propose with this rule to acknowledge and add standards governing such arrangements.

In proposed paragraph (b), we would establish the basic standards for programs that apply risk corridor or similar risk sharing arrangements, incentive arrangements, and withhold arrangements. In §438.6(b)(1), we propose to redesignate the existing standard (in current §438.6(c)(2)) that the contract include a description of any risk sharing mechanisms, such as

reinsurance, risk corridors, or stop-loss limits, applied to the MCO, PIHP, or PAHP. Although the proposed regulation text includes these examples, this list is not exhaustive and we intend to interpret and apply this regulation to any mechanism or arrangement that has the effect of sharing risk between the MCO, PIHP, or PAHP and the state. Given the new proposed standards on a minimum MLR in §438.8, we believe that states should consider the parameters of the minimum MLR when developing any risk sharing mechanisms to ensure upper and lower bounds are within those MLR standards but we have not made that a standard. We request comment on this approach.

In §438.6(b)(2), we propose to redesignate the existing standards for incentive arrangements currently stated in §438.6(c)(5)(iii), but with a slight modification. We believe that the existing regulatory standards that incentive arrangements be time-limited and not subject to automatic renewal, available to both public and private contractors, not conditioned on intergovernmental transfer (IGT) agreements, necessary for the specified activity, and limited to 5 percent of the certified capitation rate are appropriate standards, as they support the fiscal integrity of the capitation rate and the development of quality and outcome-based initiatives. However, we believe that an additional standard is appropriate. We propose to add a new standard in §438.6(b)(2)(v) that incentive arrangements would have to be designed to support program initiatives tied to meaningful quality goals and performance measure outcomes. We believe this change would support delivery system reform initiatives that include incentive arrangements for quality goals and outcomes. We also clarify that not conditioning the incentive payment on IGTs means that the health plan's receipt of the incentive is solely based on satisfactory performance and not conditioned on the health plan's compliance with an IGT agreement. We request comment as to whether the existing upper limit (5 percent) on the amount attributable to incentive

arrangements is perceived as a barrier to designing performance initiatives and achieving desired outcomes and whether CMS must continue to set forth expectations for incentive arrangements between the state and contracted health plans.

Unlike incentive arrangements that are an add-on to the base capitation rate received by the MCO, PIHP, or PAHP, a withhold arrangement is an amount retained by the state from the base capitation rate payable to the MCO, PIHP, or PAHP; the withhold amount is paid based on satisfactory performance of specified measures or outcomes related to the contract. In paragraph (b)(3), we propose that the capitation rate under the contract with the MCO, PIHP, or PAHP, minus any portion of the withhold amount that is not reasonably achievable, must be certified as actuarially sound. For example, if the contract permits the state to hold back 3 percent of the final capitation rate under the contract, or 3 percent from a particular rate cell of the capitation rate under the contract, the actuary must determine the portion of the withhold that is reasonably achievable. We request comment on how an actuary would conduct such an assessment to inform future guidance in this area. If the actuary determines that only two thirds of the withhold is reasonably achievable (that is, 2 percent of the final contract capitation rate), the capitation rate, minus the portion that is not reasonably achievable (that is, 1 percent of the final capitation rate), must be actuarially sound. Thus, the total amount of the withhold, achievable or not, must be reasonable and take into account an MCO's, PIHP's, or PAHP's capital reserves and financial operating needs for expected medical and administrative costs. When determining the reasonableness of the amount of the withhold, the actuary should also consider the cash flow requirements and financial operating needs of the MCOs, PIHPs, and PAHPs, taking into account such factors as the size and characteristics of the populations covered under the contract. The reasonableness of the amount of the withhold should also reflect an MCO's, PIHP's, or PAHP's

capital reserves as measured by risk-based capital levels or other appropriate measures (for example, months of claims reserve) and ability of those reserves to address expected financial needs. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be included in the documentation for rate certification specified under §438.7(b). We note that the proposed terms for the design of the withhold arrangement mirror the terms for incentive arrangements minus the upper limit, as the rate received by the MCO, PIHP, or PAHP absent the portion of withhold amount that is not reasonably achievable must be certified as actuarially sound. We believe that incentive and withhold arrangements are two approaches to drive health plan performance toward specified goals or outcomes. While we understand the legitimate uses for withhold arrangements, we are concerned that an excessively large withhold could inappropriately reduce the amount received by an MCO, PIHP, or PAHP on a prepaid basis to the extent that the amount is insufficient to cover expected benefit costs, which would result in rates that are not actuarially sound. The proposed regulations are designed to ensure that any withhold arrangements meet the following goals: (1) the withhold arrangement does not provide an opportunity for MCOs, PIHPs, or PAHPs to receive more than the actuarially certified capitation rate; (2) the withhold arrangement provides MCOs, PIHPs, and PAHPs an opportunity to reasonably achieve an amount of the withhold, such that if the state had set the capitation rate at the actual amount paid after accounting for the effect of the withhold, it would be certifiable as actuarially sound; and (3) the actuarial soundness of the capitation rates after consideration of the withhold arrangement is assessed at an aggregate level, across all contracted MCOs, PIHPs, or PAHPs. We welcome comment on appropriate approaches to evaluating the reasonableness of these arrangements and the extent to which the withholds are reasonably achievable and solicit comment on whether our proposed regulation text sufficiently accomplishes

our stated goals.

We propose to redesignate the existing standard at §438.6(c)(5)(v) related to adjustments to actuarially sound capitation rates to account for graduate medical education (GME) payments authorized under the state plan at the proposed §438.6(b)(4) without any changes to the substantive standard.

We propose to add a new paragraph (c) to §438.6 to formalize our longstanding policy on the extent to which a state may direct the MCO's, PIHP's or PAHP's expenditures under a risk contract. Existing standards in §438.6(c)(4) (proposed to be redesignated as §438.3(c)) limit the capitation rate paid to MCOs, PIHPs, or PAHPs to the cost of state plan services covered under the contract and associated administrative costs to provide those services to Medicaid eligible individuals. Furthermore, under §438.60, the state must ensure that additional payments are not made to a provider for a service covered under the contract other than payment to the MCO, PIHP or PAHP with specific exceptions. Current CMS policy has interpreted these regulations to mean that the contract with the MCO, PIHP or PAHP defines the comprehensive cost for the delivery of services under the contract, and that the MCO, PIHP or PAHP, as risk-bearing organizations, maintain the ability to fully utilize the payment under that contract for the delivery of services. In paragraph (c)(1), we propose the general rule that the state may not direct the MCO's, PIHP's, or PAHP's expenditures under the contract.

However, we also want to encourage states to use health plans as partners to assist the states in achieving overall delivery system and payment reform and performance improvements. We also want states to be able, at their discretion, to incentivize and retain certain types of providers to participate in the delivery of care to Medicaid beneficiaries under a managed care arrangement. Managed care plans are a key partner in achieving the goals of improved population

health and better care at lower cost. We are therefore proposing in paragraphs (c)(1)(i) through (c)(1)(iii), ways that a state may set parameters on how expenditures under the contract are made by the MCO, PIHP, or PAHP. Proposed paragraph (c)(1)(i) provides that states may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement. In this approach, the contract between the state and the managed care plan would set forth methodologies or approaches to provider reimbursement that prioritize achieving health outcomes versus simply the delivery of services. Implementing this flexibility in regulation would assure that these regulations promote paying for quality or health outcomes rather than the volume of services. These proposed flexibilities support states and Medicaid managed care plans to adopt and build upon the 30/50 and 85/90 value-based payment targets established by HHS for the Medicare FFS program for 2016-2018.¹⁰ These targets for the Medicare FFS program involve value-based provider reimbursement. Medicaid managed care programs across the country provide integrated and coordinated systems of health care to Medicaid beneficiaries and value-based purchasing models are a tool that states and Medicaid managed care plans can use to achieve and sustain better care at lower costs. In paragraph (c)(1)(ii), we reiterate that states have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives. This approach would permit states to specify in the contract that MCOs, PIHPs, or PAHPs participate in multi-payer or Medicaid-specific initiatives, such as patient-centered medical homes, efforts to reduce the number of low birth weight babies, broad-based provider health information exchange projects, and delivery system reform projects to improve access to services, among others. For example, states could make available incentive payments for the use of technology that supports interoperable health information exchange by

¹⁰ See, e.g., Burwell, Sylvia M., "Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care," N. Engl. J. Med. at 1 (January 27, 2015).

network providers that were not eligible for EHR incentive payments under the HITECH Act (for example, long-term/post-acute care, behavioral health, and home and community based providers). The state would be permitted to use the health plan payments as a tool to incentivize providers to participate in particular initiatives that operate according to state-established and uniform conditions for participation and eligibility for additional payments. The capitation rates to the health plans would reflect an amount for incentive payments to providers for meeting performance targets, however the health plans retain control over the amount and frequency of payments. We believe that this approach balances the need to have a health plan participate in a multi-payer or community-wide initiative, while giving the health plan a measure of control to participate as an equal collaborator with other payers and participants. We also clarify that because funds associated with delivery system reform or performance initiatives are part of the capitation payment, any unspent funds remain with the MCO, PIHP, or PAHP. This approach ensures that any additional payment is associated with a value relative to innovation and statewide reform goals.

Proposed paragraph (c)(1)(iii) would support two state practices critical to ensuring timely access to high-quality, integrated care, specifically: (1) setting minimum reimbursement standards or fee schedules for providers that deliver a particular covered service; and (2) raising provider rates in an effort to enhance the accessibility or quality of covered services. For example, some states have opted to continue paying primary care providers at Medicare reimbursement rates under section 1202 of the Affordable Care Act for calendar years 2013-2014. Because actuarially sound capitation rates are based on all reasonable, appropriate and attainable costs (see section I.B.3.b. of this proposed rule), the contractual expectation that primary care providers would be paid at least according to Medicare reimbursement levels must be accounted for in pricing the

primary care component of the capitation rate. These amounts would be subject to the same actuarial adjustments as the service component of the rate and would be blended into the final contract rate certified by the actuary. Under the contract, the state would direct the MCO, PIHP, or PAHP to adopt a minimum fee schedule created by the state for services rendered by that class of providers. This proposal is reflected in paragraph (c)(1)(iii)(A).

In proposed paragraph (c)(1)(iii)(B), we note the state could specify a uniform dollar or percentage increase for all providers that provide a particular service under the contract. This option would have the state treat all providers of the services equally and does not permit the state to direct the MCO, PIHP, or PAHP to reimburse specific providers specific amounts at specified intervals. We believe this option would help ensure that additional funding is directed toward enhancing services and ensuring access rather than benefitting particular providers. It would also support the standard that total reimbursement to a provider is based on utilization and the quality of services delivered. Finally, we believe that this option would be consistent with and build upon the existing standard that the capitation rate reflects the costs of services under the contract. Under both approaches in (c)(1)(iii), the MCO, PIHP or PAHP would be permitted to negotiate higher payment amounts under their specific provider agreements.

To ensure that state direction of expenditures promotes delivery system or provider payment initiatives, we expect that states will, as part of the federal approval process, demonstrate that such arrangements are based on utilization and the delivery of high-quality services, as specified in paragraph (c)(2)(i)(A). Our review will also ensure that state directed expenditures support the delivery of covered services. Consequently, we expect that would demonstrate that all providers of the service are being treated equally, including both public and private providers, as specified in paragraph (c)(2)(i)(B). The ultimate goal for state-directed expenditures is to support

improved population health and better care at lower cost. These efforts cannot occur in isolation. Therefore, in paragraph (c)(2)(i)(D), we would link approval of the arrangement to supporting at least one of the objectives in the comprehensive quality strategy in §438.340 (proposed paragraph (c)(2)(i)(C)) and that the state would implement an evaluation plan to measure how the arrangement supports that objective (proposed paragraph (c)(2)(i)(D)). This will enable us and states to demonstrate that these arrangements are effective in achieving their goals. In proposed paragraph (c)(2)(i)(E), we would not permit provider participation in these arrangements to be conditioned on intergovernmental transfer agreements so that the arrangement remains focused on proactive efforts to improve care delivery and reduce costs. Finally, in proposed paragraph (c)(2)(i)(F), because we seek to evaluate and measure the impact of these reforms, such agreements would not be renewed automatically. We establish standards in proposed paragraphs (c)(2)(i) and (c)(2)(ii) for our approval of permitted state direction of expenditures for delivery system or provider payment initiatives to ensure that the arrangement is consistent with the specific provisions of this section.

Under proposed paragraph (c)(2)(ii), any contract arrangement that directs expenditures made by the MCO, PIHP, or PAHP under paragraphs (c)(1)(i) or (c)(1)(ii) for delivery system or payment provider initiatives would use a common set of performance measures across all payers and providers. Having a set of common performance measures would be critical to evaluate the degree to which multi-payer efforts achieve the stated goals of the collaboration. We seek comment on the proposed general standard, and the three exceptions, providing a state the ability to direct MCO's, PIHP's, or PAHP's expenditures. Specifically, we seek comment on the extent to which the three exceptions are adequate to support efforts to improve population health and better care at lower cost, while maintaining MCO's, PIHP's or PAHP's ability to fully utilize the

payment under that contract for the delivery of services to which that value was assigned.

We also take this opportunity to clarify that the regulations in part 438 are not a barrier to the operation of programs that promote wellness among beneficiaries by Medicaid managed care plans. Positive incentives to promote wellness among the Medicaid population can help promote health and well-being and improve health outcomes. States and managed care plans that undertake efforts to reward beneficiary health care decisions and behaviors through inexpensive gifts or services are, however, advised to consult OIG guidance for compliance with section 1128A(a)(5) of the Act. See, for example, OIG, [Special Advisory Bulletin: Offering Gifts and Other Inducements to Beneficiaries](#) (August 2002), available at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf>.

e. Rate Certification Submission (§438.7)

In new §438.7, we propose the content of the rate certification that is submitted by the state for CMS review and approval. This section is distinguished from the rate development standards in §438.5 in that it focuses on documentation of rate development as opposed to the actual steps taken by states and actuaries to develop capitation rates. This section includes a new proposal that states receive CMS' approval of the rate certification in addition to the contract, as provided in §438.3(a). The rate certification is part of the procedural mechanism for CMS to ensure that the capitated rates payable to MCOs, PIHPs, and PAHPs are actuarially sound as specified in section 1903(m)(2)(A)(iii) of the Act. We propose that rate certifications in §438.7(a) follow the same procedures as for contract submissions through a cross-reference to §438.3(a). Our proposal therefore includes the regulatory flexibility to set forth timeframes and more detailed processes for the submission of the rate certification review and approval process in subregulatory guidance, which is in addition to the specific proposed standard that states seeking contract and rate approval

prior to an anticipated effective date should submit such contracts and rate certifications to CMS no later than 90 days before anticipated effective date. We believe that review and approval of the rate certification separate from the approval of a contract is an integral step to work with states to ensure appropriate rates under these programs and to modernize our oversight of Medicaid managed care rate setting practices. In addition, we believe that this approach will streamline the approval process as the rate certification supports the payment terms in the contract. We believe that section 1903(m)(2)(A)(iii) authorizes us to stipulate review and approval of both the contract and the rate certification for MCOs as the contract must include the payment rates, which are developed via the rate certification. Consistent with existing standards for CMS review and approval for PIHP and PAHP contract in §438.6(a) (redesignated as §438.3(a) in this proposed rule), we propose to extend the review and approval standards for the rate certification for PIHPs and PAHPs under our authority under section 1902(a)(4) of the Act. As proposed here, the rate certification describes and provides the necessary documentation and evidence that the rates were developed consistent with generally accepted actuarial principles and practices and regulatory standards. In the event that the certification and the contract are submitted to CMS at different times, we would approve the rate certification prior to approval of the contract, but FFP for the program is contingent upon approval of the contract. This process would satisfy CMS' statutory authority to oversee the Medicaid program and to ensure that capitation rates are actuarially sound, which in turn helps states and health plans to improve access to and quality of care for Medicaid beneficiaries.

Proposed §438.7(b) would set forth the content that must be in the rate certification to initiate the CMS review process. As proposed in paragraph (b)(1), the certification would describe the base data. The rate certification would describe how the actuary used professional judgment to

determine which data was appropriate after examination of all data sources and the data sources used, as well as reasons if the other data sources provided to the actuary were not used in the rate development process.

In proposed paragraph (b)(2), we propose specific documentation standards for trend factors. We propose that the rate certification be detailed enough so that CMS or an actuary can understand and evaluate the development and reasonableness of the trend and any meaningful differences among trend factors applied across rate cells, populations, or services. In proposed paragraph (b)(3), we propose that the basis for determining the non-benefit component of the rate must be included in the actuarial certification with enough detail so CMS or an actuary can understand each type of non-benefit expense and evaluate the reasonableness of each cost assumption underlying each non-benefit expense.

In proposed paragraphs (b)(4)(i) through (iii), we propose standards for transparency in the rate certification on how the material adjustments were developed and the reasonableness of the adjustment for the population, the cost impacts of each material adjustment and where in the rate development process the adjustment was applied. We understand there may be multiple adjustments applied in the rate-setting process, ranging from minor adjustments, which on their own do not impact the overall rate by a material amount, to other adjustments, which may be much greater in scope and magnitude. Therefore, we have proposed that states only provide information on the development of and cost impact for each of the material adjustments. Adjustments that do not meet this threshold, or non-material adjustments, may be aggregated and only the cost impact of that aggregated bundle would need to be shown in the certification as set forth in proposed paragraph (b)(4)(ii). In §438.7(b)(4)(iv), we propose that the actuarial certification include a list of all the non-material adjustments used in rate development, but specifics of each non-material

adjustment will not be necessary. As we gain experience in reviewing adjustments consistent with these standards and further consult with states, we may issue guidance on what we believe to be material and non-material adjustments, but until that time, we would expect the actuary to exercise reasonable judgment and good faith when characterizing or treating an adjustment as material or non-material.

In paragraph (b)(5), we propose to establish documentation standards in the certification for prospective and retrospective risk adjustment. In paragraph (b)(5)(i), we propose that the rate certification should include sufficient detail of the prospective risk adjustment methodology because the methodology is an integral part of the rate development process. To evaluate the appropriateness of the prospective risk adjustment methodology, we propose that the following specific pieces of information be included in the rate certification: the model selected and data used by the state; the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk of the respective populations; the magnitude of the adjustment on the capitation rate for each MCO, PIHP, or PAHP; and an assessment of the predictive value of the methodology compared to prior rating periods, and any concerns the actuary may have with the risk adjustment process. Retrospective risk adjustment methodologies are calculated and applied after the rates are certified; however, we propose in §438.7(b)(5)(ii) that the certification must document who is calculating the risk adjustment; the timing and frequency of the risk adjustment; the model and the data to be used and any adjustments to them; and any concerns the actuary may have with the risk adjustment process. For either approach to risk adjustment, our proposal would require adjustment to be budget neutral under §438.5(b)(6).

Use of the risk adjustment model as a method to retrospectively increase or decrease the total payments across all Medicaid managed care plans based on the overall health status or risk of

the population would not be permitted. Such retrospective increases or decreases in the total payments do not meet the standard in §438.5(g) that the risk adjustment methodology be developed in a budget neutral manner. We believe that an adjustment applied to the total payments across all health plans to account for significant uncertainty about the health status or risk of a population is an acuity adjustment, which is a permissible adjustment under §438.5(f), but would need to be documented under proposed paragraph (b)(4) of this section regarding adjustments. While retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection. In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.

In §438.7(b)(6), we propose that the rate certification include a description of any of the special contract provisions related to payment in proposed §438.6, such as risk sharing mechanisms and incentive or withhold arrangements.

In paragraph (c), we propose the rate certification standards for rates paid under risk contracts. In paragraph (c)(1), we acknowledge that states may pay different capitation rates to different plans; for example, some states already account for differences in final capitation rates paid to contracted managed care plans through risk adjustment. States that choose to pay different rates to plans for factors such as differing administrative assumptions, service area adjustments or other non-risk adjustment methodologies will need to provide documentation for the different

assumptions used in the development of each of the individual rates paid to each plan. While such variations are permissible, we take this opportunity to remind states as reflected and strengthened in this proposed rule, that all payment rates must be actuarially sound under existing law.

In §438.7(c)(2), we propose to establish parameters for retroactive adjustments to capitation rates paid under the risk contract. Specifically, we propose that the state submit a revised rate certification (and contract amendment) that describes the specific rationale, data, assumptions, and methodologies of the adjustment in sufficient detail to understand and evaluate the proffered retroactive adjustments to the payment rate. All such adjustments are also subject to federal timely filing standards for federal financial participation.

In paragraph (d), we propose to require states to include additional information in the rate certification if pertinent to CMS' approval of the contract rates and to identify whether that additional information, which may supplement the rate certification, is proffered by the state, the actuary, or another party. We believe that clarifying our expectations and setting parameters for consistent and transparent documentation of the rate setting process will allow CMS to conduct more efficient reviews of the rate certification submissions and to expedite the approval process.

We propose to remove the standard currently at §438.6(c)(4)(iii) that states document the projected expenditures under the proposed contract compared to the prior year's contract, or with FFS if the managed care program is new. We do not believe that this information is integral to the review of the rate certification or contract and that such information can be reasonably calculated by CMS if necessary.

4. Other Payment and Accountability Improvements

a. Prohibition of Additional Payments for Services Covered under MCO, PIHP, or PAHP Contracts (§438.60)

We propose a new heading for §438.60 and to make minor revisions to the regulatory text to clarify the intent of the prohibition of additional payments to network providers that are contracted with an MCO, PIHP or PAHP. The original heading of §438.60 was “Limit on payments to other providers;” we believe that heading was potentially ambiguous or confusing when paired with the regulatory text as it could be read to treat an MCO, PIHP, or PAHP as a provider. We propose to revise the section heading as “Prohibition of additional payments for services covered under MCO, PIHP, or PAHP contracts” to make clear that the capitation payments are to be inclusive of all service and associated administrative costs under such contracts. Within this provision, we propose to add the word “by” preceding “the MCO, PIHP, or PAHP” so that the term “provider” clearly refers to health care professionals contracted with the MCO, PIHP, or PAHP. We have clarified the language that made overly broad references to Title XIX of the Act and this title of the CFR to clarify that such payments are permitted only when statute and regulation specifically stipulate that the state make those payments directly to a provider. We believe that the exception to this standard has always been limited to cases where other law (statutory or regulatory) explicitly directs the state to make the additional payment to the health care provider and propose to strengthen the language accordingly. Finally, we propose to update the cross-reference for GME payments from its current location at §438.6(c)(5)(v) to proposed §438.6(b)(4) to reflect the proposed restructuring of §438.6 as discussed above in the preamble related to setting actuarially sound capitation rates.

b. Subcontractual Relationships and Delegation (§438.230)

We propose to replace the current standards in §438.230 with clearer expectations for MCOs, PIHPs, or PAHPs that enter into subcontractual relationships and delegate responsibilities under the contract with the State. These expectations are modeled on the MA standards relating to

MA organization relationships with first tier, downstream, and related entities at §422.504(i). The MA framework for the flow of responsibilities and obligations are effective program integrity safeguards that are appropriate for Medicaid managed care programs.

In paragraph (a), we propose to more clearly state when §438.230 would apply by adding language specifying that the standards of this section would apply to all contracts and written arrangements that a MCO, PIHP, or PAHP has with any individual or entity that relates directly or indirectly to the performance of the MCO's, PIHP's, or PAHP's obligations under the contract.

In a proposed new paragraph (b)(1), we would stipulate that regardless of any relationship that a MCO, PIHP, or PAHP may have, it alone is accountable for complying with all terms of the contract with the state. While this is not a new standard, we believe this revised wording more clearly states our intent. We propose in new paragraph (b)(2) to specify that all contracts and written arrangements comply with the provisions of paragraph (c).

Existing paragraphs (b)(2)(i) (requiring the contract to specify the delegated activities, obligations, and responsibilities) and (b)(2)(ii) (providing for revocation of any delegation) would be redesignated as (c)(1)(i) and (c)(1)(iii) but otherwise remain substantively the same with revisions for clarity. In paragraph (c)(1)(ii), we propose to add that the individual or entity accepting the delegation agrees to perform the activities in compliance with the MCO's, PIHP's, or PAHP's contract with the state. In paragraph (c)(2), we propose a general standard that the entity or individual performing the delegated activities must comply with all applicable laws, regulations, subregulatory guidance, and contract provisions. Lastly, in paragraphs (c)(3)(i) through (iv), we propose that the entity or individual performing the delegated activities must agree to grant the state, CMS, HHS, OIG, or the Comptroller General the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems that pertain to services performed or

determinations of amounts payable; make available for audit, evaluation, or inspection, its premises, physical facilities, equipment and records; preserve the rights under (c)(3)(i) for 10 years from completion; and grant the state, CMS, HHS, or the Comptroller General the right to audit, evaluate, and inspect at any time if the reasonable possibility of fraud is determined to exist by any of these entities.

c. Program Integrity (§438.600, §438.602, §438.604, §438.606, §438.608, and §438.610)

Current regulatory language implements the provisions of section 1932(d)(1) of the Act regarding MCO and PCCM affiliations with debarred individuals, and addresses certification of data provided by MCOs and PIHPs to the state. Thus, the current regulations related to program integrity are fairly limited in scope. Since the publication of those regulations in 2002, significant new legislative changes have been made to Medicaid program integrity operations. The Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171, enacted on February 8, 2006) created the Medicaid Integrity Program (MIP) under section 1936 of the Act. Subsequently, section 6401 of the Affordable Care Act added new sections 1902(a)(77) and 1902(kk)(1) of the Act that require states to comply with the process for screening providers established by the Secretary under section 1866(j)(2) of the Act. Section 6401 of the Affordable Care Act also added a new section 1902(kk)(7) of the Act, which provides that states must enroll all ordering and referring physicians or other professionals as participating providers (and thus screen them according to the aforementioned screening process). We issued final regulations implementing these Affordable Care Act provisions in the February 2, 2011 **Federal Register**, “Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers” (76 FR 5862). However, those regulations specifically exclude from enrollment

requirements Medicaid providers that only order or refer services as part of a risk-based managed care plans' network (76 FR 5904). Reasons cited at that time were consistency of treatment between MA organizations and Medicaid managed care plans as well as the administrative burden that enrollment of managed care plans' ordering and referring physicians and other professionals would impose on state Medicaid agencies. In addition to standards established by the Affordable Care Act, section 1902(a)(27) of the Act stipulates that states must enroll "person(s) or institution(s) providing services under the State plan." In the past, we have not interpreted that provision as applying to providers or institutions that furnish state plan services in the managed care context.

Since issuance of the final rule for the aforementioned Affordable Care Act provisions, states, primarily through communications from the National Association of Medicaid Directors (NAMD), have reported that state program integrity reviews have identified as a vulnerability the lack of consistency in the application of the provider screening and enrollment provisions applicable to FFS providers in states' managed care programs. The HHS Office of the Inspector General (OIG) has issued similar findings and recommendations in the reports identified below. Given the growing reliance of states on managed care plans to administer covered benefits, we are concerned that the vulnerability of state and federal Medicaid funds to fraud by network providers will only increase. We therefore, address the provider screening and enrollment processes for network providers in this proposed rule.

In addition, we are taking a broader approach to rethinking Medicaid managed care program integrity provisions. Specifically, we have considered findings from the State Program Integrity Reviews undertaken by CMS through the Center for Program Integrity, as well as recommendations from the OIG to inform our proposals for this subpart and improve managed

care program integrity processes. See, for example, OIG, State and CMS Oversight of the Medicaid Managed Care Credentialing Process (OEI-09-10-00270) (Nov. 2013), available at <http://oig.hhs.gov/oei/reports/oei-09-10-00270.pdf>; OIG, Excluded Providers in Medicaid Managed Care Entities (OEI-07-09-00630) (Feb. 2012), available at <https://oig.hhs.gov/oei/reports/oei-07-09-00630.pdf>; OIG, Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards (OEI-01-09-00550) (Dec. 2011), available at <http://oig.hhs.gov/oei/reports/oei-01-09-00550.pdf>. Of particular concern are two types of program integrity risks: fraud committed by Medicaid managed care health plans and the vulnerability of state and federal Medicaid funds to fraud by network providers. Through the changes proposed in this rule, we intend to address both of these types of risk, as well as tighten standards for MCO, PIHP, PAHP, PCCM, and PCCM entity submission of certified data, information and documentation that is critical to program integrity oversight by state and federal agencies. Our proposal would modify the title of subpart H to “Additional Program Integrity Safeguards” from the current title “Certifications and Program Integrity” to recognize that various program integrity standards, such as those relating to audited financial data, MLR, and subcontractual relationships, among others, are proposed to be added throughout this part. In addition, we propose to add entirely new provisions and amend existing provisions to address program integrity risks.

(1) Proposed Revisions to §438.600

In §438.600, we propose to add to the existing list of statutory provisions related to program integrity that support our proposed changes to this subpart. Our proposal would include the following statutory provisions: sections 1128, 1128J(d), 1902(a)(4), 1902(a)(19), 1902(a)(27), 1902(a)(68), 1902(a)(77), 1902(a)(80), 1902(kk)(7), 1903(i), 1903(m), and 1932(d)(1) of the Act.

In the description of section 1932(d)(1) of the Act in §438.600, we propose to remove the term “excluded” and replace it with “debarred” to reflect the statutory standard. As a general matter, we rely on section 1902(a)(4) of the Act when standards in this subpart are proposed to extend beyond MCOs to PIHPs, PAHPs, PCCMs, and PCCM entities.

(2) Proposed Revisions to §438.602

We propose to replace §438.602 in its entirety. The current regulation provides a general statement of applicability under this subpart that MCOs, PIHPs, PAHPs, and PCCMs must comply with the program integrity and certification standards of the subpart as a condition of payment. The intent of the revisions to §438.602 is to contain all state responsibilities associated with program integrity in one section. Proposed paragraph (a) sets forth the state’s monitoring standards for contractor compliance with provisions in this subpart and §438.230 (subcontractual relationships and delegation) and §438.808 (excluded entities).

In §438.602(b), we propose that states must enroll all network providers of MCOs, PIHPs, and PAHPs that are not otherwise enrolled with the state to provide services to FFS Medicaid beneficiaries. Such enrollment would include all applicable screening and disclosure standards under part 455, subparts B and E. This standard would ensure that all providers that order, refer or furnish services under the state plan or waiver are appropriately screened and enrolled. We also propose that this standard apply to PCCMs and PCCM entities, to the extent that the primary care case manager is not otherwise enrolled with the state to provide services to FFS Medicaid beneficiaries. Our proposal that states must screen and enroll network providers would not obligate the network provider to also render services to FFS beneficiaries.

This proposal is based on an expanded interpretation of sections 1902(kk)(1) and 1902(kk)(7) and 1902(a)(27) of the Act to apply to providers that order, refer, or furnish services

in the context of Medicaid managed care to ensure that there are no ‘safe havens’ for providers who, though unable to enroll in Medicaid FFS programs, shift participation from managed care plan to managed care plan to avoid detection. We further expect that, absent additional requirements in managed care contracts, this approach will result in administrative and cost efficiencies by eliminating the need for each managed care plan to conduct duplicative screening activities as part of the credentialing process as described in §438.214 for network providers and having that function performed instead by states (or, in the case of dually-participating providers, by Medicare contractors) for all providers. However, this approach would not prohibit managed care plans from conducting their own additional level of provider screening if so desired or states from incorporating other screening requirements into their contracts. This approach also has the advantage of applying the ‘limited,’ ‘moderate’ and ‘high’ risk provider screening protocols (including site visits for providers in the moderate and high risk categories) to all providers that order, refer, or furnish services to Medicaid beneficiaries, whether through managed care or FFS. We request comment on this approach; in particular, we seek feedback on any barriers to rapid network development that this approach might create by limiting the ability of MCOs, PIHPs, or PAHPs to contract with providers until the results of the state’s screening and enrollment process are complete. This proposal does not alter the MCO’s, PIHP’s, or PAHP’s responsibility under §438.214(c) to operate a provider selection process that does not discriminate against providers that serve high-risk populations or that specialize in costly treatments or the state’s responsibility to monitor the implementation of provider selection policies in §438.214(a).

In paragraph (c), we propose that the state must review the ownership and control disclosures submitted by the, MCO, PIHP, PAHP, PCCM, or PCCM entity, and any subcontractors, in accordance with 42 CFR part 455, subpart B. In paragraph (d), we propose that

states must conduct federal database checks, consistent with the standards in 42 CFR 455.436, to confirm the identity of and determine the exclusion status of the MCO, PIHP, PAHP, PCCM, or PCCM entity, any subcontractor, any person with an ownership or control interest, or any agent or managing employee at the time of entering into the contract and no less frequently than monthly thereafter. If a state determines a match, it must promptly notify the MCO, PIHP, PAHP, PCCM, or PCCM entity and take action consistent with proposed §438.610(c). In paragraph (e), we propose that the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP, and PAHP. In paragraph (f), we propose to incorporate the requirement for states to receive and investigate information from whistleblowers. In paragraph (g), we propose that each state must post on its website or otherwise make available, the MCO, PIHP, PAHP, or PCCM entity contract, the data submitted to the state under proposed §438.604, and the results of any audits conducted under paragraph (e) of this section. We propose to add PCCM entity contracts to this standard as we propose in §438.3(r) that such contracts be submitted for our review and approval. This proposal is discussed in detail in section I.B.6.e. of this proposed rule. In paragraph (h), we propose that states have conflict of interest safeguards in place consistent with proposed §438.58. In paragraph (i), we propose that the state must ensure, consistent with section 1902(a)(80) of the Act, that the MCO, PIHP, PAHP, PCCM, or PCCM entity is not located outside of the United States and that no payments are made for services or items to any entity or financial institution outside of the U.S. We interpret this payment prohibition to mean that no such payments made by an MCO, PIHP, or PAHP to an entity or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates.

(3) Proposed Revisions to §438.604 and §438.606

We propose to modify existing standards regarding submission and certification of data by managed care plans to the state which currently exist in §§438.604 and 438.606. We propose to revise §438.604(a) and (b) to specify data, information and documentation that must be submitted by each MCO, PIHP, PAHP, PCCM, or PCCM entity to the state, including encounter data and other data generated by the health plan for purposes of rate-setting; data on which the state determined that the entity met the MLR standards; data to ensure solvency standards are met; data to ensure availability and accessibility of services; disclosure information as described at 42 CFR part 455, subpart B; the annual report on recoveries of overpayments as proposed in §438.608(d)(3); and any other data related to the performance of the entity's obligations as specified by the state or the Secretary. For example, the state or the Secretary could specify that MCOs, PIHP, or PAHPs submit to the state elements of claims from network providers (for example, rendering provider NPI, services dates, place of service, procedure code, etc.) to enable the state to review the claims paid for program integrity purposes. These data submission proposals are tied to the substantive standards on these issues proposed and discussed elsewhere in this proposed rule. We believe it is critical and necessary for the proper and efficient administration of the state plan that key program data submitted by MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities to states is certified as accurate, complete and truthful, as that data will be the basis for any state or federal program integrity reviews. Therefore, the proposed §438.606 stipulates that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities must certify the data, information and documentation specified in §438.604.

Our proposal builds upon existing provisions in §438.606. We propose to expand the certification requirement to documentation and information as well as data and propose to cross-

reference the submission standards in §438.604 to identify the scope of the certification requirement. Further, we propose to extend the applicability of §438.606 from MCOs and PIHPs to PAHPs, PCCMs, and PCCM entities, based on our authority under section 1902(a)(4) of the Act to identify and stipulate activities that are necessary for the proper and efficient administration of the state plan. In §438.606(a), we propose to eliminate the option for a MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's executive leadership to delegate the certification, since we believe that in these critical program areas, the CEO or CFO must be personally responsible for the accuracy, completeness, and truthfulness of the reported data, documentation or information.

In §438.606(b), we propose to include documentation or information after the existing reference to data for consistency with the addition of such terms in §438.604 and §438.606 and to specify that the certification attests that the MCO, PIHP, PAHP, PCCM, or PCCM entity has conducted a reasonably diligent review of the data, documentation, and information in §438.604(a) and (b) and that such data, documentation, and information is accurate, complete, and truthful. We propose this modification to the certification to clarify that the attesting individual has an affirmative obligation to ensure that a reasonably diligent review has been conducted and that the information being certified is accurate, complete, and truthful. For a certification to be helpful for program integrity purposes, an individual who is certifying information must make some effort to ensure that the information is accurate. It is not enough to simply believe the information is the best; the individual must make an effort to determine the information is accurate. The proposed clarification to the certification requirement is consistent with other program integrity safeguards in this proposed rule, such as those in §438.608(a) that include requirements to take affirmative action (for example, routine auditing and monitoring) to detect and prevent fraud, waste, and abuse. For purposes of determining if a "reasonably diligent" review has been conducted, we

propose to borrow from the standards in the final rule for MA and Part D overpayment rules published in the **Federal Register** on May 23, 2014 (79 FR 29844, 29923). In the preamble for that final rule, we clarified that “at a minimum, reasonable diligence would include proactive compliance activities conducted in good faith by qualified individuals. However, conducting proactive compliance activities does not mean that the person has satisfied the reasonable diligence standard in all circumstances. In certain circumstances, for example, reasonable diligence might require an investigation conducted in good faith and in a timely manner by qualified individuals. . . .” We request comment on the proposal to clarify the certification standard, including comments on using the existing reasonably diligent review standard from the MA and Part D context.

In paragraph (c), we propose to maintain the existing standard that the certification is provided concurrently with the submission of the data, documentation or information specified in §438.604.

(4) Proposed Revisions to §438.608

Current §438.608 specifies the elements that must be included in a MCO’s and PIHP’s program integrity/compliance program and administrative procedures to detect and prevent fraud, waste and abuse; we are proposing to expand those standards to PAHPs, and to subcontractors to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims under the contract between the State and the MCO, PIHP, or PAHP, to include or redesignate the following:

- Establishment of written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements (propose to redesignate §438.608(b)(1) as §438.608(a)(1)(i)).

- Direct reporting by the Compliance Officer to both the CEO and board of directors of the MCO, PIHP, or PAHP, which is consistent with MA requirements at 42 CFR 422.503(b)(4)(vi)(B)(2); the designation of compliance officer that is accountable to senior management is at current §438.608(b)(2) (proposed §438.608(a)(1)(ii));
- Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with oversight of the compliance program, which is consistent with MA requirements at 42 CFR 422.502(b)(4)(vi)(B); the establishment of a compliance committee is at current §438.608(b)(2) (proposed §438.608(a)(1)(iii));
- Establishment of a system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract, which is consistent with MA organization requirements at 42 CFR 422.503(b)(4)(vi)(C); effective training and education for the compliance officer and the organization's employees is at current §438.608(b)(3) (proposed §438.608(a)(1)(iv));
- Establishment of a system for effective communication between the compliance officer and the organization's employees (propose to redesignate §438.608(a)(4) as §438.608(a)(1)(v));
- Enforcement of standards through well-publicized disciplinary guidelines (propose to redesignate §438.608(b)(5) as §438.608(a)(1)(vi));
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for

recurrence, and ongoing compliance with the requirements under the contract; the provision for internal monitoring and auditing and prompt response to detected offenses is at current

§438.608(b)(6) and (7) (proposed §438.608(a)(vii));

- Mandatory reporting to the state of potential fraud and improper payments identified or recovered by managed care plans (proposed §438.608(a)(2));

- Mandatory reporting to the state of information received by managed care plans about changes in an enrollee's circumstances that may affect the enrollee's eligibility (proposed §438.608(a)(3));

- Mandatory reporting to the state of information received by the managed care plan about changes in a provider's circumstances that may affect the provider's participation in the managed care program. Such changes in circumstances would include the termination of the provider agreement with the health plan (proposed §438.608(a)(4));

- Verification by sampling or other methods, whether services that were represented to have been delivered by network providers were actually received (proposed §438.608(a)(5));

- Establishment of written policies related to the Federal False Claims Act, including information about rights of employees to be protected as whistleblowers (proposed §438.608(a)(6));

- Mandatory referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (proposed §438.608(a)(7)). States that have a Medicaid Fraud Control Unit (MFCU) may choose, as part of their contracts with MCOs, PIHPs, or PAHPs, to stipulate that suspected provider fraud be referred only to the MFCU, to both the MFCU and to the Medicaid program integrity unit, or only to the Medicaid program integrity unit. For those matters

referred to the Medicaid program integrity unit, 42 CFR part 455 provides that the unit must conduct a preliminary investigate and cooperate with the MFCU in determining whether there is a credible allegation of fraud. For those MCOs, PIHPs, and PAHPs with their own Special Investigation Unit (SIU) to investigate suspected provider fraud, the program integrity unit should assess the adequacy of the preliminary investigation conducted by those units and seek to avoid the duplication and delay of their own preliminary investigation.

- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with §455.23 (proposed §438.608(a)(8)). Under §455.23, which implements section 1903(i)(2)(C) of the Act, the state must suspend payments to an individual or entity against which there is a pending investigation or a credible allegation of fraud against the individual or entity, unless the state determines that there is good cause not to suspend such payments. We note that the state's obligation to suspend payments is not limited to FFS payments. In the final rule for the suspension of payment provisions (76 FR 5862, 5938), we discussed the applicability of the suspension of payment requirements to Medicaid managed care plans. We stated that "if there is a pending investigation of a credible allegation of fraud against a Medicaid MCO, PIHP, or PAHP, the state should address the issue either through imposing a payment suspension or through other authorities that may be available to them under state law or as part of the state's negotiated agreement with the Medicaid MCO, PIHP, or PAHP. The same would hold true for pending investigations of credible allegations of fraud regarding individual network providers. Managed care capitation payments may be included in a suspension when an individual network provider is under investigation based upon credible allegations of fraud." Since the publication of the final rule it has become clear that suspension of capitation payments to MCOs, PIHPs, or PAHPs is not the

most effective means of suspending payments to individual network providers who are subject to pending investigations for credible allegations of fraud. Accordingly, under our authority in sections 1903(i)(2)(C) and 1902(a)(4) of the Act, we propose to require that the state make provision for the MCO, PIHP, or PAHP to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. This will enable states to carry out section 1903(i)(2)(C) of the Act and safeguard federal Medicaid funds by not making payments to network providers under investigation for credible allegations of fraud, whether those providers are participating in Medicaid FFS or in Medicaid managed care networks. Under this provision, the responsibility of MCOs, PIHPs, and PAHPs would be limited to promptly suspending payments at the direction of the state until notified by the state that the investigation has concluded.

These additional elements of a MCO's, PIHP's, or PAHP's program integrity program have been recommended by CMS and OIG reports or, in the case of eligibility information, address any identified gap in information flow from MCOs, PIHPs, or PAHPs to the state about enrollees.

As part of the compliance program, we propose in §438.608(a)(1)(vi) that the MCO, PIHP, or PAHP establish procedures and a system, including dedicated staff, for promptly responding to compliance issues, including possible criminal acts such as provider fraud. Many MCOs, PIHPs, and PAHPs employ a SIU to specifically focus on suspected provider fraud and to coordinate with State program integrity officials and law enforcement agencies, such as the state MFCU. A managed care plan's coordination with law enforcement to ensure the effective investigation of fraud, waste, and abuse is a vital component of a successful program integrity program. As part of

their coordination with law enforcement, MCOs, PIHPs, and PAHPs should adopt policies and procedures that ensure information exchange between the managed care plans, the state, and law enforcement so that all stakeholders can be aware of fraud trends across their respective geographic areas. In addition, effective coordination between MCOs, PIHPs, and PAHPs with law enforcement and the state will ensure that the state meets its program integrity obligations under 42 CFR part 455 and the provisions of this part.

Proposed §438.608(b) incorporates the provider screening and enrollment standards in §438.602(b).

In paragraph (c) of §438.608, we propose additional expectations for performance by managed care plans that the state must include in their contracts, including:

- Requiring MCOs, PIHPs, and PAHPs to disclose in writing any prohibited affiliation outlined in §438.610 (proposed paragraph (c)(1));
- Requiring written disclosures of information on control and ownership under §455.104 (proposed paragraph (c)(2)); and
- Requiring MCOs, PIHPs, and PAHPs to report to the state within 60 calendar days of when they identify receipt of payments in excess of the capitation rate or other payments established in the contract. For example, the state may remit payment to the MCO, PIHP, or PAHP in accordance with an erroneous number of member months and such overpayments should be a matter for prompt disclosure and remediation by the state. Other payments under the contract would be kick-payments for high cost services that were not delivered or amounts received under incentive or withhold arrangements (as proposed in §438.6(a) and (b)) for which the MCO, PIHP, or PAHP did not satisfy the performance criteria under the arrangement (proposed paragraph (c)(3)).

We request comment on whether we should establish timeframes for the disclosures proposed in this section to be provided to the state.

In §438.608(d)(1), we propose that MCO, PIHP, and PAHP contracts specify that recoveries of overpayments made by the MCO, PIHP, or PAHP to providers that were excluded from Medicaid participation or that were due to fraud, waste or abuse are to be retained by the MCO, PIHP, or PAHP. Because these overpayments represent state and federal Medicaid funds that were paid to the excluded or fraudulent providers by the MCO, PIHP, or PAHP, states are then expected to take such recoveries into account in the development of future actuarially sound capitation rates as proposed in §438.608(d)(4). This approach is similar to that taken by CMS in addressing provider recoveries in the MA program; in that program, encounter data that reflects services paid to excluded providers or other variations of provider fraud are excluded from consideration for future rate development. This has been an area of confusion for both states and health plans, since federal statute and regulations do not currently specify who may retain MCO, PIHP, or PAHP recoveries. In addition, we believe that the retention of recoveries made by the managed care plan further supports the overall program integrity oversight and monitoring framework for managed care plans proposed in §438.608. The proposal in §438.608(d) does not prohibit the federal government or states from retaining the appropriate share of recoveries of overpayments due to their own audits and investigation. We solicit comment on this proposal to allow MCOs, PIHPs, and PAHPs to retain overpayment recoveries of payments made to providers that were excluded from Medicaid participation or that were due to fraud, waste or abuse that were made by the managed care plan, while also allowing the federal government and states retain overpayment recoveries they make. We also request comment on alternative approaches to determining when a recovery may be retained by an MCO, PIHP, or PAHP. Specifically, whether

we should instead impose a timeframe between 6 months to 1 year for which the MCO, PIHP, or PAHP may act to initiate the recovery process and retain such recovered overpayments. We further propose that, consistent with that contractual language, the state collect reports from each MCO, PIHP, or PAHP about recoveries of overpayments in proposed §438.608(d)(3). To aid in the creation and submission of such reports in proposed paragraph (d)(3), in paragraph (d)(2) we propose a standard that the MCO, PIHP, or PAHP must have a mechanism in place for network providers to report the receipt of overpayments and to return such overpayments to the MCO, PIHP, or PAHP within 60 calendar days after the overpayment was identified. For clarity, in proposed (d)(5) we define the term “overpayment.”

(5) Proposed Revisions to §438.610

We propose to revise the title of §438.610 from “Prohibited affiliations with individuals debarred by federal agencies” to “Prohibited affiliations.” This proposed change is in recognition of the addition of individuals or entities excluded from Medicaid participation under section 1128 of the Act. The current title also did not adequately reflect the proposed scope of this section as it did not include “entities.” In paragraph (a), which provides the general standards under this section, we have added PCCM and PCCM entities through our authority for the proper and efficient administration of the state plan in section 1902(a)(4) of the Act. In paragraphs (a)(1) and (a)(2) that specify the types of knowing relationships in section 1932(d)(1)(C) of the Act, we propose to clarify that these relationships may be with individuals or entities that meet those criteria. The existing language refers only to individuals and the proposed addition is consistent with the definition of “persons” in the Federal Acquisition Regulation and the Nonprocurement Common Rule. In addition, we propose to add paragraph (b) to include individuals or entities excluded from Medicaid participation under section 1128 or 1128A of the Act in the list of

prohibited relationships by the MCO, PIHP, PAHP, PCCM, or PCCM entity, as specified in section 1902(p)(2) of the Act. We note that in the case of excluded individuals and entities, the prohibition applies whether or not the relationship is known to the MCO, PIHP, PAHP, PCCM, or PCCM entity. We propose to redesignate paragraph (b) that specifies the relationships that are prohibited as paragraph (c) to accommodate the proposed inclusion of individuals or entities excluded from participation under section 1128 of the Act. In addition, we propose to add subcontractors of the MCO, PIHP, PAHP, PCCM, or PCCM entity as described in §438.230 to the types of prohibited relationships in paragraph (c)(3). In paragraph (c)(4), we propose to add network providers to clarify that they fall under the employment or other consulting arrangement for items and services under the contract between the state and the managed care plan. Due to the proposed restructuring of paragraphs within this section, we propose to redesignate paragraph (c) as paragraph (d) without change, with the exception of those described below. In paragraph (d)(3), we propose to clarify that the compelling reasons for continuation of a managed care plan's agreement with a prohibited individual or entity must be so despite the prohibited affiliation. In addition, we propose a new paragraph (d)(4) to clarify that this section does not limit or affect any remedies available to the federal government under sections 1128, 1128A or 1128B of the Act. Finally, we propose to redesignate paragraph (d) as paragraph (e) without change.

d. Sanctions (§438.700, §438.702, §438.704, §438.706, §438.708, §438.722, and §438.730)

Throughout subpart I pertaining to sanctions, we propose to extend standards applicable to PCCMs to PCCM entities, as we propose to recognize PCCM entities as a type of primary care case manager as defined in section 1905(t)(2) and referenced in section 1932(a)(1)(B)(ii) of the Act. The discussion of the proposed recognition and application of standards in this part to PCCM entities is described in section I.B.6.e. of this proposed rule. Therefore, we propose to add PCCM

entities to §438.700(a), (c), and (d)(2); §438.704(a), §438.708, and §438.722.

In §438.700(a), we propose to clarify that the intermediate sanctions specified in §438.702 “may” be used by the state, rather than providing that these “must” be the sanctions that the state establishes. The current regulation could be interpreted to mean that the specific intermediate sanctions enumerated must be used by the state, even though section 1932(e)(1) of the Act only stipulates that intermediate sanctions be in place for the specified violations, and that such intermediate sanctions may include those specified in section 1932(e)(2) and set forth in §438.702. The standard in section 1932(e)(1) of the Act that is a condition for having or renewing a MCO contract is only that there be intermediate sanctions in place.

In §438.700(c), we propose to delete PIHPs and PAHPs from the state’s determination that unapproved or misleading marketing materials have been distributed as provided for in the last sentence of section 1932(e)(1) of the Act. In the 2002 final rule, we included PIHPs and PAHPs in the regulation text implementing this sentence but have determined that this provision, by its terms only applies to a “managed care entity.” While a PCCM may be both a managed care entity and a PAHP, if it is paid on a risk basis, it would only be subject to this provision based on its managed care entity status, and not based on its status as a PAHP. In this paragraph, we propose to add PCCM entities consistent with the discussion of PCCM entities in the opening paragraph of this section of this proposed rule, and with the fact that the definition of managed care entity includes a PCCM.

In §438.702(a)(4), we propose to delete the phrase “after the effective date of the sanction,” and insert “after the date the Secretary or the State notifies the MCO or PCCM of a determination of a violation of any standard under sections 1903(m) or 1932 of the Act.” The proposed language is identical to the statutory standard in section 1932(e)(2)D) of the Act and we believe that the

current language did not fully reflect the statutory directive.

Currently, §438.706 discusses special rules for temporary management and, in paragraph (a), we reference “onsite survey, enrollee complaints, financial audits, or any other means” as acceptable ways to determine if an MCO must be subjected to temporary management. However, this language is inconsistent with language at §438.700(a) that references “onsite surveys, enrollee or other complaints, financial status, or any other source” as a means to determine imposable sanctions. We propose to correct this inconsistency by revising §438.706(a) to incorporate the language of §438.700(a).

In §438.724(a), we propose to delete the reference to “Regional Office,” consistent with proposed changes in §438.3(a) and §438.7(a).

Section 438.730 currently addresses sanctions imposed by us on MCOs and paragraphs (e)(1) and (e)(2) use the term “HMO.” The Balanced Budget Act of 1997 (BBA) replaced the term “Health Maintenance Organization (HMO)” with “Managed Care Organization (MCO).” We propose to correct these obsolete references to HMO in paragraphs (e)(1) and (2) by replacing the term with “MCO.” In addition, current §438.730 uses “State agency” or “agency,” which is inconsistent with references to the state in subpart H as well as our proposal to create a uniform definition for “state” in §438.2. We therefore propose revisions to address this.

We also propose to correct several inaccurate cross-references to other provisions of the regulations text. In §438.730(f)(1), the reference to “paragraph (b)” would be revised to reference “paragraph (c).” In §438.730(f)(2)(i) and (ii), the reference to “(d)(2)(ii)” would be revised to reference “(d)(2)” and the reference to “(c)(1)(ii)” would be revised to reference “(d)(1)(ii).” Finally, in §438.730(g)(1), the reference to “paragraph (c)(1)(i)” would be revised to reference “paragraph (c)(1).”

e. Deferral and/or Disallowance of FFP for Non-compliance with Federal Standards (§438.807)

We propose to add a new §438.807 to specify that we may defer and/or disallow FFP for expenditures under a MCO contract identified in section 1903(m)(2)(A) of the Act when the state's contract, as submitted for our approval or as administered, is non-compliant with standards therein, with section 1932 of the Act, or with the provisions of 42 CFR part 438 implementing such standards. These standards include whether final capitation rates, as specified in the contract and detailed in the rate certification, are consistent with the standards of actuarial soundness proposed in §§438.4 through 438.7. The proposed process for issuance of a deferral or a disallowance is the same as the process identified in §430.40 and §430.42, respectively.

Section 1903(m)(2)(A) of the Act specifies that if the requirements set forth in paragraphs (i) through (xiii) therein are not satisfied, no federal financial participation (FFP) is authorized for expenditures incurred by the state for services under a prepaid capitation or other risk-based contract under which the payment is for inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a), or for the provision of any three or more of the services described in such paragraphs. We have previously interpreted this to mean that if the state fails to comply with any of the listed conditions, there could be no FFP at all for payments under the contract, even for amounts associated with services for which there was full compliance with all requirements of section 1903(m)(2)(A) of the Act. This interpretation has resulted in a potential penalty that in some cases would be out of proportion to the nature of the violation, under which FFP would be withheld for payment amounts representing services which are in compliance.

We interpret section 1903(m)(2)(A) of the Act that the enumerated services are for purposes of defining the minimum scope of covered services under a comprehensive risk, or MCO,

contract. We propose that deferrals and/or disallowances of FFP can be targeted to all services under the MCO contract even if not listed explicitly in section 1903(m)(2)(A), rather than FFP in the full payment amount made under the contract. Specifically, we are proposing in §438.807 to interpret section 1903(m)(2)(A) of the Act to condition FFP in contract payment amounts on a service by service basis, so that, for example, if the violation involved the payment amount associated with coverage of inpatient hospital costs and that is the only portion of the payment amount that is not actuarially sound, then FFP in only that portion of the payment would be deferred or disallowed. This approach is supported by an interpretation of section 1903(m)(2)(A) of the Act that the phrase “no payment shall be made under this title to a State with respect to expenditures incurred by it for payment. . .for services provided by any entity” is read to place the emphasis on “payment for services provided by any entity” without regard to what the services are, so long as the minimum scope of covered services for a MCO contract is satisfied. Under our proposal, we would be able to defer and/or disallow partial FFP under the contract associated with only a particular service category if a violation involves only that category of services and not the delivery of services generally. Such determinations may be made prospectively, for example, when the contract or rate certification is submitted for CMS’ review and approval, or on a retroactive basis based on how the contract is operationalized or if it is determined through audit that the rate development standards supporting the rate certification were not compliant with the requirements proposed in this part. We believe that this proposal would result in a more fair and measured penalties for violations, and lead to more expedient resolution of compliance actions.

The deferral of FFP would be taken against the state’s request for grant awards attributed to managed care contracts on the CMS-37. States must request the grant award 45 days prior to the start of the quarter. The CMS-64, which reconciles the amount of the grant award to actual

expenditures, is due within 30 days of the expiration of the quarter. The timeframe for the CMS-64 submission overlaps with the timeframe for the grant request on the CMS-37 for the next quarter. We provide the following example to illustrate when the deferral would be applied for a noncompliant contract effective on January 1. The state would have included the expenditures under the managed care contract on the CMS-37 no later than November 15. In the interim, we would conduct a review of the contract and rate certifications and identify any compliance issues. The state submits the CMS-64 for the first quarter of the calendar year by April 30, and the CMS-37 grant request for the second quarter was submitted by February 15. Assuming that CMS and the state were unable to resolve the compliance issue according to the process set forth in the regulation, we would assess the deferral of FFP against the CMS-37 request for the third quarter of the calendar year in a proportionate amount of the contract rate that reflects the non-compliant activity. We seek comment on these proposals.

f. Exclusion of entities

Section 438.808 implements the requirements in section 1902(p)(2) of the Act for the types of organizations or entities that the state must not contract with in order for the state to receive federal payments for medical assistance. The existing regulation in paragraph (a) includes MCOs but does not incorporate the statutory directive in section 1902(p)(2) of the Act to similarly exclude “an entity furnishing services under a waiver approved under section 1915(b)(1)” that would fall under the entities that must be excluded in paragraph (b) of this section. We propose to include such entities in paragraph (a) to clarify that PIHPs, PAHPs, PCCMs or PCCM entities that have contracts with the state under a section 1915(b)(1) waiver would also be subject to the this provision. There is no requirement in the statute that MCO contracts be tied to a specific managed care authority so we propose that all MCO contracts under any authority be subject to this

provision.

5. Beneficiary Protections

a. Enrollment (§438.54)

In this section we address a gap in the current managed care regulations regarding the enrollment process. Other than the default enrollment standards currently in §438.50(e) and (f) for MCOs and PCCMs, there are no federal regulations governing enrollment of beneficiaries into managed care programs. In the absence of specific federal regulatory provisions, states have used a number of different approaches to enrolling beneficiaries into voluntary and mandatory managed care programs. The variation in proposed processes revealed a need for guidance to ensure an appropriate, minimum level of beneficiary protection and consistency across programs. In this section, we propose basic federal standards for enrollment while continuing to permit state flexibility in designing enrollment processes for Medicaid managed care programs.

Among states currently operating voluntary Medicaid managed care programs, which allow each beneficiary to choose to receive services through either a managed care or FFS delivery system, states have generally used a passive enrollment process to assign a beneficiary to a managed care plan immediately upon being determined eligible. Typically, the beneficiary is provided a period of time to elect to opt-out of enrollment from the state-assigned managed care plan and select a different managed care plan or elect to opt-out of managed care completely and, instead, receive services through a FFS delivery system. If the beneficiary does not make an affirmative choice, the beneficiary remains enrolled in the state-assigned managed care plan during the period of Medicaid eligibility and enrollment. Our experience shows the rate of potential enrollees that opt-out is generally very low.

In a mandatory Medicaid managed care program, beneficiaries must receive Medicaid

benefits from managed care plans. Under section 1932(a)(4)(A)(ii)(I) of the Act, beneficiaries in a mandatory managed care program have the right to change plans without cause within 90 days of enrolling in the plan and every 12 months; enrollees may also change plans for cause at any time. When the beneficiary does not actively select a managed care plan in the timeframe permitted by the state, states have generally used the default assignment process to assign individuals into plans. Section 1932(a)(4)(D) of the Act and current implementing regulations at §438.50(f) outline the process that states must follow to implement default enrollment (also commonly known as auto-assignment) in a mandatory managed care program.

In both voluntary and mandatory managed care programs, we believe that beneficiaries are best served when they affirmatively exercise their right to make a choice of delivery system or plan enrollment. Optimally, this involves both an active exercise of choice and requisite time and information to make an informed choice. Given the sensitive nature of this transition from FFS to managed care or from one managed care system to a new managed care system and the often complex medical, physical and /or cognitive needs of Medicaid beneficiaries, we believe that enrollment processes should be structured to ensure that the beneficiary has an opportunity to make an informed choice of managed care plan and that state processes support a seamless transition for an enrollee to managed care.

Our goal of alignment prompted us to consider how enrollment is conducted in the commercial market and in other public programs. We note that MA is a voluntary managed care program, in which beneficiaries actively select the MA organization during the annual open enrollment period with limited exceptions for passive enrollment. A quarter of all Medicare beneficiaries (approximately 14 million in 2013) are enrolled in MA organizations; of that number,

1.6 million are enrolled in special needs plans.¹¹

To promote integration of care for dually eligible (Medicare and Medicaid) beneficiaries, the section 1115A demonstrations under the capitated financial alignment model operated by the Medicare-Medicaid Coordination Office (MMCO) are using a form of passive enrollment. The enrollment processes generally require notifying dually eligible individuals that they can select a Medicare plan 2 months before they would be enrolled in the plan, but if no active choice is made, enrollment into the plan identified through the passive process takes effect.

We note that some states have re-examined their Medicaid managed care enrollment processes due to an interest in alignment with Marketplace enrollment procedures. Enrollment into a QHP in either the FFM or SBM requires an active selection of a health plan, and in some cases premium payment. Consequently, the online application for the FFM at Healthcare.gov provides the option to select a QHP at the time of application. The FFM single, streamlined application requires follow-up by the individual to enroll in a QHP. SBMs, as well as Medicaid and CHIP agencies, are permitted to develop an alternative single, streamlined application that must be approved by CMS. A few states with mandatory Medicaid managed care programs have included a section in their alternative benefit application that requires applicants to select a Medicaid managed care plan at the time of application. While this approach aligns the processes for Medicaid, CHIP and QHPs, it also eliminates the traditional approach of providing a choice period to select a managed care plan for Medicaid beneficiaries already eligible for FFS coverage.

We are proposing a new §438.54 to apply a consistent standard for all managed care enrollment processes. At the same time, we are proposing to move and revise, as noted below, the existing provisions in §438.50(e) and (f) to our new §438.54. Under these proposed changes,

¹¹ Kaiser Family Foundation Medicare Advantage Fact Sheet (<http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>), accessed April 15, 2014.

states would implement a set of enrollment standards that are consistent with section 1932(a)(4) of the Act and that promote high quality managed care programs. The goals of this approach are to promote accurate and timely information to beneficiaries about their managed care options; to enable and encourage active beneficiary choice periods for enrollment; and to assure the state's ability to conduct intelligent default enrollments into a managed care plan when necessary.

Through the changes discussed below, we propose to set broad parameters for a state's enrollment process rather than dictate specific elements. In paragraph §438.54(a) we propose to clarify that the provisions of this section apply to all authorities under which a state may enroll beneficiaries into a managed care delivery system to ensure a broad and consistent application. We note that this includes voluntary managed care programs under section 1915(a) of the Act, as well as mandatory or voluntary programs under sections 1932(a), 1915(b) or 1115(a) of the Act.

We propose in paragraph (b) that the state have an enrollment system for both voluntary and mandatory managed care programs, and propose definitions for those programs, respectively, in paragraphs (b)(1) and (b)(2). These proposals support clarity and consistency.

Proposed paragraph (c) specifies the standards for programs using a voluntary managed care program. In (c)(1), we propose that the state may use either an enrollment system that provides the beneficiary time to make an affirmative election to receive services through a managed care or FFS delivery system or a passive enrollment process. We propose to define a passive enrollment process as one in which the State selects a MCO, PIHP, PAHP, PCCM, or PCCM entity for a potential enrollee but provides a period of time for the potential enrollee to decline the managed care plan selection before enrollment. Using either option, the state must comply with the standards proposed in paragraphs (c)(2) through (c)(8).

In paragraph (d), we propose to set forth standards for enrollment systems for mandatory

managed care programs. In (d)(1), we propose that such a system must meet certain standards, listed in proposed paragraphs (d)(2) through (d)(7). We discuss the remaining proposals for (c) and (d) together below as these proposed standards are substantially similar.

In paragraph (c)(2) and (d)(2), we propose a specific enrollment standard applicable to both voluntary and mandatory managed care programs that all states must provide a period of time of at least 14 calendar days of FFS coverage for potential enrollees to make an active choice of their managed care plan. We acknowledge that this 14-day choice period would not be necessary in mandatory programs when there is only one contracted managed care plan within a service area as permitted in §438.52(b) for rural areas or through a specific authority within a section 1115(a) demonstration program. We believe this minimum time period is important since, similar to enrollees in a commercial insurance product, Medicaid enrollees can be ‘locked in’ to their selected health plan for up to 1 year. This minimum 14-calendar day period would have to occur between the date that the notice specified in (c)(3) and (d)(3) is sent and the date on which the enrollee becomes covered under the applicable managed care entity. We propose to clarify in (c)(2)(i), that if the state does not use a passive enrollment process and the potential enrollee does not make a choice, then the potential enrollee is enrolled into a managed care plan selected by the state’s default process when the choice period has ended. In proposed (c)(2)(ii), we clarify that if the state does use a passive enrollment process and the potential enrollee does not make a choice, then the potential enrollee is enrolled into the managed care plan selected by the state’s passive enrollment process when the choice period has ended. In the mandatory program, the minimum 14-day period would have to occur before any default enrollment process is used. However, we are not proposing any passive enrollment mechanism for mandatory managed care programs because the default enrollment mechanism provides the same measure of administrative flexibility.

We believe that 2 weeks is sufficient time given that, elsewhere in this proposed rule, we are encouraging states to move to more rapid methods of communicating with enrollees. While we are proposing to require a minimum of 14 days for the choice period, we understand that the state may end the choice period when the potential enrollee actively makes a plan selection prior to the 14th day.

We appreciate that states may want to effectuate managed care enrollment in mandatory programs as soon as possible after eligibility determination, and recognize that providing a minimum active choice period will be a change in process for some states. States would need to provide a period of FFS coverage for beneficiaries between their date of eligibility and their date of managed care enrollment. To minimize any further delay in managed care enrollment, we would allow states to operationalize the 14-day active choice period by advising beneficiaries of the managed care plan they will be enrolled into through the default process if they do not make an active choice of managed care plan in that 14-day period. According to this process, states would complete the default enrollment process outlined in §438.54(d)(5) prior to beginning the notice and education process described in paragraph (d)(3) with beneficiaries, and ensure that adequate and appropriate information is provided to beneficiaries regarding the implications of not making an active managed care plan selection. It also enables beneficiaries to override default enrollments by exercising their ability to make an active choice of health plan.

We request comment on the impact of this new standard on managed care program costs and operations, as well as the operational flexibility we are providing to relieve beneficiaries of the burden of receiving too many mailings, which can create confusion, before making the default enrollment permitted in §438.54. We also invite comment on whether a 14-day period is necessary, provides sufficient time for beneficiaries to make an election, or whether a longer

minimum period, such as 30 days or 45 days, should be adopted.

We note that all beneficiaries, regardless of whether enrollment is mandatory or voluntary, must be given the information, education, and opportunity to participate actively in their choice of managed care plan. Paragraphs (c)(3) and (d)(3) propose that states develop informational notices to clearly explain to the potential enrollee the implications of not actively making the decisions available to them and allowing the passive or default enrollment to take effect. Proposed (c)(3)(i) and (d)(3)(i) would provide that the notices comply with §438.10 and proposed (c)(3)(ii) and (d)(3)(ii) would provide that the notices have a postmark or electronic date stamp that is at least 3 calendar days prior to the first day of the 14-day choice period. We believe this provides reasonable time for either postal delivery or the potential enrollee to read the electronic communication and still have 14 days to make an active selection.

Priority for enrollment into a managed care plan is currently in §438.50(e); however, for better organization, the text is being deleted from §438.50 and is proposed as (c)(4) and (d)(4). No other changes are proposed to this text.

We propose in paragraphs (c)(5) and (d)(5) that states assign potential enrollees only to a qualified MCO, PIHP, PAHP, PCCM, or PCCM entity. This concept is currently addressed in §438.50(f)(2) but only to the extent of excluding those MCOs and PCCMs that are subject to the intermediate sanction in §438.702(a)(4). In proposed (c)(5)(i) and (d)(5)(i), we propose to exclude MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities subject to sanction under §438.702(a)(4) and to add paragraph (c)(5)(ii) and (d)(5)(ii) to ensure that a qualified MCO, PIHP, PAHP, PCCM, or PCCM entity has the capacity for new enrollments.

In proposed paragraphs (c)(6) and (d)(6), we address standards that are currently reflected in §438.50(f) which provides that states have a default enrollment process for assigning a MCO or

PCCM when the potential enrollee does not make an active managed care plan selection. As defined in statute, section 1932(a)(4)(D) of the Act provides that a state conduct such enrollments in a manner that takes existing provider-individual relationships into consideration, and if that approach is not possible, to equitably distribute individuals among the participating health plans. While the 2002 final rule strictly interpreted the provisions of section 1932(a)(4)(D) of the Act regarding default enrollment to apply only to enrollment that occurred under state plan authority in section 1932(a) of the Act, we believe that the enrollment processes currently specified in §438.50(e) and (f) should not be limited only to entities subject to section 1932(a)(4)(D). Allowing potential enrollees sufficient time to make informed decisions about their managed care plan is an important protection that should not exclude potential enrollees of PIHPs and PAHP as well all those subject to voluntary programs that utilize a passive process. Therefore, we propose to make these provisions applicable to all managed care authorities and to both passive and default processes. We add existing text from §438.50(f)(2) through (f)(4) in proposed paragraphs (c)(6) and (d)(6). While §438.50(f) currently only applies to default enrollment in mandatory managed care programs, we believe that enrollees in voluntary programs that utilize a passive enrollment process should also benefit from being assigned to a plan based on existing provider relationships or other criteria relevant to beneficiary experience. Therefore, we propose to add standards in (c)(6) for voluntary programs that mirror the standards for mandatory programs using default enrollments.

In proposed paragraphs (c)(7) and (d)(7), we set forth provisions from existing §438.50(f)(2) that provide that if a state cannot preserve existing provider-beneficiary relationships and relationships with providers that traditionally serve Medicaid, then enrollees must be equitably distributed. Proposed paragraphs (c)(7)(i) and (d)(7)(i) set forth a standard that states may not

arbitrarily exclude a MCO, PIHP, PAHP, PCCM, or PCCM entity from the assignment process. We interpret “equitable distribution” in section 1932(a)(4)(D)(ii)(II) of the Act to mean not only that the criteria applied to make default enrollments are fair and reasonable, but that the pool of contractors eligible to receive default enrollments is not based on arbitrary criteria. Section 438.50(f) in the 2002 final rule implemented this statutory provision verbatim, but in response to comments on this provision, we clarified that “states must have the flexibility to consider other factors in the design of a default enrollment process that best meets the needs of the individual,” (67 FR 41020, June 14, 2002). We believe that the flexibility to use additional criteria related to the beneficiary when making default assignments, such as the geographic location of the beneficiary, enrollment preferences of family members, previous plan assignment of the beneficiary, quality assurance and improvement performance, procurement evaluation elements, and other reasonable criteria that support the goal of the Medicaid program, should be provided for in the regulation. Further, we believe that such criteria can be part of an equitable distribution by ensuring fair treatment for enrollees and managed care plans. We note that, an informal survey of state default enrollment practices revealed that some states currently utilize such criteria in their default enrollment process.

For voluntary programs only that use passive enrollment, paragraph (c)(8) proposes that states send confirmation notices to enrollees of their plan selection that contain information explaining the enrollee’s right to disenroll from that MCO, PIHP, PAHP, PCCM, or PCCM entity within 90 days. We note that many states use a voluntary model when first starting to introduce managed care, which means the beneficiaries are not as familiar with the limitations of managed care plan enrollment. This additional confirmation notice may help limit unintended plan selections before they take effect.

b. Disenrollment Standards and Limitations (§438.56)

We propose to retain the majority of the regulation text currently in §438.56, with four substantive exceptions:

- We propose, as discussed in more detail in section I.B.5.e. of this proposed rule, to add references to “PCCM entity” as applicable;
- We propose to revise the text in paragraph (c)(2)(i) concerning the start of the statutorily mandated 90-day period during which an enrollee may disenroll without cause;
- We propose to explicitly provide that a state may impose either oral or written requests for disenrollment; and
- We propose in (d)(2)(iv) to specify an additional cause for disenrollment. We also propose grammatical and clarifying corrections to the regulation text.

Paragraphs (a) through (c)(1) are unchanged except for the addition of PCCM entity. In paragraph (c)(2)(i), we propose to modify our approach to an enrollee’s 90-day without cause disenrollment period. Section 1932(a)(4)(A) of the Act specifies that a state plan must permit disenrollment without cause from a managed care entity during the first 90 days of enrollment under mandatory managed care programs. As part of the 2002 final rule, we exercised authority under section 1902(a)(4) of the Act to extend this standard to state plans with voluntary managed care programs and to PIHPs and PAHPs (whether voluntary or mandatory). As finalized in 2002, we interpreted the clause “90 days following the date of the beneficiary’s initial enrollment” to mean enrollment with a particular MCO, PIHP, PAHP, or PCCM. That interpretation was intended to allow an enrollee to disenroll from a MCO, PIHP, PAHP, or PCCM every 90 days until he or she had exhausted all contracted MCO, PIHP, PAHP, or PCCM options for which he or she is eligible. We believe that this provision has been applied in an inconsistent manner, and that

such an approach is disruptive to the goals of establishing enrollee-provider relationships that support a coordinated delivery system and contribute to medical and administrative inefficiencies. We propose in paragraph (c)(2)(i) to revise the regulation to limit the 90-day without cause disenrollment period to the first 90 days of an enrollee's initial enrollment into any MCO, PIHP, PAHP, or PCCM offered through the state plan; therefore, an enrollee would have only one 90-day without cause disenrollment per enrollment period. We believe that the revised approach is consistent with the intent of section 1932(a)(4)(A)(ii) of the Act, represents current practice in the states, and supports efficiency under the Medicaid program. We propose no changes to paragraphs (c)(2)(ii) through (iv).

We propose to add the phrase “as required by the state” to §438.56(d)(1) to clarify that this section of the regulation was intended to give states the flexibility to accept disenrollment requests either orally, or in written form, or both ways if the state so desires. We intend to interpret “written request” for purposes of this regulation to include online transactions or requests conducted with an electronic signature. A state could also accept requests orally, but require written confirmation of the oral request. Under our proposal, the state’s standard for the form of disenrollment requests would have to be clearly communicated to enrollees to take advantage of this flexibility.

We propose two minor grammatical corrections to paragraph (d) of this section. In paragraph (d)(1)(ii), the term “PIHP” is in its singular form, but must be changed to plural to conform to other terms in the paragraph. We also propose to use the possessive form for MCO, PIHP, and PAHP where applicable. In paragraph (d)(2)(iv), we propose to add a new cause for disenrollment: the exit of a residential, institutional, or employment supports provider from an enrollee’s MCO, PIHP, or PAHP network. Provider network changes can have a significant

impact on those enrolled in MLTSS programs, since such providers are typically integral to residential and work services and supports. Therefore, if the state does not permit participants enrolled in MLTSS to switch managed care plans (or disenroll to FFS), at any time, states must permit enrollees to disenroll and switch to another managed care plan or FFS when the termination of a provider from their MLTSS network would result in a disruption in their residence or employment. We propose to codify this additional cause for disenrollment as §438.56(d)(2)(iv) and to redesignate the existing text at that paragraph to (d)(2)(v). In paragraph (d)(3), we propose to add text to clarify that disenrollment requests that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not approve would have to be referred to the state for review. This would not change the meaning but we believe it would improve the readability of the sentence. The existing text is otherwise retained in paragraph (d)(5), except to add PCCM entities to its scope as discussed elsewhere.

In paragraph (e)(1), we propose changes for clarification. Currently in paragraph (e)(1) of this section, the timeframe for a state to process a disenrollment request is intended to apply to enrollee requests for disenrollment. The timeframe applies regardless of whether the enrollee submits the request- directly to the state or to the MCO, PIHP, PAHP, PCCM, or PCCM entity (if permitted by its contract with the state.) However, §438.56(d)(1)(ii) permits states to allow MCOs, PIHPs, PAHPs, and PCCMS to process disenrollment requests. In these instances, the health plan can approve the request, but it cannot actually disapprove the request. Instead, per §438.56(d)(3), it must forward the request to the state. In these instances, the timeframe for the state to process a disenrollment request referred by the plan is the same as if the enrollee had submitted it directly to the state. To clarify this intent, in paragraph (e)(1), we propose to insert the term “requests” after the term “enrollee” and replaced the term “files” with “refers.” No changes

are proposed in paragraphs (f) and (g).

c. Beneficiary Support System (§438.71)

In existing regulations at §438.10, we acknowledged the importance of information and disclosure in helping the beneficiary choose a managed care plan. However, we recognize that some beneficiaries may need additional assistance when evaluating their choices. This additional assistance includes having access to personalized assistance – whether by phone, internet, or in person – to help beneficiaries understand the materials provided, answer questions about options available, and facilitate enrollment with a particular health plan or provider. Some states have found that having such personalized assistance has helped to limit the number of beneficiaries assigned through their default enrollment process.

This personalized assistance concept is similar to existing programs in the Marketplace or State Health Insurance Programs (SHIPs) for Medicare beneficiaries, with someone assisting the beneficiary in a helpful, neutral and non-coercive way to make an informed choice that best suits their health care needs. Choice counseling is currently defined in §438.810 and we propose to move the definition to §438.2 and define the term as the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care health plans and primary care providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP.

We propose a new §438.71, entitled Beneficiary Support System. Proposed paragraph (a) establishes the standard that a state develops and implements a beneficiary support system to provide support before and after managed care enrollment. Paragraph (b) proposes four minimum functions for a beneficiary support system: Paragraph (b)(1)(i) would ensure that the provision of

choice counseling is made available to all beneficiaries, paragraph (b)(1)(ii) would add training on the type and availability of community based resources and supports, paragraph (b)(1)(iii) would require assistance to all beneficiaries in understanding managed care, and paragraph (b)(1)(iv) would add assistance for enrollees who receive or desire to receive LTSS. In paragraph (b)(2), we propose that the system be available to the beneficiaries in multiple ways including phone, internet, in-person, and via auxiliary aids and services when requested. As we discussed in the Collection of Information (COI) section of this proposed rule, we support the use of traditional and electronic means of communicating with beneficiaries.

We propose to add a standard at §438.71(c)(1) for states to provide choice counseling services for any potential enrollee (that is, prior to first enrollment in managed care) or to managed care enrollees when they have the opportunity to change enrollment or must change enrollment as described in §438.56(b) and (c). States have the flexibility to decide who can provide choice counseling. However, in paragraph (c)(2), we clarify that any individual or entity providing choice counseling services is considered an enrollment broker under our regulations, and therefore, must meet the independence and conflict of interest standards of §438.810 to provide those services. This means the entity cannot have a financial relationship with any MCO, PIHP, PAHP, PCCM, or PCCM entity which operates in the state where the entity is providing choice counseling. This would include participating with the MCO, PIHP, PAHP, PCCM, or PCCM entity as a contracted provider. In states where the county is acting as a managed care plan, the county may not provide choice counseling as serving in both capacities is incompatible with the conflict of interest and independence standards. We understand that some entities may receive federal grant funding distinct from Medicaid funding that may require those entities, such as FQHCs or Ryan White providers, to conduct activities similar to those that would fall under the definition of choice

counseling. (This is not an exhaustive list of federal grantees and is provided for illustrative purposes). If those entities do not have a memorandum of agreement or contract with the state to provide choice counseling on the state's behalf, such entities would not be required to adhere to the conflict of interest standards in 438.810 under our proposal at §438.71(c)(2). We request comment on whether entities that provide non-Medicaid federally-financed protections to beneficiaries that includes representation at hearings should be allowed to also contract with the Medicaid agency to provide choice counseling as long as appropriate firewalls are in place; we do propose in paragraph (e)(3)(i) a similar exemption and firewall requirement for such grantees to represent enrollees receiving LTSS from the managed care entity. We would expect such requirements to include appropriate firewalls in both staff responsibilities and billing practices for choice counseling services. We also seek comment on what should constitute the minimum firewall standards between the choice counseling and other federally funded advocacy functions to preserve the independence of the choice counseling.

In proposed paragraph (d), the beneficiary support system would provide training to MCO, PIHP, and PAHP staff and network providers on community based resources and supports that can be linked with covered benefits. Community services often facilitate or promote compliance with service or treatment plans and thus, the managed care plan, provider and beneficiary all benefit from the state ensuring that information on available resources is known and understood by all parties providing or coordinating care for beneficiaries.

We understand that states may include many of these services already within their Medicaid program and we do not intend that states develop a new system of delivering all the functions proposed in §438.71(e) for MLTSS. Under our proposal, states would be permitted to draw upon and expand, if necessary, those existing resources to meet the standards of this section.

In paragraph (e), we propose four elements for a beneficiary support system specific to beneficiaries who use, or desire to use, LTSS: (1) An access point for complaints and concerns about enrollment, access to covered services, and other related matters; (2) education on enrollees' grievance and appeal rights, the state fair hearing process, and rights and responsibilities; (3) assistance, upon request, in navigating the grievance and appeal process and appealing adverse benefit determinations made by a plan to a state fair hearing; and (4) review and oversight of LTSS program data to assist the state Medicaid Agency on identification and resolution of systemic issues. Proposed paragraph (e)(1) applies to enrollees of MCOs, PIHPs, PAHPs, PCCMS, and PCCM entities while (e)(2) through (e)(4) apply only to MCOs, PIHPs, and PAHPs since they reference the grievance and appeal process which PCCMs are not required to have.

Given the increased complexity of care and service needs for beneficiaries receiving, or in need of, LTSS, we believe this added level of support is appropriate. The proposed changes to this paragraph are discussed in more detail in section I.B.6.e. of this proposed rule. Finally, we note that the proposed scope of services for LTSS beneficiary supports may include what has been traditionally considered "ombudsman" services; however, rules concerning Medicaid-reimbursable expenditures remain in place, so we caution that not all ombudsman activities traditionally found in a Long-Term Care Ombudsman office may be eligible for Medicaid payment under this proposal. We issued an informational bulletin on June 18, 2013, entitled "Medicaid Administrative Funding Available for Long-Term Care Ombudsman Expenditures," that provided guidance on this issue. The informational bulletin is available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-18-2013.pdf>. We request comments on our overall approach to §438.71.

d. Coverage and Authorization of Services and Continuation of Benefits While the MCO, PIHP,

or PAHP Appeal and the State Fair Hearing are Pending (§438.210 and §438.420)

We group together our discussion of proposals for §§438.210 and 438.420 because they address related benefit issues about the receipt and provision of covered services. Section 438.210 establishes standards for authorization periods set by managed care plans and §438.420 addresses the duration of continued benefits pending appeal resolution. Although the current regulation at §438.210 addresses MCOs, PIHPs, and PAHPs, the current regulation at §438.420 addresses only MCOs and PIHPs. We propose to add PAHPs to the subpart F appeal and grievance regulations as discussed in the Appeals and Grievance section of this proposed rule (I.B.1.b.).

Under existing regulations, continuation of benefits during an appeal is tied to coverage and authorization decisions made by the MCO, PIHP, or PAHP. As more managed care programs include enrollees with ongoing and chronic care needs, including LTSS, we believe it is important that authorization periods for such services reflect the ongoing need for these services to avoid disruptions in care.

While we recognize that MCOs, PIHPs, and PAHPs have flexibility in applying utilization management controls for covered services, exercising that flexibility could result in the inappropriate curtailment of necessary services, particularly for those requiring on-going and chronic care services, including LTSS. We acknowledge that our current standards reflect an acute care model of health care delivery and do not speak to the appropriate medical management of individuals with ongoing or chronic conditions, or the authorization of non-clinical services that maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting. Therefore, we propose to modernize the language in §438.210 governing the coverage and authorization of services and establish standards for states through the managed care contract to ensure that MCOs, PIHPs, and PAHPs

employ utilization management strategies that adequately support individuals with ongoing or chronic conditions or who require long-term services and supports.

As background, the foundation of coverage and authorization of services is that services in Medicaid must be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished, and services must not be arbitrarily denied or reduced because of the diagnosis or condition of the enrollee. Our proposal would permit a MCO, PIHP, or PAHP to place appropriate limits on a service on the basis of criteria applied under the state plan, such as medical necessity, or for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. This is the same standard applied to a state's coverage decisions under the state plan, see §440.230 and we propose to reflect this by revising pertinent text in §438.210(a).

We propose no changes to §438.210(a)(1) and (2). In paragraph (a)(3)(i), we propose to delete “be expected to” as it is used relative to services reasonably achieving their results and align with the FFS standard in 42 CFR 440.230.

We propose that existing paragraph (a)(3)(iii) be redesignated as (a)(4) and existing paragraphs (a)(3)(iii)(A) and (B) be redesignated without change as paragraphs (a)(4)(i) and (ii), with new paragraphs (a)(4)(ii)(A), (B) and (C). In paragraph (a)(4)(ii)(A), we propose text to incorporate the proposed revisions in paragraph (a)(3)(i) deleting the phrase “to be expected to” as it is used relative to services reasonably achieving their purpose in stating a limit on how utilization controls may be used. We also propose to add two new conditions on when and how an MCO, PIHP, or PAHP may impose utilization controls. First, we propose in paragraph (a)(4)(ii)(B) that the state must ensure, through its contracts, that service authorization standards are appropriate for and do not disadvantage those individuals that have ongoing chronic conditions

or needing LTSS. The expectation is that clinical services that support individuals with ongoing or chronic conditions, as well as LTSS would be authorized in a manner that reflects the beneficiary's continual need for such services and supports. As this would be a contractual standard for managed care programs that cover both medical and LTSS, we expect states to monitor MCO, PIHP, and PAHP compliance with setting reasonable authorization periods, and have included a standard for monitoring utilization management in our proposed revisions to §438.66. Second, we propose that utilization controls may not interfere with the enrollee's freedom to choose a method of family planning. Specifically, we propose that utilization controls are permissible so long as family planning services are provided in a manner that protects the enrollee's freedom to choose the method of family planning to be used consistent with §441.20. We propose this language pursuant with our authority under section 1902(a)(4) of the Act to ensure that beneficiaries, whether receiving family planning services through FFS or managed care, have the same freedom to choose the method of family planning to be used. This proposal does not alter the state's ability under FFS or a managed care plan's ability to apply medical necessity criteria for an individual's request for family planning services but provides that utilization controls that would interfere with an enrollee's freedom to choose the method of family planning would not be permitted. We request comment on this proposal.

We propose that existing paragraph (a)(4) be redesignated as (a)(5) and paragraph (5)(i) is unchanged. In paragraph (a)(5)(ii), we propose to revise the criteria for defining medically necessary services by adding that such criteria must meet the requirements for providing early and periodic screening and diagnosis of beneficiaries under age 21 to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found (EPSDT). We believe this addition is necessary to ensure that State definitions of medical

necessity comply with federal EPSDT laws. In paragraph (a)(5)(iii)(A), we propose to revise the criteria for defining medically necessary services by adding disease, condition, or disorder that results in health impairment and/or disability. We believe this is more comprehensive and more accurately reflects our intent than the existing provision. In paragraph (a)(5)(iii)(A) through (C), we propose grammatical revisions to accommodate a proposed new paragraph (a)(5)(iii)(D) that would add an LTSS focus by requiring that medically necessary services address the opportunity for an enrollee to have access to the benefits of community living.

In paragraph (b), we propose to add specificity related to LTSS services. No changes are proposed for (b)(1) and (2)(i); however, in (b)(2)(ii) we propose to add “for medical services” to address requests for non-LTSS, and in paragraph (b)(2)(iii) we propose to add a standard that MCOs, PIHPs, and PAHPs authorize LTSS based on an enrollee’s current needs assessment and consistent with the person-centered service plan. Paragraph (b)(3) proposes to change from referencing treating a condition or disease to addressing medical, behavioral health, or LTSS needs.

The proposed changes in paragraph (c) are to add “PAHP” to the standards of this paragraph and revise notices of adverse action to notices of adverse benefit determination. As discussed in section I.B.1.b. of this proposed rule, we propose to add PAHPs to subpart F and replace “action” with “adverse benefit determination.” Thus, both of these are necessary conforming changes.

In paragraph (c), we also propose to correct the heading to reflect the change from action to adverse benefit determination as discussed in section I.B.1.b. of this proposed rule. We also propose to remove the provision that references notices to providers of adverse benefit determinations need not be in writing as an exception to §438.404. Provider notices are not

currently addressed in §438.404, thus this reference is erroneous.

The only change proposed to paragraph (d)(1) is to delete “health” to make “condition” more comprehensive.

We propose in §438.210(d)(2)(i) and (ii) to change the timeframe for MCOs, PIHPs, and PAHPs to make expedited authorization determinations within 72 hours, rather than the current standard of 3 working days, after receipt of the request for the service to align expedited authorization determination timeframes with expedited health plan level appeals in proposed §438.408(b)(3). We discuss in section I.B.1.b. of this proposed rule how these proposed timelines align with the MA and commercial standards for expedited appeals. We are not proposing any to revisions to §438.210(e)

In section §438.420, we propose conforming revisions, consistent with other proposals throughout subpart F: specifically, to change “action” to “adverse benefit determination,” to add PAHPs to standards currently applicable only to MCOs and PIHPs, and to specify all time limits expressed in days as calendar days. To address the limit on enrollee’s access to benefits pending resolution of an appeal, we also propose to eliminate the link between the duration of continued benefits pending appeal and the original service authorization period. Thus, we propose to delete existing §438.420(c)(4) that permits MCOs and PIHPs to discontinue coverage of services pending appeal when the time period or service limits of a previously authorized service has been met. The removal of this paragraph would mean that an enrollee must continue to receive benefits without interruption, if elected by the enrollee, through the conclusion of the SFH process if the enrollee appeals an MCO’s, PIHP’s, or PAHP’s adverse benefit determination. This change would apply to all authorized services covered by the MCO, PIHP, or PAHP as §438.420. We believe this a critical enrollee protection given the nature and frequency of many ongoing services, particularly

for enrollees receiving LTSS.

In addition, in §438.420(d), we propose that the MCO's, PIHP's, or PAHP's ability for recoupment from the beneficiary under a final adverse decision be addressed in the contract and that such practices be consistent across both FFS and managed care delivery systems within the state. Under both managed care and FFS, the right to continuation of benefits is not exercised without potential financial risk to the beneficiary of payment for services provided if the final decision is adverse to the beneficiary. The decision to hold the beneficiary financially liable for such services is left to the state under §431.230(b) and that decision would be applied equally to FFS and managed care programs. For example, if the state does not exercise the authority for recoupment under §431.230(b) for FFS, the same practice must be followed by the state's contracted MCOs, PIHPs, and PAHPs. We request comments on the proposed revisions to §§438.210 and 438.420.

e. Continued Services to Beneficiaries and Coordination and Continuity of Care (§438.62, §438.208)

To ensure consistent continuity of care and coordination of services for beneficiaries, we are proposing revisions to §438.62 and §438.208.

The existing regulatory framework for coordination of care focuses on three elements: (1) all enrollees must have an ongoing source of primary care; (2) a person or entity will coordinate the care provided by the MCO, PIHP, or PAHP; and (3) additional assessments and treatment plans are in place for individuals identified by the state as having special health care needs. In 2002, when the current regulations were finalized, the use of managed care for delivery of LTSS or providing medical services to more complex populations was not prevalent and, therefore, not substantially reflected in the regulations.

The proposed changes discussed below aim to align the Medicaid managed care framework with other public and private programs and improve coordination and continuity of care. To that end, we propose the following: set standards for transition plans when a beneficiary moves into a new MCO, PIHP, or PAHP; expand beyond the emphasis on primary care when considering care coordination; strengthen the role of the assigned care coordinator; ensure there is more accurate and timely data gathering and sharing; and include enrollees with LTSS needs in the identification, assessment and service planning processes. These proposed changes would modify sections §438.62 and §438.208.

(1) Transition between Medicaid delivery systems (§438.62)

Our only explicit transition of care standards included in current Medicaid managed care regulations (codified at §438.52) focus on when a beneficiary is mandated into a single MCO, PIHP or PAHP in a rural area. We believe there should be transition of care standards for all Medicaid beneficiaries transitioning from one delivery system to another within Medicaid (even MCO to MCO), and not just rural area enrollees.

We propose no changes to paragraph (a) other than to add PCCM entity as discussed elsewhere in this rule. We propose to add a standard to §438.62(b) which would require that states have a transition of care policy in place for individuals moving to managed care from FFS, or from one MCO, PIHP, PAHP, PCCM, or PCCM entity to another when an enrollee without continued services would experience serious detriment to their health or put them at risk of hospitalization or institutionalization. Under this proposal, states would define the transition policy, as long as it meets the standards proposed in paragraph (b)(1), and would have the flexibility to determine the types of enrollees for which the MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities would need to provide transition activities. Paragraph (b)(1) proposes that transition policies include: Permitting

the enrollee to continue to receive the services they are currently receiving from their current provider for a specified period of time in paragraph (b)(1)(i); referring the enrollee to an appropriate participating provider in (b)(1)(ii); assuring that the state or MCO, PIHP or PAHP comply with requests for historical utilization data in (b)(1)(iii); and assuring that the enrollee's new provider is able to obtain appropriate medical records in (b)(1)(iv). We note here that references to "services" mean services covered under the contract, which would include prescription drugs if the managed care plan is obligated to provide such services under the contract. We also propose, at paragraph (b)(1)(v), that additional procedures for the transition plan may be specified by the Secretary as necessary to ensure continued access to services for an enrollee to prevent serious detriment to the enrollee's health or to reduce the risk of hospitalization or institutionalization. We request comment on these proposed elements and whether we should propose any other provisions.

In paragraph (b)(2), we propose that states include a transition of care policy standard in their MCO, PIHP, and PAHP contracts. We propose to provide flexibility for states to decide whether to apply the state developed policy consistently to their MCOs, PIHPs, and PAHPs, or whether to permit the health plans to have different policies, as long as the state's minimum standards are met. We believe this approach achieves an appropriate balance between assuring ongoing care for individuals who have significant needs while permitting states flexibility to determine how best to implement these transitions. At a minimum, the transition policies should be included in the state's comprehensive quality strategy and included in information provided to potential enrollees.

(2) Ongoing Source of Primary Care (§438.208(a))

In the existing Medicaid managed care regulations, there is a singular focus on establishing

primary care relationships between providers and enrollees. However, this focus does not sufficiently address an enrollee's need for ongoing sources of all types of care, including ongoing relationships with behavioral health or LTSS providers. In consideration of our proposal to ensure continued access to care appropriate to an individual's needs, we also believe changes to the exceptions for MCOs, PIHPs, and PAHPs serving dually eligible individuals are necessary. We propose no changes to paragraph (a)(1). We propose to delete paragraph (a)(2)(i) as it is redundant to proposed language in paragraph (b)(1); however, doing this necessitates incorporating the existing provisions in paragraph (a)(2)(ii) into (a)(2). We propose minor technical corrections in §438.208(a)(3)(i) to replace the outdated reference to "Medicare+Choice plan" with "Medicare Advantage organization." Additionally, in §438.208(a)(3)(ii), we propose that the decision to grant an exception to a MCO serving dually eligible individuals would be based on the needs of the population served rather than on what services are covered under the contract.

(3) Care Coordination Activities (§438.208(b))

The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."¹² These concepts are embedded in the regulations governing the MA program as well as the Marketplaces. Both the MA program and the Marketplace regulations seek to ensure that the needs of enrollees are assessed, and that care is coordinated across settings and with services delivered inside and outside the health plans. Although we believe most MCOs, PIHPs,

¹² AHRQ website: <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>

and PAHPs are already doing these activities, we propose to update our regulations to align with the governing policies of the MA program and the Marketplaces. At the same time, we propose several modifications to §438.208(b) and (b)(1): (1) to revise the language in paragraph (b)(1) from services “furnished to” enrollees, to services “accessed by” enrollees, to more adequately describe the entire range of services covered by the regulations; (2) to remove references to “primary” to ensure each enrollee receives access to an ongoing source of care appropriate to their needs, regardless of whether the service provider is considered a primary care provider; and (3) to remove the words “health care” to explicitly recognize that MCOs, PIHPs, and PAHPs may coordinate not only health care services but a full range of community based support services to provide services in the most integrated setting to enrollees.

We propose to expand the standards in paragraph (b)(2) so that care coordination activities at MCOs, PIHPs, and PAHPs involve coordination between care settings in paragraph (b)(2)(i) and coordination with services provided outside of the MCO, PIHP or PAHP, including with another MCO, PIHP, or PAHP in paragraph (b)(2)(ii) and FFS Medicaid in paragraph (b)(2)(iii). We request comment on including an additional standard relating to community or social support services in paragraph. These could include linking enrollees to services through organizations such as Protection and Advocacy organizations, Legal Aid, Aging and Disability Resources Centers, Centers for Independent Living, Area Agencies on Aging, or United Way 311 lines. Given the historically high rate of utilization of these services by the Medicaid population, Medicaid managed care plans have experience in facilitating and coordination access to these services. This language would acknowledge existing industry practice. We request comment on this approach and on any potential costs associated with this addition.

We believe that health plans must ensure that appropriate information is available to,

shared with, and maintained by all providers and the MCO, PIHP, or PAHP that is coordinating the care. Therefore, we propose to add standards in new paragraphs (b)(3) and (b)(5) that each MCO, PIHP and PAHP make their best effort to complete an initial health risk assessment within 90 days of the effective date of enrollment for all new enrollees and that all providers, practitioners and suppliers maintain and share an enrollee health record according to MCO, PIHP, or PAHP standards under our authority at section 1902(a)(4) of the Act. We also propose to remove phrase “with special health care needs” from existing paragraph (b)(3) (redesignated at (b)(4)) and change the word “its” to “any” in that same paragraph to broaden the standard for sharing assessment results to avoid duplication of services. The standard of an initial health assessment is explicit in the MA regulations in §422.112(b)(4)(i), so we believe these changes establish consistent standards for MCOs participating in Medicare and Medicaid, thereby easing administrative burden. Finally, in the redesignated paragraph (b)(4) regarding the sharing of the results of an enrollee’s need assessment with another MCO, PIHP, or PAHP that serves the enrollee, we propose to add the state as a recipient of that information if the state (through FFS) provides coverage of some services to an enrollee, such as behavioral health or pharmacy coverage. In addition, we propose that existing paragraph (b)(4) be moved without change to paragraph (b)(6).

(4) Long-Term Services and Supports (§438.208(c))

The current Medicaid managed care regulations were written at a time when a managed care delivery system was not frequently utilized for LTSS. With states using managed care to deliver covered services to populations with more complex needs, care coordination that is appropriate for individuals using LTSS becomes an important component of managed care. We propose to codify the elements contained in our May 2013 guidance for managed long-term

services and supports¹³ programs operated under section 1915(b) waivers and section 1115(a) demonstration projects. See section I.B.6.e. of this proposed rule for more information on the 2013 guidance.

We propose changes in paragraph (c)(1) of §438.208 to add enrollees who need LTSS to the populations for which the state must have mechanisms to identify these enrollees to the MCO, PIHP, or PAHP. We propose a change to paragraph (c)(1)(i) to reflect that the mechanisms required in paragraph (c)(1) must be included in the state's comprehensive quality strategy as defined in proposed §438.340. We also propose that states may use their staff, their enrollment brokers, and the MCOs, PIHPs, and PAHPs as part of these identification mechanisms. There are no changes proposed to paragraph (c)(1)(ii). Other changes we are proposing to paragraph (c) include:

- Amending paragraph (c)(2) so that assessments for both individuals in need of LTSS as well as those with special health care needs are comprehensive and are conducted by appropriate LTSS service coordinators having qualifications specified by the state or the MCO, PIHP, or PAHP, or by health care professionals. We believe this to be a critical standard to avoid insufficient service or treatment plans or a disruption in services to enrollees.
- Amending paragraph (c)(3) to propose clarifications that treatment plans would also be considered service plans and that they are developed for individuals needing LTSS in addition to individuals with special health care needs.
- Amending paragraph (c)(3)(i) to propose that treatment or service plans are developed by the enrollee's provider or an individual meeting the health plan or state's service coordination provider standards in consultation with other health care professionals caring for the enrollee. This

¹³ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf>

change is intended to permit a MCO, PIHP, or PAHP to use internal staff for service coordination, even though those staff would not be considered providers and, thus, not permitted to perform assessments under current regulation.

- Adding new standards under paragraphs (c)(3)(ii) to propose that treatment or service plans developed for those in need of LTSS conform with the person centered planning standards found in §441.301(c)(1) and (2). This proposal is consistent with the HCBS final rule released in 2014.

- Redesignating current paragraphs (c)(3)(ii) and (iii) without change as paragraphs (c)(3)(iii) and (iv). Proposing a new standard under paragraph (c)(3)(v) that service and treatment plans be reviewed and revised upon reassessment of the enrollee's functional needs, at least every 12 months, when the enrollee's circumstances or needs change significantly, or at the request of the enrollee.

No changes are proposed for paragraph (c)(4).

f. Advancing Health Information Exchange

Health information technology and the electronic exchange of health information is an important tool for achieving the care coordination objectives proposed in section §438.62, §438.208, and other parts of this proposed rule. The Department supports the principle that all individuals, their families, their healthcare and social service providers, and payers should have consistent and timely access to health information in a standardized format that can be securely exchanged among the patient, providers, and others involved in the individual's care (HHS August 2013 Statement, "Principles and Strategies for Accelerating Health Information Exchange.") Further, the Department is committed to accelerating health information exchange through the use of health information technology (health IT) across the broader care continuum and across payers.

Health IT that facilitates the secure, efficient and effective sharing and use of health-related information when and where it is needed is an important contributor to improving health outcomes, improving health care quality and lowering health care costs. Health IT can help health care providers recommend treatments that are better tailored to an individual's preferences, genetics and concurrent treatments. In addition, it can help individuals make better treatment decisions and health-impacting decisions outside of the care delivery system.

In January 2015, the Office of the National Coordinator for Health Information Technology (ONC) published "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap" (available at <http://www.healthit.gov/sites/default/files/nationwide-interoperability-roadmap-draft-version-1.0.pdf>) for public comment. This draft document focuses on how interoperable health IT can enable better health and wellness for all Americans, regardless of where they live, learn, work and play.

In addition, ONC has released a draft of the "2015 Interoperability Standards Advisory" (available at <http://www.healthit.gov/standards-advisory>) for public comment; the public comment period is open until May 1, 2015. This draft document contains an initial list of the best available standards and implementation specifications to enable priority health information exchange functions. Providers, payers, and vendors are encouraged to take these "best available standards" into account as they implement interoperable health information exchange across the continuum of care, including care settings such as behavioral health, long-term and post-acute care, and community service providers (e.g., home and community-based service providers).

We encourage states, MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and other stakeholders to utilize health information exchange and certified health IT to effectively and efficiently help providers improve internal care delivery practices, support management of care

across the continuum, enable the reporting of electronically specified clinical quality measures (eCQMs), and improve efficiencies and reduce unnecessary costs. We welcome comment on how we might reinforce standards through future rulemaking or guidance to states and plans as standards become more mature and adoption of certified health IT increases. For example, as standards become available to electronically integrate long-term services and supports, we could reference them in guidance documents that could then inform contractual requirements for vendors.

g. Managed Long-Term Services and Supports (§438.2, §438.3, §438.70, §438.71, §438.214, §438.816)

MLTSS refers to an arrangement between state Medicaid programs and MCOs, PIHPs or PAHPs through which the MCO, PIHP, or PAHP receives a capitated payment for providing long-term services and supports (LTSS). MLTSS programs have grown significantly over the past decade and are expected to increase even more in the coming years. Recognizing this significant shift in delivery system design, we developed ten key principles inherent in a strong MLTSS program. These principles were released on May 21, 2013, in guidance¹⁴ for states using a section 1915(b) waiver or section 1115(a) demonstration to implement a MLTSS program. We propose to revise the Medicaid managed care regulations to ensure that all MLTSS programs, regardless of underlying authority, operate in accordance with these elements. The elements are incorporated in proposed changes throughout this part and include LTSS specific changes in sections discussed below. Some of the changes we propose – while prompted by MLTSS considerations – apply broadly to all beneficiaries, and so have been applied to all managed care programs.

(1) Defining Long-Term Services and Supports

¹⁴ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf>

We propose to add a definition of LTSS to §438.2 for purposes of applying the rules in part 438 of this chapter; however, the definition would not be applicable to any other part of title 42 of the CFR. Our proposal defines LTSS as “services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual’s home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.” We intend for community based services within the scope of this definition to be largely non-medical in nature and focused on functionally supporting people living in the community. Examples of what we would consider community based LTSS include Home- and Community-Based Services (HCBS) delivered through a section 1915(c) waiver, section 1915(i), or section 1915(k) state plan amendments, as well as personal care services otherwise authorized under the state plan. We note that individuals with chronic illness that may receive LTSS include individuals with mental health conditions and substance use disorders.

We considered defining LTSS in a way that references specific services in title 42 of the CFR such as HCBS and Nursing Facility services (defined in part 440), but determined that would be too limiting and not allow for future innovation in what services are considered LTSS. We request comment on the proposed definition and whether it is appropriate in scope.

2. Codifying MLTSS Guidance

The principles in CMS’ May 2013 guidance were developed after extensive review of numerous published findings, interviews with states as to lessons learned in the start-up and implementation of MLTSS programs, and recommendations from our HHS partners and other external stakeholders. The 10 elements identified in our 2013 guidance and proposed for regulation are:

1. Adequate Planning
2. Stakeholder Engagement
3. Enhanced Provision of Home and Community Based Services
4. Alignment of Payment Structures and Goals
5. Support for Beneficiaries
6. Person-centered Processes
7. Comprehensive, Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

In the following discussion, we describe how we have incorporated these elements into this proposed rule. As noted previously, the elements are incorporated in proposed changes throughout this part, and we reference those sections of this proposed rule where the associated proposals are further discussed. In this section, we summarize the LTSS specific proposals in the context of the ten elements of our guidance and explain how, together, they strengthen MLTSS programs. We request comment on the incorporation of these proposals.

Element 1: Adequate Planning: We believe the most effective MLTSS systems are the result of a thoughtful and deliberative planning process with a clear vision for the program. Thoughtful planning in the development of MLTSS programs helps to ensure a smooth transition for persons with LTSS needs as they transition from FFS to managed care delivery systems. We propose to incorporate this element in the existing regulatory structure as follows:

- Amending §438.66 to propose that there is appropriate state monitoring and accountability of the program that includes readiness reviews. While this standard would apply

broadly to all managed care programs and is discussed in section I.B.6.c. of this proposed rule, LTSS, as a covered service under the contract, would be included in this review to the same extent as all other covered services.

- Amending §438.10 to propose additional standards for enrollee and potential enrollee materials, including information on transition of care, who to contact for support and other standards for provider directories. The specific proposed changes to §438.10 are discussed in the Member materials preamble of this proposed rule in section I.B.6.d. While LTSS is not specifically referenced, states (under §438.10(e)) and managed care plans (under §438.10(g) and (h)) to provide information on all covered benefits and provider directory information.

Element 2: Stakeholder Engagement: Successful MLTSS programs have developed a structure for engaging stakeholders regularly in the ongoing monitoring and oversight of the MLTSS program. Educated stakeholders, including beneficiaries, providers, and advocacy groups inform decisions as to what works and what does not in the managed care system, allowing the state to design systems that are responsive to the needs of stakeholders and to address any implementation issues discovered early in the process. While Medicaid already has a standard for a Medical Care Advisory Committee (MCAC) outlined in §431.12 and while in some states this forum has proved to be a useful venue for actionable feedback regarding a state's managed care program, the MCAC in other states may not provide the opportunity to receive meaningful input from MLTSS stakeholders. Our proposed provisions for gathering stakeholder input are discussed in more detail in section I.B.6.h. of this proposed rule.

Element 3: Provision of Home and Community Based Services: All MLTSS programs must be implemented consistent with the Americans with Disabilities Act (ADA) and the Supreme Court's Olmstead v. L.C., 527 U.S. 581 (1999) decision. Further, all contracts with MCOs, PIHPs,

and PAHPs must comply with all applicable federal and state laws including the ADA under our current regulations. Proposed §438.3(o) is discussed in section I.B.2.a. of this proposed rule.

Element 4: Alignment of Payment Structures and Goals: Payment to MCOs, PIHPs, and PAHPs should support the goals of MLTSS programs to improve the health of populations, support the beneficiary's experience of care, support community integration of enrollees, and reduce costs. We incorporated this element to propose that states include MLTSS program elements in the annual program summary report proposed under §438.66. These program elements are discussed in section I.B.6.c. of this proposed rule.

Element 5: Support for Beneficiaries: Support and education, including enrollment and disenrollment assistance and advocacy support services, are critical for all beneficiaries in a MLTSS program. As discussed in more detail in section I.B.5.c of this proposed rule, we are incorporating this element by proposing §438.71, which would have states provide a beneficiary support system, including choice counseling services. While applicable to all managed care programs, the proposed changes to §438.71 would provide assistance to those with complex needs, such as those receiving LTSS, who would benefit most from these activities. We also note that under proposed §438.71(d) the state would provide training to MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and network providers on the specific community-based resources and supports that can be linked with covered benefits. Finally, in §438.71, as described previously, states would incorporate four beneficiary support functions for all individuals using, or expressing a desire to use, LTSS within a managed care program:

- Provide an access point for complaints and concerns pertaining to the MCO, PIHP, PAHP, PCCM, or PCCM entity on the enrollment process, access to services, and other related matters (§438.71(e)(1));

- Educate beneficiaries on the grievance and appeal process, the SFH process, enrollee rights and responsibilities, as well as resources outside of the MCO, PIHP or PAHP

(§438.71(e)(2));

- Assist in navigating the grievance and appeal process for MCOs, PIHPs and PAHPs or SFH excluding providing representation (§438.71(e)(3)); and

- Review and oversight of LTSS program data to assist the state Medicaid Agency on identification, remediation, and resolution of systemic issues (§438.71(e)(4)) .

We also incorporate this element by proposing a new for cause reason for disenrollment for enrollees receiving LTSS in §438.56(d)(2)(iv), which is discussed in section I.B.5.b. of this proposed rule. This proposal recognizes that provider network changes can have a significant impact on those enrolled in MLTSS programs, since some providers are integral to residential and employment services and supports. Therefore, if the state does not permit participants enrolled in MLTSS to switch managed care plans (or disenroll to FFS), at any time, states should permit MLTSS enrollees to disenroll and switch to another MCO, PIHP, PAHP, or FFS when the termination of a provider from their MLTSS network would result in a disruption in the enrollee's use of that provider. Under this proposal, an enrollee would be permitted to change their MCO, PIHP, or PAHP if their residential, institutional, or employment supports provider terminates their participation with the enrollee's current MCO, PIHP, or PAHP.

Finally, we are incorporating this element in our proposed new section §438.816 Expenditures for Independent Consumer Support Services for Enrollees using LTSS that would describe the conditions that must be met for the state to claim FFP for the LTSS-specific beneficiary support system activities proposed in §438.71(e). We have modeled this standard, in part, on current rules for administrative services claiming and, in part, on the current rules for

enrollment broker services. We propose, consistent with our current policy, that beneficiary support services for MLTSS enrollees are eligible for administrative match subject to certain standards. Specifically, in paragraph (a), we propose that costs must be supported by an allocation methodology that appears in the state's Public Assistance Cost Allocation Plan; in paragraph (b) that the costs do not duplicate payment for activities that are already being offered or should be provided by other entities or paid by other programs; in paragraph (c) that the person or entity providing the service must meet independence and conflict of interest provisions applicable to enrollment brokers in §438.810(b) standard; and in paragraph (d) that the initial contract or agreement for services in this section be reviewed and approved by CMS. More specific guidance around claiming for Ombudsman services can be found in the CMCS Informational Bulletin released on June 18, 2013, available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-18-2013.pdf>.

Element 6: Person Centered Process: Ensuring that beneficiaries' medical and non-medical needs are met and that they have the quality of life and level of independence they desire within a MLTSS program starts with person-centered processes including comprehensive needs assessments and service planning policies. We are incorporating this element through proposed changes to §438.208(c) requiring identification, assessment, and treatment/service planning for individuals receiving LTSS who are enrolled in a MCO, PIHP or PAHP. This proposal is discussed in section I.B.4.e. of this proposed rule and would have an overall effect of shifting from a strictly medical, acute care focus to one that addresses all covered services.

Element 7: Comprehensive, Integrated Service Package: In instances in which a state managed care program divides services between contracts or delivery systems, it is important that there is robust coordination and referral by the managed care plan to ensure that the beneficiary's

service plan, which may include LTSS, is comprehensive and person-centered. We incorporate this element by proposing to expand §438.208(b)(2), so that MCOs, PIHPs, and PAHPs coordinate an enrollee's care between settings of care, with services received from another MCO, PIHP, or PAHP, and with services received from FFS. This proposal is discussed more fully in section I.B.5.e. of this proposed rule.

Element 8: Qualified Providers: As with traditional managed care programs, MCOs, PIHPs, and PAHPs in a MLTSS program must have an adequate network of qualified providers to meet the needs of their enrollees. While current credentialing and network adequacy systems have been developed based on an acute and primary care service delivery model, managed care networks also meet the needs of MLTSS beneficiaries, including adequate capacity and expertise to provide access to services that support community integration, such as employment supports, and the provision of training and technical assistance to providers. We propose the following changes to incorporate this element:

- Amending §438.68(b)(2) to propose that states establish time and distance standards specifically for MLTSS programs. This proposal addresses time and distance standards for LTSS provider types in which the enrollee must travel to the provider and the use of standards other than time and distance for LTSS provider types that travel to the enrollee to deliver the service. We believe it is important to recognize that standards must reflect the high utilization of services outside of the traditional medical office setting by enrollees using LTSS. Other changes to §438.68 are discussed in section I.B.6.a. of this proposed rule.

- Amending §438.206(c)(3) to propose that MCOs, PIHP, and PAHPs ensure that network providers have capabilities to ensure physical access, accommodations, and accessible equipment for enrollees with physical and mental disabilities. Given the high number of enrollees

with a disability receiving some LTSS, we believe this to be an important factor when evaluating qualified providers in a MLTSS program. Other changes to §438.206 are discussed in section I.B.6.a. of this proposed rule.

- Amending §438.207(b)(1) to propose that MCOs, PIHPs, or PAHPs submit documentation to the state to demonstrate that it complies with offering the full range of preventive, primary care, specialty care, and LTSS services adequate for the anticipated number of enrollees. Under this proposal, the state would review the submitted documentation and certify its adequacy in paragraph (d) of this section. These changes are discussed in section I.B.6.a. of this proposed rule.

- Amending §438.214(b)(1) to propose that each state establish a credentialing and re-credentialing policy that addresses all the providers, including LTSS providers, covered in their managed care program regardless of the type of service provided by such providers. We propose this to emphasize the importance of a credentialing and re-credentialing policy for all provider types for the services covered under the contracts. We also propose that each MCO, PIHP, and PAHP must follow the state policy but do not propose to prohibit additional policies at the state or managed care plan level.

Elements 9 and 10: Participant Protections and Quality: Participant health and welfare is an important tenet in a program providing LTSS. We are incorporating these two elements by proposing to add a contract standard in §438.330(b)(6) that MCOs, PIHPs, and PAHPs participate in state efforts to prevent, detect, and remediate all critical incidents. We intend this standard to be interpreted to apply to incidents that adversely impact enrollee health and welfare and the achievement of quality outcomes described in the person centered plan. Under this proposal, states would specify the MCO, PIHP, or PAHP's roles and responsibilities related to these activities in

the MCOs, PIHPs, and PAHP's contract.

We believe that a quality system for MLTSS is fundamentally the same as a quality system for a state's entire managed care program, but should include MLTSS-specific quality elements. Other revisions previously discussed in this section address the delivery of MLTSS services in a high-quality manner, and we specifically propose to amend §438.330(b)(5) to include references to specific MLTSS quality considerations. Under proposed paragraph (b)(5), the MCO, PIHP, or PAHP would have mechanisms to assess the quality and appropriateness of care provided to LTSS enrollees including between settings of care and as compared to the enrollee's service plan. In addition, under §438.330(e)(1)(iii), we propose that the state includes the results of any rebalancing efforts by the MCO, PIHP, or PAHP for individuals using LTSS in its annual program review. These provisions are discussed in more detail in section I.B.6.b. of this proposed rule.

These ten elements are the basis for many of our proposals related to LTSS provided through a managed care delivery system. We solicit comment on the extent to which our proposals – those discussed specifically above and the other LTSS-specific provisions in this proposed rule – incorporate the elements.

h. Stakeholder Engagement in LTSS

Since stakeholder engagement plays a critical role in the success of a MLTSS program, we propose that states and managed care plans must have appropriate minimum mechanisms in place to accomplish this. Therefore, we propose to add a new §438.70 regarding the state's creation and maintenance of a stakeholder group so that opinions of beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of the MLTSS program. We propose significant flexibility for states in meeting this standard, specifically that states set the composition of the stakeholder group and the frequency of meetings

to ensure meaningful stakeholder engagement. Our proposal specifically uses a “sufficiency” standard rather than setting quantitative parameters for the composition of the group or the frequency of meetings. We request comments on the overall approach for these changes, as well as on the composition of the stakeholder group, stakeholder group responsibilities, and approach to meeting frequency for both states and managed care plans.

In concert with the new §438.70, we also propose a new §438.110. While the stakeholder group proposed in §438.70 is maintained by the state, each MCO, PIHP, and PAHP should establish a regular process to solicit direct input on the enrollees’ experiences. Therefore, in paragraph (a), we propose that for any MCO, PIHP, or PAHP contract that includes LTSS, the MCO, PIHP, or PAHP must establish and maintain a member advisory committee. Paragraph (b) proposes that the committee include a reasonably representative sample of the covered LTSS populations. We included PAHPs in this standard, because we understand there are some PAHPs in operation that cover LTSS.

6. Modernize Regulatory Standards

a. Availability of Services, Assurances of Adequate Capacity and Services, and Network Adequacy Standards (§438.206, §438.207, §438.68, §440.262)

Assessment of the network adequacy of contracted MCOs, PIHPs, and PAHPs is a primary component of our determination of a state’s readiness to implement and sustain managed care programs. Under section 1932(b)(5) and (c)(1)(A)(i) of the Act, respectively, an MCO must provide assurances about its capacity and ability to provide services and a state must develop a quality assessment and improvement strategy for its managed care program that includes access standards for enrollees. Relying on this authority and on section 1902(a)(4) of the Act, we established in the 2002 Medicaid managed care final rule standards for the availability of services

and assurances of adequate capacity from MCOs, PIHPs, and PAHPs. Since that time, our ongoing work with states has revealed variation in how states define adequate health plan networks and the frequency with which states evaluate MCO, PIHP, and PAHP network adequacy. The OIG conducted a study of network adequacy standards used by states and confirmed our findings regarding a high level of variation in evaluation method and frequency:

<http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>. We propose a new regulation section and revisions to existing regulations to establish minimum standards in this area. The proposed changes aim to maintain state flexibility while modernizing the current regulatory framework to reflect the maturity and prevalence of Medicaid managed care delivery systems, promote processes for ensuring access to care, and align, where feasible, with other private and public health care coverage programs. To that end, we propose to set standards to ensure ongoing state assessment and certification of MCO, PIHP, and PAHP networks, set threshold standards for the establishment of network adequacy measures for a specified set of providers, establish criteria for developing network adequacy standards for MLTSS programs, and ensure the transparency of network adequacy standards. These proposed changes would create a new §438.68 specific to the development of network adequacy standards for medical services and LTSS and modify §438.206 and §438.207.

(1) Requirements for the Network Adequacy Standards set by the State for a Specified Set of Providers (§438.68)

As discussed above, our current regulatory framework provides states with significant flexibility to determine whether an MCO, PIHP, or PAHP adequately makes services accessible and available to enrollees under the managed care contract. In addition, our regulations were developed at a time when managed care for the delivery of LTSS was extremely limited and

involved only a handful of programs limited in geographic scope. We propose to establish standards for states to follow in the development of Medicaid managed care network adequacy standards that address medical services, behavioral health services, and LTSS. In accordance with our underlying goal to align Medicaid managed care standards with other public programs where appropriate, we analyzed the network adequacy standards applicable under the Marketplace and the MA program to inform our proposed rule. As background, we provide a short summary of the standards utilized by these programs below.

A health plan offered by an issuer must be certified as a Qualified Health Plan (QHP) to offer coverage in the Marketplace. To meet QHP certification standards, health plans must maintain a network that: (1) includes essential community providers; (2) is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services would be accessible without unreasonable delay; and (3) is consistent with the network adequacy provisions of section 2702(c) of the PHS Act. See 45 CFR 156.230(a). The Marketplace standard of requiring a health plan to ensure a sufficient number and types of providers is included in a network to ensure accessibility of services is similar to Medicaid managed care standards. To ensure this standard is met, the Federally Facilitated Marketplace (FFM) receives attestations from organizations applying for certification of their health plans as QHPs. During 2014, the FFM utilized a combination of issuer accreditation status, the identification of states with review processes at least as stringent as the QHP certification standard, and network access plans as part of its evaluation of health plans' network adequacy. In the Final 2015 Letter to Issuers, the FFM discussed its policies about network adequacy and accessibility of services in connection with QHP certification.

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer->

[letter-3-14-2014.pdf](#), pp.17-18). For 2015 and 2016 certification, the FFM has moved to assessing provider networks using a “reasonable access” standard to identify networks that fail to provide access without unreasonable delay, focusing on those areas which have historically raised network adequacy concerns, including hospital systems, mental health providers, oncology providers, and primary care providers.

CMS has a detailed approach for setting standards in the MA program that includes the minimum number of providers, maximum travel time, and maximum travel distance per county for all provider types covered under the MA organization contract. To determine the minimum number of providers per county, we calculate the 95th percentile of beneficiaries to cover based on annual MA enrollment and the designation of a county as large metro, metro, micro, rural or Counties with Extreme Access Criteria (CEAC). To establish minimum provider ratios for all provider types in MA organizations, CMS relies on primary and secondary research on utilization patterns and clinical needs of the covered population to calculate the number of providers per 1,000 beneficiaries per county. We also set time and distance criteria by interfacing mapped beneficiary residence locations against provider practice locations. Health plans applying for MA participation must ensure that at least 90 percent of the beneficiaries residing in a county have access to at least one provider or facility of each type within the published time and distance criteria and must complete a comprehensive worksheet demonstrating compliance with these standards per desired counties. If an applicant’s network does not meet the criteria, we would issue a deficiency notice, which would trigger the applicant’s ability to request an exception to the minimum number of providers and/or maximum time/distance criteria for a particular provider type. A template outlines specific supporting documentation that the applicant must show that local community patterns of care support the proposed provider network for which the applicant is

requesting an exception. For a further guidance on the network adequacy criteria for MA organizations, see <http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2014-HSD-Provider-and-Facility-Specialties-Criteria-Guidancev2.pdf>.

In the existing rules for Medicaid managed care and the rules finalized for Marketplaces and QHPs, the network adequacy standards are similar in that we did not establish detailed and specific time and distance standards or provider to enrollee ratios but deferred to each Marketplace or state to develop specific standards; our regulatory framework in both cases relies heavily on attestations and certifications from the applicable health plan, with supporting documentation, about the adequacy of the network. Consistent with the primary role of states in this, we intend to keep that general approach for the Medicaid program, rather than taking the more detailed approach used in the MA program. This approach is also consistent with our role in the Medicaid managed care context compared to MA; while we have an oversight and administrative role in both cases, the state has the primary responsibility for administering and monitoring the Medicaid managed care program. We propose to add a new §438.68 that would stipulate that the state must establish, at a minimum, network adequacy standards for specified provider types.

Proposed paragraph (a) specifies that a state that contracts with an MCO, PIHP, or PAHP must develop network adequacy standards that satisfy the minimum parameters in §438.68. This proposed provision is the counterpart to our proposal at §438.206 that the state ensures that enrollees of MCOs, PIHPs, and PAHPs have access to all services covered under the state plan in a manner that is consistent with the state-set standards for access and availability. These proposed regulations would apply to contracts that cover medical services, behavioral health services, and LTSS; the standards for LTSS proposed in (b)(2) and (c)(2) are described in the MLTSS-specific

discussion at the end of this section.

Proposed paragraph (b)(1) would stipulate that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric); OB/GYN; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types when it promotes the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. We intend this proposal to be applicable only to the services covered under the MCO, PIHP, or PAHP contract. We propose that states, at a minimum, establish time and distance standards as such standards are currently common in the commercial market and many state Medicaid managed care programs; further, we believe time and distance standards present a more accurate measure of the enrollee's ability to have timely access to covered services than provider-to-enrollee ratios. We request comment on whether we should propose a different national type of measure for states to further define, such as provider-to-enrollee ratios, or whether we should permit states the flexibility to select and define the type of measure for the network's adequacy of the specified provider types. Additionally, we request comment on whether we should define the actual measures to be used by states such that we would set the time and distance or provider-to-enrollee ratio standard per provider type, per county, or other appropriate geographic basis.

Given the large number of pediatric Medicaid enrollees, we believe it is important for states and plans to specifically include pediatric primary, specialty, and dental providers in their network adequacy standards. Network adequacy is often assessed without regard to practice age limitations which can mask critical shortages and increase the need for out-of-network authorizations and coordination. We request comment on whether standards for behavioral health providers should distinguish between adult and pediatric providers. We considered adding family planning

providers to the list of providers that would be subject to time and distance standards but declined to do so because section 1902(a)(23) of the Act guarantees freedom of choice of family planning providers and providers of family planning services would include physicians and OB/GYNs. We request comment on this approach.

Appreciating that provider networks can vary between geographic areas of a state and states have different geographic areas covered under managed care contracts, as proposed in paragraph (b)(3), states would have to establish time and distance standards for specified provider types that reflect the geographic scope of the program. Our proposal would permit states to vary those standards in different geographic areas to account for the number of providers practicing in a particular area. Our proposal would not limit states to only the mandatory time and distance standards but also would have states consider additional elements when developing network adequacy standards.

Proposed paragraph (c)(1) specifies the minimum factors a state must consider in developing network adequacy standards; most of the elements proposed here are currently part of §438.206(b)(1) as considerations for MCOs, PIHPs, and PAHPs in developing their managed care networks. These are: anticipated Medicaid enrollment; expected utilization of services; taking into account the characteristics and health needs of the covered population; number and types of health care professionals needed to provide covered services; number of network providers that are not accepting new Medicaid patients; and the geographic location and accessibility of the providers and enrollees.

Disparities in access to care related to demographic factors such as race, ethnicity, language, or disability status are, in part, a function of the availability of the accessible providers who are willing to provide care and are competent in meeting the needs of populations in

medically underserved communities. Additionally, new enrollees in Medicaid managed care, including those who are dually eligible for Medicare and Medicaid, may present with multiple chronic conditions and need the services of multiple specialists. Absent an adjustment for new populations enrolled in a state's Medicaid managed care program, existing plan networks may be inadequate to meet new enrollees' needs.

Accordingly, we propose changes to the factors that we are proposing to move from current §438.206(b)(1). We propose to make existing §438.206(b)(1)(ii) into separate factors that the state must consider: expected utilization and the characteristics and health needs of the covered population; these would be codified as §438.68(c)(1)(ii) and (iii) and use substantially the same language as in the current regulation. Similarly, we propose two separate factors, to be codified at §438.68(c)(1)(vi) and (viii), in place of the current §438.206(b)(1)(v), which are geographic location and accessibility. Although we propose to use the same language regarding geographic considerations, we propose in §438.68(c)(1)(viii) that each state must also consider the ability of providers to ensure physical access, accommodations, and accessible equipment available for Medicaid enrollees with physical or mental disabilities, with proposed additional standards that the accommodations be reasonable and that the ability of providers to ensure culturally competent communication be considered as well. Also, we propose to add a new element, at proposed paragraph (c)(1)(vii), so that states must also consider the ability of network providers to communicate with limited English proficient enrollees in their preferred language when the state is developing time and distance access standards.

In effect, our proposal is that the states develop standards by which to review the provider networks used in Medicaid managed care, which should ensure that these elements are also taken into consideration by MCOs, PIHPs, and PAHPs that maintain and monitor the provider networks.

We intend that compliance with our proposal would be best met if states look to standards established by the insurance regulator (for example, Department of Insurance, or similar agency within the state) for commercial insurance, and the standards set under the MA program, as well as historical patterns of Medicaid utilization – including utilization specific to sub-populations that may be more relevant to the Medicaid program than in commercial or Medicare markets – to inform the standards the state establishes for Medicaid managed care programs under §438.68. The time and distance standards per county are published annually in the MA Health Services Delivery (HSD) Reference file, which is accessible at the MA Applications page at <http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/>. While we are not proposing to dictate the particular time and distance standards or set a quantitative minimum to be adopted by a state, we intend to assess the reasonableness of the particular standard adopted by a state under our proposed §438.68 within the context of other existing standards should the need for such evaluation arise.

We recognize that situations may arise where a MCO, PIHP, or PAHP may need an exception to the state established provider network standards. A number of states currently permit exceptions, and have a process for seeking exceptions, under the state standards imposed on a managed care entity under existing §§438.206 and 438.207. Therefore, proposed §438.68(d) provides that, to the extent a state permits an exception to any of the provider network standards, the standard by which an exception would be evaluated must be specified in the contract and must be based, at a minimum, on the number of health care professionals in that specialty practicing in the service area. Under our proposal, the state must monitor enrollee access to providers in managed care networks that operate under an exception and report its findings to us as part of its

annual managed care program monitoring report provided under proposed §438.66 . We invite comment on our proposal related to exceptions a state may grant to its network adequacy standards established by the state for Medicaid MCOs, PIHPs, or PAHPs.

Finally, in proposed paragraph (e), to promote transparency and public input for these managed care network adequacy standards, states would have to publish the network adequacy standards developed in accordance with §438.68 on the Medicaid managed care website under §438.10. In addition, states would have to make these standards available at no cost, upon request, to individuals with disabilities through alternate formats and using auxiliary aids and services.

(2) Criteria for Developing Network Adequacy Standards for MLTSS Programs (§438.68(b)(2) and (c)(2))

Unlike medical and behavioral health services, there are no commonly used access standards for LTSS in the commercial market or in Medicare, as LTSS are primarily covered through Medicaid. As states have begun to deliver LTSS through managed care, they have created standards for their individual programs, which vary widely. Likewise, the level of oversight by the state that is necessary to enforce network adequacy standards for LTSS provided through managed care contracts varies, ranging from a minimal level of effort to an in-depth review of service plan authorizations compared to actual claims experience. We expect that, as MLTSS programs mature, states and managed care plans would develop innovative ways to ensure access to a high quality network of LTSS providers. As those initiatives evolve, we propose here minimum standards for how states adopt network adequacy standards to ensure the availability of critical services and supports for beneficiaries as more of them transition to MLTSS programs.

LTSS is commonly thought of as being provided in a beneficiary's home, like personal care services, but LTSS can also be delivered in a provider's office, in various community locations,

such as places of employment or recreation, and in an institution. Therefore, considerations for setting network adequacy standards should include time and distance, and other standards for ensuring access to adequate services. In §438.68(b)(2), we propose that states set standards that encompass time and distance and other measures of access when delivering LTSS through their managed care plans; the type of standard that the state would have to adopt under our proposal depends on whether the enrollee or the provider must travel to provide the services. While we do not specify a specific set of providers in our LTSS-specific proposal, we expect the state to consider all LTSS delivered through managed care when developing the standards which may include, but are not limited to, institutional, community-based, residential, and employment supports providers, depending on the program. Proposed paragraph (c)(2) sets forth the elements that states would have to consider when developing standards for LTSS in a managed care program. Under our proposal, when developing time and distance standards, states would consider the same elements as when setting medical services network standards and also consider strategies to ensure the health and welfare of enrollees using LTSS and to support community integration of individuals receiving LTSS. LTSS enrollees may have different needs than those enrollees only using acute, primary, and behavioral health services. For example, assessing network adequacy for individuals receiving LTSS in their place of residence may be based on enrollee-to-provider ratios. Additionally, the ability of the enrollee to choose a provider is a key protection that must be considered when developing network standards for MLTSS so we propose to include that here. Supporting health and welfare and choice of provider are important tenets already in place in the LTSS FFS system and MLTSS should maintain those protections. Finally, our proposal includes a substantive standard which we would apply to determine if states must include other considerations under §438.68(c)(2)(iv).

(3) Availability of Services (§438.206 and §440.262)

Currently, in §438.206, states have to ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs. Throughout §438.206, we propose to use the terms “network provider” and “health care professional” as applicable to be consistent with the proposed new definitions of these terms (see section I.B.8. of this proposed rule) and to provide greater clarity to our regulations. We consider such proposed changes largely technical in nature.

We propose to revise paragraph (a), which currently sets forth the basic rule for the availability of services, to add a new sentence such that states must ensure that MCO, PIHP, and PAHP provider networks for services covered under the MCO, PIHP, or PAHP contract meet the state’s network adequacy standards established under proposed §438.68. In this paragraph, we also propose to clarify that services are to be made available and accessible in a timely manner. The timeliness standard is currently in paragraph (b)(4), pertaining to access to out-of-network providers, and in paragraph (c)(1); therefore we believe it is appropriate to incorporate timeliness into the general rule for availability of services in paragraph (a).

In paragraph (b), we propose substantive changes only to (b)(1) and (b)(5). We propose to move the second sentence of (b)(1) and the provisions at existing paragraphs (b)(1)(i) through (b)(1)(v) to the new §438.68(c) so that all regulatory standards related to the measurement of adequate MCO, PIHP, and PAHP provider networks are contained in one section. We propose to add text to (b)(1) to clarify that the sufficiency and adequacy of the provider network and access to services is for all enrollees, including those with limited English proficiency and physical or mental disabilities. We propose to amend paragraph (b)(5) to include PAHPs in the payment standard for covered services that are provided out-of-network. We consider this a technical

correction as the preamble for the 2002 final rule refers to PAHPs (67 FR 41038) and we believe PAHPs were inadvertently excluded from the final regulatory text.

Currently, in paragraph (c)(1), MCOs, PIHPs, or PAHPs have to follow state-defined timely access standards for services covered under the contract, and such standards must be enumerated in the MCO, PIHP, or PAHP contract. We do not propose any substantive changes to existing paragraph (c)(1) but are proposing changes to improve the readability and clarity of the regulation text. We also clarify our intent to interpret and apply the provisions here as requiring states to set standards for timely access to all state plan services covered under the managed care contract. For purposes of setting timely access standards, state plan services may be reasonably classified as routine, urgent, or emergency care. We believe that for access standards to be effective, states will need to have mechanisms in place for ensuring that those standards are being met by the managed care plan networks. We considered requiring a mix of approaches, such as conducting enrollee surveys, reviewing encounter data, calculating and reporting of HEDIS measures related to access, implementing secret shopper efforts, and a systematic evaluation of consumer service calls. We request comment on approaches to measuring enrollee's timely access to covered services and to evaluating whether managed care plan networks are compliant with such standards. We also request comment on the value of requiring some or all of these mechanisms for ensuring that access standards are being met.

In paragraph (c)(2), we propose to add to the standards to ensure that MCOs, PIHPs, and PAHPs participate in states' efforts to promote access in a culturally competent manner to all enrollees. This includes those with limited English proficiency, diverse cultural and ethnic background, disabilities, and regardless of an enrollee's gender, sexual orientation, or gender identity. We are also proposing to add a corresponding standard in a new §440.262 so that the

state would similarly ensure nondiscrimination in access to services under FFS. We believe that the obligation for the state plan to promote access and delivery of services without discrimination is necessary to assure that care and services are provided in a manner consistent with the best interest of beneficiaries under section 1902(a)(19) of the Act. The best interest of beneficiaries is appropriately met when access is provided in a non-discriminatory manner; adopting these additional methods of administration is also necessary for the proper operation of the state plan under section 1902(a)(4) of the Act.

We propose to add a new paragraph (c)(3) to emphasize the importance of network providers having the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to Medicaid enrollees with physical or mental disabilities. This is mirrored in proposed §438.68(c)(1)(vii) relating to considerations for developing network adequacy standards.

(4) Assurances of Adequate Capacity and Services (§438.207)

Currently in §438.207(a), states have to ensure, through the contracts and submission of assurances and documentation from managed care entities, that the managed care health plans have the capacity to serve the expected enrollment in accordance with state-set standards for access to care; under current §438.207(b), the specified documentation must demonstrate the adequacy of the range of covered services and the provider network. We propose to keep the existing regulation text in paragraphs (a) and (b) substantially the same, with a minor amendment to specify in paragraph (b)(1) that supporting documentation must also address LTSS. This change is consistent with the broader proposal to incorporate LTSS throughout part 438, where applicable. Although we do not specifically reference LTSS anywhere else in our proposals for §438.206 or

§438.207, the standards outlined in those sections are applicable to all managed care programs, including MLTSS.

Under current §438.207, states, through their contracts, must stipulate that MCOs, PIHPs, and PAHPs to submit documentation that their network is sufficient in number, mix, and geographic distribution to meet, in accordance with state-set standards, the needs of anticipated enrollees. Under paragraph (c), such documentation must be submitted at least at the time MCOs, PIHPs and PAHPs enter into a contract with the state or at any time there has been a significant change in operations that would affect the adequacy of the network. The state has a corresponding responsibility, under paragraph (d), to review the documentation and certify to CMS that the applicable MCO, PIHP, or PAHP meets the state's standards for availability of services.

Appreciating that health plan networks are not static, we have considered the periodicity at which network adequacy documentation should be submitted by plans to be reviewed and certified by states. We propose to amend §438.207 so that health plans have to submit documentation and the state to certify the adequacy of the provider networks on at least an annual basis. We request comment on the appropriate timeframe for submission and review of network certification materials.

To implement this proposal, we propose to amend paragraph (c)(2) to add annual submission of the documentation and to redesignate the regulation text currently at §438.207(c)(2) as (c)(3), which, stipulates submission of documentation of adequate networks when there has been a significant change in the health plan's operations that would affect capacity and services; we consider such changes as warranting a reexamination of provider networks outside of an annual cycle. As in the existing regulation, changes such as enrollment of a new population or changes in benefits, service area, or payment would trigger a submission of documentation. We propose that

a significant change in the composition of a MCO, PIHP, or PAHP's network itself would also trigger a submission of documentation to be codified in §438.207(c)(3)(i). For example, a significant change in the composition of the provider network would occur when the only participating hospital terminates the provider contract, or similarly when a hospital that provides tertiary or trauma care exits a health plan network. We also propose minor edits to introductory text in paragraph (c)(3) to improve the readability of the paragraph.

In paragraph (d) of §438.207, addressing the obligation of the state to review documentation from the MCO, PIHP, or PAHP and submit an assurance to us that the managed care plan meets the state's standards for access to services, we propose to add an explicit standard that the submission include documentation of the analysis supporting the certification of the network for each contracted MCO, PIHP, or PAHP. We believe that this is appropriate because it would demonstrate to us how the state evaluates plan compliance with state standards and that the state's assurance is supported by the data. In addition, we are proposing to replace the word "certify" with "submit an assurance of compliance" to more clearly describe the responsibility of the state under paragraph (d). Finally, we are not proposing any revision to §438.207(e), which establishes our right to inspect the documentation provided under §438.207. We request comments on the overall approach to §438.207.

b. Quality of Care (subparts D and E of part 438)

Section 1932(c) of the Act established quality assurance standards for Medicaid managed care programs, specifically, a quality assessment and improvement strategy and an external independent review of contracting MCOs. Regulations at 42 CFR part 438, subparts D (Quality Assessment and Performance Improvement) and E (External Quality Review) implemented this statute; subpart D became effective on August 13, 2002 (67 FR 40989) and subpart E became

effective on March 25, 2003 (68 FR 3586). Based on our authority under section 1902(a)(4) of the Act, we expanded the scope of the regulations to capitated entities in addition to MCOs. The existing regulations describe quality standards for all states contracting with MCOs, PIHPs, and in some cases PAHPs, for the delivery of Medicaid services to beneficiaries. This proposed rule would modify these standards.

Approaches to assessing quality, access, and timeliness of care have evolved significantly over the past 10 years. At the federal level, CHIPRA, the American Recovery and Reinvestment Act (ARRA), the Affordable Care Act, the National Quality Strategy, and the CMS Quality Strategy all build on one another to decrease burdens, improve alignment, and encourage innovative approaches to quality measurement and improvement. In developing this proposed rule, we recognized how states have expanded the use of managed care for the delivery of primary care, acute care, behavioral health services, and LTSS to Medicaid beneficiaries. Throughout the rule, we propose changes to maximize the opportunity to improve health outcomes over the lifetime of individuals. Specifically, we propose to strengthen quality measurement and improvement efforts in managed care by focusing on the following three principles:

1. Transparency: Public reporting of information on quality of care is a widely recognized tool for driving improvements in care. A key component in designing health care quality transparency initiatives is the use of meaningful and reliable data that is comparable across health plans, providers, and programs. The regulatory changes proposed here are intended to improve transparency with the goal of increasing both state and health plan accountability in the quality of care provided to Medicaid beneficiaries. This would help stakeholders (including consumers) to engage in informed advocacy, compare the performance of providers and health plans, and make informed program and plan choices.

2. Alignment with other systems of care: Aligning, where appropriate, quality standards for Medicaid managed care with that of MA and the Marketplace would result in a simplified and integrated approach to quality measurement and improvement. The regulatory changes proposed here would incorporate the theme of alignment by improving oversight and strengthening programmatic operations to result in more comprehensive, coordinated care across states, and a reduction of administrative burden where possible.

3. Consumer and Stakeholder Engagement: Consumer and stakeholder engagement is particularly important when designing an approach to measuring quality for Medicaid managed care, including programs delivering LTSS. Providing consumers with information about their health plan is one tool for engaging them in health care decision-making; however, another useful tool is consumer participation in the development of state strategies for improving care and quality of life. The regulatory changes proposed here would strengthen the role of the consumer in health care decision-making through new tools to enhance active engagement.

(1) Proposed Revisions of subpart D

(a) Subpart D title and sub-headings

As discussed in the proposed revisions to subpart E below, sections related to the quality strategy found in subpart D would be moved to subpart E. We propose to make minor conforming changes to subpart D and to change the name from “Quality Assessment and Performance Improvement” to “MCO, PIHP, and PAHP Standards.” We believe this change would more accurately describe the remaining sections of subpart D, which address MCO, PIHP, and PAHP activities, some of which are measured as part of the state quality strategy. Additionally, we propose to remove the subheadings found in subpart D to be consistent with the remaining subparts in part 438. These subheadings would no longer be necessary because the section titles discuss

what types of standards are found in subpart D.

(b) Removal of §438.200, §438.202, §438.218, and §438.226

As mentioned in section I.B.6.b(1)(a), the proposed consolidation of all quality-related standards under subpart E would render §438.200, which describes the quality-centric scope of subpart D, unnecessary. We propose to remove §438.200 in its entirety.

We propose to remove §438.202, due to the standards we propose in the new part 431, subpart I.

We propose to remove §438.218, which incorporates enrollee information standards in §438.10 into the state's quality strategy. Proposed changes to both enrollee information standards at §438.10 and the elements of a state's comprehensive quality strategy at §438.340 would render §438.218 duplicative and unnecessary.

Similarly, we propose to remove §438.226, which incorporates the enrollment and disenrollment standards in §438.56 into the state's comprehensive quality strategy. Because we propose deleting these elements from inclusion in a state's comprehensive quality strategy (see §438.340), it would render §438.226 unnecessary.

(2) Proposed Revisions of subpart E

(a) Scope (§438.310)

This section currently explains the basis, scope, and applicability of subpart E, which provides details on the external quality review (EQR) process for MCOs and PIHPs. Generally, subpart E covers the selection of EQR reviewers, their qualifications, types of EQR-related activities, the availability of EQR results, and the circumstances in which a Medicare or private accreditation review may be used to satisfy elements of the EQR. Because we propose to move and revise the existing standards related to both the managed care quality strategy and the quality

assessment and performance improvement program from subpart D to subpart E, we propose in paragraph (a) to include section 1932(c)(1) of the Act as part of the statutory basis for the quality strategy provisions. In addition, we propose to include section 1902(a)(19) of the Act as part of the statutory basis, which maintains that each state “provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients.” We believe this authority would be applicable to both existing provisions of the regulation and some of our proposed changes.

Under the existing quality provisions, states contracting with MCOs and PIHPs must draft and implement a quality strategy and all MCOs and PIHPs must undergo an annual EQR. As states expand their use of managed care for other services or populations, it is increasingly important to develop a comprehensive approach to measuring and improving quality. Because some PAHPs might provide dental or behavioral health services, we propose that states address such plans in the state’s comprehensive quality strategy, with performance results publicly available in the EQR technical reports. Therefore, we propose to rely on the authority of section 1902(a)(4) of the Act to apply the quality standards of section 1932(c) of the Act to PAHPs and PIHPs. Throughout subpart E, as well as in §438.10, we propose the addition of “PAHPs” as necessary to reflect this proposal. Currently, some PAHPs function as brokers of non-emergency medical transportation (NEMT), so much of subparts D and E would not apply to these NEMT PAHPs. The provisions that apply to NEMT PAHPs are discussed in the proposed changes to §438.9.

We also propose to delete the specific reference to health insuring organizations (HIOs), throughout this subpart E because with the exception of those HIOs that are expressly exempt by

statutory law, HIOs under our proposal would be treated in the same manner as a MCO. We propose in §438.310(b) to identify the scope of subpart E, including specifications for a process ensuring review and approval of managed care plans, quality ratings, the quality strategy, and external quality reviews. In paragraph (c)(1), we propose that these specifications apply to MCO, PIHPs, and PAHPs (including certain HIOs as mentioned in this proposed rule). Finally, we propose in §438.310(c)(2) to address the elements related to quality assessment and improvement for states contracting with PCCM entities. Specifically, we propose that states assess the performance of PCCM entities consistent with §438.3(r); such assessment would include a review of at least the mechanisms to detect under- and over-utilization of services, performance measures, and program review (by reference to specific provisions proposed at §438.330).

(b) Definitions (§438.320)

This section currently defines terms related to the EQR process, including EQR, EQRO, financial relationship, quality, and validation. We do not propose to change the definitions for EQR, financial relationship, and validation, other than the addition of “PAHP” as necessary. Because the EQR process involves an analysis and evaluation of the quality, timeliness, and access to services that a health plan furnishes, we propose adding a definition for access and to update the definition of quality. We also propose to clarify the definition of “external quality review organization.”

The current regulations do not include a definition for access; however, there are availability of services standards in §438.206 and proposed network adequacy standards in §438.68. We propose a new definition for access, as it pertains to EQR, by referring to the timely provision of services in accordance with the network adequacy standards proposed in §438.68 and availability of services standards in §438.206.

The current regulations define “external quality review organization” (EQRO) in terms of its qualifications and the services it performs, namely the competence and independence standards in §438.354, and the EQR and other EQR-related activities set forth in §438.358. We propose revising this definition to clarify that an entity must also hold an active contract with a state to perform EQR or EQR-related activities to be considered an EQRO. Therefore, an entity itself would not be considered an EQRO if it has not yet entered into an EQRO arrangement with a state even if it meets all qualifications for entering into such a contract. We believe that this is implicit in our current regulations and propose this primarily as a clarification.

The current regulations define quality, as it pertains to EQR, as “the degree to which a MCO or PIHP 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.” We propose to modify this definition to reflect that this professional knowledge be evidence-based and supported by current science. We believe that modifying the definition in this way would recognize the current efforts that states and their plans engage in to stay up-to-date on the latest scientific findings and translate those findings into effective clinical practices. We also propose to modify this definition by tying performance measure trends and performance improvement outcomes to the definition of quality (which, for individuals receiving MLTSS, would include considerations around quality of life). We believe this would highlight the importance of the relationship between these efforts and overall plan quality and is supported by our proposed use of standardized performance measurement tools.

(c) Quality assessment and performance improvement program (§438.330, formerly §438.240)

The current §438.240 describes standards related to a quality assessment and performance improvement program. In our proposed §438.330(a)(1), we would carry over this standard, and

again, propose incorporating PAHPs for the reasons mentioned elsewhere in this preamble. Since the finalization of the managed care rules in 2002, the scope of managed care in states has greatly expanded. We propose including the word “comprehensive” to signal that states should consider all populations and services covered by managed care when developing quality assessment and performance improvement standards for their contracted managed care health plans.

In §438.330(a)(2), we propose to revise the existing regulatory language at §438.240(a)(2) to permit us, in consultation with states and other stakeholders, to specify standardized performance measures and topics for performance improvement projects (PIPs) for inclusion alongside state-specified measures and topics in state contracts with their MCOs, PIHPs, and PAHPs. We propose to add that we would also establish a methodology for quality ratings, which is discussed in more detail below in connection with our proposed §438.334. Our proposed addition of “through a public notice and comment process” would clarify the manner in which CMS would proceed with this set of performance measures and/or PIP topics. We propose this would be accomplished after notice and public comment to ensure that states, beneficiaries, and other stakeholders have the opportunity to provide input during the measure selection process. However, our proposal would also continue to support flexibility for states to adopt state-specific performance measures and performance improvement topics for their managed care plans.

We propose, in §438.330(a)(2)(ii), to adopt a mechanism for an exemption from the nationally identified PIP topics and metrics for states that request one. Reasons for an exemption might be if a selected measure is not applicable to the population enrolled in a state’s managed care program (for example, a measure related to behavioral health services, but the state carves those services out of managed care); if the number of enrollees for a particular measure is too small to calculate the measure; or if a MCO’s, PIHP’s, or PAHP’s performance on a particular

measure has exceeded the 90th percentile for more than 3 years in a row. We are considering whether these or other criteria are appropriate for the exemption process and invite comment on other instances in which a state may believe an exemption would be necessary.

In paragraph (b), we propose to recodify and slightly reorganize the substance of existing §438.240(b) consistent with our proposal to move all quality program provisions to subpart E. In paragraph (b)(1), for purposes of reorganization and consolidation of standards related to PIPs, we propose moving the description of what PIPs are designed to achieve to paragraph (d). This would result in having all PIP-specific details in one place. In paragraph (b)(2), we propose to modify the existing language from “submit performance measurement data” to “collect and submit performance measurement data.” We believe this change would clarify that the collection of relevant data is necessary as part of the submission process.

We recognize that MCOs, PIHPs, and PAHPs delivering LTSS should evaluate and measure the quality and appropriateness of services in a manner that is designed for LTSS and the population receiving those services (for example, inclusion of quality of life measures when selecting performance measures). Because of this, we propose in paragraph (b)(5) that MCOs, PIHPs, and PAHPs have specialized mechanisms to assess the quality and appropriateness of care furnished to enrollees receiving LTSS. This would include an assessment of the care that individuals receive when moving to different service settings, such as residential to community (or vice versa) or residential to hospital (or vice versa). We encourage states to consider including language in their MCO, PIHP, and PAHP contracts that incorporates the use of surveys to assess the experience of beneficiaries receiving LTSS as a key component of the plan’s LTSS assessment process. We solicit comment on the current use of such surveys and how they may best be used to improve the delivery of LTSS to beneficiaries and to improve their experience of care. We also

propose that MCOs, PIHPs, and PAHPs compare the services that an individual receiving LTSS has obtained with those that were in the individual's LTSS treatment plan. Lastly, we propose in paragraph (b)(6) that MCOs, PIHP, and PAHPs participate in efforts by the state to prevent, detect, and remediate critical incidents, based on applicable standards on the state for home and community based waiver programs.

In paragraph (c)(1), we propose to delete the reference to §438.204(c), as we propose removing this from the managed care elements for inclusion in a state's comprehensive quality strategy, as described in the proposed §438.340 (currently §438.204); our other proposed revisions to paragraphs (c)(1) through (c)(3) are to conform it to the remainder of our proposal and to incorporate PAHPs.

We propose the addition of paragraph (c)(4), which would focus on performance measurement as it relates to LTSS. Under this proposal, MCOs, PIHPs, and PAHPs that provide LTSS would include, in addition to other performance measures under paragraphs (c)(1) through (c)(3), LTSS-specific performance measures that examine, at a minimum, beneficiaries' quality of life and a plan's rebalancing and community integration outcomes. We expect these measures would support and align with a plan's quality assessment and performance improvement program function as proposed in paragraph (b)(5). States whose MLTSS programs include a self-direction option should consider including measures specific to self-direction under this paragraph.

As mentioned above, we propose moving the description of what a PIP is designed to achieve to paragraph (d)(1) for purposes of better organization and readability. To streamline quality improvement standards for plans exclusively serving dual eligible beneficiaries, we propose the option in paragraph (d)(3) for states to substitute an MA plan's quality improvement project conducted under §422.152(d) in the place of a Medicaid PIP. This would prevent

unnecessary duplication and increase flexibility for plans exclusively serving dual eligibles.

Finally, under our proposal in §438.330(e), states would continue to annually review the impact and effectiveness of each MCO's, PIHP's, and PAHP's quality assessment and improvement program. We also propose in paragraph (e)(1)(iii), that the state incorporate the results of any LTSS balancing efforts (community integration) at the managed care plan level into this program review. This would expand the program review from a single focus on acute care services, making it more comprehensive and valuable. We request comment on our approach to §438.330.

(d) State Review and Approval of MCOs, PIHPs, and PAHPs (new §438.332)

This new section proposes that as a condition of entering a contracting relationship with a state, MCOs, PIHPs, and PAHPs undergo a review on the basis of performance in accordance with standards that are at least as stringent as the standards used by a private accreditation entity approved or recognized by CMS for purposes of accrediting MA Organizations and QHPs. This process would align standards of review for Medicaid managed care plans with those found in other health care coverage options.

As described elsewhere in this preamble, aligning, where appropriate, Medicaid managed care quality initiatives with those of MA and the Marketplace would result in a streamlined approach to quality measurement and improvement. Under Section 1311 of the Affordable Care Act, QHPs are to be accredited, by a CMS-recognized entity, based on a number of criteria, including clinical quality measures, patient experience, utilization management, quality assurance, complaints and appeals, and network adequacy and access. We have issued regulations at 45 CFR 156.275 to govern the accreditation process for QHPs. In general, MA Organizations do not have to obtain accreditation; however, if an MA Organization elects to become accredited by a CMS-

approved accrediting organization it may be “deemed” compliant in one or more of six standards set forth in section 1852(e)(4)(B) of the Act. For QHPs and MA Organizations, CMS has the ability to recognize or approve accrediting organizations; to become recognized or approved, the entity must demonstrate to CMS that its standards are at least as stringent as those established by Medicare and the Marketplace. In addition, specialized plans for special needs individuals, per amendments made by section 3205 of the Affordable Care Act, must receive approval from the National Committee for Quality Assurance (NCQA).

By proposing a process similar to accreditation for Medicaid managed care plans, we would align the expectations for these plans in a manner that is consistent with other coverage options. Alignment of Medicaid plan review standards with those in other coverage options would protect beneficiaries by ensuring that plans meet certain performance levels and continue to do so over time. Furthermore, we believe this proposal would assist states in identifying plans that have a commitment to providing high quality care.

While having a set of performance standards for Medicaid managed care plans will benefit the Medicaid program and its beneficiaries, state flexibility is critical given the wide variety of state managed care contracting arrangements. Therefore, we propose to give states a choice of two options (or a combination of those options) to comply with our proposal. Both options are mechanisms to achieve the goal of attracting and retaining higher performing plans for participation in the Medicaid program.

In paragraph (a)(1), we propose the first option for states, which is a state review and approval process that would be at least as stringent as that used by a private accreditation entity. Our proposal also incorporates the standards used in the Marketplace and MA to set the parameters for the review and approval process. Specifically, we propose that the state review and approval

be based on standards that are at least as stringent as those used by the accreditation organizations that are recognized by CMS in MA or the Marketplace. We anticipate that states would purchase standards from one of the CMS-recognized accrediting organizations for this purpose. We propose in paragraph (a)(2) that states review and reissue approval of each MCO, PIHP, and PAHP at least once every 3 years. In paragraph (a)(3), we propose that MCOs, PIHPs, and PAHPs maintain performance with state standards at the level necessary for approval for as long as they participate in the state's managed care program.

The second option, proposed in paragraph (b), would allow a state to elect to use evidence that an MCO, PIHP, or PAHP has obtained accreditation by one of the CMS-recognized private accrediting entities to deem compliance with the review and approval standard proposed in paragraph (a)(1). This would allow states to take advantage of existing private sector infrastructure for the accreditation process and deem compliance based on the private independent accreditation of an MCO, PIHP, or PAHP. While there are costs for health plans associated with obtaining accreditation, we believe that this would be a valuable investment for plans, would provide an efficient method of state oversight, and would increase accountability on the part of Medicaid health plans. Additionally, the costs associated with private accreditation may be offset by a reduction in duplicative EQR processes.

In paragraph (b)(2), we propose that if a state were to elect this option, the MCO, PIHP, or PAHP would need to authorize the private accreditation entity to provide the state with copies of its most recent accreditation survey. This would allow the state to ensure that the MCO, PIHP, or PAHP has obtained an acceptable level of accreditation status (as proposed in §438.322(b)(2)(i)), review the actual findings of the survey (as proposed in §438.322(b)(2)(ii)), and determine when the accreditation is due to expire (as proposed in §438.322(b)(2)(iii)).

The two options proposed in this section are not exclusive; a state may elect to use the first option for one plan and the second option for other plans. In other words, states would be able to establish their own review and approval process, but also allow plans that have obtained private accreditation to submit documentation in accordance with the second option. We believe that this flexibility will enable states to use this process in a manner that fits with a state's vision and resources for managing Medicaid managed care quality and performance.

Finally, in paragraph (c), we propose that states make the final approval status of each MCO, PIHP, and PAHP, publicly available on the state's Medicaid website, regardless of whether this is based on the state review or private accreditation option. Examples of information that a state might post include: whether the approval is based on state review or the accreditation deeming process; if accreditation, which entity has accredited the plan and what level of accreditation the plan obtained; the expiration date of the approval, etc. We solicit comment on this approach to achieving our goals of attracting and retaining higher performing plans for participation in the Medicaid program and ensuring that performance standards are aligned across the health care system. We request comments on our approach to §438.332.

(e) Medicaid managed care quality rating system (new §438.334)

This new section proposes minimum standards that all states contracting with MCOs, PIHPs, and PAHPs would use in developing and implementing a Medicaid managed care quality rating system. The publication of standardized, reliable, and meaningful quality information for each MCO, PIHP, and PAHP would increase transparency regarding Medicaid managed care health plan performance. Such a system would support alignment and consumer and stakeholder engagement, and enable beneficiaries to consider quality when choosing a Medicaid health plan. States would be able to use this information in formulating quality improvement goals and

objectives, state contracting and enrollment decisions, and quality oversight of health plans. In addition, the proposed rating system would also assist states in evaluating the prior performance of Medicaid health plans looking to enter new markets.

To develop this proposal, we examined both the quality rating system established for the QHPs offered through the Marketplaces and the five-star rating system used for MA and Prescription Drug Plans. These existing systems were developed through a process that accommodates public comment. Section 1311(c)(3) of the Affordable Care Act directed the Secretary to develop a system that would rate QHPs offered through the Marketplaces and enable consumers to compare such QHPs based on relative quality, price, and enrollee satisfaction. In a November 19, 2013 **Federal Register** notice (78 FR 69418), the Department solicited comment on a process for selecting and organizing measures for the QHP quality rating system (<http://www.gpo.gov/fdsys/pkg/FR-2013-11-19/pdf/2013-27649.pdf>). This notice with comment set forth, among other things, the proposed general principles of the QHP quality rating system as well as proposed measures that were evidence-based and aligned, to the maximum extent possible, with measures in other federal, state, and private sector health care programs.

In the 2015 Quality Rating System and Qualified Health Plan Enrollee Experience Survey Technical Guidance (available online at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>), we announced the final domains and measures that will be used in 2015 to beta test the QHP quality ratings.¹⁵ The selected domains and measures are grouped under three summary indicators, which align with CMS and national priorities under the National Quality

¹⁵ Some of the measures in the QHP Quality Rating System measure set will be collected as part of the QHP Enrollee Experience Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Strategy: (1) Clinical Quality Management; (2) Member Experience; and (3) Plan Efficiency, Affordability and Management. Beneath these three summary indicators fall a set of eight domains that represent important aspects of quality: (1) Clinical Effectiveness; (2) Patient Safety; (3) Care Coordination; (4) Prevention; (5) Access; (6) Doctor and Care; (7) Efficiency and Affordability; and (8) Plan Service. Each domain then has a set of associated performance measures (19 clinical and 10 survey measures), which all factor in to create a rating that consumers may use when evaluating health plan options. The QHP quality rating system uses a five-star scale, similar in style and format to that of the MA and Prescription Drug Plan rating system.

Given that the overall Medicaid population more closely resembles that of the Marketplace, modeling the quality rating system for Medicaid on that of the QHPs offered through Marketplaces makes the most sense; however, there are some instances in which performance measures from the MA five-star rating system may be appropriate for use for some Medicaid populations, such as dual eligible beneficiaries or individuals in need of LTSS (see <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS.html> for more information on the MA five-star rating system). Alignment with the rating system currently in place for the QHPs offered through Marketplaces would minimize the burden on health plans that operate in both markets and provide data for the various quality rating systems.

The use of a rating system that is consistent in format and scope with those for QHPs in the Marketplaces and MA plans would make it easier for beneficiaries, who may be transitioning among these various coverage programs, to understand the quality rating of their health plan regardless of the payer. Medicaid consumers would also have useful and understandable quality information to assist them in making an informed choice among the health coverage choices

available to them in a state. While some states currently operate performance rating systems for Medicaid managed care plans and report publicly on plan performance, this is not the case in all Medicaid programs.

To ensure that states and other stakeholders have ample opportunity to comment and offer feedback during the development of the proposed Medicaid quality rating system, we would utilize a robust public engagement process, similar to that used by CCIIO in the development of the QHP quality rating system. This may include a series of listening sessions or town halls, the release of a request for information, and/or a series of notice and comment periods. Our intention is that the Medicaid managed care quality rating system standards would be refined over a period of three to five years prior to implementation. This would allow CMS time to further identify the respective state and federal roles in implementation and maintenance of the system.

Based on these considerations and desired outcomes, we propose in §438.334(a)(1) that states establish a rating system that includes specific factors outlined in the rest of the section. We propose in §438.334(a)(2), that the components of the rating system be based on the same three summary indicators that are currently used to frame the QHP quality rating system (clinical quality management, member experience, and plan efficiency, affordability, and management). In paragraph (a)(3), we propose that the state's quality rating system would measure and report on performance data collected from each MCO, PIHP, and PAHP on a standardized set of measures that will be determined by CMS, through the public notice and comment process and published in the **Federal Register**, as outlined in proposed §438.330(a)(2). This notice and comment period would allow CMS and the states to jointly identify measures through a multi-stakeholder process that includes Medicaid state partners, representatives of MCOs, PIHPs, and PAHPs, consumer groups, and performance measure experts. This would also enable CMS, the states, and other

stakeholders to give consideration to the types of measures that are frequently collected by states, that are reported under other reporting systems, and that are standardized, validated, and appropriate to the types of services provided and populations served by Medicaid health plans. We anticipate that we would propose measures for this purpose and through this process based on considerations such as importance of underlying performance, performance gaps, reliability and validity, feasibility, and alignment. Further, as proposed in paragraph (a)(3), the measures would be categorized within the components proposed in paragraph (a)(1), and the state would be able to adopt additional measures.

Paragraph (b) proposes that each state apply a methodology, also established by CMS under §438.330(a)(2), to the performance measures described in paragraph (a)(3) to determine the quality rating or ratings of each MCO, PIHP, and PAHP. The methodology would also provide for the use of state-identified measures in determining the quality rating or ratings for each MCO, PIHP, or PAHP. We invite comment on the feasibility of adding flexibility for states to change the way in which a measure is weighted in their quality rating methodology, as we recognize that there is diversity in state quality improvement goals and in the populations served by each state's managed care program. We envision that this measure selection/methodology development process would occur once every 2 to 3 years, to ensure that the selected measures and/or methodology be updated or changed if necessary.

Recognizing the need for state flexibility, we propose in paragraph (c) that, contingent on CMS approval, states may elect to use an alternative or preexisting quality rating system in place of the rating system that we propose in paragraphs (a) and (b) of this new section. This would allow states that have already invested in the development and implementation of their own quality rating system the option of either adopting or modifying the preexisting system. An alternative

rating system would potentially utilize different components than those described in paragraph (a)(2), incorporate the use of different performance measures described in paragraph (a)(3), and/or apply a different methodology from that described in paragraph (b).

To avoid duplication of effort, in paragraph (d), we propose providing states with the option to default to the MA five-star rating system for those plans that serve dual eligible beneficiaries only. Finally, in paragraph (e), we propose that states prominently display the results of their quality rating system or systems online in a manner that complies with the language and format standards of §438.10. This would ensure that beneficiaries have access to the quality ratings to assist them in making choices among health plans. We solicit comment on our proposal for a Medicaid managed care quality rating system, including whether our proposal provides sufficient flexibility for states, ensures enough alignment of Medicaid managed care plans with those operating in the Marketplaces and MA, and provides adequate parameters for the establishment of the quality rating systems.

(f) Comprehensive State Quality Strategy (new §431.500, §431.502, §431.504, §431.506, and §438.340)

Under the existing regulation at §438.202(a), states contracting with MCOs or PIHPs currently maintain a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Regardless of delivery system, it is important to measure performance to develop a plan to strengthen and improve the quality of care. Because of this, we propose adding a new subpart I to part 431 that would extend the comprehensive quality strategy to all state Medicaid programs.

(1) Basis and scope (new §431.500)

With recent developments in delivery system reforms and as state health information

exchanges become more interoperable with state-based Marketplaces, other payers, and state agencies, we believe each state should have a quality strategy to address and support efforts to strengthen quality in a state's Medicaid managed care program (inclusive of MLTSS programs, where applicable), as well as other types of delivery systems for Medicaid services. Our proposal below integrates guidance contained in the State Health Official letter entitled Quality Considerations in Medicaid and CHIP (SHO #13-007, available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf>), which explains how to incorporate a state's managed care quality strategy into a larger, statewide comprehensive Medicaid quality strategy. This guidance allows for state flexibility in how to convert an existing quality strategy into a comprehensive document; for example, in some cases, LTSS strategies should be aligned with, but not the same as, acute care strategies.

In §431.500, we describe the statutory basis and scope of the proposed new subpart I. Our statutory authority to adopt standards for a quality strategy is established in section 1932(c) of the Act for MCOs and based on section 1902(a)(4) of the Act for PIHPs. We rely as well on section 1902(a)(4) of the Act to establish a standard for a comprehensive quality strategy for delivery of services to all Medicaid beneficiaries because such a strategy would promote efficient and proper administration of the state plan as a whole. We also propose to rely on section 1902(a)(6), for purposes of the proposed reporting in §431.504, which provides that “the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports”; section 1902(a)(19), which obligates the provision of “such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner

consistent with simplicity of administration and the best interests of the recipients”; and section 1902(a)(22) which allows CMS to request that states “include descriptions of...other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality.”

In paragraph (b), we propose that the scope of this new section establish parameters for states to develop a comprehensive quality strategy to monitor the delivery of quality health care to Medicaid beneficiaries. This would include states contracting with MCOs, PIHPs, or PAHPs, those utilizing a PCCM arrangement, and those that deliver services through FFS. CMS will provide technical assistance to those states that do not currently contract with MCOs or PIHPs and thus, would need to develop a quality strategy if they have not already done so. We solicit comments on our proposal for a comprehensive quality strategy.

(2) State comprehensive quality strategy (new §431.502)

The current §438.202(a) identifies responsibilities for the managed care quality strategy for states contracting with MCOs and PIHPs. Consistent with the goal of supporting quality improvement for all Medicaid delivery systems, in our proposed §431.502(a) we identify a general rule for state comprehensive quality strategies: all states, regardless of whether they contract with a MCO under section 1903(m) of the Act or another managed care entity under part 438, would draft and implement a written comprehensive quality strategy to assess and improve the quality of health care and services provided to all Medicaid beneficiaries.

In paragraph (b)(1), we propose that the strategy include the state’s goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of all Medicaid-covered populations in the state. States should take into account a variety of data (such as population health status, service utilization and expenditure information, quality of

life issues, quality metrics, etc.) when developing such goals. In paragraph (b)(2), we propose that states identify the specific quality metrics and performance targets that they plan to use to measure performance and improvement; these should be linked to the goals identified in paragraph (b)(1). Existing, validated quality metrics, such as the CMS Medicaid/CHIP Child and Adult core measure sets, may serve as a basis for selecting metrics under this proposed paragraph. CMS will provide technical assistance to help states in determining minimum performance levels and/or appropriate performance targets for each metric. Further, we propose that states annually publish these quality metrics and performance standards on their website.

(3) Comprehensive quality strategy development, evaluation, and revision (new §431.504)

In the new §431.504, we propose to recodify and slightly modify the existing state responsibilities related to the quality strategy in the current §438.202(b), (d), and (e), expanding the application of these standards to the comprehensive quality strategy and not just the strategy for the managed care program. These state responsibilities include obtaining public input in the development and revision of the quality strategy, an evaluation of the effectiveness of the quality strategy, and submission of the quality strategy to CMS for review. Our proposal carries over much of the substance of the current rule.

In developing the comprehensive quality strategy, we believe that states should continue to work cooperatively with beneficiaries, stakeholders, and other interested parties, to benefit from their knowledge, expertise, and unique perspectives with regard to the delivery of Medicaid services. Stakeholders may possess on-the-ground knowledge that would benefit states in identifying quality improvement goals and selecting the best approach to achieve better health outcomes. Accordingly, we propose in paragraph (a) to add the State Medical Care Advisory Committee and tribes (through tribal consultation), as appropriate, to the existing list of persons

and entities from which the state would obtain input when developing the strategy. We propose that this input be obtained prior to submitting the comprehensive quality strategy to CMS, to ensure that stakeholder concerns have been taken into consideration at an early phase in the quality strategy development process.

In paragraph (b), we propose to expand to the comprehensive quality strategy the existing standard that states review and update the document “as needed”, but replace the word “periodically” with a timeframe to update the strategy at least once every 3 years. Currently, some states operate under quality strategies that were drafted more than 5 years ago, and thus may not be reflective of today’s programs and populations. We encourage states to view the comprehensive quality strategy as a living document, which should be updated on a regular basis to account for changes in population, delivery system structure, emerging information system technology, and benefit design. We also propose to improve clarity by using “review and update” instead of “conduct reviews...and update” in the regulation text.

In further support of improved clarity, we propose moving the evaluation of the effectiveness of the quality strategy into a new paragraph (b)(1) and, in paragraph (b)(2), we propose that states make the results and findings of this effectiveness evaluation publicly available on the state’s Medicaid website. The language from the current §438.202(e)(2) related to the submission of regular reports on the implementation and effectiveness of the strategy would be captured in our proposed §431.504(b)(1) and (b)(2). To streamline the submission of these regular reports, we propose that states post these on their Medicaid website, rather than submitting such reports to CMS as the current regulation states.

In paragraph (c)(1), we propose slightly modifying, for purposes of clarification, the existing language in §438.202(e)(1) that the state submit a copy of the initial strategy to CMS. We

clarify that this submission would be for purposes of receiving CMS comment and feedback before adopting the comprehensive quality strategy in final. In paragraph (c)(2), we propose that states submit a copy of the revised strategy whenever significant changes are made. We also propose that states include their definition of “significant changes” within the body of the quality strategy, as this would improve transparency regarding the elements that would trigger a revision of the document.

Finally, in paragraph (d), we propose that states make their final comprehensive quality strategy available on the state’s Medicaid website. While this is already the practice of many states, this would help to increase transparency of a state’s quality development and oversight process, and support our efforts in maintaining an up-to-date library of state comprehensive quality strategies on Medicaid.gov.

(4) Applicability to Medicaid managed care programs (new §431.506)

To reduce the burden on states contracting with managed care entities and to ensure that the comprehensive quality strategy addresses all populations, we propose to cross-reference the managed care elements of a quality strategy in part 438 that apply to MCOs, PIHP, and PAHPs, as well as PCCM entities described in the proposed §438.3(r). This section proposes that states contracting with one of the aforementioned managed care entities would be able to create the managed care quality strategy by incorporating the part 438 elements into the larger, comprehensive quality strategy. We would be available to provide technical assistance to managed care states that shift their existing quality strategy from managed care to a more universal blueprint for quality at the state level.

(g) Managed care elements of State comprehensive quality strategies (new §438.340, formerly §438.204)

The current §438.204 identifies the minimum elements of a managed care state quality strategy, including: (1) MCO and PIHP contract provisions that incorporate the standards in existing subpart D; (2) procedures for assessing the quality and appropriateness of care and services furnished to all enrollees under the contract, providing information about the race, ethnicity and language of beneficiaries to MCOs and PIHPs at the time of enrollment, and regular monitoring and evaluation of MCO and PIHP compliance with the standards in subpart D; (3) specification of any national performance measures identified by CMS; (4) arrangements for annual, external independent reviews of quality outcomes, and timeliness of, and access to, services provided by each MCO and PIHP; (5) appropriate use of intermediate sanctions for MCOs; (6) an information system sufficient to support initial and ongoing operation and review of the state's quality strategy; and (7) standards, at least as stringent as those under the applicable subpart D of the regulations.

Consistent with our proposal in part 431, subpart I, and to more accurately reflect the substance of this section, we propose to title this section “managed care elements of the state comprehensive quality strategy”. In addition, our proposal to extend the quality strategy to states contracting with PAHPs is reflected throughout the proposed text. We propose to use the existing format of §438.204 (elements of State quality strategies) and list out the minimum elements related to managed care for inclusion in the state comprehensive quality strategy; however, we propose to remove some of the existing content elements and clarify that these are in addition to the other elements proposed in part 431, subpart I.

In paragraph (a), instead of a reference to the standards in the current subpart D, we propose that states include only their network adequacy and availability of service standards and examples of evidence-based clinical practice guidelines that its managed care plans follow. We

believe this would transition states toward defining metrics for assessing improvement strategies rather than simply repeating contractual language. It would also allow stakeholders, including beneficiaries, to understand state-specific access standards without having to refer to the MCO, PIHP, or PAHP contract.

We propose to delete the content of the existing §438.204(b)(1), as we believe that a description of procedures to assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO, PIHP and PAHP contract(s) is captured in our proposed part 431 subpart I. We propose deleting reference to the other information currently found in §§438.204(b)(2) and (b)(3), as we plan to address this in future guidance related to the comprehensive quality strategy.

In §438.340(b), we propose that the state's goals and objectives developed under our proposed §431.502(b)(i) incorporate a description of quality metrics and performance targets that the state will use to assess Medicaid managed care quality, including any performance measures in accordance with our proposed §438.330(c) and any performance improvement projects in accordance with our proposed §438.330(d). We believe this standard would take the place of the existing element in §438.204(c). In the event that the state directs its managed care plans to implement certain interventions when conducting a performance improvement project, we propose they include a description of those interventions within the quality strategy. We believe the provision of this information would help states and their health plans link the selection of measures and improvement projects directly to the state's quality improvement goals and objectives.

We propose redesignating the current §438.204(d) and (e) to §438.340(c) and (d), respectively, and to expand the external review element to PAHP contracts as well. We propose to eliminate the text currently found in §438.204(g), which calls for states to include standards, at

least as stringent as those in subpart D, within the quality strategy because we believe this is redundant to the proposed changes we explained in paragraph (a). Finally, in paragraph (e), we propose that states address how they would assess the performance and quality outcomes achieved by each PCCM entity, to conform to other changes made in this part.

(h) External quality review (§438.350)

In §438.350, we propose to modify the title of the section that identifies the state's responsibilities related to EQR to clarify that these responsibilities are specific to the EQR process. In addition to proposing the application of EQR to PAHPs, consistent with our proposal discussed in §438.310, we propose a minor restructuring of §438.350 and a few substantive changes. We propose to redesignate existing paragraphs (a) through (f) as (a)(1) through (a)(6). In paragraph (a)(3), we propose that information from Medicare or private accreditation reviews is a permissible source of information for use in the EQR, in addition to information gathered from the EQR-related activities as described in §438.358. We also propose clarification in (a)(4) that the information gathered from each EQR-related activity is for use in the EQR and resulting EQR technical report. Finally, in paragraph (b), we propose to add that if a state chooses to perform an EQR on a PCCM entity, the standards laid out in paragraphs (a)(2) through (6) apply. As mentioned earlier in this proposed rule, based on the range of functions that PCCM entities can provide to states, states may elect to subject (at their option) each PCCM entity – specifically, those with contracts which provide for shared savings or other payment incentives – to the EQR process, but we believe most of the same standards (as used by MCOs, PIHPs, and PAHPs) concerning EQR should apply for reasons mentioned elsewhere in this preamble.

(i) External quality review protocols (§438.352)

We are not proposing any changes to §438.352. This section sets forth the parameters for

the EQR protocols. Protocols are detailed instructions from CMS for personnel to follow when performing the EQR-related activities. Protocols must specify: (1) The data to be gathered; (2) the source of the data; (3) the activities and steps to be followed in collecting the data to promote its accuracy, validity, and reliability; (4) the proposed methods for valid analysis and interpretation of the data; and (5) all instructions, guidelines, worksheets and any other documents or tools necessary for implementing the protocol. Under section 1932(c)(2)(A)(iii) of the Act, the Secretary, in coordination with the National Governors' Association, contracts with an independent quality review organization to develop such protocols.

(j) Qualifications of external quality review organizations (§438.354)

We propose two modifications to §438.354, which sets forth the competence and independence standards that an entity must meet to qualify as an EQRO. First, we propose additional text, consistent with our overall proposal, to expand EQR to PAHPs. Second, in paragraph (c)(3)(iv), we propose that an accrediting body may not also serve as an EQRO for a health plan it has accredited within the previous 3 years. This is due to our proposal that an EQRO be allowed use the results of an accreditation review to perform the final EQR analyses; we do not want the financial relationship between a health plan and its accrediting body to influence the results of the EQR (or the information that is included in the resulting EQR technical report). We also propose a corresponding redesignation of existing paragraph (c)(3)(iv) to (c)(3)(v).

(k) State contract options for external quality review (§438.356)

Our proposed revisions to §438.356 would provide additional clarification to the existing EQRO contracting process. We propose changing the title of this section to clarify that it is specific to EQR contracting. In paragraph (a)(2), we propose adding that other entities, in addition to or instead of an EQRO (such as the state or its agent that is not an MCO, PIHP, or PAHP) may

conduct the EQR-related activities to comport with this same flexibility afforded to states in §438.358. In paragraph (e), we propose the addition of a cross-reference to paragraph (a), with the addition of “with an EQRO” to make clear that the contract subject to the open, competitive process is the state’s contract with the EQRO. We also, in paragraph (e), propose to update the cross-reference to the part of 45 CFR that governs grants to state governments from part 74 to part 75, to reflect changes that occurred after the existing regulations were finalized.

(l) Activities related to external quality review (§438.358)

This section sets forth the activities that produce information that the EQRO must use to conduct the EQR, to draw conclusions regarding access, timeliness, and quality of services provided by managed care plans, and to draft the final EQR technical report. There are currently three mandatory and five optional EQR activities under this regulation. The three mandatory EQR-related activities are: (1) Validation of performance improvement projects; (2) validation of performance measures; and (3) determination of compliance with the standards set forth in subpart D. The five optional activities are: (1) Validation of encounter data; (2) administration or validation of surveys; (3) calculation of additional performance measures; (4) conduct of additional performance improvement projects; and (5) conduct focused studies of quality of care. The current regulation also permits EQROs to provide technical assistance if the state directs. We propose several changes to this section, including the addition of text to be consistent with our proposal to extend EQR to PAHPs.

We propose separating the current paragraph (a) into two paragraphs, the first of which would retain the language in the current general rule. Our proposed paragraph (a)(2) would clarify that the information resulting from the performance of the EQR-related activities would be used in accordance with §438.350(a)(3) to complete the EQR. In paragraph (b), we propose minor

technical changes to make clear that the mandatory activities would be performed for each MCO, PIHP, and PAHP. In paragraphs (b)(1) and (b)(2), we include reference to the proposed CMS-identified measures and PIPs, which would be developed by CMS, in consultation with the states and other stakeholders, through the public process as described in the proposed §438.330(a)(2). In paragraph (b)(3) we propose that the mandatory compliance review would consist of an evaluation of the MCO, PIHP, and PAHP standards proposed in subpart D, and because we propose moving the quality assessment and performance improvement program standards to subpart E (as described in the proposed §438.330), we reference that section as well. This does not propose any significant change from what comprises the current compliance review activity.

We propose the addition of a new mandatory EQR-related activity in paragraph (b)(4), the analysis of which would be included in the annual EQR technical report in accordance with §438.364. This proposed EQR-related activity, would validate MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with the state standards developed in accordance with §438.68. An assessment of compliance with §438.206 (availability of services) would occur as part of the mandatory compliance review described in §438.358(b)(3); however, because the methods that are frequently used to do so are limited to the review of policies and procedures and onsite interviews of personnel, we propose that this proposed EQR-related activity would go beyond the compliance activity by directly evaluating and validating network adequacy on an annual basis. While the specifics of this activity would be identified in a new EQR protocol, we envision the inclusion of steps such as measurement of how effectively a plan is meeting a state's specific access standards (for example, time and distance standards), direct testing to determine the accuracy of network information maintained by health plans, and telephone calls to providers that either assess compliance with a specific standard, such as wait times for

appointments, or assess the accuracy of provider information, such as whether a provider is participating in a plan.

Finally, in paragraph (d), we propose a minor technical change by clarifying that technical assistance may be provided by the EQRO to assist health plans in conducting activities that would produce information for the resulting EQR technical report.

(m) Non-duplication of mandatory activities (§438.360)

This section is based on section 1932(c)(2)(B) of the Act, which provides the option for states to exempt health plans from EQR-related activities that would duplicate activities conducted as a part of a Medicare review conducted of an MA plan or a private accreditation survey. To avoid duplication of work, the state may currently use information about contracted MCOs or PIHPs that is obtained from a Medicare or private accreditation review to provide information otherwise gathered from performing the mandatory EQR-related compliance review, but not for the validation of performance measures or PIPs. In addition, for plans that exclusively serve dual eligible beneficiaries, states may use information obtained from the Medicare program in place of information otherwise gathered from performing the mandatory EQR-related activities of validating performance measures and validating PIPs.

We propose giving states the option to rely on information obtained from a review performed by Medicare or a private accrediting entity in lieu of performing the three existing mandatory EQR-related activities: (1) the validation of PIPs, (2) the validation of performance measures, and (3) the compliance review. The purpose of this proposal is to prevent duplication of effort for the three EQR-related activities. For example, MCOs that are accredited by NCQA already collect the performance measurement data known as HEDIS® measures, and part of the NCQA accreditation process is for one of its approved vendors to validate the statistical accuracy

of the data. If the measure validation process used by the approved vendor is consistent with guidance in the CMS EQR protocol on the validation of performance measures, and each accredited plan submits their most recent accreditation results to the state, at the state's option the state or its agent would no longer have to perform the mandatory EQR-related activity of performance measure validation. However, the state would still provide the results of the accreditation survey to the EQRO, so that the EQRO could perform an analysis and aggregation of data to satisfy the deliverables described in §438.364.

To effectuate these changes and to clarify the regulatory language, we propose in paragraph (a) that the state may use information about an MCO, PIHP, or PAHP obtained from a Medicare or private accreditation review within the past 3 years in place of the information that would be obtained by completing one or more of the three existing EQR-related mandatory activities. We do not propose extending this option for non-duplication to the fourth, newly proposed EQR-related mandatory activity for validation of network adequacy, as we do not yet know the scope of what this newly proposed activity will entail or how well it would line up with current accreditation standards.

Because of our proposal to extend the non-duplication option to three mandatory activities, we propose to combine and streamline the content in the current §438.360(b) and (c), as it would no longer be necessary to separately address plans serving only dual eligibles. In paragraph (b)(1), we propose clarifying that the Medicare or private accreditation review standards must be substantially comparable to the standards for the three EQR-related activities to be eligible for non-duplication. The reason for this is that the information obtained should be similar enough to that which would be obtained through an EQR-related activity so that the state's EQRO would be able to effectively perform an analysis in accordance with §438.364, as we specify in the proposed

paragraph (b)(2).

Finally, we retain that states identify whether they opt to deem any of the EQR-related activities under this option, and include the reasons for doing so, in the comprehensive quality strategy. This redesignates the current §438.360(b)(4) and (c)(4) to paragraph (c).

(n) Exemption from external quality review (§438.362)

This section is based on section 1932(c)(2)(C) of the Act, which provides that a state may exempt a health plan from undergoing an EQR if the MCO has a current Medicare contract under part C of Title XVIII or under section 1876 of the Act, and, for at least 2 years, has had in effect a Medicaid contract under section 1903(m) of the Act. We propose the removal of PIHPs, as they are not entities that fall under section 1903(m) of the Act. We also propose to update the phrase “Medicare+Choice” to “Medicare Advantage”.

(o) External quality review results (§438.364)

This section sets forth the information, or final deliverables, that annually result from the EQR. We propose several changes to this regulation to assist CMS and the states in meaningfully assessing the performance of each health plan. Currently, the EQR activities in §438.358(b)(1) and (2) only refer to validation of the data. While we continue to believe that data validation is important and should remain a core function of the EQR process, a statement of validation alone is insufficient to provide insight into plan performance on quality, timeliness, and access to care. Therefore, under §438.364(a)(1) we propose that each EQR technical report include performance measurement data for any collected performance measures and implemented PIPs (in accordance with each EQR activity conducted in accordance with §438.358(b)(1) and (2)). There are several benefits from modifying the EQR technical report, particularly in combination with a standardized sub-set of EQR topics and measures. First, public reporting on a common set of measures would

align with the approach used by Medicare and the Marketplace to monitor and support continuous quality improvement. Second, displaying the performance results of these common measures would allow beneficiaries and stakeholders to compare the quality of care across health plans. Finally, sharing this information publicly would allow states to learn best practices from one another and reveal lessons learned in dealing with challenges faced by states and plans when engaged in quality measurement and improvement.

In paragraph (a)(3), we propose the inclusion of recommendations for how states can target the goals and objectives in the comprehensive quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. In paragraph (a)(4), we propose deleting the language that allows the state alone to decide the appropriate methodology of comparative information about managed care plans, as we believe this should be a determination made by the state in conjunction with CMS (via the Protocols, as described in §438.352).

In paragraph (b)(1), we propose that states contract with a qualified EQRO to produce the final EQR technical report (that is, we clarify that there is no other entity which may produce the EQR technical report) and we propose that this report be completed and available for public consumption no later than April 30th of each year. An April 30th submission date would align with the timeframe needed for the collection and annual reporting of managed care data by the Secretary each September 30th as prescribed by section 401 of CHIPRA and section 2701 of the Affordable Care Act. We also propose in this same paragraph that states may not substantively revise the content of the final EQR technical report without evidence of error or omission, or upon requesting an exception from CMS. Allowing states to substantively alter information in the EQR technical report could possibly result in a departure from the original statutory intent for the

performance of an external, independent review.

Paragraph (b)(2) proposes that states maintain the most recent copy of the EQR technical report on the state's Medicaid website, proposed under §438.10(c)(3). We believe this would serve to facilitate public access to the EQR technical reports. This would also allow CMS to directly link the reports to the Medicaid.gov website, thus creating a comprehensive library of state EQR technical reports. We also propose to separate out the existing language for states to make the information available in alternative formats for persons with disabilities in a new paragraph (b)(3). As part of this proposal, we replace the phrase “sensory impairments” with “disabilities”.

(p) Federal financial participation (§438.370)

This section sets forth the matching rates for expenditures for EQR, including the production of EQR results and the conduct of EQR-related activities when performed by a qualified EQRO or other entity. The changes proposed in this section mark a departure from previous interpretation of the entities eligible for the enhanced 75 percent EQR match rate as found in section 1903(a)(3)(C)(ii) of the Act. In the 2003 final rule, CMS used the authority of section 1902(a)(4) of the Act to extend EQR to PIHPs. We determined that, because we were extending the performance of EQR under section 1932(c)(2) of the Act to PIHPs, such review could be considered to be performed “under” section 1932(c)(2) of the Act, even though it was not “required” by section 1932(c)(2) of the Act itself for purposes of qualifying for the enhanced federal match rate of 75 percent. Upon closer examination of the applicable statutory language, we have reconsidered that interpretation and now believe the reference in section 1903(a)(3)(C)(ii) of the Act to review “under” section 1932(c)(2) of the Act should be construed to refer to review “required” by that section. Therefore, we propose in paragraph (a) that only EQR or EQR-related activities performed by EQROs for MCOs with contracts under section 1903(m) of the Act are

eligible for the 75 percent match.

In paragraph (b), we propose clarifying that EQR and EQR-related activities performed on entities other than MCOs (including PIHPs, PAHPs, primary care case management arrangements, or other types of integrated care models) would be eligible for a 50 percent administrative match, regardless of what type of entity performs the review (that is, the state, its agent that is not an MCO, PIHP, or PAHP, or an EQRO).

Finally, in paragraph (c), we propose that states submit their EQRO contracts to CMS prior to claiming the 75 percent match. Although section 1932(c)(2) of the Act does not require review and approval by CMS of EQRO contracts, we believe the reason for doing so remains the same as it is today - to allow CMS to determine if the EQRO contract complies with the EQR-related provisions of this rule (for example, by confirming that contracting entities meet the standards set forth in §438.354 for qualified EQROs), and, if so, which activities under the contract are eligible for the 75 percent match.

c. State Monitoring Standards (§438.66)

Experience since the 2002 final rule has shown that strong state management and oversight of managed care is important throughout a program's evolution but is particularly critical when states transition large numbers of beneficiaries from FFS to managed care or when new managed care plans are contracted. We have observed that states must train and deploy staff or utilize vendors to verify that plans have sufficient provider capacity to serve new enrollees, are ready to pay provider claims accurately and on time, can respond promptly to enrollee complaints and problems, and have IT systems that can receive and generate state data and reports. Further, when a managed care plan contracts with the state for the first time, states need time to conduct readiness reviews.

We are proposing modernization of state monitoring standards. We rely on the authority in section 1902(a)(4) of the Act for the proper and effective operation of the state plan to strengthen our existing regulation at §438.66, noting that many of these practices are employed by states today. We begin by proposing a minor change in the title of this regulation section to clarify that the monitoring required here is a state activity.

In paragraph (a), we propose that the state have a monitoring system for all of its managed care programs; we intend the term monitoring to include oversight responsibilities. In paragraph (b), we propose that the state's monitoring system address, at a minimum, specific aspects of the managed care program that include: administration and management; appeal and grievance systems; claims management; enrollee materials and customer services; finance, including medical loss ratio reporting; information systems, including encounter data reporting; marketing; medical management, including utilization management; program integrity; provider network management; quality improvement; the delivery of LTSS; and other items of the contract as appropriate. Research has highlighted these program areas as critical for state success. See, for example, the research report by the AARP Public Policy Institute titled "Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports"¹⁶ (July 2012).

In §438.66(c), we propose that states use data collected from its monitoring activities to improve the performance of its managed care program. While we expect that many states already take this approach, we propose to set it out here as a baseline standard for all managed care programs. In this section we provide a list of activities for which data should be used for performance improvement. This list encompasses the areas that we believe are fundamental to every managed care program and for which data is readily available. We do not propose an

¹⁶ <http://www.aarp.org/health/medicare-insurance/info-07-2012/keeping-watch-building-state-capacity-to-oversee-medicare-managed-long-term-services-and-supports-AARP-ppi-health.html>

exhaustive list in §438.66(c) of the performance areas about which data should be used in improvement efforts to provide flexibility for the state to collect and use additional data they find useful and pertinent for its program.

In §438.66(d), we propose to establish a new standard for states to conduct readiness reviews of MCOs, PIHPs, PAHPs and PCCM entities prior to the effective date of new or modified managed care programs, although experience has shown that states employ this practice today. As proposed in paragraph (d)(1)(i) through (iv), readiness reviews would have to be conducted prior to the start of a new managed care program; when a new contractor enters an existing program; or when the state adds new benefits, populations or geographic areas to the scope of its contracted managed care plans. We propose in paragraph (d)(2)(i) and (ii) that these readiness reviews would have to be started at least 3 months before the State implements any of those program changes, so that states ensure that critical MCO functions are operational far enough in advance for successful implementation. In paragraph (d)(2)(iii), we propose that the results of those readiness reviews would have to be submitted to us to enable us to determine if the contract or contract amendment is approved. This would permit both CMS and the state to review the findings, discuss any possible issues, and arrive at a mutual understanding of expectations. In paragraph (d)(3), we propose that the readiness reviews would consist of both a desk review of documents and an on-site visit that includes (at a minimum) interviews with staff and leadership that manage key operational areas. We do not propose to define the key operational areas but rely on states to reasonably identify those areas in light of the areas which are identified in proposed paragraph (d)(4). We believe these are customary in readiness reviews of this kind and have proven effective in helping states gather all of the information needed. Finally, proposed paragraph (d)(4) would require four broad areas for inclusion in the readiness review and outline

sub-components within each area. The broad areas are: (1) operations and administration; (2) service delivery; (3) financial management; and (4) systems management. While a state can add more areas to their review, we believe these provide a minimum foundation from which to build an effective readiness assessment.

We note that these standards reflect our current guidance. For example, our guidance for MLTSS programs under section 1915(b) waivers and section 1115(a) demonstration projects set forth MCO readiness to implement LTSS as a key element under adequate planning; likewise under Special Terms and Conditions for new or expanding managed care programs under these waiver and demonstration authorities, states conduct readiness reviews of their contracted managed care plans. Health plans participating in the Capitated Financial Alignment Demonstration have to undergo an extensive readiness review process before contracts will be signed and enrollment of dual-eligible beneficiaries will be permitted.

Finally, to address the fragmented program information we currently receive about states' managed care programs and to help improve our oversight efforts, we propose in §438.66(e) that states provide an annual program assessment report to us. States would have to submit these to us no later than 150 days after the end of the managed care plan's period of performance; this is intended to provide flexibility to states which operate their programs on calendar year, state fiscal year, or some other basis. We request comment on whether 150 days is enough time after the end of a program year for the state to provide the type of information we are proposing. In (e)(1), we propose flexibility for states which already have to provide an annual report under section 1115(a) demonstrations to submit that report for this purpose if the information in the annual report is duplicative of the information specified here.

We outline in proposed paragraph (e)(2) the areas on which information and an assessment

would have to be submitted by the state in the report. We propose that the report include information about, and assessments of the 8 areas of the managed care program detailed in paragraph (b)(2). We take the opportunity here to emphasize that states providing LTSS through managed care plans would also have to include areas specific to MLTSS in this assessment; these could include alignment of payment rates and incentives/penalties with the goals of the program, any activities the managed care plans have undertaken to further the state's rebalancing efforts, and the satisfaction of enrollees with their service planners. In (e)(3), we also propose that this annual program assessment would have to be posted publicly and provided to the Medical Care Advisory Committee and, if applicable the LTSS stakeholder group specified in §438.70.

d. Information Standards (§438.10)

We are concerned that current §438.10 pertaining to information standards is not sufficiently clear or direct and does not reflect current technology advances that provide access to information more quickly and less expensively. For that reason, we propose to replace the entire existing regulation section with a more structured and coherent set of state and managed care plan standards for beneficiary information. Electronic communications are becoming typical, and we propose to explicitly permit both states and managed care plans to make beneficiary information available in electronic form. Electronic information will need to be disseminated in a manner compliant with Section 504 of the Rehabilitation Act. In addition, we believe that this proposed acceptance of electronic information delivery would further our goal of alignment across insurance affordability programs by aligning Medicaid managed care beneficiary information dissemination practices with those of the MA program and the commercial insurance market. We note that in this proposed rewrite of §438.10, we have removed the distinctions among MCO, PIHP and PAHP information standards. We believe that regardless of the scope of the managed care plan's

benefits, the information that should be provided to potential enrollees and enrollees is the same for all types of plans. Consequently, the standards for MCO, PIHP, and PAHP enrollee handbooks, provider directories, and formularies must be consistent. States retain the flexibility within the minimum federal elements - to tailor the information as needed; for example, specific benefit explanations for potential enrollees can be provided consistent with the scope of the managed care program and contracted managed care plans.

We propose to move the current definitions in paragraph (a) to §438.2 because those terms (“potential enrollee” and “enrollee”) are used throughout this part. It is important, however, to note the differences in these definitions: “potential enrollee” refers to a beneficiary that has been determined eligible for Medicaid but is not yet enrolled in a managed care plan, while “enrollee” refers to a beneficiary who is a member of a specific MCO, PIHP, PAHP, PCCM or PCCM entity. Proposed paragraph (a) would revise the definition of “prevalent” and add a definition of “readily accessible” for use in this section. The term “prevalent” is currently defined in §438.10(c)(1); we propose to amend the current definition of “prevalent” to clarify that the non-English languages that are relevant are those spoken by a significant number or percentage of potential enrollees and enrollees in the state that are limited English proficient, consistent with standards used by the Office for Civil Rights in enforcing anti-discrimination provisions related to individuals with limited English proficiency,.

We propose to add a definition of “readily accessible” to clarify parameters for the provision of electronic information. States, MCOs, PIHP, PAHPs, and PCCM entities should consult the latest section 508 guidelines issued by the U.S. Access Board or W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA (see <http://www.access-board.gov/sec508/guide/index.htm> and <http://www.w3.org/TR/WCAG20/>) for additional

information. We believe it is important to specifically address this issue given the inclusion of more complex populations in managed care programs.

Proposed paragraph (b) would clarify that the standards in this section apply to all managed care programs regardless of authority. We propose this scope deliberately because the distinctions among managed care programs that operate under the state plan and waivers or demonstration projects are immaterial for purposes of beneficiary educational materials that are provided in a managed care program. This proposed rule incorporates those statutory standards of section 1932(a)(5)(B) through (D) of the Act and proposes to expand upon them to encompass additional information for all beneficiaries based on our authority under section 1902(a)(4) of the Act to adopt standards and standards that are necessary for the proper and efficient operation of the state plan.

Proposed paragraph (c) lays out basic standards for information in managed care programs. Several of the proposed standards (that is, paragraphs (c)(1) through (c)(5)) are applicable to the state as part of its responsibility for ensuring delivery of critical program information to beneficiaries. Proposed paragraphs (c)(1), (c)(6) and (c)(7) are applicable to MCOs, PIHPs, PAHPs, and PCCM entities; however, PCCMs would need to comply only with paragraph (c)(1).

In proposed paragraph (c)(1), we state the fundamental standard that each state, enrollment broker, MCO, PIHP, PAHP, PCCM and PCCM entity provide all information in an easily understood and readily accessible manner and format, which includes the use of TTY/TDY and American sign language interpreters; this is similar to the current regulation at §438.10(b)(1) but would add PCCM entities consistent with our proposal discussed in section I.B.6.e. of this proposed rule. Except for PIHPs and PAHPs, this language implements the statutory provision in section 1932(a)(5)(A) of the Act for all enrollment, informational and instructional materials. We

would rely on section 1902(a)(4) of the Act authority to extend such standards on PIHPs, PAHPs, and PCCMs for the proper and efficient operation of the State plan to ensure that enrollees and potential enrollees receive information in a form and manner that they can understand. In paragraph (c)(2), we propose that states would need to use the beneficiary support system proposed under §438.71 in this proposed rule to provide education and choice counseling to all beneficiaries. We believe that this cross-reference more clearly expresses what states should do than the current regulation text. Currently in §438.10(b)(2), states must have in place a mechanism to help enrollees and potential enrollees understand the managed care program. We propose in paragraph (c)(3) that states, as noted earlier in this proposed rule, would need to operate a website for information about the state's managed care program. We are confident that all states already operate a website and that this proposal would merely codify existing practices. Proposed paragraph (c)(4) would have states develop standardized managed care definitions and terminology, and model enrollee handbooks and notices for use by its contracted managed care plans. The suggested list of definitions and terminology has been adapted from the standards for a uniform glossary that commercial insurers must include as part of their summary of benefits and coverage (SBC) in 45 CFR part 147. Model handbooks and enrollee notices are already used by mature managed care programs that have been in operation for several years and have proven to be a good tool for ensuring consistent information and tone in enrollee communications across a variety of managed care plans. In paragraph (c)(5), states would need to ensure, through their managed care contracts, that MCOs, PIHPs, PAHPs, and PCCM entities provide the information outlined in this section.

Proposed paragraph (c)(6) lists the standards for providing information electronically. Specifically, electronic information would have to be compliant with all language, formatting, and

accessibility standards; be in a prominent place on the state's, MCO's, PIHP's, PAHP's, or PCCM entity's website; and be able to be retained and printed. Additionally, all information must be made available to enrollees and potential enrollees in paper format upon request at no cost and provided within 5 calendar days. These standards are consistent with those for QHPs operating in the Marketplace; thus we believe that by proposing them we further our goal of alignment across insurance affordability programs.

Proposed paragraph (d) addresses federal standards for the language and format used for beneficiary information, and largely carries over existing standards from current paragraph (c). However, we are proposing to add three new standards, which we believe are important beneficiary standards and recognize the cultural and linguistic diversity of Medicaid beneficiaries. The first two changes, proposed in paragraph (d)(2) and (d)(3), would have materials for potential enrollees disseminated by the state, as well as enrollee materials disseminated by MCOs, PIHPs, PAHPs or PCCM entities, to be available in prevalent languages and include taglines in each prevalent non-English language and large print explaining the availability of written materials in those languages as well as oral interpretation in understanding the materials. We also propose, based on guidance from the American Printing House for the Blind, Inc., that large print must be no smaller than 18 pt. We also propose in (d)(3) that written materials must also be made available in alternative formats and auxiliary aids and services should be made available upon request of the potential enrollee and enrollee at no cost. The third change is proposed in paragraph (d)(3)(i) where we more specifically identify the 'materials' which each MCO, PIHP, PAHP or PCCM entity would have to make available in each prevalent non-English language in its service area. To determine the types of materials to which this standard should apply, we consulted guidance provided by HHS regarding access to programs and services for persons with LEP: HHS Guidance

to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons 68 Fed. Reg. 47,311 (Aug. 8, 2003) and Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency" at www.lep.gov. The HHS Guidance urges recipients of federal financial assistance, such as Medicaid agencies, to ensure that vital documents are translated into the non-English language of each regularly encountered LEP group eligible to be served or likely to be affected by the program or activity. Vital documents are those which contain information that is critical for obtaining benefits. We are proposing that provider directories, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services be considered vital documents, and therefore would have to be made available in each prevalent non-English language in its service area. The current standard for oral interpretation services would remain mostly unchanged in paragraphs (d)(4) except for adding a clarification that interpretive services include the use of auxiliary aids such as TTY/TDY and American sign language. Currently, under paragraphs (b)(5)(i) and (ii), states have to notify enrollees of the availability of interpretation and translation services and how to access them. We propose to add a new (d)(5)(ii) clarifying that potential enrollees and enrollees must be also be notified that auxiliary aids and services are available upon request and at no cost for enrollees with disabilities. This proposed addition would clarify that interpretive services are not limited to limited English proficient potential enrollees and enrollees. We propose to redesignate current paragraph (d)(5)(ii) as (d)(5)(iii). We request comment on the provisions of this paragraph.

Paragraph (d)(6) includes a standard that the availability of alternative formats for beneficiary materials must include a large print tagline and information on how to request auxiliary aids and services, including the provision of materials in alternative formats. Auxiliary aids

would include but are not limited to the use of TTY/TDY and American Sign Language interpreters. We also propose, based on guidance from the American Printing House for the Blind, Inc., that large print must be no smaller than 18 pt. We believe that the proposed changes in paragraph (d) represent important protections for beneficiaries who have limited English proficiency or need materials in other formats due to disabilities to adequately understand managed care programs and successfully navigate managed care plan processes.

In paragraph (e), we propose the information that must be provided to potential enrollees. As this information is provided to beneficiaries who either have the choice to enroll in the managed care program or must be enrolled in the managed care program to receive Medicaid benefits, we believe that it is important for the State to provide enough information for beneficiaries to know and understand the implications of participating in the managed care program. It is also important, for purposes of making an active selection of a MCO, PIHP, PAHP or PCCM entity, that the potential enrollee receive information about each choice available, including service area, participating providers, and quality and performance information to the extent available. We propose in paragraph (e)(1) to provide flexibility to the states to provide this information in paper or electronic format to ease the administrative burden and cost of mailing paper materials to potential enrollees. Interpretation of our current regulations, which did not provide alternatives to paper, has resulted in compliance actions against states that did not give these materials to potential enrollees in paper. States and MCOs are expected to assure effective communications consistent with the ADA and Section 504 of the Rehabilitation Act, consistent with applicable DOJ guidance. (See: <http://www.ada.gov/effective-comm.htm>), and at a minimum provide auxiliary aids and services to consumers with disabilities who need this information in alternative formats, upon request. We request comment on the flexibility offered to

the state on both the information elements and the provision of this information electronically or on paper. Proposed paragraphs (e)(1)(i) and (ii) would maintain current timeframes for the provision of the information.

In paragraphs (e)(2)(i) through (x), we propose a minimum list of topics that the state would need to provide in the information they send to potential enrollees; this includes disenrollment rights, basic features of managed care, populations excluded from enrollment, service area of each managed care plan, covered benefits, provider directory information, cost sharing, network adequacy standards, care coordination services available, and quality indicators for each MCO, PIHP, PAHP, and PCCM entity.

The next paragraphs of proposed §438.10 focus exclusively on information standards for managed care plan enrollees – that is, once they have selected and enrolled in a managed care plan. Paragraph (f) proposes general standards for both the state and managed care plans regarding enrollee information; paragraph (g) proposes the minimum content of enrollee handbooks and paragraph (h) proposes the minimum content of provider directories. The products of the standards proposed in these paragraphs would provide enrollees with a substantial and valuable source of information on most aspects of how to access care and fully utilize the benefits of their managed care enrollment. These documents, whether electronic or hard copy, offer the enrollee an easy to use reference that can often provide the information they seek. The proposed language in these paragraphs incorporates elements from the current regulatory standards for commercial insurers in 45 CFR part 147 regarding the provision of its SBC. While we recognize that electronic communication is easier and less expensive, we remain concerned that electronic communication not be the sole method for communicating this critical information to enrollees. To that end, we provide flexibility for a range of communication methods, including mail, email,

and website posting; however, managed care plans would need to notify enrollees that these materials are available in paper form and through auxiliary aids and services at no cost upon request.

As proposed, paragraph (f) would set forth basic standards applicable to information that must be disclosed to enrollees of MCOs, PIHPs, PAHPs, and PCCMs. In proposed §438.10(f)(1), we propose to redesignate an existing regulatory standard in current §438.10(f)(5); that standard is that the managed care entity must make a good faith effort to provide notice of the termination of a contracted (that is, in-network) provider to each affected enrollee within 15 days of receipt or issuance of the termination notice. For purpose of these standards, an affected enrollee is one who received his or her primary care from the provider or was seen on a regular basis by the provider. In paragraph (f)(2), we propose to redesignate an existing regulatory standard in current §438.10(f)(1); the state must notify all enrollees of their right to disenroll and clearly explain the process for doing so and, if enrollment is restricted for 90 days or more, provide this notice at least 60 calendar days in advance of each enrollment period. We propose to add “calendar” to remove ambiguity. Lastly, in proposed paragraph (f)(3), MCOs, PIHPs, PAHPs, and when appropriate PCCM entities, would have to provide any physician incentive plans in place as specified in §438.3(i), upon request.

The regulatory standards in proposed paragraphs (g), (h), and (i) address enrollee handbooks, provider directories, and formularies because we believe these are foundational tools to help enrollees utilize the benefits and services available to them from their managed care plan. Since the majority of Medicaid beneficiaries use managed care plans to access covered benefits, we believe it is critical for enrollees to have the information necessary to understand their rights, maximize their benefits, and be an effective self-advocate when necessary. We have declined to

propose regulatory standards for other types of plan-enrollee communications, recognizing that those decisions are best made at the state level based on the maturity and structure of each state's managed care program.

Proposed paragraph (g) outlines minimum content standards for the enrollee handbook and we have attempted to align with commercial insurance standards by reflecting similarities to the SBC in both content and appearance. In proposed paragraph (g)(1), each MCO, PIHP, PAHP or PCCM entity would have to provide an enrollee handbook to each enrollee within a reasonable time after receiving the enrollment notice from the state. While the information proposed to be included in the handbook (in proposed paragraph (g)(2)) already exists in current §438.10, it is currently not well organized or all in one section for easy reference. Paragraph (g)(2) proposes to compile all of the existing elements in one paragraph for easy reference. Taken together, these elements will be referred to as a "handbook" consistent with how the term is typically used in Medicaid managed care. While some minor grammatical revisions have been made for clarity, the elements remain the same as in current regulation. Paragraph (g)(3) proposes to clarify the circumstances under which the MCO, PIHP, PAHP, or PCCM entity would be considered to have provided the information in paragraph (g)(2). We propose mail, email if enrollee consent obtained, website with paper and electronic notification, auxiliary aids and services at no cost (upon request), and any other method that can reasonably be expected to result in the enrollee receiving the information. We propose this last method to provide flexibility for communication methods not commonly used, such as alternative communication devices for persons with disabilities, and other technological advances in communication not yet widely available. Proposed paragraph (g)(4) continues the current standard that enrollees be notified 30 days in advance of any significant change to any of the information in paragraph (g). This is an important enrollee

protection as it allows the enrollee, if impacted, time to seek additional information or assistance and make appropriate decisions. Consistent with other proposed revisions throughout §438.10, we propose to delete the standard that this notice be written and let the provisions of paragraphs (c) and (d) control regarding the standards for the use of written and electronic communications. Proposed paragraph (h) specifies the minimum content standards for provider directories. The content and accuracy of provider directories has long been an issue of contention between states, managed care plans and stakeholders. The move to electronic provision of this document would improve the accuracy of the information; however, even web-based provider directories can be out of date quickly without accurate information from participating providers to the managed care plans. Additionally, there is wide variation in the information provided in managed care plan provider directories. While we recognize that our proposed elements may not address every type of information that may be helpful for enrollees, we have attempted in this paragraph to balance all perspectives as well as recognize that managed care plans provide member services call centers and auxiliary aids and services (including TDY/TTY lines) which can provide more personalized and timely assistance to enrollees in locating appropriate providers.

Proposed paragraph (h)(1)(i) through (viii) would include all of the elements that exist currently in §438.10(f)(6)(i) but expands on them in four key ways. In addition to name, address, telephone number, and open panel status, we propose to add four additional elements: a provider's group/site affiliation, website URL (if available), the provider's cultural and linguistic capabilities, and the accessibility of the provider's office to enrollees with physical disabilities. Physicians' affiliation with a group/site would assist enrollees in more quickly identifying physicians they are searching for; likewise, a group practice/site website can be a good source of information for enrollees. Finally, accommodations available for persons with physical disabilities as stipulated by

the Americans with Disabilities Act and Section 504 are critical for managed care plans, which increasingly provide services to individuals with disabilities. This is important both operationally so that enrollees with limited vision and other impairments can reasonably access that information online as well as on paper, as well as in the delivery of services. It also is important for deaf and hard of hearing enrollees who may need in-person ASL interpreters as well as the use of TTY/TDY lines and/or relay services. We believe that meaningful access for those enrollees is available only when they can utilize the full scope of services at a provider's office. We request comment on these new elements, which deviate from the elements that are generally included in provider directories provided by MA plans and group health and private insurers. Paragraph (h)(2)(i) through (v) proposes five provider types that would have to be included in the directory, if applicable under the contract: physicians, hospitals, pharmacies, behavioral health, and LTSS. In paragraph (h)(3) we propose that paper provider directories must be updated at least monthly and electronic directories within 3 business days of receiving updated provider information. Lastly, to align managed care with both QHPs and MA, in paragraph (h)(4), we propose that provider directories be made available on the MCO's, PIHP's, PAHP's, or if applicable, PCCM entity's website. The current rule for MA plans (§422.111(h)) requires such plans to post provider directories online. In a recent final rule (80 FR 10873), HHS finalized a requirement for QHPs in a federally facilitated Marketplace to post provider directories in a machine readable format specified by the Secretary. The purpose of establishing machine readable files with provider directories would be to provide the opportunity for third parties to create resources that aggregate information on different plans. We believe posting machine readable formats of directories will increase transparency by allowing software developers to access this information and create innovative and informative tools to help enrollees better understand the availability of providers in

a specific plan. Therefore, we are proposing here that MCOs, PIHPs, PAHPs, and if applicable, PCCM entities must post provider directories on their websites in a machine readable file and format specified by the Secretary. We invite comment on this proposal.

Going forward, we believe that the accuracy and usefulness of provider directories could be improved by requiring that their data be held in a standardized format and be exposed through open and standardized application programming interfaces (APIs). Specifically, we are considering requiring the best available provider directory standard as listed in the ONC draft of the “2015 Interoperability Standards Advisory” published for public comment (available at <http://healthit.gov/standards-advisory>); that advisory lists the IHE IT Infrastructure Technical Framework Supplement, Healthcare Provider Directory (HPD), Trial Implementation Profile. This would allow CMS, State Medicaid, or private third parties to “plug into” the provider directories to perform automated accuracy checks. This could be done by comparing the directories against other data sources with bidirectional connections and interfaces, such as death registries and licensure registries. Provider directories with standardized APIs could also be leveraged by developers to create applications that are more useful for consumers than static, non-standardized websites. We invite comments on this strategy.

We also propose a new paragraph (i), Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities- Formulary. This proposed paragraph would have MCOs, PIHPs, PAHPs, and PCCM entities provide their medication formularies electronically or paper, if requested. Under proposed paragraph (i)(1) and (i)(2), the formulary must display all covered medications, both generic and brand name, and have the tier of each medication. We are proposing this paragraph because understanding how medications are covered by the managed care plan is important information for enrollees, particularly for those with chronic conditions or on-

going needs. Additionally, we propose that formulary drug lists be made available on the MCO's, PIHP's, PAHP's, or if applicable, PCCM entity's website in a machine readable file and format as specified by the Secretary for the same reasons discussed in this section of this proposed rule in connection with provider directories. Machine readable files with formulary drug lists would provide the opportunity for third parties to create resources that aggregate information on different plans. We believe this will increase transparency by allowing software developers to access this information and create innovative and informative tools to help enrollees better understand formulary drug lists across specific plans. We invite comment on this proposal.

e. Primary Care Case Management (§438.2, §438.3, §438.330, §438.340, and §438.350)

Primary Care Case Manager (PCCM) services have a unique status in the Medicaid program. PCCM services are considered a State-plan covered benefit through section 1905(a)(25) of the Act. Section 1905(t) of the Act defines PCCM services, the providers that may furnish them, and the standards for a PCCM contract – one of which is that the State's contract with the PCCM complies with applicable sections of 1932 of the Act (the managed care rules in the Act). A primary care case manager, as defined in section 1905(t)(2) of the Act, is considered a managed care entity under section 1932(a)(1)(B)(ii) of the Act. Current regulatory standards in part 438 have minimal standards that PCCM programs have to meet; they generally mirror the statutory standards specified in section 1932 of the Act.

Current regulations reflect the prevailing PCCM program design that existed in 1998. At that time, virtually all PCCM programs were intended to layer a 'gatekeeper' model on top of states' FFS programs. Each primary care provider who acted as a PCCM was paid a small monthly fee (typically less than \$5.00) per beneficiary in recognition of the provision of PCCM services, in addition to any direct service payment the provider might also receive from the state,

to coordinate access to primary care services and manage referrals to specialty care for Medicaid beneficiaries. The Medicaid provider was not held accountable for quality or health outcomes for that enrollee. We believe the current regulatory structure still works reasonably well for these ‘gatekeeper’ PCCM programs, which generally are very small and remain exclusively focused on individual primary care providers.

Over the past 8 years, however, states have determined that they need additional tools to better manage utilization of Medicaid services. Some states have added a more intensive care coordination function to their PCCM programs and these care coordination/case management activities have generally been provided, under contract, with regional non-profit networks in some states or for-profit organizations in others. Such entities typically oversee the case management/care coordination activities performed by the primary care case managers and administer provider financial incentives, provider profiling, and performance and quality reporting. The activities performed by the broader entity and the additional responsibilities and incentives available to primary care case managers built upon the early PCCM model; therefore, this expanded approach to primary care case management has been generally referred to as the “enhanced” PCCM model. Current regulations in part 438 do not explicitly address these entities as they were not a common model when the current regulations were drafted. Typically, a more robust PMPM fee has been paid to these entities, depending upon the scope of activities under the contract; however, these payments are not considered risk-based capitation payments subject to the actuarial soundness standards of §438.4 through §438.7 because the entities are not responsible for the provision of medical services under the state plan. Rather, the state continues to pay for medical services on a FFS basis. As these PMPM fees are not subject to the actuarial soundness standards, federal review and approval of these payments has been limited. In this rule, we

propose to adopt a term for these more intensive care case management entities: PCCM entities. Our proposed term reflects our view that these entities are PCCMs subject to the statutory minimum standards for PCCMs but by distinguishing these entities from the traditional PCCM model – one based on the use of individual providers to act as gatekeepers – we can effectively exercise our authority under section 1902(a)(4) of the Act to adopt additional standards for those PCCM entities that provide more intensive case management and care coordination, measure performance outcomes and quality improvement activities, and receive higher reimbursement.

In at least seven states, PCCM entities provide many administrative functions of health plans – such as network management, data analysis, quality improvement support (including HEDIS measures and enrollee satisfaction surveys), utilization and case management of a whole range of services including behavioral health and LTSS. Finally, in a few instances, the state has built in shared savings or other incentive payment arrangements with the PCCM entity and that entity's participating providers which result in the PCCM entity realizing profits from its effective exercise of its functions. In essence, the only difference between an MCO and PCCM entity in these states is that the PCCM entity does not accept financial risk for acute care or LTSS services. However, if the entity receives shared savings or other payments as a result of decreasing costs for those services through the provision of primary care case management services, the entity shares the same financial incentives as managed care plans.

In 2009, the Center for Health Care Strategies, Inc., produced a report analyzing what they termed 'enhanced' PCCM programs in five states: North Carolina, Pennsylvania, Oklahoma, Indiana and Arkansas.¹⁷ Since that time, both Colorado and Louisiana have implemented enhanced PCCM programs. These programs focus on intensive care management strategies

¹⁷ http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf

coupled with financial incentives, provider profiling, and performance and quality reporting.

The benefit to these arrangements is that the state is able to receive FFP for payments to the PCCM entities, because primary care case management services are a state plan covered service under section 1905(a)(25) of the Act, rather than the 50 percent administrative match they would receive if the state conducted these case management activities, network management, data analysis, and quality improvement support (including HEDIS measures and enrollee satisfaction surveys) themselves. However, these activities are significantly more involved than those PCCM services described in the current regulatory definition of a PCCM: “locating, coordinating and monitoring primary care services.” Consistent with our goal of modernization, we propose to update our regulatory structure to recognize these expanded set of services, but couple that modernization with new standards on PCCM entities that have the same operational responsibilities and financial incentives as managed care plans – absent the financial risk for medical services.

We propose to also distinguish the PCCM programs that are considered managed care, and therefore, subject to the specified standards of part 438, from other health care delivery systems, such as integrated care models, patient-centered medical homes, and accountable care organizations which would remain outside the purview of the regulatory changes we are proposing in this rule. State Medicaid Director Letters (SMDL) issued in 2012 outlined new flexibilities for states to implement integrated care models that fall on the spectrum between unmanaged FFS and full-risk managed care. SMDL #12-002 specifically highlighted that primary care case management is a state plan service, which does not necessarily have to be a managed care delivery system, available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf>.

Notwithstanding the guidance in those SMDLs, states continue to seek clarification on the attributes of a PCCM program that make it “managed care” and they perceive that there are additional burdens if the program is considered a managed care program. We clarify in this preamble that states may operate PCCM programs- under the rubric of integrated care models, accountable care organizations or other similar terms- without triggering the standards of part 438 (which include additional contractual obligations) as long as enrollees’ freedom of choice is not constrained and any willing and qualified provider can participate- that is, where traditional FFS rules for provider participation remain in place. For such programs that use FFS provider participation, only the statutory standards in section 1905(t) of the Act that apply to PCCM contracts will apply, and not our further interpretations and applications of the provisions of section 1932 of the Act. We request comment on this proposal and our underlying analysis; further, we request comment on whether we should consider further rule-making to better explain these differences.

The framework we are using to modernize the managed care standards for PCCM programs (consistent with the discussion above) distinguishes between PCCM programs that utilize individual provider approaches to provide a basic level of primary care case management and PCCM programs that are using entities to provide a more robust set of administrative functions similar to that of a managed care plan. To clarify these distinctions, we propose in §438.2 to exercise our flexibility under section 1902(a)(4) of the Act – to ensure proper and efficient management of the state plan – to update definitions for primary care case management and primary care case manager. We propose to modify the existing definition in §438.2 for a “primary care case management system” as a system under which a state contracts either with an individual (primary care case manager) to provide case management services or when a state contracts with

an entity to furnish case management services or a defined set of functions that go beyond case management services. We also propose to remove the reference to an “entity” under the existing definition of “primary care case manager” as an “entity” that provides primary care case management services is defined in the proposed new definition of “PCCM entity” that would permit a broader scope of functions to be provided than those focused on primary care case management services; these include such activities as intensive case management, development of enrollee care plans, execution of contracts and/or oversight responsibilities for the activities of FFS providers, provision of payments to FFS providers, enrollee outreach and education, operation of a customer service call center, provider profiling and quality improvement and measurement, coordination with behavioral health providers, and coordination with LTSS providers. We believe these functions are inclusive of the range of functions that current PCCM programs cover.

Throughout this document and in the revisions to part 438, we have included a reference to a PCCM entity wherever there was an existing standard on PCCMs. We have also identified those standards that only apply to PCCM entities when they undertake certain responsibilities on behalf of the state.

Existing law at §438.6(k) (which we propose above to move to §438.3(q)) implements the statutory provisions in section 1905(t) of the Act for PCCM contracts, which does not include a standard for our review and approval of those contracts. While we encourage states to submit them to us to assess compliance with the contract standards in this paragraph, most states do not do so. However, based on the range of functions that PCCM entities, as we have defined them, can provide to states as noted above, we believe that contract review and approval – similar to that of PIHPs and PAHPs under our authority under section 1902(a)(4) of the Act – is appropriate in this context. We believe our review would improve oversight and understanding of these programs.

Therefore, we propose a new §438.3(r) to have states obtain our approval of PCCM entity contracts. This proposed paragraph also specifies new standards that we propose elsewhere in this rule. For PCCM entities that have the same administrative responsibilities and financial incentives as MCOs, PIHPs, and PAHPs, states which hold their PCCM entities accountable for provider behavior and quality outcomes would have to monitor and evaluate the performance of their networks accordingly. Specifically, those PCCM entity contracts which provide for shared savings or other payment incentives – the same financial incentives that managed care plans have – should be held to higher standards in terms of enrollee information and quality improvement.

This proposed approach is consistent with the guidance that CMS has provided for integrated care models in SMDL #13-005 and SHO #13-007, available at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf> and <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-007.pdf>. The SMDL and SHO letter expressed our interest in achieving improved health, quality care and reduced costs. We noted that quality improvement and measurement are the foundation for payment models that can improve care and reduce costs, and encouraged states to develop statewide quality strategies that can guide efforts to improve quality across state Medicaid programs. Further, we laid out our expectations that states pursuing models that rely on measurable improvements as the basis for validation of payment, be able to articulate a comprehensive quality strategy that describes their overall goals and interventions. The difference in regulatory authority between integrated care models operating under the state plan and PCCM entities operating as a managed care entity should not result in differential treatment or expectations when the activities and responsibilities under an integrated care model and a PCCM entity are similar.

We have proposed changes to the following sections to effectuate these new standards

related to PCCM entities that are also discussed in proposed §438.3(r) at section I.B.2. of this proposed rule: §438.10; §438.330; §438.340; and §438.350. However, we do not propose to subject traditional PCCMs to these standards because PCCMs are not responsible for the activities that PCCM entities are responsible for under our proposed framework. In §438.10, we propose to treat PCCM entities like MCOs, PIHPs and PAHPs in areas including oral and written translation standards; general and miscellaneous enrollee information standards; and enrollee handbook and provider directory content standards. In §438.330, §438.340 and §438.350, we propose small modifications in each section, as follows, to propose new standards for PCCM entities:

- In §438.330, we propose that states assess the performance of each PCCM entity to detect over- and underutilization of services; performance measurement using standard measures; and conduct a program review.

- In §438.340, we propose that the state's quality strategy, consistent with the guidance provided in SMDL #13-007, describe how the state is assessing the performance and quality outcomes achieved by each PCCM entity.

- In §438.350, we propose – based on inquiries received by states with PCCM entities – that the state may have their EQRO perform an external quality review of each PCCM entity. Since EQRs of MCOs, PIHPs, and PAHPs focus on the operation of the managed care plan, we believe that applying similar review principles to PCCM entities is reasonable and appropriate.

f. Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM Entities (§438.52)

One of the key principles in federal statute and regulations is that enrollees – to the maximum extent possible – have a choice of more than one managed care plan. Section 1932(a)(3) of the Act requires that choice be an element of a mandatory managed care program for MCOs and PCCMs and we adopted, in the 2002 final rule at current §438.52, an application of that

standard for PIHPs and PAHPs. By statute, enrollees in a mandatory managed care program must be given the choice of at least two “managed care entities,” a term defined as PCCMs and MCOs.

We are proposing modifications to §438.52(a) to clarify current standards regarding the choice of two entities. Under the current regulation, states must give enrollees a choice of two MCOs, PIHPs, PAHPs, or PCCMs if enrollment with such an entity is necessary. In paragraph (a)(1), we propose to remove the reference to PCCM and provide that states that enroll beneficiaries in an MCO, PIHP or PAHP must give those beneficiaries a choice of at least two MCOs, PIHPs or PAHPs. As background, elsewhere in this proposed rule, we propose to separate PCCMs that are an individual physician (or physician assistant or certified nurse mid-wife) or a physician group practice from an entity or organization that employs such health care professionals and performs services on the state’s behalf in addition to basic primary case management services. That proposal underlies the proposed amendments here for how the statutory choice standards would be implemented for PCCMs and PCCM entities. In paragraph (a)(2), we propose that in a primary care case management system, as currently defined in §438.2, beneficiaries must be permitted to choose from at least two primary care case managers (PCCMs) employed by or contracted with the state. In paragraph (a)(3) we propose that beneficiaries who must enroll in a PCCM entity may be limited to one PCCM entity, but beneficiaries must be permitted to choose from at least two primary care case managers employed by or contracted with the PCCM entity. When a state’s primary care case management system uses individual providers (physicians, physician assistants, etc.), for the provision of primary care case management services, beneficiary choice is exercised at that level. We recognize that for programs which use PCCM entities, virtually all states employ either regional organizations that serve every enrollee residing in that region or a single statewide organization. We believe that the statutory standard for choice is

satisfied when a beneficiary is provided a choice of actual manager, namely that a beneficiary has the right under section 1932(a)(3) of the Act to select either a care manager/care coordinator employed by the entity or a primary care provider contracted with the entity (or in some cases, by the state directly). Our proposed changes explicitly permit such an approach.

In addition, section 1932(a)(3)(B) of the Act provided an exception to the standard that an enrollee have the choice of at least two MCOs, or PCCMs, if applicable, for states with rural areas. This exception is reflected in the current regulations at §438.52(b), wherein the exception to choice was extended to PIHPs and PAHPs. We propose two significant changes to the implementation of the rural area exception. First, as a consequence of our proposal to change the implementation of the enrollee choice standards, we propose to eliminate the rural exception for PCCMs.

Second, we propose to change the definition of a rural area for purposes of the state option to contract with one MCO, PIHP, PAHP, or PCCM under mandatory Medicaid managed care programs. The current definition of a rural area at §438.52(b)(3) is any area other than an “urban” area as specified in the Office of Management and Budget’s (OMB) delineation of Metropolitan Statistical Areas (hereinafter OMB Bulletin). The OMB Bulletin produces geographic distinctions focused on a core population center that has a high degree of social and economic integration with adjacent territories as measured by commuting ties, which can include less densely populated areas within a Metropolitan Statistical Area (MSA). OMB has consistently warned against the non-statistical use of the delineations within the OMB Bulletin, noting that: “Metropolitan and Micropolitan Statistical Area Standards do not produce an urban-rural classification, and confusion of these concepts can lead to difficulties in program implementation [for programs that rely on such distinctions].” See for example 75 FR 37236 (June 28, 2010).

Our experience working with states that have sought to exercise the rural exception to

choice gives credence to OMB's statement. We have encountered a number of states seeking to contract with one MCO, PIHP, PAHP, or PCCM system in sparsely populated counties that are classified as part of an MSA and cannot meet the current regulatory definition for a rural area. We believe the intent of the provision was to recognize the health care access challenges unique to rural areas as well as the likelihood that MCOs, PIHPs, and PAHPs could not sustain their financial model in areas with low Medicaid enrollment.

To better reflect the intent of the provision, we propose to adopt Medicare's county-based classifications to set network adequacy standards under the MA program. Medicare establishes population and density parameters based on approaches taken by the Census Bureau in defining "urbanized areas" and OMB's delineation of "metropolitan" and "micropolitan" areas. These parameters are then used to set nationwide county designations as "large metro," "metro," "micro," "rural," or "Counties with Extreme Access Considerations (CEAC)." The county designations are published annually in the MA Health Services Delivery (HSD) Reference file, which is accessible at the MA Applications page at <http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/>. We propose that a county with a designation other than large metro or metro would fall under the definition of a rural area for purposes of the rural exception to choice. We believe that the Medicare county designations would be easy for states to research and for us to confirm a county's classification as rural. In addition, we believe that a number of states that were barred from exercising the rural exception to choice under the existing standard would see greater flexibility with the proposed change. We believe that the modification to the definition of a "rural" area for purposes of exercising the exception to choice of health plans addresses past challenges faced by some states. However, consistent with the key principle in favor of plan choice outlined earlier,

we continue to encourage the provision of such choice to beneficiaries where feasible.

We considered adopting the geographic distinctions used by the Office of Rural Health Policy (ORHP) within the Health Resources and Services Administration (HRSA) for purposes of determining a provider's eligibility for grant funding available through that agency. ORHP's definition of a rural area identifies lower population counties or census tracts within a county that otherwise fall under OMB's delineation of MSAs. Census tracts are defined at the zip code rather than county level, so it is possible for a county to include multiple census tracts of different population densities. If we were to adopt ORHP's approach, we would need to establish a review standard for a county that as a whole did not qualify as rural and states would have the burden of researching the nature and scope of the census tracts to meet the standard.

g. Non-Emergency Medicaid Transportation PAHPs (§438.9)

As states' managed care programs have matured, states have used PAHPs for a broader scope of services than was initially considered when the Medicaid managed care rules were finalized in 2002. With that in consideration, we propose additional provisions throughout part 438 to address PAHPs providing medical services (as currently defined in §438.2) which are discussed throughout the preamble of this proposed rule. However, we understand that states may also use a PAHP structure to deliver only Non-Emergency Medical Transportation (NEMT) services when they are not using the state plan brokerage option authorized through section 1902 of the Act or providing NEMT through Medicaid FFS or as an administrative activity. We do not believe that states and PAHPs providing only NEMT services should have to comply with the full scope of PAHP provisions included in part 438. Therefore, we propose to amend the existing §438.8 to include only the specific provisions applicable to NEMT PAHPs.

First, we propose to change the section number of §438.8 to §438.9 because of additional

sections added to the beginning of the subpart. Second, in an effort to avoid duplicative information, we propose to delete the existing language in paragraphs (a) and (b) as all the PIHP and PAHP provisions listed in the existing paragraphs are specified throughout the regulatory text of part 438 and, therefore, it is unnecessary to include a separate section listing the standards applicable to PIHPs and PAHPs. We propose a new paragraph (a) which defines an NEMT PAHP as an entity that provides only NEMT services to enrollees under contract with the state on a pre-paid capitated basis or other payment arrangement that do not use state plan payment rates. If a state chooses to use a PAHP to provide NEMT services along with any other ambulatory medical service, that PAHP would then be considered a traditional PAHP as defined in §438.2 and all the PAHP provisions throughout part 438 would apply. Lastly, in paragraph (b) we list the specific provisions in part 438 that would apply to NEMT PAHPs in the same way they apply to any other PAHP. The provisions that apply include contracting provisions, actuarial soundness standards, information standards, anti-discrimination provisions, certain state responsibility provisions, certain enrollee rights and responsibilities, certain PAHP standards, right to fair hearings, and certain program integrity standards. We believe this list achieves the appropriate balance of beneficiary protections and administrative efficiency for States and NEMT PAHPs.

h. State Plan Standards (§438.50)

Section 438.50 governs state plan standards for programs with mandatory managed care enrollment and currently has a reference to “managed care entities.” Although defined in the statute, “managed care entities” is an undefined term in the regulation. Because this provision only applies to MCOs and PCCMs as referenced later in §438.50, we propose to replace the term “managed care entities” with “MCOs, PCCMs, or PCCM entities, as applicable.”

In addition, we propose to delete paragraphs (e) and (f), which addressed priority and

default enrollments for managed care programs operated under section 1932(a) of the Act. These processes, along with other general standards for enrollment, that are applicable to all authorities for managed care programs are provided in the proposed new §438.54.

7. Implementing Statutory Provisions

a. Encounter Data and Health Information Systems (§438.2, §438.242 and §438.818)

Sections 6402(c)(3) and 6504(b)(1) of the Affordable Care Act reorganize, amend, and add to the provisions of sections 1903(i)(25) and 1903(m)(2)(A)(xi) of the Act by adding provisions related to routine reporting of encounter data as a condition for receiving federal matching payments for medical assistance. Section 1903(i)(25) of the Act mandates that, effective March 23, 2010, federal matching payments to the states must not be made for individuals for whom the state does not report enrollee encounter data to us. Further, section 1903(m)(2)(A)(xi) of the Act specifies that an MCO must report “patient encounter data” for contract years after January 1, 2010, to the state in a timeframe and level of detail specified by the Secretary. As discussed below, the data that must be collected and reported under these provisions is the same, but the population of “enrollees,” compared to “patients,” includes enrollees of PIHPs and PAHPs under our interpretation.

Since effective monitoring of all programs from which enrollees receive services is a critical function, we are proposing to expand the contract standards that apply the provisions of section 1903(m)(2)(A)(xi) of the Act to PIHPs and PAHPs by utilizing authority under section 1902(a)(4) of the Act to ensure the proper and efficient operation of the State plan.

In issuing these provisions, we propose to add the following:

- A definition of enrollee encounter data in §438.2;
- Additional MCO, PIHP, and PAHP contract standards defining enrollee encounter data

submission and maintenance standards;

- Clarifications to better align the basic elements of a health information system with the Affordable Care Act; and
- Standards on the state to report accurate, complete, and timely enrollee encounter data to us as a condition for receiving federal matching payments on its MCO, PIHP, and PAHP contract expenditures.

In §438.2, we propose to define enrollee encounter data as the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP that is subject to the standards of §§438.242 and 438.818.

We propose to revise §438.242 to clarify and align the basic elements of a MCO, PIHP, or PAHP health information system with the Affordable Care Act. The size and scope of today's Medicaid programs need robust, timely, and accurate data to ensure the highest financial and program performance, support policy analyses, and maintain ongoing improvement that enables data-driven decision making. In August 2013, we released SMDL #13-004 that issued guidance to states on the Transformed Medicaid Statistical Information System (T-MSIS) <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf>. We intend to review whether managed care entities provide timely and accurate encounter data to facilitate the transition to T-MSIS. Future guidance and revisions to the CMS EQR protocols would reflect this ongoing effort. In paragraph (a) we use authority in section 1902(a)(4) of the Act for the proper and efficient administration of the state plan and propose to include PAHPs as being subject to the standards. This is in alignment with the reasoning for expanding numerous other standards throughout this part to PAHPs; that is, the services they are contracted to provide are important and they must be held as fully accountable as MCOs and PIHPs and enrollees of PAHPs must be

afforded the same protections as MCO and PIHP enrollees. Additionally, the reference to having sufficient data to achieve the objectives of “this subpart” is changed to “this part” to emphasize the critical role data plays in achieving the objectives throughout part 438.

In §438.242(b)(1), we propose a specific reference to the new standard in section 6504(a) of the Affordable Care Act, which would mandate that state claims processing and retrieval systems be able to submit data elements to us deemed necessary for Medicaid program integrity, oversight, and improvement. Existing paragraph (b)(1) is redesignated as paragraph (b)(2) and proposes to add “all” to clearly indicate that data collected by the State would have to include all services furnished to an enrollee. To further support our intent, in paragraph (b)(3)(i), we propose to add “including capitated providers” as this is currently a data weakness for many states, MCOs, PIHPs, and PAHPs. Utilization data from capitated providers is frequently less robust, or in some cases non-existent. This data is equally as important as the data from providers paid on a FFS basis and must be incorporated and utilized in all MCO, PIHP, and PAHP functions.

We propose a new §438.242(c) to add enrollee encounter data standards that would have to be incorporated in all MCO, PIHP, and PAHP contracts. Contracts would have to specify that enrollee encounter data must: include rendering provider information; be submitted in a manner compliant with our specifications and in accordance with the standards of §438.818; and be submitted to the State in a format consistent with the industry standard ASC X12N 835, ASC X12N 837, and NCPDP formatting. In paragraph (c)(2), we propose that MCOs, PIHPs, and PAHPs submit data at a level of detail to be specified by CMS. To retain flexibility to adapt to changes in payment practices over time, we anticipate issuing clarifying guidance in the future to provide specificity. At a minimum, we expect the initial guidance to include standards for MCOs, PIHPs, and PAHPs to submit to the state: enrollee and provider identifying information; service,

procedure and diagnosis codes; allowed/paid, enrollee responsibility, and third party liability amounts; and service, claim submission, adjudication, and payment dates.

We propose to add a new §438.818 entitled Enrollee Encounter Data to implement the standard for enrollee encounter data reporting by the state. In this section, we propose that federal matching payments would not be available for states that do not meet established data submission benchmarks for accuracy, completeness, and timeliness. Timeliness and frequency of reporting encounter data is a key issue in terms of alignment between the managed care delivery system and the FFS Medicaid delivery system. We released guidance in 2013¹⁸ that clarified the data elements, reporting structure for, and frequency of enrollee encounter data in the Medicaid Statistical Information System (MSIS). Those standards mandate monthly submission for all FFS and managed care data.

In addition to receipt of data in a timely manner, receipt of data that is accurate and complete is integral to our administration and oversight of state Medicaid programs. This means that encounter data submitted to us must represent all services received by an enrollee regardless of payment methodology, including services sub-capitated by a MCO, PIHP, or PAHP to a provider. In proposed §438.818(a), we restate the statutory provision prohibiting FFP unless the state meets the standards for submitting encounter data. Proposed paragraph (a)(1) would have the submission of encounter data be compliant with current HIPAA security and privacy standards and in the format needed by the Medicaid Statistical Information System (MSIS) or any successor format. MSIS and T-MSIS are the repositories of all encounter data for the Medicaid program and although submission of data to MSIS has been a standard for years, states have not always invested the resources needed to ensure the quality of the submissions. We propose these changes to

¹⁸ <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf>

support efforts currently underway to improve the accuracy, timeliness, and completeness of submissions. In proposed paragraph (a)(2), the state would have to validate enrollee encounter data before each submission to us. States may use various methods to ensure the accuracy and completeness of the encounter data. One such method may be to use the protocol defining the optional External Quality Review (EQR) activity for Encounter Data Validation. States that use their EQRO to conduct Encounter Data Validation can receive 75 percent match for those contract expenses as specified in section 1903(a)(3)(C)(ii) of the Act. We expect that if a State chooses a different method, it will ensure that there is sufficient analytic rigor in the chosen method. We request comment on other possible methods for achieving validated data in each submission.

Proposed §438.818(a)(3) would reinforce the importance of complying with all MSIS encounter data reporting standards as a condition for receipt of FFP. Encounter data is just one piece of a complete MSIS submission. To maximize our ability to fully integrate and utilize all MSIS data for comprehensive analysis and oversight, encounter data needs to be fully compliant. In §438.818(b) and (c), we propose to review each encounter data submission for accuracy and potentially defer or disallow payment to a state if it is determined that the enrollee encounter data set is not complete, accurate, and timely. If, after review of an encounter data submission, we determine that it does not comply with established criteria, we propose to provide the State with a reasonable opportunity to make the submission compliant. If the State is unable to make the submission compliant within the time allowed, we propose to defer and/or disallow FFP for the MCO, PIHP, or PAHP contract in question. We believe that the statute contemplates a per-enrollee disallowance for a failure to report enrollee encounter data. We believe it is more accurate to calculate the deferral and/or disallowance amount based on the enrollee and the specific service type of the non-compliant data. Using this methodology, only the portion of the

capitation payment attributable to that enrollee for the service type of the non-compliant data would be considered for deferral and/or disallowance. For example, if the non-compliant encounter data is for inpatient hospital services, then only the inpatient hospital portion of the capitation payment for that enrollee would be subject to deferral and/or disallowance.

Any reduction in FFP would be effectuated through the process outlined in §430.40 and §430.42.

In §438.818(d), we are proposing that within 90 calendar days of the effective date of the final regulation, states would have to submit to us a detailed plan of their procedures to ensure that complete and accurate data are being submitted timely. We would work with the states to develop a comprehensive and workable procedure and would review and approve the states' plans for compliance.

b. Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Entities (§438.14)

This section implements section 5006(d) of the American Reinvestment and Recovery Act of 2009, which created section 1932(h) of the Act governing the treatment of Indians, Indian health care providers and Indian managed care entities, participating in Medicaid managed care programs. We had previously provided guidance on this statutory provision in a State Medicaid Director Letter on January 22, 2010 (SMDL #10-001, ARRA #6)

<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10001.PDF>. The regulations proposed below implement that guidance consistent with statutory language. To ensure the proper and efficient operation of the state plan, we are proposing to expand the standards that apply the provisions of section 1932(h) of the Act to PIHPs and PAHPs through the authority under section 1902(a)(4) of the Act.

In this section and for this purpose, we propose in paragraph (a) to define the following terms: “Indian,” “Indian health care provider (IHCP),” and “Indian managed care entity (IMCE)” consistent with statutory and existing regulatory definitions.

In paragraph (b), we propose that each MCO, PIHP, PAHP, and PCCM entity’s contract must demonstrate sufficient IHCPs in the managed care network and that Indian enrollees be able to obtain services from them; that IHCPs be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers whether the IHCP participates in the managed care network or not; permit any Indian who is enrolled in a non-Indian managed care entity and eligible to receive services from a participating IHCP to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services; permit Indian enrollees to obtain covered services from out-of-network IHCPs; and in any state where timely access to covered services cannot be ensured due to few or no IHCPs, a MCO, PIHP or PAHP would be considered to have met the standard for adequacy of IHCP providers if either Indian enrollees are permitted to access out-of-state IHCPs, or the state deems the lack of IHCP providers to justify good cause for an Indian’s disenrollment from both the MCO, PIHP or PAHP and the State’s managed care program in accordance with §438.56(c). We believe the criteria established in proposed paragraph (b)(5) complies with section 1932(h)(2)(A)(ii) of the Act which provides for the Secretary to establish procedures for determining compliance with this standard.

We invite comment on other possible ways to approach this issue.

Proposed §438.14(c) outlines payment standards. Proposed paragraph (c)(1) specifies that when an IHCP is enrolled in Medicaid as a FQHC but is not a participating provider with a MCO, PIHP or PAHP, it must be paid FQHC payment rates, including any supplemental payment due from the state. Where the IHCPs is not enrolled in Medicaid as a FQHC, proposed paragraph

(c)(2) would have the MCO, PIHP, or PAHP payment be the same payment as it would receive using a FFS payment methodology under the State plan or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, regardless of its contracting status with the MCO, PIHP or PAHP.

Proposed paragraph (d) would implement the statutory provision permitting an IMCE to restrict its enrollment to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians, without being in violation of the standards in §438.3(d).

This proposed rule has tribal implications and is therefore, subject to the CMS Tribal Consultation Policy (November 2011) http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTCP_FINAL_11_17_11.pdf. Consistent with this policy, we held an All Tribes' Call on May 7, 2014 and considered tribal comments received at that time. In addition, prior to publication of the final rule, we will conduct further tribal consultation. This consultation process is in addition to the notice and opportunity for comment otherwise provided in the rulemaking process. We provided a detailed review of the provisions proposed in §438.14 as well as a brief overview of the entire scope of changes being made to the part. One participant provided feedback on two areas: the applicability of these provisions to PIHPs and PAHPs; and the applicability of the prompt payment provisions to the state for wrap payments. Our staff explained that the proposed regulations would apply to PIHPs and PAHPs to the same extent as they would apply to MCOs. We also clarified that the prompt payment provisions proposed in §438.14(d) do not apply to payments made by the state; however, section 1902(bb)(5)(B) of the Act addresses prompt payment standards for states.

We seek comment on the overall approach to this provision, including as to whether these proposals are adequate to ensure that Indian enrollees have timely and integrated access to covered

services consistent with section 5006 of the ARRA. We seek comment on how to facilitate a coordinated approach for care for Indian enrollees who receive services from a non-participating IHCP and who need Medicaid covered services through a referral to a specialty provider. Also, we seek comment on the potential barriers to contracting with managed care plans for IHCPs and what technical assistance and resources should be made available to states, managed care plans, and IHCPs to facilitate these relationships. Such resources might include an I/T/U contract addendum, similar to those created for the QHPs and organizations delivering the Medicare Part D benefit.

See

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Model_QHP_Addendum_Indian_Health_Care_Providers_04-25-14.pdf

and [http://www.cms.gov/Medicare/Prescription-Drug-](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/2014-Part-D-Application.pdf)

[Coverage/PrescriptionDrugCovContra/Downloads/2014-Part-D-Application.pdf](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/2014-Part-D-Application.pdf), at Appendix

XVII.

c. Emergency and Post-Stabilization Services (§438.114)

We propose to revise portions of §438.114 to make technical corrections to the existing regulations. We are not proposing any changes to paragraph (a), (d), and (f).

We propose to correct an error in the current regulations at paragraph (b) by removing paragraph (2) which refers to PCCMs with a risk contract. This provision is inconsistent with the rest of our managed care regulatory structure, in that a PCCM which accepts risk for medical services – including the emergency services referenced in this section – would be considered either a PAHP or PIHP (depending on the scope of medical services at risk). Because a PCCM would never be responsible for coverage and payment of emergency services, we have struck that reference from paragraph (b). A state will always be responsible for coverage and payment of

emergency services if it operates a PCCM program, which is reflected in the proposed revisions to paragraph (b)(2), where we propose to move the existing text in (b)(3) with the addition of “PCCM entities.”

In paragraph (c)(1), we propose to add PCCM entity to each reference to “MCO, PIHP, PAHP, or PCCM” for consistency with changes discussed in I.B.6.e of this proposed rule. In paragraph (c)(2), we propose to redesignate (c)(2)(i) as (c)(2) and delete (c)(2)(ii) for the reason described previously for paragraph (b).

Currently in paragraph (e), MCOs, PIHPs, and PAHPs must follow MA guidelines when covering post-stabilization services and be paid in accordance with Medicare guidelines. However, payment for post-stabilization services to Medicaid enrollees is governed by Medicaid and State rules. We correct this misleading provision by proposing language that ensures that hospitals providing post-stabilization services receive payment consistent with federal and State Medicaid payment standards, not based on Medicare rates. The resulting language would apply MA coverage guidelines to MCOs, PIHPs and PAHPs but Medicaid payment standards for covered post-stabilization services.

8. Definitions and Technical Corrections

a. Definitions

As discussed throughout this proposed rule, we propose to redesignate and add several definitions to §438.2 in connection with changes we have proposed to specific sections and subparts. In addition, we are proposing several modifications and additions to §438.2 to address terms used throughout this part. In §438.2 we propose to modify existing definitions for “capitation payment,” “comprehensive risk contract,” “health care professional,” “health insuring organization,” “managed care organization,” “nonrisk contract,” “prepaid ambulatory health plan,”

“prepaid inpatient health plan,” and “risk contract.” In addition, we propose to add definitions for “managed care program,” “network provider,” and “state,” which are terms used with some frequency in part 438 but are not currently defined.

For the existing definition of “capitation payment,” we propose to delete the word “agency” following “state,” consistent with our proposal to add a definition for “state.” In addition, we propose to remove the word “medical” that modifies “services” in recognition of our proposed changes throughout this proposed rule to incorporate managed long-term services and supports in part 438.

For the existing definition of a “comprehensive risk contract” we propose to add that the contract is “between the State and an MCO.” We believe that this proposed modification would make clear that only MCOs can have comprehensive risk contracts and it is also appropriate to identify the parties to the contract.

We propose to revise the definition for “health care professional.” For purposes of section 1932(b)(3)(C) of the Act, “health care professional” is defined as a “physician . . . or other health care professional if coverage for the professional’s services is provided under the contract” and sets forth a minimum list of health care professionals that may provide services covered under the managed care contract. We propose to include language from the statutory definition in the regulation that the physician’s or provider’s services are covered under the contract in our regulatory definition of “health care professional” to clarify that providers of services other than medical services, such as long-term services and supports, would be included in this definition. We also propose to delete the list of professionals in section 1932(b)(3)(C) of the Act from our regulatory definition of “health care professional” because the list was not intended to be exclusive and inclusion of this list in the regulatory definition does not clarify our intent for this definition.

We request comment on this approach.

In the existing definition of a “health insuring organization,” we propose to correct a technical error to the citation to the Omnibus Budget Reconciliation Act of 1985 and update the reference to statutes that have since amended the HIO-related provisions established in the 1985 statute.

In the existing definition of a “managed care organization” we propose to clarify, consistent with section 1903(m) of the Act that the Secretary determines if the conditions specified are met by an entity seeking to qualify for a comprehensive risk contract. The existing language does not identify who makes such a determination.

In the proposed definition of a “nonrisk contract,” we propose language to clarify that such a contract is between the state and a PIHP or PAHP. This proposed revision is consistent with the proposed change to identify the parties subject to a “comprehensive risk contract.” Consistent with the revisions proposed for “capitation payments,” we propose to remove “medical” as the modifier for “services” in the definitions for “prepaid ambulatory health plan” and “prepaid inpatient health plan.” We also propose to remove “agency” that follows “state” consistent with our proposal to add a definition for “state.”

In the existing definition of a “risk contract,” we propose to clarify that such a contract is between the state and MCO, PIHP or PAHP. This proposed revision is consistent with the proposed change to identify the parties subject to a “comprehensive risk contract.”

We propose to add a definition for the phrase “managed care program,” which is currently used in several sections of this part. We propose this term mean a managed care delivery system operated by a state as authorized in the 1915(a) or (b), 1932(a), or 1115(a) of the Act.

We propose to add a definition for “network provider,” a term that is currently used in

several sections of this part, as “a health care professional, group of health care professionals, or entity that receives Medicaid funding directly or indirectly to order, refer, or render covered services as the result of the state’s arrangement with an MCO, PIHP, or PAHP.” We intend this term to include all types of health care professionals, either as an individual or through a group, and entities that order, refer, or render covered Medicaid services. We believe that these distinctions recognize the arrangements in some state where MCOs, PIHPs, or PAHPs contract with provider groups or other MCOs, PIHPs, or PAHPs to carry out the obligations under the contract. We also propose to insert “network provider” in place of “affiliated provider” as used in this part for consistency in use of terminology.

We currently have inconsistent references to the “state,” “state Medicaid agency” or “agency” throughout part 438. Therefore, we propose to add a definition for “state” as the “Single State Agency” as defined in §431.10. We also propose to replace the aforementioned terms with “state” for consistency throughout part 438.

b. Technical corrections

We propose to correct a limited number of technical and typographical errors identified in the June 14, 2002 final rule and the October 25, 2002 correcting amendment, as well as those identified through our review of the existing regulations in part 438.

- We propose to update the cross-reference to cost-sharing rules in §438.108 to reflect recent revisions to part 447.
- For purposes of consistency throughout part 438, we are removing specific references to our Regional Office in §438.806(a)(1) and replacing it with a general reference to CMS. This proposed change does not represent a modification in the role of the Regional Offices; rather, we would prefer to establish workflow processes in sub-regulatory guidance rather than in regulation.

- We propose to delete §438.804 related the primary care provider payment increase under section 1202 of the Affordable Care Act as that provision expired at the close of calendar year 2014.

II. CHIP Requirements

A. Background

CHIPRA and the Affordable Care Act applied several Medicaid managed care provisions in section 1932 of the Act to CHIP. Specific Medicaid statutory provisions that apply to CHIP include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; section 1932(e), Sanctions for Noncompliance; and sections 1902(a)(77) and 1902(kk) of the Act related to provider and supplier screening, oversight, and reporting.

This proposed rule builds on initial guidance on the implementation of section 403 of CHIPRA provided in State Health Official (SHO) letters 09-008 and 09-013, issued on August 31, 2009 and October 21, 2009, respectively. (SHO #09-008 is available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109a.pdf>. SHO #09-013 is available at <http://www.medicare.gov/Federal-Policy-Guidance/downloads/SHO102109.pdf>.) The SHO letters specified that all CHIP managed care contracts were to include the provisions of section 2103(f) of the Act, as amended by section 403 of CHIPRA effective July 1, 2009. Because the provisions addressed in this proposed rule codify statute and guidance that has been in place since 2009, we anticipate that states have already implemented many of these provisions as outlined in the SHOs.

Our goal for these regulations is to align CHIP managed care standards with those of the

Marketplace and Medicaid where practical. This will ensure consistency across programs. In this same rule, we propose revisions to existing Medicaid regulations as part of an effort to modernize managed care contracting and service delivery while improving health care outcomes and beneficiary experience in a cost effective manner. Therefore, where appropriate, we propose to align the CHIP managed care regulations with some of the proposed revisions to the Medicaid managed care rules.

We recognize that CHIP has historically had few regulations related to managed care. Our intent with this proposed rule is to ensure transparency by increasing the information about CHIP managed care available to both the Federal government and the public. We have worked to balance the need for information about state oversight of CHIP managed care plans against the administrative burden of complying with the proposed regulations. To that end, we propose to only apply the rules that are most important for aligning CHIP managed care with Marketplace and Medicaid managed care rules. The scope of the CHIP proposed regulations is narrower than the proposed revisions and amendments to the Medicaid managed care regulations. Most of the proposed CHIP regulatory changes are limited in scope to those included in section 403 of CHIPRA and, where allowable, those changes that will align the program with the Marketplace. We seek comment on the breadth of the proposed CHIP managed care regulations compared to the proposed Medicaid managed care regulations and whether CHIP should incorporate additional standards from Medicaid.

B. Provisions of the Proposed Regulations

We propose adding a new subpart L to part 457, which will contain all of the regulations related to CHIP managed care plans. Most of the proposed regulations in this subpart are new, however we also propose to move portions of §457.940 and §457.950 and all of §457.955 from

subpart I to the new subpart. This will ensure that all information related to managed care is contained in one subpart. We propose to make revisions to §457.204 related to federal financial participation. In addition, we propose to revise §457.760 related to Strategic Planning, Reporting, and Evaluation.

1. Definitions (§457.10, §457.902)

We propose to update the definitions section at §457.10. First, we propose to separately define managed care organization (MCO), prepaid ambulatory health plan (PAHP), prepaid inpatient health plan (PIHP), primary care case management primary care case manager (PCCM), and PCCM entity, using the Medicaid definitions at §438.2. This is a change from our previous approach which included all types of managed care entities in a single term (managed care entity). We also propose to adopt the Medicaid definitions of comprehensive risk contract, external quality review (EQR), external quality review organization (EQRO), and risk contract. Finally, we propose to move, unchanged, the definition of actuarially sound principles and FFS entity to §457.10 from §457.902.

2. Federal financial participation (§457.204)

We are not adopting Medicaid managed care regulations related to withholding Federal financial participation for failure to comply with Federal regulations in subpart J of part 438, because we believe CHIP has an existing regulation (§457.204) that serves a similar purpose. We propose to clarify in §457.204(a) that CMS may withhold federal financial participation if the administrator finds that the state plan or state practice is in substantial non-compliance with the regulations in part 457. In addition, we propose to include examples of substantial non-compliance, including failure to comply with requirements that significantly affect federal or state oversight or state reporting. We do not intend the list of examples in §457.204 to be

comprehensive; we leave open the possibility that other actions or failures to act could amount to substantial non-compliance with title XXI of the Act or the regulations in part 457.

3. Basis, Scope, and Applicability (§457.1200)

In §457.1200, we describe the statutory basis and scope of proposed subpart L. We propose to primarily limit the scope of the CHIP regulations to those included in section 2103(f)(3) of the Act, as added by section 403 of CHIPRA. That section applies sections 1932(a)(4), 1932(a)(5), 1932(b), 1932(c), 1932(d), and 1932(e) of the Act to CHIP. In addition, we propose to implement section 2107(e)(1)(M) of the Act, as added by section 5006 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5, ARRA). This provision applies sections 1932(a)(2)(C) and 1932(h) of the Act, which provide protections for American Indians to CHIP. We also propose to implement statutory provisions related to program integrity, specifically sections 2107(b) and 2107(e)(2)(C) through (E) of the Act. Finally, we also rely on section 2101(a) of the Act, which provides that the purpose of Title XXI is to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. We seek comment on whether this approach is appropriate, or whether we should narrow or broaden the CHIP regulations.

4. Contracting Requirements (§457.950, §457.1201)

Previously, all CHIP contracting requirements, including managed care contracting requirements, were at §457.950. We propose to move some pieces of §457.950 related to managed care into a new §457.1201 and eliminate others. Specifically, we have retained from §457.950(a)(2) the provision that an MCO, PAHP, or PIHP (formerly referred to as MCEs) contract include an attestation to the accuracy, completeness, and truthfulness of claims and payment data at §457.1201(n). Similarly, at §457.1201(o), we retain the language from

§457.950(a)(4) that contracts include a guarantee that an MCO, PAHP, or PIHP (formerly MCE) will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. We propose to eliminate the requirements at §457.950(a)(1) and §457.950(a)(3) for contracts to include enrollment and other information, and for the state, CMS, and HHS Office of the Inspector General to have access to claims and payment data. We believe these requirements are subsumed in the other standards in §457.1201, described below, and do not need to be retained, however we seek comment on this approach.

We also propose new contracting standards in §457.1201, under the authority of section 2101(a) of the Act. Although we previously did not require submission of managed care contracts, there were also few statutory managed care requirements. Now that the CHIP statute has been amended to incorporate some of the Medicaid managed care requirements, it is more important for CMS to have oversight through contract review. We propose some CHIP-specific contracting requirements and propose to adopt some of the Medicaid standards from §438.3. The Medicaid standards we have adopted without modification relate to the relevant entities eligible for comprehensive risk contracts, the inclusion of payment rates, some of the prohibitions on enrollment discrimination, complying with applicable laws and conflict of interest safeguards, the inspection and audit of records and access to facilities, physician incentive plans, provider choice, audited financial reports, and some of the additional rules for contracts with PCCMs and PCCM entities.

Our proposed CHIP-specific provisions at §457.1201(a) would have states submit CHIP managed care contracts in accordance with standards that will be specified by the Secretary. We do not propose to condition FFP on CMS' prior approval of MCO contracts, which diverges from the Medicaid standards at §438.3 and §438.806. We considered two alternative policies: aligning

CHIP with the Medicaid standard that prior approval of the contract is a condition to receive FFP; or requiring submission of the contract to receive FFP. Because we do not currently require contract review and preapproval as a condition for FFP in CHIP managed care, we have proposed an approach that would begin to give CMS and the public information on CHIP managed care contracting. Once we have learned more, we may consider adopting additional standards. We seek comment on our proposed approach and the alternatives, and on the timing of submission of contracts.

Similarly, although we are not adopting Medicaid rules related to rate review, the proposed language at §457.1201(a) does require that CHIP contracts submitted to CMS include the rate that will be paid to the managed care entity. We believe this information will help us evaluate the cost, efficiency, and effectiveness of managed care contracts.

There are several standards at §438.3 that we do not propose to adopt in CHIP, either because we do not have authority or because they are not appropriate for the CHIP population. Specifically, we are not proposing to adopt the following standards for purposes of CHIP managed care plans:

- That health insurance organizations (HIO) described in §438.3(b)(4) and (b)(5) are eligible for comprehensive risk contracts, and the special rules related to HIOs in §438.3(p) because CHIP does not have such entities.
- Voluntary enrollment at §438.3(d)(2), because states may have exclusively mandatory enrollment in CHIP managed care;
- The list of services that may be provided by a managed care entity at §438.3(e) because we review rates in CHIP;
- The provider preventable condition standards at §438.3(g), because we do not require

such reporting in CHIP;

- The advance directives standard at §438.3(j) or LTSS contract standards at §438.3(o)

because we do not believe they are applicable to the CHIP population;

- The standards related to coverage of outpatient drugs at §438.3(s); and
- The standards related to dually eligible beneficiaries at §438.3(t) and enrollees that are

patients in an IMD at §438.3(u), because there are not applicable populations in CHIP.

5. Rate Development Standards and Medical Loss Ratio (§457.940, §457.1203, §457.1205)

Currently, regulations related to CHIP managed care rate setting are in §457.940(b)(2), (c), and (e). We propose to move those standards to §457.1203. The standards would remain substantively unchanged, although we propose to change the term “principles of actuarial soundness” to “actuarially sound principles,” to match the definition, which we propose to move to §457.10. The standards unrelated to managed care rate setting in §457.940(a), (b)(1), and (d) would remain in that section. In addition, to align with the private market and the Medicaid managed care proposal in this rule, we propose at §457.1203(c) to adopt a minimum medical loss ratio (MLR) in CHIP. This proposal is the same as the Medicaid proposal at §438.4(b)(7). As discussed in more detail elsewhere in this proposed rule, a standardized MLR calculation allows regulators the ability to conduct a retrospective analysis of rates paid compared to overall expenditures to ensure a fair and equitable arrangement is maintained and is a useful means to ensure that capitation rates are actuarially sound. Both reasons are applicable to CHIP managed care plans because of the similarity of the CHIP managed care program to the Medicaid managed care program. We believe MLR calculation and reporting are important tools to ensure that the CHIP program is administered in an effective and efficient manner in accordance with section 2101(a) of the Act.

This is the only standard we propose to adopt from §438.4. We do not propose to adopt any of the other Medicaid standards related to rate development (§438.5), contract provisions related to payment (§438.6), or rate certification (§438.7).

To effectuate the medical loss ratio described in §457.1203(c), we propose to align with the Medicaid proposed regulations at §438.8 and §438.74.

6. Non-Emergency Medical Transportation PAHPs (§457.1206)

We believe states may use a PAHP structure to deliver non-emergency medical transportation (NEMT) services in CHIP as is done in Medicaid. As such, we propose to adopt the Medicaid approach to regulating NEMT PAHPs. However, if a state chooses to use a PAHP to provide NEMT services along with any other ambulatory medical service, that PAHP will then be considered a traditional PAHP as defined in §457.10 and all the PAHP provisions throughout subpart L of this part will apply.

At §457.1206, we propose to largely adopt §438.9, which sets out the standards that apply to PAHPs that provide only NEMT services. The only difference between §438.9 and §457.1206 is that we have not included standards related to advance directives, and long-term services and supports, because we have not adopted these standards in CHIP. Instead of requiring actuarial soundness, we propose to require that NEMT PAHPs follow the standards of §457.1203 related to rate development standards.

7. Information Requirements (§457.1207)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the provision of information standards at section 1932(a)(5) apply to CHIP managed care programs. As such, we are proposing to align CHIP with Medicaid information standards at §438.10, which effectuate section 1932(a)(5) of the Act. We propose adding §457.1207, which

provides that states must require CHIP MCOs, PAHPs, PIHPs, PCCMs, and PCCM entities to provide enrollment notices, informational materials and instructional materials relating to enrollees and potential enrollees as provided in §438.10. Including the cross reference to Medicaid managed care information standards supports CMS' goal to align and maximize coordination between insurance affordability programs. The proposed revisions include a more structured and coherent set of state and managed care plan standards for beneficiary information, and permit the availability of beneficiary information in electronic form. In this way, we propose to align CHIP and managed care beneficiary information dissemination practices with those of Medicaid and the commercial insurance market.

8. Requirement related to Indians, Indian Health Care Providers, and Indian Managed Care Entities (§457.1208)

Section 2107(e)(1)(M) of the Act, as added by section 5006 of ARRA, specifies that the provisions related to managed care contracts that involve Indians, Indian health care providers (IHCP), and Indian managed care entities (IMCE) at sections 1932(a)(2)(C) and 1932(h) of the Act apply to CHIP. As such, we are proposing to align CHIP with Medicaid when MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities enroll Indians at §438.14, which effectuate sections 1932(a)(2)(C) and 1932(h) of the Act.

9. Managed Care Enrollment (§457.1210), Disenrollment (§457.1212), and Continued Services to Beneficiaries (§457.1216)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the enrollment, termination of enrollment, and change in enrollment provisions at section 1932(a)(4) of the Act apply to CHIP managed care programs.

Related to enrollment, we propose adding §457.1210. The proposed regulation closely

follows the statutory language of section 1932(a)(4)(C) and (D) of the Act, setting out the standards for states that use the default enrollment process in paragraph (a), and ensuring the process prioritizes continuity of coverage in paragraph (b). This approach is similar to current Medicaid managed care regulations in §438.50(e) and (f). Although section 1932(a)(4)(D) of the Act appears to require states to set up a default enrollment process, that paragraph is qualified by a reference to section 1932(a)(1) of the Act— namely the phrase “in carrying out paragraph (a)(1),” — but section 1932(a)(1) of the Act has not been incorporated into the CHIP statute. As a result, we do not propose to require states to set up a default process for CHIP. However, we seek comment on whether the CHIP provision that incorporates section 1932(a)(4)(D) of the Act should instead be read in a manner that requires states to establish a default enrollment process.

The proposed CHIP regulation deviates from the Medicaid managed care proposed regulation at §438.54. There, Medicaid proposes standards for several enrollment processes, including requiring that states provide at least 14 days for potential enrollees to make an active choice of a managed care plan. Discussion of the rationale for the changes to the Medicaid regulations can be found in section I.B.5.a of this proposed rule. We considered adopting the Medicaid approach, but ultimately decided that it was not well suited to CHIP because of the historic flexibility granted to states in administering the program. In addition, CHIP enrollment is often prospective, so children are not enrolled in the program until they have selected a managed care plan and, if applicable, paid a premium. In a state that uses prospective enrollment, requiring a 14-day choice period would delay coverage. We also considered developing enrollment standards based on the type of delivery system used in the state (FFS, managed care, or both). We seek comment on our proposed approach to enrollment and any alternatives.

Related to disenrollment, we propose adding §457.1212, which implements section

1932(a)(4)(A) and (B) of the Act. The proposed regulation would provide that states must follow, and ensure MCOs, PAHPs, PIHPs, PCCMs, and PCCM entities follow, the Medicaid disenrollment standards provided at §438.56. It is important to note that because section 1932(a)(4) of the Act gives individuals the right to disenroll from their managed care entity (MCE) while still remaining eligible to receive benefits, the state must contract with at least two MCEs, or contract with one MCE and operate an alternate delivery system, such as FFS, to provide CHIP benefits to those who have disenrolled from the state's contracted MCE. To meet the statutory disenrollment standards, a state currently providing CHIP benefits through one delivery system (for example, managed care) could either contract with at least two MCEs, establish a FFS option, or contract with some, or all, of the state's existing Medicaid provider network. While section 403 of CHIPRA applies the disenrollment standards set forth in section 1932(a)(4) of the Act, it did not apply the choice of MCE standard in section 1932(a)(3) of the Act; therefore, the state does not need to offer alternative delivery systems at the time of enrollment but only in the event an enrollee disenrolls from the state's contracted MCE.

Finally, related to change in enrollment, we propose adding §457.1216, which provides that states must follow the Medicaid standards related to continued services to enrollees at §438.62, for the same reasons we propose to adopt such standards for Medicaid managed care plans. Further discussion related to our rationale for adopting these standards can be found in the preamble discussion of the Medicaid standard at I.B.5.e.

10. Conflict of Interest Safeguards (§457.1214)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the conflict of interest provisions at section 1932(d)(3) of the Act apply to CHIP managed care programs. As such, we are proposing to align CHIP with Medicaid conflict of interest safeguards

at §438.58, which effectuate section 1932(d)(3) of the Act. We propose adding §457.1214, which provides that states have safeguards against conflict of interest as provided in §438.58.

11. Network Adequacy Standards (§457.1218)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that that the provisions at section 1932(a)(5) of the Act, requiring that MCEs assure adequate capacity to serve the expected enrollment, apply to CHIP managed care programs. As such, we are proposing to align CHIP with Medicaid network adequacy standards at §438.68, which effectuate section 1932(a)(5) of the Act. We propose adding §457.1218, which provides that states have network adequacy standards and ensure that managed care entities meet such standards as provided in §438.68. Acknowledging that CHIP serves a child-focused population, we seek comment on whether we should include additional standards for additional pediatric providers, for example children's hospitals or child and adolescent behavioral health providers.

12. Enrollee Rights (§457.1220)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the enrollee rights provisions at section 1932(a)(5)(B)(ii) of the Act apply to CHIP managed care programs. As such, we are proposing to align CHIP with Medicaid enrollee rights provisions at §438.100, which effectuate section 1932(a)(5)(B)(ii) of the Act. We propose adding §457.1220, which provides that states must ensure that MCOs, PAHPs, PIHPs, PCCMs, and PCCM entities follow the enrollee rights standards as provided in §438.100.

13. Provider-Enrollee Communication (§457.1222)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the enrollee rights provisions at section 1932(b)(3) of the Act apply to CHIP managed care programs. As such, we are proposing to align CHIP with Medicaid's enrollee rights protections of

communications between providers and enrollees at §438.102, which effectuate section 1932(b)(3) of the Act. We propose adding §457.1222, which provides that states must ensure that MCOs, PAHPs, and PIHPs protect communications between providers and enrollees as provided in §438.102.

14. Marketing Activities (§457.1224)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the restrictions on marketing at section 1932(d)(2) of the Act apply to CHIP managed care programs. As such, we are proposing to align CHIP with Medicaid standards related to marketing at §438.104, which effectuate section 1932(d)(2) of the Act. We propose adding §457.1224, which provides that states must ensure that MCOs, PAHPs, PIHPs, PCCMs, and PCCM entities follow the standards of §438.104. This proposed rule is not intended to limit QHP issuers who are also CHIP managed care plans from marketing QHPs to the parents of CHIP eligible children. The proposed definition of marketing in §438.104(a), as adopted in §457.1224, excludes the communication to a CHIP beneficiary from the issuer of a QHP. Therefore, a QHP issuer that also operates a CHIP managed care plan would not be prohibited from contacting a family about QHP coverage. Indeed, we recognize that there may be benefit to the family from being informed about the availability of coverage through the Marketplace and selecting a carrier who offers both types of products.

We acknowledge that plan marketing has historically played a unique role in CHIP (for example, in some states plans have been allowed to directly enroll children into CHIP). Therefore, we seek comment on whether our proposed approach is appropriate, or whether we should take an alternate approach, for example by following the QHP marketing regulations at 45 CFR 156.225 or adopting a subset of the Medicaid regulations. We also seek comment on our proposal to apply to

CHIP the standard at §438.104(c) that the state must consult with the Medical Care Advisory Committee or an advisory committee with similar membership.

15. Liability for Payment (§457.1226)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the protections for enrollees against liability for payment at section 1932(b)(6) apply to CHIP managed care programs. As such, we are proposing to align CHIP with Medicaid liability protections at §438.106, which effectuate section 1932(b)(6) of the Act. We propose adding §457.1226, which provides that states must ensure that MCOs, PAHPs, and PIHPs do not hold enrollees liable for services or debts of the MCO, PAHP, and PIHP as provided in §438.106.

16. Emergency and poststabilization services (§457.1228)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the standard that MCEs provide emergency and poststabilization services at section 1932(b)(2) of the Act apply to CHIP managed care programs. As such, we are proposing to align CHIP with the Medicaid emergency and poststabilization services standard at §438.114, which effectuate section 1932(b)(2) of the Act. We propose adding §457.1228, which provides that states must ensure that MCOs, PAHPs, and PIHPs make emergency and poststabilization services available, and that the state make emergency and poststabilization services available to enrollees of PCCMs and PCCM entities, as provided in §438.114.

17. Access Standards (§457.1230)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the quality assurance standards at section 1932(c) of the Act apply to CHIP managed care programs. Section 1932(c)(1) of the Act requires states that contract with managed care organizations to develop and implement a quality assessment and improvement strategy, including standards

related to access standards. Such access standards include the availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. As such, we are proposing to align CHIP with Medicaid availability of services standards at §438.206, §438.207, §438.208, and §438.210, which implement section 1932(c)(1) of the Act.

We propose adding §457.1230(a), which provides that states must require CHIP MCOs, PAHPs, and PIHPs to ensure that covered services are available and accessible to enrollees as provided in §438.206. At §457.1230(b), we propose that states must ensure that CHIP MCOs, PAHPs, and PIHPs have adequate capacity to serve expected enrollees as provided in §438.207. At §457.1230(c), we propose that states must ensure that CHIP MCOs, PAHPs, and PIHPs comply with the coordination and continuity of care standards as provided in §438.208. In proposing this alignment, we recognize the importance of care coordination when beneficiaries move between managed care entities and between settings, however we seek comment on the applicability of the Medicaid managed care standards in §438.208 to the CHIP population.

Finally, at §457.1230(d), we propose that states must ensure that CHIP MCOs, PAHPs, and PIHPs comply with some of the coverage and authorization of services standards as provided in §438.210. There are several paragraphs of §438.210 that we do not propose to adopt; however, we seek comment on this approach. Specifically, we do not propose to adopt the standards related to medically necessary services in §438.210(a)(5), because title XXI of the Act does not include a requirement to provide medically necessary services. In addition, we do not propose to adopt the time frames for decisions in §438.210(d). Instead, we propose to follow the time frames described in §457.1160. We also seek comment on whether we should create an exception for §438.210(b)(2)(iii) related to authorizing LTSS based on an enrollee's current needs assessment

and consistent with the person-centered service plan should apply to CHIP, since it is not a required service and few separate CHIP programs provide this service.

18. Structure and Operation Standards (§457.1233)

Section 1932(c)(1) of the Act related to the development and implementation of a quality assessment and improvement strategy also includes standards related to the structure and operation of managed care contracts. We are proposing to align CHIP with Medicaid structure and operation standards at §438.214 related to provider selection and §438.230 related to subcontractual relationships and delegation, which effectuate section 1932(c)(1) of the Act. We propose adding §457.1233(a) for provider selection and §457.1233(b) for subcontractual relationships and delegation.

The standard under section 1932(c)(1) of the Act related to the development and implementation of a quality assessment and improvement strategy, also includes measurement and improvement standards. We are proposing to align CHIP with Medicaid standards at §438.236 and §438.242 which implement section 1932(c)(1) of the Act. We propose adding §457.1233(c) related to practice guidelines as provided in §438.236 and adding §457.1233(d) related to health information systems as provided in §438.242. Including the cross references to Medicaid quality assessment and improvement strategy standards supports CMS' goal to align insurance affordability program rules. We have elected not to propose that rules for CHIP align with the Medicaid confidentiality provision as set forth in §438.224 because there is an existing confidentiality requirement at §457.1110, which we believe is sufficient to address this standard.

19. Quality Measurement and Improvement (§457.1240, §457.760)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that section 1932(c) of the Act applies to CHIP managed care programs. As such, we are proposing to

align CHIP with Medicaid quality measurement and improvement standards at §438.310, which implement section 1932(c) of the Act. We propose adding §457.1240(a), to align with the scope set forth in §438.310, which outlines standards for a quality assessment and performance improvement program that states must require of each contracting MCO, PIHP, or PAHP. At §457.1240(b), we propose that states must ensure that CHIP MCOs, PIHPs or PAHPs have an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to enrollees as set forth in §438.330. Section §438.330 also references standards for LTSS, which we propose to apply to CHIP to align with the Medicaid standards. We seek comments on the appropriateness of applying this standard for the CHIP program. At §457.1240(c), we propose that states must review and approve the performance of each MCO, PIHP, and PAHP in accordance with the requirements set forth in §438.332. At §457.1240(d), we propose that states must collect data and apply the methodology established under the process described in §438.330(a)(2) to determine a Managed Care rating or ratings for each CHIP MCO, PIHP, and PAHP in accordance with the standards set forth in §438.334. At §457.1240(e), we propose the managed care elements of the state comprehensive quality strategy for assessing and improving the quality of managed care services provided by CHIP MCOs, PIHPs, and PAHPs as set forth in §438.340. Finally, at §457.760, we propose that states must incorporate CHIP into their state comprehensive quality strategy that establishes the minimum standards inclusive of all delivery systems as set forth in §431 subpart I. We considered whether CHIP could have its own comprehensive quality strategy, but determined that it would be more efficient and promote alignment of quality improvement to include CHIP in a single, state comprehensive quality strategy that includes all children in Medicaid and CHIP. We seek comment on this approach.

20. External Quality Review (§457.1250)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the external quality review standards at section 1932(c) of the Act apply to CHIP managed care programs. Section 1932(c)(2) of the Act requires external independent review of managed care activities. As such, we are proposing to align CHIP with Medicaid external quality review standards at §438.350, which effectuate section 1932(c)(2) of the Act. Currently, funding for CHIP quality activities would be limited to the ten percent administrative expenditures allotted for non-primary services as set forth in §457.618. We seek comments on any issues this may present to implementing these standards. We propose adding §457.1250(a), which requires each state that contracts with MCOs, PIHPs or PAHPs follow all applicable external quality review standards as set forth in §§438.350, 438.352, 438.354, 438.356, 438.358, and 438.364. We do not adopt any provision related to plans serving dual eligible populations, because CHIP does not have such populations. At §457.1250(b), we outline the provisions that do not apply to the CHIP external quality review process for states contracting with MCOs, PIHPs or PAHPs, including the nonduplication of mandatory activities at §438.360 and the exemption from external quality review at §438.362. CHIP elected not to align with the Medicaid exemption from EQR as set forth in §438.362. This provision specifies that, if an 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, the state may exempt them from EQR if all the conditions are met. The MCO, PIHP, or PAHP must submit the findings from the Medicare report to meet this standard. This would not be applicable to CHIP, as the findings through Medicare would not include children. We also propose allowing states to amend current external quality review contracts to add CHIP as long as the existing contract meets standards outlined in §438.356. Adding the cross references to Medicaid quality measurement and improvement and

external quality review standards to CHIP will help achieve the goal of increased program alignment and streamlined processes.

21. Grievances (§457.1260)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the grievance provision at section 1932(b)(4) of the Act apply to CHIP managed care programs. As such, we are proposing to align CHIP with the Medicaid grievance and appeals sections at subpart F of part 438, which implement section 1932(b)(4) of the Act. We propose adding §457.1260, which provides that states must ensure that MCOs, PAHPs, and PIHPs comply with subpart F of part 438, with two exceptions. First, we do not propose to adopt §438.420, which requires continuation of benefits pending appeal. We considered following Medicaid by requiring benefits to continue pending appeal, but CHIP has not previously had this standard, so we decided not to extend it to CHIP managed care through this rule. We seek comment on this approach. The second deviation from Medicaid is that we note that, in the CHIP context, references to fair hearings should be read as references to reviews as described in subpart K of part 457.

22. Sanctions (§457.1270)

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, specifies that the sanctions provisions at section 1932(e) of the Act apply to CHIP managed care programs. As such, we are proposing to align CHIP with the Medicaid sanctions sections at subpart I of part 438, which effectuate section 1932(e) of the Act. We propose adding §457.1270, which provides that states must ensure that MCOs, PAHPs, and PIHPs comply with the sanctions standards as provided in subpart I of part 438.

23. Program Integrity – Conditions Necessary to Contract as an MCO, PAHP, or PIHP (§457.955, §457.1280, and §457.1285)

Section 2107 of the Act includes several program integrity standards, including sections 2107(b), 2107(e)(1)(D), and 2107(e)(2). We propose to effectuate those standards by adopting many of the Medicaid program integrity standards in CHIP. In addition, we propose to maintain but relocate the current CHIP regulations related to managed care program integrity.

We propose to redesignate all of §457.955 to §457.1280. This section is currently located in the general CHIP program integrity subpart I. Because the section specifies conditions necessary for entities to contract as an MCO, PAHP, PIHP, we propose to move it to the new subpart L where the other managed care regulations will be located. We propose several minor changes to the regulation text: (1) to update references to MCE to MCO, PAHP, or PIHP; (2) to add at paragraph (b)(1) that MCOs, PAHPs, and PIHPs must comply with applicable state and Federal statutes and regulations, in addition to complying with state and Federal standards; (3) and to add at paragraph (b)(3) that there must be mechanisms for MCOs, PAHPs, and PIHPs to report providers to the state.

We also propose to adopt nearly all of the of the several Medicaid program integrity standards. In §457.1285, we propose to adopt subpart H of part 438, with the exception of §438.604(a)(2), which does not apply because we are not proposing to adopt for CHIP all of the Medicaid actuarial soundness requirements.

III. Third Party Liability

A. Background

Title XIX of the Act requires State Medicaid programs to identify and seek payment from liable third parties, before billing Medicaid. Specifically, section 1902(a)(25)(A) of the Act mandated states “take all reasonable measures to ascertain legal liability of third parties . . . to pay for care and services available under the plan.”

Under section 1902(a)(25)(A) of the Act, a third party is any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. Medicaid is intended to be the payer of last resort; that is, other available resources must be used before Medicaid pays for the care and services of a Medicaid-eligible individual. These other resources are known as third party liability, or TPL.

Further provisions under section 1902(a)(25)(A)(i) of the Act specify that the Medicaid State plan must provide for the collection of sufficient information to enable the State to pursue claims against third parties. Examples of liable third parties include commercial insurance companies through employment-related or privately purchased health insurance; casualty coverage resulting from an accidental injury; payment received directly from an individual who has either voluntarily accepted or assigned legal responsibility for the health care of one or more Medicaid recipients; and fraternal groups, union, or State workers' compensation commissions. Third Party Liability also includes medical support provided by a parent under a court or administrative order.

To support identification of TPL and with the authority granted in section 1902(a)(25)(A), in 1987, we (then the Health Care Financing Administration [HCFA]) issued regulations at §433.138 establishing requirements for State Medicaid agencies to obtain information via data matching with the state Workers Compensation files or state Motor Vehicle Accident Report. Additionally, states are required to identify all paid claims (indicative of trauma), identified by diagnosis codes found in ICD-9-CM, 800 through 999, except 994.6.

Section 433.138(e) specifically references the use and application of the ICD-9-CM medical coding system, to assist in identifying liable third parties as primary payers before Medicaid. However, by 1990, HCFA realized it might have been too prescriptive to require states to review all ICD-9-CM trauma codes, and amended §433.138 to allow states to submit waiver

requests to cease editing codes proven to be unproductive in identifying liable third parties. States now have over 25 years of experience identifying trauma codes indicating third party liability, which contributes to payment of Medicaid expenses.

In 1990, the World Health Organization (WHO) approved the 10th Revision of the International Classification of Diseases (ICD), which is known as ICD-10. The Secretary adopted the ICD-10 medical code sets effective March 17, 2009, and all Health Insurance Portability and Accountability Act covered entities are required to use ICD-10 to code health services provided on or after its compliance date of October 1, 2015 (ICD-10's compliance date was previously delayed; the October 1, 2015 compliance date is specified at 79 FR 45128 (Aug. 4, 2014)).

B. Provisions of the Proposed Regulations

Section 433.138(e) mandates the use of ICD 9-CM coding, which is due to be replaced by ICD-10 coding for coding health services provided on October 1, 2015. Section 433.138(e) obliges states to comply with the soon to be replaced ICD-9-CM coding system; thus references to ICD-9-CM specific codes need to be removed from the regulation. We considered ways to best achieve this aim, keeping in mind that states bear the responsibility for interpreting and applying the increased number of new ICD-10 codes and that State Medicaid programs need greater discretionary authority in developing trauma code edits to best identify liable third parties and achieve the highest TPL return from their efforts.

In considering how best to amend the regulation we reviewed our previous amendments, which demonstrated a progression from explicit federally-prescribed requirements to less prescriptive approaches that, while maintaining the federal designation of trauma codes subject to review, allowed states to propose waivers of editing for trauma codes that were not cost-effective to pursue.

This regulation was last amended in 1995 to remove trauma code-specific waiver authority from §433.138(e) and add §433.138(l) to federal regulations, establishing the possibility of waiver of non-statutory requirements in §433.138 and §433.139, including §433.138(e). States could request adjustments to any of several non-statutory requirements, including the code editing requirements, if they determined the activity to not be cost-effective. Section 433.138(l) specified that an activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the state.

The background information in the preamble for the regulatory amendment published in the **Federal Register** on July 10, 1995 (60 FR 35498 through 35503) affirmed that we had been prescriptive in the initial 1987 regulations for trauma code editing, explaining that TPL was then in its “infancy” and there was concern that states were not identifying instances of traumatic injury for which a liable third party might exist. By 1995, when the last amendment to the trauma code was proposed, we acknowledged that states had other means of identifying potential TPL for trauma cases, including federally-required data matches with state motor vehicle administration accident files and with state worker’s compensation files, and that “the majority of states have aggressive and comprehensive TPL programs.”

It has been almost 20 years since we last amended the regulations for trauma code editing and during that time, states’ information technology systems have greatly improved and state TPL programs have refined procedures to identify instances when a Medicaid beneficiary’s traumatic injury may lead to identification of a liable third party.

The proposed amendment to §433.138(e), which removes references to ICD-9-CM, offers us an opportunity to make a substantive change to this regulation while still affirming the

continuing responsibility of state Medicaid programs to identify trauma-related claims to determine TPL and ensure that state Medicaid programs remain secondary payers as specified in federal law. Therefore, we propose to replace the reference to a specific coding system with a general description of the types of medical diagnoses indicative of trauma for which states are expected to edit claims. We believe this revision will allow states greater flexibility to focus on identification of claims likely to have TPL.

This amendment does not propose that any state change its current trauma code editing process with regard to codes that the state has identified as not being productive of third party recoveries and that CMS has agreed the state may discontinue editing. We recognize that states now have over 25 years of experience related to identifying trauma codes that are likely to have a responsible third party and generating recoveries. This amendment affords states the opportunity to revise their trauma code editing processes with regard to identifying nonproductive codes if and when they deem necessary.

Therefore, in §433.138(e)(1), we propose to remove the reference to the ICD-9-CM code range 800 through 999. This code range defined the codes that were indicative of traumatic injury. States had to follow-up on these codes, unless that requirement was specifically waived, to identify potentially liable third parties. The ICD-9-CM coding system and codes will shortly be replaced by the ICD-10 coding system and codes, which has an October 1, 2015 compliance date. The narrative statement will have greater longevity, as it is not tied to any one edition of the ICD coding system or any other coding system that the Secretary of DHHS may adopt in the future.

We have retained the regulatory references to complete trauma code editing and to the possibility of a state's pursuing waiver of the requirements of the regulation, to allow the state to request a waiver of the regulatory standards, if the state wishes to adjust its trauma code editing

process beyond the scope allowed by these changes to §433.138(e).

We propose to also remove §433.138(e)(2), as the regulation specifically refers to exclusion of the ICD-9-CM code for motion sickness and we propose to revise §433.138 to remove all references to ICD-9-CM-specific coding.

Removing paragraph (e)(2) of §433.138(e) eliminates the necessity to identify the remaining regulatory text as §433.138(e)(1), so we have eliminated the paragraph (e)(1) designation from the revised §433.138(e).

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to publish a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval.

To fairly evaluate whether an information collection should be approved by OMB, PRA section 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs) in this proposed rule.

A. Background

The burden associated with the requirements under parts 431 and 438 is the time and effort it would take each of the Medicaid programs to comply with this rule's proposed requirements. This rule would revise the Medicaid managed care regulations to implement statutory provisions, strengthen actuarial soundness and other payment regulations improving accountability of rates paid in the Medicaid managed care program, implement changes supporting alignment with other public and insurance affordability programs, strengthen beneficiary protections, and modernize the regulations recognizing changes in usage of managed care delivery systems since the release of the part 438 final rule in 2002.

Section 433.138(e)(1) would make a technical correction addressing state Medicaid agencies' review of claims with trauma codes, to identify instances where third party liability (TPL) may exist for expenditures for medical assistance covered under the state plan. The correction would remove references to the International Classification of Disease, 9th edition, Clinical Modification Volume 1 (ICD-9-CM) by replacing the references with a general description of the types of medical diagnoses indicative of trauma. States would use the International Classification of Disease that they are using at the time of claims processing. There is no additional cost to the state related to the proposed regulation changes to §433.138(e) because the proposed changes do not require any action by the state, if the state wishes to continue editing for the same types of traumatic injuries currently identified with ICD-9-CM codes after the conversion of the claims processing system to ICD-10 codes. Further, since trauma code editing is based on current MMIS claims processing, revisions to accommodate the coding system change from ICD-9-CM to ICD-10 are already in progress as a required adjustment of each state's MMIS. This proposed rule allows states to make adjustments to certain TPL activities without preparing a

formal waiver request to seek CMS's permission. There is no requirement for a state to make such adjustments.

We propose adding a new subpart L to part 457, which will contain the regulations related to CHIP managed care plans. Most of the proposed regulations in this subpart are new, however we also propose to move portions of §457.950 and all of §457.955 from subpart I to the new subpart. This will ensure that all related information is contained in one subpart.

B. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2013 National Occupational Employment and Wage Estimates for all salary estimates (www.bls.gov/oes/current/oes_nat.htm). Table 1 presents the median hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 1: Occupation Titles and Wage Rates

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefit (at 100%)	Adjusted Hourly Wage
Accountant	13-2011	\$31.55	\$31.55	\$63.10
Actuary	15-2011	\$46.00	\$46.00	\$92.00
Business Operations Specialist	13-1000	\$29.66	\$29.66	\$53.32
Computer Programmer	15-1131	\$36.80	\$36.80	\$73.60
Customer Service Rep	43-4051	\$14.84	\$14.84	\$29.68
General and Operations Mgr	11-1021	\$63.86	\$63.86	\$127.72
Healthcare Social Worker	21-1022	\$29.60	\$29.60	\$59.20
Mail Clerk	43-9051	\$13.20	\$13.20	\$26.40
Office and Administrative Support Worker	43-9000	\$14.96	\$14.96	\$29.92
Registered Nurse	29-1141	\$32.70	\$32.70	\$65.40

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

C. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding State Comprehensive Quality Strategy (§431.502)

Under §431.502 all 56 states and territories (referred to throughout this section as “states”) would have and operate a comprehensive quality strategy for all Medicaid beneficiaries in the state regardless of delivery system. This would replace the quality strategy focused exclusively on Medicaid managed care which currently exists at §438.202.

Per §431.502(a) each state would write and implement a comprehensive quality strategy. We estimate that drafting an initial state comprehensive quality strategy would take 70 hr at \$53.32/hr for a business operations specialist to develop the proposed strategy, 2 hr at \$29.92/hr for an office and administrative support worker to publicize the strategy, 15 hr at \$53.32/hr for a business operations specialist to review and incorporate public comments into the strategy, and 1 hr at \$29.92/hr for an officer and administrative support worker to submit the initial quality strategy to CMS. We also estimate that 19 states would draft an initial comprehensive quality strategy (as the other 37 states already have an initial quality strategy). In aggregate, we estimate a one-time burden of 1,672 hr (19 states x 88 hr) and \$87,817.24 [19 states x ((85 hr x \$53.32/hr) + (3 hr x \$29.92/hr))] for states to develop initial comprehensive quality strategies and submit them to CMS.

2. ICRs Regarding State Comprehensive Quality Strategy Development, Assessment, and Revision (§431.504)

Section 431.504(a) would have states engage the public in the development of the comprehensive quality strategy. The burden associated with this process is captured in §431.502 for the initial comprehensive quality strategy.

In accordance with proposed §431.504(b), states would review and revise their comprehensive quality strategies as needed, but no less frequently than once every 3 years. While

the 37 states that contract with MCOs and/or PIHPs currently revise their quality strategies periodically, approximately half of those states (18) revise their quality strategies less frequently than proposed.

We estimate a burden for the revision of a comprehensive quality strategy of, once every 3 years, 25 hr at \$53.32/hr for a business operations analyst to review and revise the comprehensive quality strategy, 2 hr at \$29.92/hr for an office and administrative support worker to publicize the strategy, 5 hr at \$53.32/hr for a business operations specialist to review and incorporate public comments, and 1 hr at \$29.92/hr for an office and administrative support worker to submit the revised quality strategy to CMS. In aggregate, we estimate an ongoing annualized state burden of 198 hr [(18 states x (33 hr) / 3 years] and \$10,136.16 [(18 states x ((30 hr x \$53.32/hr) + (3 hr x \$29.92/hr))) / 3 years].

The revision of a comprehensive quality strategy would be a new process for the 19 states that do not currently contract with MCOs and/or PIHPs. We estimate that those states would need 0.5 hr at \$53.32/hr for a business operations specialist to revise their policies and procedures. In aggregate, we estimate a one-time state burden of 9.5 hr (19 states x 0.5 hr) and \$506.54 (9.5 hr x \$53.32/hr) to update policies and procedures.

We assume that it will be less burdensome to revise an existing comprehensive quality strategy than to draft an initial strategy. Therefore, we estimate a burden for the comprehensive quality strategy revision process, once every 3 years, of 25 hr at \$53.32/hr for a business operations analyst to review and revise the comprehensive quality strategy, 2 hr at \$29.92/hr for an office and administrative support worker to publicize the strategy, 5 hr at \$53.32/hr for a business operations specialist to review and incorporate public comments, and 1 hr at \$29.92/hr for an office and administrative support worker to submit the revised quality strategy to CMS. In

aggregate, we estimate an ongoing annualized state burden of 209 hr [(19 states x (33 hr) / 3 years] and \$10,699.28 [(19 states x ((30 hr x \$53.32/hr) + (3 hr x \$29.92/hr))) / 3 years].

Of the 37 states that contract with MCOs and/or PIHPs, we estimate that 10 states already have a comprehensive quality strategy. This could be due to a variety of reasons, such as the special terms and conditions of a section 1115 demonstration or in response to SHO Letter #13-007. The remaining 27 states would, at their next revision, transition from a quality strategy to a comprehensive quality strategy. We estimate that this would pose a burden of 10 hr at \$53.32/hr for a business operations specialist at the next revision. In aggregate, we estimate a one-time state burden of 270 hr (27 states x 10 hr) and \$14,396.40 (270 hr x \$53.32/hr).

We propose in section §431.504(b)(1) that the review of the comprehensive quality strategy would include an effectiveness evaluation conducted within the previous 3 years. We estimate the burden of this evaluation at 40 hr at \$53.32/hr for a business operations specialist once every 3 years for all 56 states. The currently approved burden estimates that creating and submitting an implementation and effectiveness report to CMS for the 37 states with MCOs and/or PIHPs takes 40 hr per state once every 3 years. In its place, the review of the comprehensive quality strategy (including the effectiveness evaluation) would apply to the 56 states but the burden increase would apply to the remaining 19 states. In aggregate, we estimate an ongoing annualized burden of 253.3 hr [(19 states x 40 hr) / 3 years] and \$13,505.96 (253.3 hr x \$53.32/hr) to evaluate the effectiveness of a comprehensive quality strategy.

States would post the effectiveness evaluation on the state's Medicaid website under proposed §431.504(b)(2). While this standard is subject to the PRA, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with the aforementioned standards would be

incurred by persons during the normal course of their activities and, therefore, should be considered a usual and customary business practice.

As described in §431.504(c), states would submit to CMS a copy of the initial comprehensive quality strategy and any subsequent revisions. The burden associated with this standard has been captured in §§431.502(a) (initial strategy) and 431.504(b) (revision of strategy). As this would be a new standard for the 19 states that do not currently contract with MCOs and/or PIHPs, we believe that these states would need to modify their policies and procedures to incorporate this action. We estimate a burden of 0.5 hr \$53.32/hr for a business operations specialist. In aggregate, we estimate a one-time state burden of 9.5 hr (19 states x 0.5 hr) and \$506.54 (9.5 hr x \$53.32/hr).

Finally, §431.504(d) would have states post the final comprehensive quality strategy to their Medicaid websites. While this standard is subject to the PRA, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with the aforementioned standards would be incurred by persons during the normal course of their activities and, therefore, should be considered a usual and customary business practice.

3. ICRs Regarding Standard Contract Requirements (§§438.3, 438.10(c)(5), 438.14(b), 438.110(a), 438.210(b)(2)(iii), 438.242(c), 438.402 and 438.608)

Section 438.3 contains a list of provisions that must be included in MCO, PIHP, PAHP, HIO, and/or PCCM contracts. While the burden associated with the implementation and operation of the contracts is set out when warranted under the appropriate CFR section, the following burden estimate addresses the effort to amend existing contracts. The estimate also includes the burden for additional contract amendments that would be required under:

- §438.10(c)(5) would require specific information to be provided to enrollees.
- §438.14(b) would specify requirements for Indian enrollees and providers.
- §438.110(a) would require the establishment and maintenance of member advisory committees.
- §438.210(b)(2)(iii) would require LTSS to be authorized consistent with the enrollee's needs assessment and person centered plan
- §438.242(c) would require specific provisions for encounter data
- §438.608 would require administrative and management arrangements and procedures to detect and prevent fraud, waste, and abuse.

We estimate a one-time state burden of 6 hr at \$53.32/hr for a business operations specialist to amend all contracts. In aggregate, we estimate 3,612 hr (602 contracts x 6 hr) and \$192,591.84 (3,612 hr x \$53.32/hr).

4. ICRs Regarding Rate Standards (§438.5)

Section 438.5 describes CMS' proposal related to the development and documentation of capitation rates paid to risk-based MCOs, PIHPs and PAHPs. Generally, we would require: the use of appropriate base data; application of trends that have a basis in actual experience; a comprehensive description of the development of the non-benefit component of the rate; descriptions of the adjustments applied to the base data, rate, or trends; actuarial certification of the final contract rates paid to the plans; and a description of budget neutral risk adjustment methodologies.

We believe that the requirements related to the use appropriate base data and the adequate description of rate setting standards, such as trend, the non-benefit component, adjustments, and risk adjustment, are already required as part of actuarial standards of practice and accounted for in

§438.7. We clarified that risk adjustment should be done in a budget neutral manner, but the manner in which risk adjustment is applied should not create additional burden on the state.

In §438.5(g), the certification of final contract rates would place additional burden on the states. We estimate that most states currently certify a range as compared to the actual contract rate paid to the health plan. Therefore, out of the total 70 certifications submitted to CMS from 39 states, the process underlying 50 certifications will need to be modified.

We estimate it would take approximately 10 hr at \$92/hr for an actuary and 1 hr at \$127.72/hr for a general and operations manager to comply with this requirement. In aggregate, we estimate an annual state burden of 550 hr (50 certifications x 11 hr) and \$52,386 [50 certifications x ((10 hr x \$92/hr) + (1 hr x \$127.72/hr))].

5. ICRs Regarding Rate Certification Submission (§438.7)

Section 438.7 describes the submission and documentation requirements for all managed care actuarial rate certifications. The certification will be reviewed and approved by CMS concurrently with the corresponding contract(s). Section 438.7(b) details CMS' expectations for documentation in the rate certifications. We believe these requirements would be in line with actuarial standards of practice and previous Medicaid managed care rules.

While the 2002 final rule (under §438.6(c)) set out the burden per contract (15,872 hr based on 32 hr per plan), experience has shown that states do not submit certifications per plan. We believe a better estimation of the burden would be associated with the development of the rate certification. In this regard, we estimate it would take 230 hr to develop each certification, consisting of 100 hr (at \$92/hr) for an actuary, 10 hr (at \$127.72/hr) for a general and operations manager, 50 hr (at \$73.60/hr) for a computer programmer, 50 hr (at \$53.32/hr) for a business operations specialist, and 20 hr (at \$29.92/hr) for an office and administrative support worker.

The revised burden is based on a total of 16,100 hr (230 hr x 70 certifications) which would add 228 hr (16,100 hr – 15,872 hr) for all 70 certifications, adjusted to 3.3 hr per certification. In aggregate, we estimate an annual state burden of \$17,852.41 [70 certifications x ((1.5 hr x \$92/hr) + (0.13 hr x \$127.72/hr) + (0.73 hr x \$73.60/hr) + (0.73 hr x \$53.32/hr) + (0.26 hr x \$29.92/hr))].

6. ICRs Regarding Minimum Medical Loss Ratio (§438.8)

Section 438.8(c) would require that MCOs, PIHPs, and PAHPs report to the state annually their total expenditures on all claims and non-claims related activities, premium revenue, the calculated MLR, and, if applicable, any remittance owed.

We estimate total number of MLR reports that MCOs and PIHPs would be required to submit to the state would amount to 568 contracts. While the number of contracts includes 545 credible contracts and 23 non-credible contracts, all MCOs and PIHPs will need to report the information required under §438.8 regardless of their credibility status.

We estimate a one-time private sector burden of 168 hr for the initial administration activities. We estimate that 60 percent of the time would be completed by a computer programmer (101 hr at \$73.60/hr), 30 percent would be completed by a business operations specialist (50 hr at \$53.32/hr), and 10 percent would be completed by a general and operations manager (17 hr at \$127.72/hr). This amounts to \$12,270.84 ((101 hr x \$73.60) + (50 hr x \$53.32) + (17 hr x \$127.72)) per report or \$6,969,837.12 (568 x \$12,270.84) for 568 MCOs, PIHPs, and PAHPs in 2017 (the one-time burden).

In subsequent years, since the programming and processes established in 2017 will continue to be used, the burden will decrease from 168 hr to approximately 53 hr. Using the same proportions of labor allotment, we estimate an annual private sector burden of \$3,846.92 per report and a total of \$2,185,050.56 [568 contracts x \$3,846.92 ((32 hr x \$73.60/hr) + (16 hr x \$53.32/hr)

+ (5 hr x \$127.72/hr)]. We expect that states will permit MCOs, PIHPs, and PAHPs to submit the report electronically. Since the submission time is included in our reporting estimate, we are not setting out the burden for submitting the report.

7. ICRs Regarding Information Requirements (§438.10)

Section 438.10(c)(3) would require states to operate a website that provides the information required in §438.10(f). Since states already have websites for their Medicaid programs and most also include information about their managed care program, most states would only have to make minor revisions to their existing website.

We estimate 6 hr at \$73.60/hr for a computer programmer to make the initial changes. We also estimate 3 hr for a computer programmer to periodically add or update documents and links on the site. In aggregate, we estimate a one-time state burden of 252 hr (42 states x 6 hr) and \$18,547.20 (252 hr x \$73.60/hr). In subsequent years, we estimate an annual state burden of 126 hr (42 states x 3 hr) and \$9,273.60 (126 hr x \$73.60/hr).

Section 438.10(c)(4)(i) would recommend that states develop definitions for commonly used terms to enhance consistency of the information provided to enrollees. We estimate it would take 6 hr at \$53.32/hr for a business operations specialist to develop these definitions. In aggregate, we estimate a one-time state burden of 252 hr (42 states x 6 hr) and \$13,436.64 (252 hr x \$53.32/hr).

Section 438.10(c)(4)(ii) would recommend that states create model enrollee handbooks and notices. Since many states already provide model handbooks and notices to their entities, we estimate 20 states may need to take action to comply with this provision. We estimate it would take 20 hr at \$53.32/hr for a business operations specialist to create these documents. We also estimate 2 hr per year for a business operations specialist to revise these documents, if needed. In

aggregate, we estimate a one-time state burden of 400 hr (20 states x 20 hr) and \$21,328 (400 hr x \$53.32/hr). In subsequent years we estimate an annual burden of 40 hr (20 states x 2 hr) and \$2,132.80 (40 hr x \$53.32/hr).

Section 438.10(d)(2)(i) would require that states add taglines to all printed materials for potential enrollees explaining the availability of translation and interpreter services as well as the phone number for choice counseling assistance. As the prevalent languages within a state do not change frequently, we are not estimating the burden for the rare updates that will be needed to update these taglines. We estimate it would take 2 hr at \$53.32/hr for a business operations specialist to create the taglines and another 4 hr to revise all document originals. In aggregate, we estimate a one-time state burden of 252 hr (42 states x 6 hr) and \$13,436.64 (252 hr x \$53.32/hr).

Section 438.10(e)(1) clarifies that states can provide required information in paper or electronic format. As this is an existing requirement, the only burden change we estimate is adding two new pieces of information generated in §438.68 (network adequacy standards) and §438.330 (quality and performance indicators). We estimate 1 hr at \$53.32/hr for a business operations specialist to update or revise existing materials and 1 min at \$26.40/hr for a mail clerk to mail the materials to 5 percent of the enrollees that are new (3,135,242). In aggregate, we estimate a one-time state burden of 42 hr (42 states x 1 hr) and \$2,239.44 (42 hr x 53.32/hr) to update/revise existing materials. The currently approved burden estimates 5 min per mailing for 65,000 total hr. By updating the enrollment figure to 2,069,259 (62,704,821 x .033) and reducing the time from 5 min to 1 min (to acknowledge automated mailing processes), we estimate the annual state burden for mailing as - 30,512 hr (34,488 hr – 65,000 hr) and - \$805,516.80 (- 30,512 hr x \$26.40/hr).

Section 438.10(g)(1) would require that MCOs, PIHPs, PAHPs, and PCCMs provide an enrollee handbook. Since §438.10(g) has always required the provision of this information (although it did not specifically call it a “handbook”), we believe only new managed care entities would need to create this document. Given the requirement in §438.10(c)(4)(ii) for the state to provide a model template for the handbook, the burden on a new entity would be greatly reduced. It is not possible for us to estimate how many, if any, new managed care entities may contract with a state in any year. We invite comment on an appropriate average number of new plans each year. State burden to create the template for a model handbook is set out under §438.10(c)(4)(ii).

For existing entities that already have a method for distributing the information, we believe that 100 entities will need to modify their handbook to comply with a new model provided by the state. We estimate 100 entities would rely on a business operations specialist to spend 4 hr at \$53.32/hr to update their handbook. Once revised, the handbooks need to be sent to enrollees. We estimate 1 min by a mail clerk at \$26.40/hr to send handbooks to 10,659,819 enrollees (17 percent of total enrollment). To update the handbook, we estimate a one-time private sector burden of 400 hr (100 entities x 4 hr) and \$21,328 (400 hr x \$53.32/hr). To send the handbook to existing enrollees in the 100 entities, we estimate a one-time private sector burden of 177,699 hr (10,659,819 enrollees x 1 min) and \$4,691,258.42 (177,699 hr x \$26.40/hr).

With regard to new enrollees, they must receive a handbook within a reasonable time after receiving notice of the beneficiary’s enrollment. We assume a 3.3 percent enrollee growth rate thus 2,069,259 enrollees (5 percent of 62,704,821) would need to receive a handbook each year. We estimate 1 min by a mail clerk at \$26.40/hr to mail the handbook or 34,488 hr (2,069,259 enrollees x 1 min). The currently approved burden estimates 5 min per mailing for 390,000 enrollees or 32,500 total hr. Updating the enrollment figure and reducing the time from 5 min to 1

min (to acknowledge current automated mailing processes), the annual private sector burden is increased by 1,988 hr (34,488 hr - 32,500 hr) and \$52,483.20 (1,988 hr x \$26.40/hr).

Since all of the MCO, PIHP, PAHP, and PCCM entities would need to keep their handbook up to date, we estimate it would take 1 hr at \$53.32/hr for a business operations specialist to update the document. While the updates would be necessary when program changes occur, we estimate 1 hr since each change may only take a few minutes to make. In aggregate, we estimate an annual private sector burden of 577 hr (577 entities x 1 hr) and \$30,765.64 (577 hr x \$53.32/hr).

Section 438.10(h) would require that all MCO, PIHP, PAHP, and PCCM entities make a provider directory available in paper or electronic form. Producing a provider directory is a longstanding requirement in §438.10 and in the commercial health insurance market. Given the time sensitive nature of provider information and the high error rate in printed directories, most provider information is now obtained via the internet or by calling a customer service representative. In this regard, the only new burden is the time a computer programmer would need to add a few additional fields of data, including the provider website addresses, additional disability accommodations, and adding behavioral and long-term services and support providers.

We estimate that it would take approximately 1 hr at \$73.60/hr for a computer programmer to update the existing directory. Updates after the creation of the original program would be put on a production schedule as part of usual business operations and would not generate any additional burden. In aggregate, we estimate a one-time private sector burden of 577 hr (577 entities x 1 hr) and \$42,467.20 (577 hr x \$73.60/hr).

8. ICRs Regarding Requirements that Apply to MCO, PIHP, PAHP, and PCCM Contracts Involving Indians, Indian Health Care Providers, and Indian Managed Care Entities (§438.14)

Section 438.14(c) would require states to make supplemental payments to Indian providers if the MCO, PIHP, PAHP, and PCCM entity does not pay at least the amount paid to Indian providers under the FFS program. There are approximately 31 states with 463 managed care entities with Indian providers. This type of payment arrangement typically involves the managed care entity sending a report to the state that then calculates and pays the amount owed to the Indian health care provider.

We estimate it would take 1 hr at \$73.60/hr for a private sector computer programmer to create the claims report and approximately 12 hr at \$53.32/hr for a state business operations specialist to process the payments. We estimate that approximately 25 of the 31 states will need to use this type of arrangement. In aggregate, we estimate a one-time private sector burden of 463 hr (463 entities x 1 hr) and \$34,076.80 (463 hr x \$73.60/hr). We also estimate an annual state burden of 300 hr (25 states x 12 hr) and \$15,996 (300 hr x \$53.32/hr).

After the MCO, PIHP, PAHP, and PCCM report is created, it will most likely run automatically at designated times and sent electronically to the state as the normal course of business operations; therefore, no additional private sector burden is estimated after the first year. (Note: this process is not necessary when the MCO, PIHP, PAHP, or PCCM entity pays the ICHP at least the full amount owed under this regulation.)

9. ICRs Regarding Managed Care Enrollment (§438.54)

Section 438.54(c)(2) would require states with voluntary programs that use a passive enrollment process to provide a 14-day choice period before enrolling the potential enrollee into a managed care plan. (Currently, such states enroll the potential enrollee into a managed care plan on the first day of their eligibility.) We estimate approximately 21 states have voluntary programs and approximately 75 percent of them (15) use a passive process. To accommodate the 14-day

choice period, these 15 states would have to alter the programming of their passive enrollment algorithm to delay the enrollment in a managed care plan until the enrollee makes a plan selection or the 14-day period expires. We estimate it would take a computer programmer 2 hours at \$73.60/hr to complete this change. In aggregate, we estimate a one-time state burden of 30 hours (15 states x 2 hr) and \$2,208 (30 hours x \$73.60).

Section 438.54(c)(3) and (d)(3) would require states to notify the potential enrollee of the implications of not making an active choice during the allotted choice period. This information should be included in the notice of eligibility determination (or annual redetermination) required under §445.912, thus no additional burden is estimated here.

Section 438.54(c)(8) would require states to send a notice to enrollees in voluntary programs that utilize a passive enrollment process confirming their managed care enrollment when they have the opportunity to select a delivery system. We believe that by implementing the 14-day choice period, some states currently using passive enrollment process will discontinue its use. Therefore, we assume only 10 states will continue using a passive enrollment process, with a total of 14,929,719 enrollees. Assuming a 5 percent of these would be new each year, and of those, that approximately 75 percent will elect managed care (559,865) we estimate 1 min per notification by a mail clerk at \$26.40/hr. In aggregate, we estimate an annual state burden of 9,350 hours (559,865 enrollees x 1 min) and \$246,833.28 (9350 hr x \$26.40/hr).

10. ICRs Regarding Continued Services to Beneficiaries (§438.62)

Section 438.62(b)(1) would require states to have a transition of care policy for all beneficiaries moving from FFS Medicaid into a MCO, PIHP, PAHP or PCCM, or when an enrollee is moving from one MCO, PIHP, PAHP, or PCCM to another and that enrollee would experience a serious detriment to health or be at risk of hospitalization or institutionalization

without continued access to services. As states are currently required to ensure services for enrollees during plan transitions, they have a policy but it may need to be revised to accommodate the proposed requirements and to include transitions from FFS. We estimate it would take a business operations specialist 5 hours at \$53.32/hr to revise their policies and procedures and 4 hr at \$73.60/hr for a computer programmer to create a program to compile and send the data. In aggregate, we estimate a one-time state burden of 378 hr (42 states x 9 hr) and \$23,562.00 (210 hr x \$53.32/hr + 168 hr x \$73.60/hr). We are not estimating additional burden for the routine running of these reports since they will be put into a production schedule.

Section 438.62(b)(2) would require that MCOs, PIHPs, PAHPs, and PCCMs implement their own transition of care policy that meets the requirements of §438.62(b)(1). Under current requirements and as part of usual and customary business practice for all managed care plans, the MCOs, PIHPs, PAHPs, or PCCMs already exchange data with each other for this purpose. To revise their existing policies to reflect the standards in (b)(1), we estimate 1 hr at \$53.32 for a business operations specialist. To develop computer programs to receive and store FFS data, we estimate 4 hr at \$73.60/hr for a computer programmer. We are not estimating additional burden for the routine running of these reports since they will be put into a production schedule. In aggregate, we estimate a one-time private sector burden of 568 hr (568 MCOs, PIHPs, PAHPs, and PCCMs x 1 hr) and \$30,285.76 (568 hr x \$53.32/hr) and 2,272 hr (568 x 4 hr) and \$167,219 (2,272 hr x \$73.60/hr).

For transitions, we estimate 10 min (per request) at \$65.40/hr for a registered nurse to access the stored data and take appropriate action. We also estimate that approximately 0.05 percent of enrollees (313,704) may meet the state defined criteria for serious detriment to health and/or risk of hospitalization or institutionalization. In aggregate, we estimate an annual private

sector burden of 52,294 hr (313,704 enrollees x 10 min) and \$3,420,057.47 (52,294 hr x \$65.40/hr).

11. ICRs Regarding State Monitoring Procedures (§438.66)

Section 438.66(a) and (b) would require states with MCO, PIHP, PAHP, or PCCM programs to have a monitoring system including at least the 13 areas specified in paragraph (b). While having a monitoring system is a usual and customary business process for all of the state Medicaid agencies, including all 13 areas will require most states to make at least some revisions to their existing processes and policies. We estimate 8 hr at \$53.32/hr for a business operations specialist to expand or revise existing policies and procedures. In aggregate, we estimate a one-time state burden of 336 hr (42 states x 8 hr) and \$17,915.52 (336 hr x \$53.32/hr).

Section 438.66(c) would require states with MCO, PIHP, PAHP, or PCCM programs to utilize data gathered from its monitoring activities in 12 required areas to improve the program's performance. While all states currently utilize data for program improvement to some degree, incorporating all 12 areas will likely require some revisions to existing policies and procedures. We estimate a one-time state burden of 20 hr at \$53.32/hr for a business operations specialist to revise existing or to create new policies and procedures for utilizing the collected data. In aggregate, we estimate 840 hr (42 states x 20 hr) and \$44,788.80 (840 hr x \$53.32/hr).

Section 438.66(d)(1) through (3) would require that states include a desk review of documents and an on-site review for all readiness reviews when certain events occur. For preparation and execution of the readiness review, we estimate 5 hr (at \$127.72/hr) for a general and operations manager, 30 hr (at \$53.32/hr) for a business operations specialist, and 5 hr (at \$73.60/hr) for a computer programmer. The time and staff types are estimated for a new program or new entity review and may vary downward when the review is triggered by one of the other

events listed in (d)(1). Given the varying likelihood of the 5 events listed in (d)(1), we will use an average estimate of 20 states per year having one of the triggering events. In aggregate, we estimate an annual state burden of 800 hr (20 states x 40 hr) and \$52,124 [20 states x ((5 x \$127.72/hr) + (30 x \$53.32/hr) + (5 x \$73.60/hr))].

For MCO, PIHP, PAHP, or PCCM preparation and execution, we estimate 5 hr (at \$127.72/hr) for a general and operations manager, 30 hr (at \$53.32/hr) for a business operations specialist, and 5 hr (at \$73.60/hr) for a computer programmer. In aggregate, we estimate an annual private sector burden of 800 hr (20 entities x 40 hr) and \$52,124 [20 entities x ((5 x \$127.72/hr) + (30 x \$53.32/hr) + (5 x \$73.60/hr))].

Section 438.66(e)(1) and (2) would require that states submit an annual program assessment report to CMS covering the topics listed in §438.66(e)(2). The data collected for §438.66(b) and the utilization of the data in §438.66(c) will be used to compile this report. We estimate an annual state burden of 6 hr at \$53.32/hr for a business operations specialist to compile and submit this report to CMS. In aggregate, we estimate an annual state burden of 252 hr (42 states x 6 hr) and \$13,436.64 (252 hr x \$53.32/hr).

12. ICRs Regarding Network Adequacy (§438.68)

Section 438.68(a) would require that states set network adequacy standards that each MCO, PIHP and PAHP must follow. Section 438.68(b) and (c) would require that states set standards which must include time and distance standards for specific provider types and must develop network standards for LTSS if the MCO, PIHP or PAHP has those benefits covered through their contract.

We estimate states would spend 10 hr in the first year to develop the network adequacy standards for the specific provider types found in §438.68(b)(1). While 40 states have contracted

with at least one MCO, PIHP or PAHP, we believe that 20 will need to develop the standards. After the network standards have been established, we estimate that the maintenance of the network standards will occur only periodically as needs dictate; therefore, we do not estimate additional burden for states after the first year.

To develop network standards meeting the specific provider types found in §438.68(b)(1), we estimate a one-time state burden of 10 hr at \$53.32/hr for a business operations specialist. In aggregate, we estimate 200 hr (20 states x 10 hr) and \$10,664 (200 hr x \$53.32/hr).

To develop LTSS standards, we estimate a one-time state burden of 10 additional hr at \$53.32/hr for a business operations specialist to develop those standards. In aggregate, we estimate 160 hr (16 states with MLTSS programs x 10 hr) and \$8,531.20 (160 hr x \$53.32/hr).

Section 438.68(d) would require the state to develop an exceptions process for use by MCOs, PIHPs, and PAHPs unable to meet the network standards established in §438.68(a). We estimate a one-time state burden of 3 hr at \$53.32/hr for a business operations specialist to design an exceptions process for states to use to evaluate requests from MCOs, PIHP, and PAHPs for exceptions to the network standards. With a total of 40 states contracting with at least one MCO, PIHP or PAHP, we estimate a one-time aggregate state burden of 120 hr (40 states x 3 hr) and \$6,398.40 (120 hr x \$53.32).

The exception process should not be used very often as MCOs, PIHPs, and PAHPs meeting the established standards is critical to enrollee access to care. As such, after the exceptions process is established, we estimate that the occasional use of it will not generate any measurable burden after the first year.

States' review and reporting on exceptions granted through the process developed in §438.68(d) is estimated under §438.66 so we do not estimate any additional burden for this requirement.

13. ICRs Regarding Stakeholder Engagement When LTSS is Delivered Through a Managed Care Program (§438.70)

Section 438.70(c) would require that states continue to solicit and address public input for oversight purposes. Existing MLTSS programs already meet this requirement and we estimate no more than 14 new programs.

We estimate an annual state burden of 4 hr at \$53.32/hr for a business operations specialist to perform this task. In aggregate, we estimate 56 hr (14 states x 4 hr) and \$2,985.92 (152 hr x \$53.32/hr).

14. ICRs Regarding Beneficiary Support System (§438.71)

Section 438.71(a) would require the state to develop and implement a system for support to beneficiaries before and after enrollment in a MCO, PIHP, PAHP, or PCCM. This will most likely be accomplished via a call center including staff having email capability - internal to the state or subcontracted - that will assist beneficiaries with questions. As most state Medicaid programs already provide this service, we estimate only 20 states may need to take action to address this requirement.

We estimate a state would need 150 hr to either procure a vendor for this function or create an internal call center. The one-time state burden would consist of 125 hr (at \$53.32/hr) for a business operations specialist, and 25 hr (at \$127.72/hr) for a general and operations manager. In aggregate, we estimate 3,000 hr (20 states x 150 hr) and \$197,160 [20 states x ((125 hr x \$53.32/hr) + (25 hr x \$127.72/hr))].

Section 438.71(b) would require the system to include choice counseling for enrollees, training for providers, outreach for enrollees, and education and problem resolution for services, coverage, and access to LTSS. This system must be accessible in multiple ways including at a minimum, by telephone and email. Some in-person assistance may need to be provided in certain circumstances. Most states will likely use the call center created in §438.71(a) to handle the majority of these responsibilities and use existing community-based outreach/education and ombudsman staff, whether state employees or contractors, for the occasional in person request. The use of existing staff will add no additional burden as it is part of standard operating costs for operating a Medicaid program.

The provider training will likely involve developing materials thus we are estimating 3 hr at \$53.32/hr for a business operations specialist to create materials specifically for provider education on MLTSS and 1 hr to update those materials (given the fluid nature of community resources). As almost all materials for providers are sent electronically, we estimate only the additional time needed to produce the materials here. In aggregate, we estimate a one-time state burden of 126 hr (42 states x 3 hr) and \$6,718.32 (126 hr x \$53.32/hr). We also estimate an annual state burden of 42 hr (42 states x 1 hr) and \$2,239.44 (42 hr x \$53.32/hr).

15. ICRs Regarding Member Advisory Committee (§438.110)

Section 438.110(a) would require each MCO, PIHP, and PAHP to establish and maintain a member advisory board if the LTSS population is covered under the contract. We estimate an annual private sector burden of 6 hr at \$53.32/hr for a business operations specialist to maintain the operation of the committee (hold meetings, distribute materials to members, and maintain minutes) for up to 14 new programs. Existing programs already meet this requirement. In aggregate, we estimate 84 hr (14 states x 6 hr) and \$4,478.88 (84hr x \$53.32/hr).

16. ICRs Regarding Assurances of Adequate Capacity and Services (§438.207)

Section 438.207(c) would add a requirement that the documentation required in §438.207(b) be submitted to the state at least annually. As the MCOs, PIHPs, and PAHPs would already run and review these reports periodically to monitor their networks as part of normal network management functions and as part of the provisions of §438.68, the only additional burden would possibly be (if the state doesn't already require this at least annually) for the MCOs, PIHPs, and PAHPs to revise their policy to reflect an annual submission. We estimate a one-time private sector burden of 1 hr at \$53.32/hr for a business operations specialist to revise the policy, if needed. In aggregate, we estimate 568 hr (568 entities x 1 hr) and \$30,285.76 (568 hr x \$53.32/hr). We also estimate an annual private sector burden of 2 hr to compile and submit the information necessary to meet the requirements §438.207(b) through (d). In aggregate, we estimate 1,136 hr (568 entities x 2 hr) and \$60,571.52 (1,136 hr x \$53.32/hr).

17. ICRs Regarding Coordination and Continuity of Care (§438.208)

Section 438.208(b)(2)(iii) would require that MCOs, PIHPs and PAHPs coordinate service delivery with the services the enrollee receives in the FFS program (carved out services). This involves using data from the state to perform the needed coordination activities. The exchange of data and the reports needed to perform the coordination activity is addressed in the requirements in §438.62(b)(2). Since only a small percentage of enrollees receive carved out services and need assistance with coordination, we estimate 5 percent of all MCO, PIHP, and PAHP enrollees (2,746,476) will be affected. We estimate an ongoing private sector burden of 10 min (per enrollee) at \$59.20/hr for a healthcare social worker to perform the care coordination activities. In aggregate, we estimate 457,746 hr (2,746,476 enrollees x 10 min) and \$27,099,105.17 (457,746 hr x \$59.20/hr).

Section 438.208(b)(3) would require that a MCO, PIHP or PAHP make its best effort to conduct an initial assessment of each new enrollee's needs within 90 days of the enrollment. We believe that most MCOs and PIHPs already meet this requirement and only 25 percent of the MCOs and PIHPs (127) will need to alter their processes; however, we do not believe this to be as common a practice among PAHPs and assume that all 41 PAHPs will be need to add this assessment to their initial enrollment functions. We estimate a one-time private sector burden of 3 hr at \$53.32/hr for a business operations specialist to revise their policies and procedures. In aggregate, we estimate 504 hr [(127 MCOs/PIHPs + 41 PAHPs) x 3 hr] and \$26,873.28 (504 hr x \$53.32/hr).

We estimate that in a given year, only 5 percent (485,872) of 25 percent of MCO and PIHP and all PAHP enrollees are new to a managed care plan. We estimate an annual private sector burden of 10 min (on average) at \$29.68/hr for a customer service representative to complete the assessment. In aggregate, we estimate 80,980 hr (485,872 enrollees x 10 min) and \$2,403,494.90 (80,980 hr x \$29.68/hr).

Section 438.208(b)(4) would require that MCOs, PIHPs, and PAHPs share with other MCOs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated. The burden associated with this requirement is the time it takes each MCO, PIHP or PAHP to disclose information on new enrollees to the MCO, PIHP or PAHP providing a carved out service. This would most likely be accomplished by developing a report to collect the data and posting the completed report for the other MCO, PIHP, or PAHP to retrieve.

We estimate a one-time burden of 4 hr at \$73.60/hr for a computer programmer to develop the report. In aggregate, we estimate 2,272 hr (568 MCOs, PIHPs, and PAHPs x 4 hr) and

\$167,219 (2,272 hr x \$73.60/hr). However, while the currently approved burden sets out 45 min per enrollee and 464,782 annual hours, to provide more accurate estimates we are adjusting the burden by using one-time per plan estimates and recognizing the use of automated reporting. In aggregate, we estimate a one-time private sector burden of -462,510 hr (2,272 hr - 464,782 hr) and -\$34,040,736 (-462,510 hr x \$73.60/hr). Once put on a production schedule, no additional staff time would be needed, thus no additional burden is estimated.

Section 438.208(c)(2) and (3) currently require that MCOs, PIHPs and PAHPs complete an assessment and treatment plan for all enrollees that have special health care needs; we propose to add “enrollees who require LTSS” to this section. These assessments and treatment plans should be performed by providers or MCO, PIHP or PAHP staff that meet the qualifications required by the state. We believe the burden associated with this requirement is the time it takes to gather the information during the assessment. (Treatment plans are generally developed while the assessment occurs so we are not estimating any additional time beyond the time of the assessment.) We believe that only enrollees in MCOs and PIHPs will require this level of assessment as most PAHPs provide limited benefit packages that do not typically warrant a separate treatment plan.

While this is an existing requirement, we estimate an additional 1 percent of the total enrollment of 42,812,879 (428,128) given the surge in enrollment into managed care of enrollees utilizing LTSS. We estimate an annual private sector burden of 1 hr (on average) at \$65.40/hr for a registered nurse to complete the assessment and treatment planning. In aggregate, we estimate an additional 428,128 hr (428,128 enrollees x 1 hr) and \$27,999,571 (428,128 hr x \$65.40/hr).

Section 438.208(c)(3)(v) would add a requirement that treatment plans be updated at least annually or upon request. We estimate a one-time private sector burden of 1 hr at \$53.32/hr for a business operations specialist to revise policies and procedures to reflect a compliant time frame.

In aggregate, we estimate 568 hr (568 MCOs, PIHPs, PAHPs x 1 hr) and \$30,285.76 (568hr x \$53.32/hr).

18. ICRs Regarding Coverage and Authorization of Services (§438.210)

Section 438.210(a)(4)(ii)(B) would require that MCOs, PIHPs, and PAHPs authorize services for enrollees with chronic conditions or receiving LTSS in a way that reflects the on-going nature of the service. While we expect this to already be occurring, we would expect that most MCOs, PIHPs, and PAHPs would review their policies and procedures to ensure compliance. We estimate a one-time private sector burden of 20 hr at \$65.40/hr for a registered nurse to review and revise, if necessary, authorization policies and procedures. In aggregate, we estimate 11,360 hr (568 MCOs, PIHPs, and PAHPs x 20 hr) and \$742,944 (11,360 x \$65.40/hr)

Section 438.210(c) currently requires that each contract provide for the MCO or PIHP 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. In this proposed rule, PAHPs would be added to this requirement.

The burden associated with sending adverse benefit determination notices is included in §438.404. While we believe PAHPs already provide notification of denials, we expect they may need to be revised to be compliant with §438.404. We estimate a one-time public sector burden of 1 hr at \$53.32/hr for a business operations specialist to revise the template. In aggregate, we estimate 61 hr (61 PAHPs x 1 hr) and \$3,252.52 (61 hr x \$53.32/hr).

19. ICRs Regarding Subcontractual Relationships and Delegation (§438.230)

Section 438.230 would require additional provisions in MCO, PIHP, or PAHP subcontracts, other than agreements with network providers. We estimate a one-time private

sector burden of 3 hr at \$53.32/hr for a business operations analyst to amend appropriate contracts. In aggregate, we estimate 1,704 hr (568 MCO, PIHP, or PAHP x 3 hr) and \$90,857.28 (1,704 x \$53.32/hr).

20. ICRs Regarding Health Information Systems (§438.242)

Section 438.242(b) and (c) currently requires MCOs and PIHPs to collect and submit to the state enrollee encounter data. We propose to add PAHPs to the requirement. We estimate a one-time private sector burden of 20 hr at \$73.60/hr for a computer programmer to extract this data from a PAHP's system and report it to the state. In aggregate, we estimate 820 hr (41 entities x 20 hr) and \$60,352 (820 hr x \$73.60/hr). After creation, these reports would be set to run and sent to the state at on a production schedule.

21. ICRs Regarding Basis, Scope, and Applicability (§438.310)

Section 438.310(c)(2) is new and would have states assess the performance of each PCCM entity described in §438.3(r). Section 438.3(r) describes a specific subset of PCCM entities; therefore we estimate that this change will affect 10 states, or approximately 15 PCCM entities. At a minimum, the assessment would include the elements in §438.330(b)(3), (c), and (e).

We estimate a one-time state burden of 2 hr at \$53.32/hr for a business operations specialist to address the performance assessment of PCCM entities specified at §438.3(r) by revising a state's policies and procedures. In aggregate, we estimate 20 hr (10 states x 2 hr) and \$1,066.40 (20 hr x \$53.32/hr).

22. ICRs Regarding Quality Assessment and Performance Improvement Program (§438.330, formerly §438.240)

Section 438.330(a)(2) alters the process we would use to specify performance measures and PIP topics to include a public notice and comment process. Assuming that we do use this

process to identify performance measures and PIP topics at least once every 3 years, the burden for states will be altered. Some may experience a decrease in the time spent selecting performance measures and PIP topics while others might experience a slight increase in the form of programming their MMIS systems to account for the specified performance measures and PIP topics.

We estimate an annual state burden of 10 hr (every 3 years) at \$73.60/hr for a computer programmer to make the MMIS programming changes. In aggregate, we estimate an annualized burden of 133.3 hr [(40 states x 10 hr) / 3 years] and \$9,810.88 (133.3 hr x \$73.60/hr). We cannot estimate the amount of possible decrease in burden as we have no way to know the average amount of time a state expended on selecting performance measures or PIP topics and how this might change based on this revision.

Section 438.330(a)(2)(i) would allow states to select performance measures and performance improvement projects (PIPs) in addition to those specified by CMS under §438.330(a)(2). Since this language continues the flexibility available to states today, we do not believe this creates any change in burden for states or the private sector.

Section 438.330(a)(2)(ii) would allow states to apply for an exemption from the CMS-specified performance measures and PIP topics established under §438.330(a)(2). While we have no data on how many states would take advantage of this option, given that the performance measures and PIP topics under §438.330(a)(2) would be identified through a public notice and comment process, we estimate that 25 percent of states (11 states) would ask for an exemption every 3 years. We estimate an annual state burden of 1 hr at \$53.32/hr for a business operations specialist to comply with the exemption process. In aggregate, we estimate an annualized burden of 3.7 hr [(11 states x 1 hr)/3 years] and \$197.28 (3.7 hr x \$53.32/hr).

Section 438.330(b)(3) clarifies that MCOs, PIHPs, and PAHPs would have an approach to evaluate and address findings regarding the underutilization and overutilization of services. Because utilization review in managed care has become commonplace in the commercial, Medicare, and Medicaid settings, we do not believe that this regulatory provision imposes any new burden on MCOs, PIHPs, or PAHPs. However, in accordance with §438.310(c)(2), some PCCM entities (we estimate 15) would now be subject to this operational component.

We recognize that PCCM entities may not currently have in place mechanisms to assess and address underutilization and overutilization of services in accordance with §438.330(b)(3). We estimate a one-time private sector burden of 10 hr at \$53.32/hr for a business operations specialist to establish the policies and procedures. In aggregate, we estimate 150 hr (15 PCCM entities x 10 hr) and \$7,998 (150 hr x \$53.32/hr) for program establishment. We also estimate an annual burden of 10 hr to evaluate and address the findings. In aggregate, we estimate 150 hr (15 PCCM entities x 10 hr) and \$7,998 (150 hr x \$53.32/hr) for program maintenance.

Section 438.330(c)(1) through (3) would include conforming changes, specifically the addition of PAHPs to the list of affected managed care entities and updated citations. The section states that each MCO and PIHP annually measures its performance using standard measures specified by the state and report its performance to the state. We assume that each of the 335 MCOs and 176 PIHPs would report on three performance measures to the state. The use of performance measures is commonplace in commercial, Medicare, and Medicaid managed care markets; therefore we believe that MCOs and PIHPs already collect performance measures.

For MCOs (335) and PIHPs (176), we estimate an annual private sector burden of 0.1 hr at \$53.32/hr for a business operations specialist to report on a single performance measure to the

state. In aggregate, we estimate 153.3 hr (511 MCOs and PIHPs x 3 performance measures x 0.1 hr) and \$8,173.96 (153.3 hr x \$53.32/hr).

In accordance with §438.310(c)(2), some PCCM entities would now be subject to the performance measurement standards under §438.330(c). We recognize that PAHPs and PCCM entities may not currently engage in performance measurement as described in §438.330(c). We estimate that each PCCM entity and each PAHP would report to the state on 3 performance measures annually. For the 15 PCCM entities and 41 PAHPs, we estimate an annual private sector burden of 4 hr (per measure) at \$53.32/hr for a business operations specialist to collect, calculate, and submit each performance measure to the state. In aggregate, we estimate 672 hr (56 PAHPs and PCCMs x 3 performance measures x 4 hr) and \$35,831.04 (672 hr x \$53.32/hr).

In §438.330(c)(4) we propose that, in addition to the performance measures otherwise specified under §438.330(c)(1) through (3), MCOs, PIHPs, and PAHPs that provide LTSS services would collect and report on two categories of measures specific to LTSS. Assuming that each of the 179 MLTSS plans reports on at least one measure per category and a burden of 4 hr (per measure) at \$53.32/hr for a business operations specialist to collect, calculate, and submit each LTSS performance measure to the state, we estimate an aggregated private sector burden of 1,432 hr (179 MLTSS plans x 2 performance measures x 4 hr) and \$76,354.24 (1,432 hr x \$53.32/hr).

Section 438.330(d)(1) would have states ensure that each MCO and PIHP has an ongoing program of PIPs. In §438.330(d)(2), each MCO and PIHP would report the status and results of each such PIP to the state as requested. For the standards for ongoing PIPs in §438.240(d), we estimate that each MCO and PIHP would conduct at least 3 PIPs in any given year. We further expect that states would request the status and results of each entity's PIPs annually. The currently approved burden under this control number estimates that each of 539 MCOs and PIHPs conducts

3 PIPs, for a burden of 12,936 hr (539 MCOs and PIHPs x 3 PIPs x 8 hr). However, this figure overestimates the number of MCOs and PIHPs. Therefore, we estimate an annual private sector burden of 8 hr at \$53.32/hr for a business operations specialist to report on each PIP. In aggregate, we estimate 12,264 hr (511 MCOs and PIHPs x 8 hr x 3 PIPs) and \$653,916.48 (12,264 hr x \$53.32/hr).

Section 438.330(d)(1) and (2) would add PAHPs to the list of affected managed care entities. While we recognize that PAHPs may not currently be conducting PIPs, we assume that each PAHP would conduct at least one PIP each year. We expect that states would request the status and results of each PAHP's PIP annually. We estimate a one-time private sector burden of 2 hr at \$53.32/hr for a business operations specialist to develop policies and procedures. In aggregate, we estimate 82 hr (41 PAHPs x 2 hr) and \$4,372.24 (82 hr x \$53.32/hr). We also estimate an annual private sector burden of 8 hr to prepare a PIP report. In aggregate, we estimate 328 hr (41 PAHPs x 1 PIP x 8 hr) and \$17,488.96 (328 hr x \$53.32/hr).

Per §438.310(c)(2), PCCM entities specified at §438.3(r) would also be subject to the program components in §438.330(e). We estimate an annual state burden of 15 hr at \$53.32/hr for a business operations specialist to assess the performance of a single §438.3(r) PCCM entity. In aggregate, we estimate 225 hours (15 PCCM entities x 15 hr) and \$11,997 (225 hr x \$53.32/hr).

Under section 438.330(e)(1)(ii), states would include outcomes and trended results of each MCO, PIHP, and PAHP's PIPs in the state's annual review of quality assessment and performance improvement programs. We estimate a one-time state burden of 0.5 hr at \$53.32/hr for a business operations specialist to modify policies and procedures for the 40 states with MCOs, PIHPs and PAHPs. In aggregate, we estimate 20 hr (40 states x 0.5 hr) and \$1,066.40 (20 hr x \$53.32/hr). We also estimate an annual state burden of 1 hr to conduct the additional annual review of the

outcomes and trended results for MCOs, PIHPs, and PAHPs. In aggregate, we estimate 40 hr (40 states x 1 hr) and \$2,132.80 (40 hr x \$53.32/hr).

Section 438.330(e)(1)(iii) is a new program component, related to §438.330(b)(5), which would have a state (in its annual review) assess the results of any efforts to support state goals to promote community integration of beneficiaries using LTSS in place at the MCO, PIHP, or PAHP. We estimate that the 16 states with MLTSS plans would need to modify their policies and procedures regarding the annual review of quality assessment and performance improvement programs in their managed care entities. We estimate a one-time state burden of 0.5 hr at \$53.32/hr for a business operations specialist to modify the state's policies and procedures. In aggregate, we estimate 8 hr (16 states x 0.5 hr) and \$426.56 (8 hr x \$53.32/hr). We also estimate an annual burden of 1 hr for the assessment of rebalancing efforts. In aggregate, we estimate 16 hr (16 states x 1 hr) and \$853.12 (16 hr x \$53.32/hr) for the assessment.

23. ICRs Regarding State Review and Approval of MCOs, PIHPs, and PAHPs (§438.332)

Under this new section, states would review and approve MCO, PIHP, and PAHP performance, at least once every 3 years, in accordance with standards at least as strict as those used by a private accrediting entity that is approved or recognized by CMS under the existing Marketplace and MA programs, as a condition of contracting with the state. It would also grant states the option of allowing MCOs, PIHPs, and PAHPs to meet this standard by presenting proof of accreditation by a private accrediting entity recognized by CMS. MCOs, PIHPs, and PAHPs would maintain state approval for the duration of participation in the Medicaid program. State approval of MCOs, PIHPs, and PAHPs would be renewed every 3 years.

A number of states already either include accreditation by a private accrediting entity as a component of their managed care contracting process or recognize such accreditation. We

estimate that half of states (20 states) would elect to establish their own state review and approval process (per §438.332(a)) and the remainder (20 states) will elect to use the accreditation deeming option (per §438.332(b)). We further estimate that half (276) of the total number of MCOs, PIHPs, and PAHPs (552) will be subject to each process.

Section 438.332(a) would establish that to enter into a contract with the state, the performance of each MCO, PIHP, and PAHP would be reviewed and approved by the state, using a set of standards that are at least as stringent as those used by a private accrediting entity recognized by CMS either for MA or Qualified Health Plan accreditation. It would also define maintenance of state approval as a condition of its contract. While we are aware of at least one state that operates its own accreditation process, we do not have any data regarding the costs of this type of review and approval system and thus estimate all burdens associated with this process.

We expect that states would have to purchase the accreditation standards of a private accrediting entity recognized by CMS to determine if its standards for MCOs, PIHPs, and PAHPs are at least as stringent as those used by a private accrediting entity. We estimate that this would cost \$20,000 per state, and that states would have to purchase these standards at least once every 3 years. In aggregate, we estimate an ongoing annualized state burden of \$133,333.33 [(20 states x \$20,000) / 3 years] for the purchase of the accreditation standards of a private accrediting entity.

After purchasing these standards, the state would use them to develop its own standards which are at least as stringent as those used by the private accrediting entity. We estimate that states would conduct this process at least once every 3 years. We estimate an annual state burden of 15 hr at \$53.32/hr for a business operations specialist and 5 hr at \$127.72/hr for a general and operations manager. In aggregate, we estimate an annualized burden of 133.3 hr [(20 states x 20

hr) / 3 years] and \$9,589.33 [((20 states x 15 hr x \$53.32/hr) + (20 states x 5 hr x \$127.72/hr)) / 3 years].

The state would then use its standards to review and approve the performance of each plan at least once every 3 years. For plan review and approval, we estimate an annual state burden of 80 hr at \$53.32/hr for a business operations specialist, 5 hr at \$127.72/hr for a general and operations manager, and 5 hr at \$29.92/hr for an office and administrative support worker. In aggregate, we estimate an annualized state burden of 8,280 hr (276 MCOs, PIHPs, and PAHPs x 90 hr / 3 years) and \$464,949.60 [(276 MCOs/PIHPs/PAHPs x [(80 hr x \$53.32/hr) + (5 hr x \$127.72/hr) + (5 hr x \$29.92/hr)]) / 3 years] to review and approve MCOs, PIHPs, and PAHPs.

For the state to review and approve a plan, the MCO, PIHP, or PAHP would have to provide certain information to the state. As a condition of contracting with the states, plans would have to maintain state approval (a process which we estimate will occur at least once every 3 years); therefore plans would provide this information to the state at least once every 3 years. We estimate a burden of 40 hr at \$53.32/hr for a business operations specialist, 5 hr at \$29.92/hr for an office and administrative support worker, and 4 hr at \$127.72/hr for a general and operations manager to compile and provide this information. In aggregate we estimate an annualized private sector burden of 4,508 hr [(276 MCOs, PIHPs, and PAHPs x 49 hr / 3 years) and \$256,981.76 [(276 MCOs, PIHPs, and PAHPs x [(40 hr x \$53.32/hr) + (5 hr x \$29.92/hr) + (4 hr x \$127.72/hr)]) / 3 years].

Section 438.332(b) would allow states to deem compliance with the process in §438.332(a) for MCOs, PIHPs, and PAHPs that provide proof and documentation of accreditation by a private accrediting entity recognized by CMS. We estimate the burden for the operation of the state deeming process as 40 hr at \$53.32/hr for a business operations specialist to oversee and collect

private accreditation information from MCOs, PIHPs, and PAHPs. In aggregate, we estimate an annualized state burden of 266.7 hr [(20 states x 40 hr) / 3 years] and \$14,220.44 (266.7 hr x \$53.32/hr) for the oversight and operation of the accreditation deeming process.

Under §438.332(b)(2), MCOs, PIHPs, and PAHPs would authorize the private accrediting entity to release accreditation information to the state to deem compliance with §438.332(a). We believe that an indeterminate number (estimated to be half, or 138 MCOs, PIHPs, and PAHPs) of these entities may already have received or are independently seeking accreditation, and thus would not face any additional burden associated with this section.

The remaining 138 MCOs, PIHPs, and PAHPs would have to seek initial accreditation from a private accrediting entity. The burden for accreditation varies widely, depending on a number of factors including the type of managed care entity, the size of its population, and the accrediting body. We estimate that initial accreditation costs \$70,700 per plan (given that private accrediting entities structure prices in terms of accreditation activities, not hours, an hourly burden estimate is not available) and would be renewed once every 3 years for the same cost. In aggregate, we estimate the one-time private sector burden for initial accreditation is \$9,756,600 (138 MCOs, PIHPs, and PAHPs x \$70,700) and an annualized private sector burden of \$3,252,200 [(138 MCOs, PIHPs, and PAHPs x \$70,700) / 3 years] for accreditation renewal.

Section 438.332(c) would have the state document its determinations for all MCOs, PIHPs, and PAHPs on the state's website. The burden is included in §438.10.

24. ICRs Regarding Medicaid Managed Care Quality Rating System (§438.334)

Section 438.334 (a) would have each state which contracts with an MCO, PIHP or PAHP establish a quality rating system to generate plan ratings. These quality ratings would: (1) Be based on the three specified components (clinical quality management, member experience, and

plan efficiency, affordability, and management), (2) use outcomes data from the CMS-specified performance measures in 438.330(a)(3), and (3) be prominently displayed by the state on its website.

We assume each state would create a single quality rating system for all its MCOs, PIHPs, and PAHPs. Section 438.334(c) would provide states with the option to use their own quality rating system in place of the system proposed under this section; therefore, we estimate that 30 states would have to create quality rating systems. We further estimate that 75 percent (414) of MCOs, PIHPs, and PAHPs operate in these 30 states. We also assume that each state would utilize a public engagement process to solicit feedback on its quality rating system.

We estimate the burden for the development of a state quality rating system as 100 hr at \$53.32/hr for a business operations specialist, 40 hr at \$73.60/hr for a computer programmer, and 15 hr at \$127.72/hr for a general and operations manager. We estimate an additional 2 hr at \$29.92/hr for an office and administrative support worker for the public engagement process and an additional 15 hr at \$53.32/hr for a business operations specialist to review and incorporate public feedback. In aggregate, we estimate a one-time state burden of 5,160 hr (30 states x 172 hr) and \$331,543.20 [30 states x ((100 hr x \$53.32/hr) + (40 hr x \$73.60/hr) + (15 hr x \$127.72/hr) + (2 hr x \$29.92/hr) + (15 hr x \$53.32/hr))] for the development of a state's quality rating system.

Under §438.334(b) each state would collect information from its MCOs, PIHPs, and PAHPs to calculate and then issue a quality rating. We expect that states would rely on information and data already provided to them by their MCOs, PIHPs, and PAHPs; therefore, we do not expect this data collection to pose an additional burden on the private sector. However, each year states would rate each MCO, PIHP, or PAHP with which they contract. We estimate 20 hr at \$53.32/hr for a business operations specialist for a state to rate a MCO, PIHP, or PAHP. In

aggregate, we estimate an annual state burden of 8,280 hr (414 MCOs, PIHPs, and PAHPs x 20 hr) and \$441,489.60 (8,280 hr x \$53.32/hr).

To elect the option under §438.334(c) for states to use their own quality rating system in place of the system under §438.334(a), a state would submit a request to CMS and receive written CMS approval. Knowing that some states already operate their own quality rating systems, we estimate that one quarter (10) of states will elect to use their own quality rating system. We estimate a one-time state burden of 5 hr at \$53.32/hr for a business operations specialist to seek and receive approval from CMS for the state's own quality rating system. In aggregate, we estimate 50 hr (10 states x 5 hr) and \$2,666 (50 hr x \$53.32/hr).

Section 438.334(d) would provide states with the option to use the MA five-star rating, instead of the quality rating system established under this section, for plans that serve only dual eligibles. We estimate that states may utilize this option for 25 MCOs, PIHPs, or PAHPs. This option would reduce the burden under §438.334(b) by -500 hr (-25 MCOs, PIHPs, and PAHPs x 20 hr) and -\$26,660 (-500 hr x \$53.32/hr).

Section 438.334(e) would have states prominently display quality rating information for plans on the state website described in §438.10. The burden associated with this process is captured in §438.10.

25. ICRs Regarding Managed Care Elements of State Comprehensive Quality Strategies (§438.340, formerly §438.204)

Section 438.340 would identify the additional items which states that contract with MCOs, PIHPs, and/or PAHPS would include in the comprehensive quality strategy under §431.502. To include the additional managed care-related items in their comprehensive quality strategies, we estimate a state burden of 10 hr at \$53.32/hr for a business operations specialist each time a state

revises its comprehensive quality strategy (once every 3 years, per §431.504(b)). In aggregate, we estimate an annualized burden of 133.3 hr [(40 states x 10 hr) / 3 years] and \$7,107.56 (133.3 hr x \$53.32/hr).

Current regulations at §438.204(b)(2) describe a quality strategy element, specifically that states contracting with MCOs and/or PIHPs identify the race, ethnicity, and primary language spoken of each Medicaid enrollee, and report this information to MCOs and PIHPs upon enrollment into a plan. We propose removing this item from the proposed managed care elements for a comprehensive quality strategy. The currently approved burden estimates 80 hr per state (for 15 states) to complete the programming necessary to collect and report on these three factors; we would remove this burden, for an aggregate reduction in burden of -1200 hr (15 states x 80 hr).

26. ICRs Regarding Activities Related to External Quality Review (§438.358)

Section 438.358(b) describes the mandatory EQR-related activities. These activities may be conducted by the state, its agent that is not an MCO, PIHP, or PAHP, or an EQRO; we will describe the burden assuming that the state conducts these activities. The burden associated with these activities would be the time and effort for a state to conduct and document the findings of the four mandatory activities: (1) The annual validation of PIPs conducted by the MCO, PIHP, or PAHP, (2) the annual validation of performance measures calculated by the MCO, PIHP, or PAHP, (3) a review of MCO, PIHP, or PAHP compliance with structural and operational standards, performed once every 3 years, and (4) validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months. Each of the activities would be conducted on the 552 MCOs, PIHPs, and PAHPs that we estimate are currently providing Medicaid services.

The types of services provided by MCOs, PIHPs, and PAHPs and the number of PIPs conducted and performance measures calculated will vary. The currently approved burden under

control number 0938-0786 (CMS-R-305) for these three activities assumes that each of the then-estimated 458 MCOs and PIHPs validate one PIP by a professional at \$63/hr for 65 hr, validate one performance measure by a professional at \$63/hr for 53 hr, and complete an annual a compliance review by a professional at \$63/hr for 361 hr. The currently approved annual burden is 219,382 hr (479 hr x 458 MCOs and PIHPs) and \$13,821,066 (219,382 hr x \$63/hr). However, based on recent experience, we estimate that each MCO or PIHP will conduct 3 PIPs, each PAHP will conduct 1 PIP, and that each MCO, PIHP, or PAHP will calculate 3 performance measures. Furthermore, using the time estimates developed for MCOs and PIHPs for the currently approved burden estimates under control number 0938-0786 (CMS-R-305) (and assuming that the same time estimates will also apply to PAHPs), we estimate it would take an average of 65 hr/PIP validation, 53 hr/performance measure validation, and 361 hr/compliance review (occurs once every 3 years) for a business operations specialist, at \$53.32/hr, to conduct the mandatory EQR activities. For MCOs and PIHPS, we estimate an annual state burden of 242,367.3 hr (511 MCOs and PIHPs x [(65 hr x 3 PIPs) + (53 hr x 3 performance measures) + (361 hr / 3 year)]) and \$12,923,024.44 (242,367.3 hr x \$53.32/hr) for the first three mandatory EQR-related activities.

For PAHPs, we estimate an annual state burden of 14,116.3 hr (41 PAHPs x 344.3 hr [(65 hr x 1 PIPs) + (53 hr x 3 performance measures) + (361 hr / 3 years)]) and \$752,681.12 (14,116.3 hr x \$53.32/hr) for the first three mandatory EQR-related activities.

Section 438.358(b)(4) would establish a new mandatory activity (the fourth) to validate MCO, PIHP, and PAHP network adequacy during the preceding 12 months. States would conduct this activity for each MCO, PIHP, and PAHP. Given that this is a new activity, we do not have historic data on which to base an hourly burden estimate for the network validation process. We estimate that it will take less time than the validation of a PIP but more time than the validation of

a performance measure. Therefore, we estimate an annual state burden of 60 hr at \$53.32/hr for a business operations specialist to support the validation of network adequacy activity. In aggregate, we estimate 33,120 hr (552 MCOs, PIHPs, and PAHPs x 60 hr) and \$1,765,958.40 (33,120 hr x \$53.32/hr) for the validation of network adequacy activity.

To summarize, for the proposed four mandatory EQR-related activities, we estimate an annual aggregated state burden of 70,221.6 hr $[(22,985.3 \text{ hr} + 14,116.3 \text{ hr} + 33,120 \text{ hr}) - 219,382 \text{ hr}]$ and \$1,620,597.96 $[(-\$898,041.56 + \$752,681.12 + \$1,765,958.40) - \$13,821,066]$.

The burden associated with §438.358(b)(1) through (4) would also include the time for an MCO, PIHP, or PAHP to prepare the information necessary for the state to conduct the mandatory EQR-related activities. We estimate that it would take each MCO, PIHP, or PAHP 200 hr to prepare the documentation for these four activities, half (100 hr) at \$53.32/hr by a business operations specialist and half (100 hr) at \$29.92/hr by an office and administrative support worker. In aggregate, we estimate an annual private sector burden of 110,400 hr (552 MCOs, PIHPs, and PAHPs x 200 hr) and \$4,594,848 $[(55,200 \text{ hr} \times \$53.32/\text{hr}) + (55,200 \text{ hr} \times \$29.92/\text{hr})]$. However, the currently approved burden under control number 0938-0786 (CMS-R-305) estimates 160 hr per MCO or PIHP to prepare the information for the three existing mandatory EQR-related activities (§438.358(b)(1) through (3)), half by a professional at \$63/hr and half by clerical staff at \$12/hr. The currently approved burden for information preparation is 73,280 hr (438 MCOs and PIHPs x 160 hr) and \$2,748,000 $[(36,640 \text{ hr} \times \$63/\text{hr}) + (36,640 \text{ hr} \times \$12/\text{hr})]$. When comparing the currently approved burden against this rule's proposed burden, we estimate a net burden of 37,120 hr $(110,400 \text{ hr} - 73,280 \text{ hr})$ and \$1,846,848 $(\$4,594,848 - \$2,748,000)$ for the preparation of information for the mandatory EQR-related activities described in §438.358(b)(1) through (4).

Section 438.358(c) describes the five optional EQR-related activities: (1) Validation of client level data (such as claims and encounters); (2) administration or validation of consumer or provider surveys; (3) calculation of performance measures; (4) conduct of PIPs; and (5) conduct of focused studies. As with the mandatory activities described in §438.358(b), these activities may be conducted by the state, its agent that is not an MCO, PIHP, or PAHP, or an EQRO, but for the purposes of this burden estimate we assume that the state conducts the activities.

We have no data to estimate the hours associated with how long it will take to conduct the optional EQR activities. Without that information, we estimate is that it would take 350 hr to validate client level data and 50 hr to validate consumer or provider surveys. We estimate it would take three times as long to calculate performance measures as it takes on average to validate (159 hr) and three times as long to conduct PIPs and focused studies as it takes on average to validate PIPs (195 hr). We also estimate that it would take three times as long to administer a consumer or provider survey than it takes to validate a survey (150 hr).

The currently approved burden under control number 0938-0786 (CMS-R-305) uses state-reported data from 2001 to estimate that states will: (1) Validate the encounter data of 69 percent (316) of MCOs and PIHPs; (2) administer or validate consumer or provider surveys of 43 percent (197) of MCOs and PIHPs; (3) calculate performance measures of 29 percent (133) of MCOs and PIHPs; (4) conduct PIPs of 38 percent (174) of MCOs and PIHPs; and (5) conduct focused studies of 76 percent (348) of MCOs and PIHPs. Using the hourly estimates (above) for each task and assuming the work is completed by a professional at \$63/hr, CMS-R-305 estimates a total burden of 240,759 hr and \$15,167,817. However, based on our review of EQR technical report submissions since the original promulgation of these regulations, we have observed that many states do not conduct the optional EQR-related activities as frequently as assumed in our original

estimates. While the exact states and number vary from year to year, we have not observed participation at the level observed in 2001 state-reported data. Therefore, we revise our estimate and assume that 10 percent (51) of MCOs and PIHPs will be subject to each of the optional EQR-related activities. Regarding the administration or validation of consumer or provider surveys, we assume that half of the MCOs and PIHPs (25) will administer surveys while half (26) will validate surveys. We also estimate that a mix of professionals will work on each optional EQR-related activity: 20 percent by a general and operations manager (\$127.72/hr); 25 percent by a computer programs (\$73.60/hr); and 55 percent by a business operations specialist (\$53.32/hr).

To validate client level data, we estimate 17,850 hr (51 MCOs and PIHPs x 350 hr) and \$1,307,869.50 [(17,850 hr x 20 percent x \$127.72/hr) + (17,850 hr x 25 percent x \$73.60/hr) + (17,850 hr x 55 percent x \$53.32/hr)]. To administer consumer or provider surveys, we estimate 3,750 hr (25 MCOs and PIHPs x 150 hr) and \$274,762.50 [(3,750 hr x 20 percent x \$127.72/hr) + (3,750 hr x 25 percent x \$73.60/hr) + (3,750 hr x 55 percent x \$53.32/hr)]. To validate consumer or provider surveys, we estimate 1,300 hr (26 MCOs and PIHPs x 50 hr) and \$95,251 [(1,300 hr x 20 percent x \$127.72/hr) + (1,300 hr x 25 percent x \$73.60/hr) + (1,300 hr x 55 percent x \$53.32/hr)]. To calculate performance measures, we estimate 8,109 hr (51 MCOs and PIHPs x 159 hr) and \$594,146.43 [(8,109 hr x 20 percent x \$127.72/hr) + (8,109 hr x 25 percent x \$73.60/hr) + (8,109 hr x 55 percent x \$53.32/hr)]. To conduct PIPs, we estimate 9,945 hr (51 MCOs and PIHPs x 195 hr) and \$728,670.15 [(9,945 hr x 20 percent x \$127.72/hr) + (9,945 hr x 25 percent x \$73.60/hr) + (9,945 hr x 55 percent x \$53.32/hr)]. To conduct focused studies, we estimate 9,945 hr (51 MCOs and PIHPs x 195 hr) and \$728,670.15 [(9,945 hr x 20 percent x \$127.72/hr) + (9,945 hr x 25 percent x \$73.60/hr) + (9,945 hr x 55 percent x \$53.32/hr)]. In aggregate, the annual burden for optional EQR-related activities for MCOs and PIHPs is 50,899 hr

(17,850 hr + 3,750 hr + 1,300 hr + 8,109 hr + 9,945 hr + 9,945 hr) and \$3,729,369.73 [(50,899 hr x 20 percent x \$127.72/hr) + (50,899 hr x 25 percent x \$73.60/hr) + (50,899 hr x 55 percent x \$53.32/hr)].

Section 438.358(c) would also be revised to include PAHPs. Since PAHPs are not currently subject to EQR, we do not have any data on which to base an estimate regarding how states would apply the optional EQR-related activities. Therefore, we will apply the time, wage, and participation estimates developed for MCOs and PIHPs to PAHPs. To validate client level data, we estimate 1,400 hr (4 PAHPs x 350 hr) and \$102,578 [(1,400 hr x 20 percent x \$127.72/hr) + (1,400 hr x 25 percent x \$73.60/hr) + (1,400 hr x 55 percent x \$53.32/hr)]. To administer consumer or provider surveys, we estimate 300 hr (2 PAHPs x 150 hr) and \$21,981 [(300 hr x 20 percent x \$127.72/hr) + (300 hr x 25 percent x \$73.60/hr) + (300 hr x 55 percent x \$53.32/hr)]. To validate consumer or provider surveys, we estimate 100 hr (2 PAHPs x 50 hr) and \$7,327 [(100 hr x 20 percent x \$127.72/hr) + (100 hr x 25 percent x \$73.60/hr) + (100 hr x 55 percent x \$53.32/hr)]. To calculate performance measures, we estimate 636 hr (4 PAHPs x 159 hr) and \$46,599.72 [(636 hr x 20 percent x \$127.72/hr) + (636 hr x 25 percent x \$73.60/hr) + (636 hr x 55 percent x \$53.32/hr)]. To conduct PIPs, we estimate 780 hr (4 PAHPs x 195 hr) and \$57,150.60 [(780 hr x 20 percent x \$127.72/hr) + (780 hr x 25 percent x \$73.60/hr) + (780 hr x 55 percent x \$53.32/hr)]. To conduct focused studies, we estimate 780 hr (4 PAHPs x 195 hr) and \$57,150.60 [(780 hr x 20 percent x \$127.72/hr) + (780 hr x 25 percent x \$73.60/hr) + (780 hr x 55 percent x \$53.32/hr)]. In aggregate, the total annual burden for optional EQR-related activities for PAHPs is 3,996 hr (1,400 hr + 300 hr + 100 hr + 636 hr + 780 hr + 780 hr) and \$292,786.92 [(3,996 hr x 20 percent x \$127.72/hr) + (3,996 hr x 25 percent x \$73.60/hr) + (3,996 hr x 55 percent x \$53.32/hr)].

27. ICRs Regarding Nonduplication of Mandatory Activities (§438.360)

Section 438.360(a) would grant states the option to use the information obtained from a Medicare or private accreditation review of an MCO, PIHP, or PAHP in place of information otherwise generated from the three mandatory activities specified in §438.358(b)(1) through (3). The proposed revisions would: (1) Allow states to apply the non-duplication option to PAHPs, in addition to MCOs and PIHPs; (2) allow states to apply the non-duplication option to the validation of performance measures and PIPs, in addition to the compliance review, for all MCOs, PIHPs, and PAHPs; (3) remove current §438.360(c), as there would no longer be a difference in the application of non-duplication to plans serving only dual eligibles; and (4) combine current §438.360(b)(4) and (c)(4) into proposed §438.360(c), to maintain a discussion of non-duplication as an element of the comprehensive quality strategy.

Section 438.360(b) would describe when a state could elect to use information from a Medicaid or private accreditation review in place of information that would otherwise be generated by the mandatory EQR-related activities in §438.358(b)(1) through (3). The burden associated with non-duplication is the time and effort for an MCO, PIHP, or PAHP to disclose the reports, findings, and other results of the Medicare or private accreditation review to the state agency.

While states could elect to allow all 552 MCOs, PIHPs, and PAHPs to substitute information from a Medicare or private accreditation review for the three mandatory EQR-related activities specified at §438.358(b)(1) through (3), in practice we find that states utilize this option infrequently. Therefore, we estimate that states would apply the non-duplication option to 10 percent (55) of MCOs (33), PIHPs (18), and PAHPs (4). The currently approved burden under control number 0938-0786 (CMS-R-305) estimates that 336 MCOs and/or PIHPs take advantage of the nonduplication provision, requiring 8 hr at \$37.50/hr per MCO or PIHP to disclose the

necessary information to the state, for a total currently approved burden of 2,688 hr (336 MCOs and PIHPs x 8 hr) and \$100,800 (2,688 hr x \$37.50/hr). Since this appears to be an overestimate of the burden for MCOs and PIHPs, we estimate a revised annual private sector burden of 2 hr at \$53.32/hr for a business operations specialist and 6 hr at \$29.92/hr for an office and administrative support worker to disclose the necessary documentation to the state each year for a single MCO or PIHP. In aggregate, we estimate 408 hr (51 MCOs and PIHPs x 8 hr) and \$14,594.16 [(51 MCOs and PIHPs x (2 hr x \$53.32/hr) + (6 hr x \$29.92/hr)]. Under this proposal, states could apply the nonduplication provisions to PAHPs. In aggregate, we estimate 32 hr (4 PAHPs x 8 hr) and \$1,144.64 [4 PAHPs x (2 hr x \$53.32/hr) + (6 hr x \$29.92/hr)].

The process in §438.360(b) would include having a state agency provide all of the reports, findings, and other results of the Medicare or private accreditation review to the appropriate EQRO. The currently approved burden under control number 0938-0786 (CMS-R-305) estimates that sharing the reports, findings, and results with EQROs for 336 MCOs and PIHPs would take states 8 hr at \$37.50/hr per plan, for a total burden of 2,688 hr (336 MCOs x 8 hr) and \$100,800 (2,688 hr x \$37.50/hr). However, we estimate it would take, on average, 2 hr at \$29.92/hr for an office and administrative support worker to disclose the necessary documentation to the appropriate EQRO. This represents a decrease in the estimated hourly burden for this task, as we believe that the use of electronic tracking and transmission tools has significantly decreased the hourly burden associated with state staff forwarding the documentation to the EQRO. In aggregate, we estimate an annual state burden of 110 hr (55 MCOs, PIHPs, and PAHPs x 2 hr) and \$3,291.20 (110 hr x \$29.92/hr) to forward non-duplication-related documentation to the EQROs.

Assuming that states would apply the non-duplication provision to 10 percent of MCOs, PIHPs, and PAHPs, we estimate that this provision would offset the burden associated with

§438.358(b)(1) through (3) for 51 MCOs and PIHPs, and 4 PAHPs (since these activities would no longer be necessary for these 55 plans). Consistent with the estimates used in §438.358(b)(1) through (3), we estimate an aggregated offset of $-25,566.50$ hr $[(-51 \text{ MCOs and PIHPs} \times 474.3 \text{ hr}) + (-4 \text{ PAHPs} \times 344.3 \text{ hr})]$ and $-\$1,363,205.78$ $(-25,566.50 \text{ hr} \times \$53.32)$.

Additionally, the MCOs, PIHPs, and PAHPs subject to non-duplication would not have to prepare the documentation necessary for the three mandatory EQR-related activities. Based on the assumption in §438.358(b) that an MCO, PIHP, or PAHP would need 200 hr to prepare the documentation for the four mandatory activities, we estimate that it would take 150 hr to prepare the documentation for the three activities subject to non-duplication, half (100 hr) at $\$53.32/\text{hr}$ by a business operations specialist and half (100 hr) at $\$29.92/\text{hr}$ by an office and administrative support worker. In aggregate, we estimate a decrease in annual private sector burden of $-8,250$ hr $(-55 \text{ MCOs, PIHPs, and PAHPs} \times 150 \text{ hr})$ and $-\$343,365$ $[(-4,125 \text{ hr} \times \$53.32/\text{hr}) + (-4,125 \times \$29.92)]$.

28. ICRs Regarding Exemption from External Quality Review (§438.362)

Section 438.362 would be modified to reflect that PIHPs cannot be exempted from EQR, as they do not qualify as a MA Organization under part C of Title XVII of the Act or under section 1876 of the Act, and they do not qualify as an MCO under section 1903(m) of the Act. This would lead to a decrease in our estimate of the number of plans that might be exempt from the EQR process.

Under §438.362, exempted MCOs would have to provide (annually) to the state agency the most recent Medicare review findings reported to the MCO by CMS or its agent. Of the approximately 335 MCOs, we estimate that approximately half (168) might provide Medicare services in addition to Medicaid services. Of these 168 MCOs that might potentially provide

Medicare services in addition to Medicaid services, we further estimate that state agencies would allow approximately 10 percent (17) of the MCOs to be exempt from the EQR process.

We estimate an annual private sector burden of 8 hr (2 hr at \$53.32/hr for a business operations specialist and 6 hr at \$29.92/hr for an office and administrative support worker) for an MCO to prepare and submit the necessary documentation to the state agency. In aggregate, we estimate 136 hr (17 MCOs x 8 hr) and \$4,864.72 (17 MCOs x [(2 hr x \$53.32/hr) + (6 hr x \$29.92/hr)]).

The currently approved burden under control number 0938-0786 (CMS-R-305) estimates that states would allow 10 percent (20) of the 202 MCOs (which might provide Medicare services in addition to Medicaid services) to be exempt from the EQR process, and that it would take each MCO approximately 8 hr at \$37.50/hr to prepare the necessary materials for a total burden of 160 hr (20 MCOs x 8 hr) and \$6,000 (160 hr x \$37.50/hr).

Therefore, we estimate a net burden of -24 hr (136 hr - 160 hr) and -\$1,135.28 (\$4,864.72 - \$6,000).

29. ICRs Regarding External Quality Review Results (§438.364)

Section 438.364(a) would describe the information that would be included in the annual detailed technical report that is the product of the EQR. Section 438.364(a)(1)(iii) would specify that the EQR technical report include baseline and outcomes data regarding PIPs and performance measures. Many states already provide much of this information in their final EQR technical report. The burden of compiling this data for MCOs, PIHPs, and PAHPs is captured in §438.358. Under §438.364(a)(3), EQR technical reports would include recommendations on how the state can use the goals and objectives of its comprehensive quality strategy to support improvement in the quality, timeliness, and access to care for beneficiaries. We believe that states would amend

their EQRO contracts to address the changes to §438.364(a). We estimate a one-time state burden of 0.5 hr at \$53.32/hr for a business operations specialist to amend the EQRO contract. In aggregate, we estimate 20 hr (40 states x 0.5 hr) and \$1,066.40 (20 hr x \$53.32/hr).

Section 438.364(b)(1) would clarify that the EQRO would produce and submit to the state an annual EQR technical report, and that states may not substantively revise the report without evidence of error or omission, or permission from CMS. This is consistent with existing policy and should not pose a burden on the states or the private sector. The proposed April 30th deadline for the finalization and submission of EQR technical reports is consistent with existing subregulatory guidance.

While we do not anticipate that these changes would pose a significant burden on states or the private sector, we estimate that this provision may necessitate a change in a state's EQRO contract for approximately 10 states. In this regard, we estimate a one-time state burden of 0.5 hr at \$53.32/hr for a business operations specialist to modify the EQRO contract. In aggregate, we estimate 5 hr (10 states x 0.5 hr) and \$266.60 (5 hr x \$53.32/hr).

Under §438.364(b)(2), each state agency would provide copies of technical reports, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, or PAHP, beneficiary advocacy groups, and members of the general public. States would also make the most recent EQR technical report publicly available on the state's website, the burden for which is included in §438.10.

We believe that by making these reports available online, states would be able to significantly decrease the burden associated with responding to requests from the public for this information, as it will already be easily accessible. The burden associated with section is the time and effort for a state agency to furnish copies of a given technical report to interested parties. The

currently approved burden under control number 0938-0786 (CMS-R-305) estimates a burden of 91,600 hr and \$1,099,200. This assumed 329 MCOs and 129 PIHPs (for a total of 458), 25 requests per MCO or PIHP, and 8 hr to respond to each request by staff at \$12/hr. In light of recent technological changes described in this section of this proposed rule, we estimate an annual state burden of 5 min (on average) at \$29.92/hr for an office and administrative support worker to disclose the reports (per request), and that a state would receive 5 requests per MCO, PIHP, or PAHP per year. In aggregate, we estimate 230 hr [(552 MCOs, PIHPs, and PAHPs x 5 requests x 5 min) / 60 min] and \$6,881.60 (230 hr x \$29.92/hr). Overall, we estimate a net burden of -91,370 hr (230 hr - 91,600 hr) and -\$1,092,318.40 (\$6,881.60 - \$1,099,200).

30. ICRs Regarding Federal Financial Participation (§438.370)

Section 438.370(c) would have states submit their EQRO contracts to CMS for review and approval prior to claiming FFP at the 75 percent rate. Since most states already consult with CMS regarding EQRO contracts, we estimate only 12 states will need to amend their policies and procedures to comply with this process. We estimate a one-time state burden of 0.5 hr at \$53.32/hr for a business operations specialist to amend their state's policies and procedures. In aggregate, we estimate 6 hr (12 states x 0.5 hr) and \$319.92 (6 hr x \$53.32/hr).

The 12 states which do not currently work with CMS on their EQRO contracts would need to submit the EQRO contracts to CMS for review and approval if they plan to claim the enhanced 75 percent federal match. We estimate 0.25 hr at \$29.92/hr for an office and administrative support worker to submit the EQRO contract to CMS. In aggregate, we estimate 3 hr (12 states x 0.25 hr) and \$89.76 (3 hr x \$29.92/hr).

31. ICRs Regarding Statutory Basis and Definitions (§438.400)

Section 438.400(b) would replace “action” with “adverse benefit determination” and revise

the definition. It would also revise the definitions of “appeal” and “grievance” and add a definition for “grievance system.” In response, states, MCOs and PIHPs would need to update any documents where these terms are used. (PAHPs will use these updated definitions when they develop their systems in §438.402.)

We estimate a one-time private sector burden of 5 hr at \$53.32/hr for a business operations specialist to amend all associated documents to the new nomenclature and definitions. In aggregate, we estimate 2,535 hr (507 MCO and PIHP entities x 5 hr) and \$135,166.20 (2,535 hr x \$53.32/hr). We also estimate a one-time state burden for states of 200 hr (40 states x 5 hr) and \$10,664 (200 hr x \$53.32/hr) to make similar revisions.

32. ICRs Regarding General Requirements for Grievance System (§438.402)

Section 438.402(a) would add PAHPs to the existing requirement for MCOs and PIHPs to have a grievance system. There are 41 non-NEMT PAHPs that would need to have their contract amended. The burden for revising their contract is included in §438.3.

To set up a grievance system, we estimate it would take 100 hr (10 hr at \$127.72/hr for a general and operations manager, 75 hr at \$53.32/hr for a business operations specialist, and 15 hr at \$73.60/hr for a computer programmer) for each PAHP. In aggregate, we estimate a one-time private sector burden of 4,100 hr (41 PAHPs x 100 hr) and \$261,383.20 [41 PAHPs x ((10 hr x \$127.72/hr) + (75 hr x \$53.32/hr) + (15 hr x \$73.60/hr))].

We further estimate that the average PAHP would only receive 10 grievances per month due to their limited benefit package and will only require 3 hr at \$53.32/hr for a business operations specialist to process and handle grievances and adverse benefit determinations. In aggregate, we estimate an annual private sector burden of 14,760 hr (41 PAHPs x 10 grievances x 3 hr x 12 months) and \$787,003.20 (14,760 hr x \$53.32/hr).

Section 438.402(b) would limit MCOs, PIHPs, and PAHPs to one level of appeal for enrollees. This will likely eliminate a substantial amount of burden from those that currently have more than one, but we are unable to estimate that amount since we do not know how many levels each managed care plan currently utilizes. We request comment from managed care plans to help us estimate the savings from this provision.

33. ICRs Regarding Timely and Adequate Notice of Adverse Benefit Determination (§438.404)

Section 438.404(a) would add PAHPs as an entity that must give the enrollee timely written notice. It also sets forth the requirements of that notice. Consistent with the requirements for MCOs and PIHPs, PAHPs must give the enrollee timely written notice if it intends to: deny, limit, reduce, or terminate a service; deny payment; deny the request of an enrollee in a rural area with one plan to go out of network to obtain a service; or fails to furnish, arrange, provide, or pay for a service in a timely manner.

We estimate an annual private sector burden of 1 min at \$26.40/hr for a mail clerk to send this notification. We also estimate that 2 percent (240,000) of the 12 million PAHP enrollees will receive one notice of adverse benefit determination per year from a PAHP. In aggregate, we estimate an annual state burden of 4,000 hr (240,000 enrollees x 1 min) and \$105,811.20 (4,000 hr x \$26.40/hr).

34. ICRs Regarding Resolution and Notification: Grievances and Appeals (§438.408)

Section 438.408(b) would change the time frame for appeal resolution from 45 days to 30 days. For MCOs, PIHPs, and PAHPs that have Medicare and/or QHP lines of business, this reflects a reduction in burden as this would align Medicaid time frames with Medicare and QHP. For MCOs, PIHPs, and PAHPs that do not have Medicare and/or QHP lines of business, and whose state has an existing time frame longer than 30 days, they would need to revise their

policies and procedures. Among the 200 MCOs, PIHPs, and PAHPs, we estimate a one-time private sector burden of 1 hr at \$53.32/hr for a business operations specialist. In aggregate, we estimate 200 hr (200 MCOs, PIHPs, and PAHPs x 1 hr) and \$10,664 (200 hr x \$53.32).

35. ICRs Regarding Recordkeeping Requirements (§438.416)

This section would add PAHPs to the requirement to maintain records of grievances and appeals. We estimate that approximately 240,000 enrollees (2 percent) of the approximately 12 million PAHP enrollees file a grievance or appeal with their PAHP. As the required elements will be stored and tracked electronically, we estimate 1 min per grievance and appeal at \$29.92/hr for an office and administrative support worker to maintain each grievance and appeals record. In aggregate, we estimate an annual private sector burden of 4,000 hr (240,000 grievances x 1 min) and \$119,919.36 (4,000 hr x \$29.92/hr).

Maintaining records for grievances and appeals has always been required for MCOs and PIHPs. However, we propose specific data so MCOs and PIHPs will have to revise their policies and systems to record the required information. We estimate 3 hr at \$73.60 for a computer programmer to make necessary changes. We estimate a one-time private sector burden of 168 hr (56 MCOs and PIHPs x 3 hr) and \$12,364.80 (168 hr x \$73.60/hr). As the required elements will be stored and tracked electronically, we estimate 1 min per grievance and appeal at \$29.92/hr for an office and administrative support worker to maintain each grievance and appeals record. In aggregate, we estimate an annual private sector burden of 14,271 hr (856,257 grievances x 1 min) and \$426,986.82 (14,271 hr x \$29.92/hr).

Section 438.420(c)(4) would remove the “time period or service limit of a previously authorized service has been met” as a criteria for defining the duration of continued benefits and would add “PAHP” as a conforming change to §438.400. This action would require that MCOs

and PIHPs revise current policies and procedures to reflect having only 3 criteria instead of 4. PAHPs would incorporate the options in §438.420(c)(1) through (3) when developing their system under §438.402 and thus the elimination of paragraph (c)(4) would have no impact on PAHPs.

For MCOs and PIHPs, we estimate a one-time private sector burden of 4 hr at \$53.32/hr for a business operations specialist to revise current policies and procedures. In aggregate, we estimate 2,028 hr (507 MCOs and PIHPs x 4 hr) and \$108,132.96 (2,028 hr x \$53.32/hr).

Section 438.420(d) would add PAHPs to the list of entities that can recover costs if the adverse determination is upheld. PAHPs would include the policies and procedures necessary to recover costs when developing their system under §438.402 and thus would incur no additional burden.

36. ICRs Regarding State Responsibilities (§438.602)

Section 438.602(a) would detail state responsibilities for monitoring MCO, PIHP, PAHP, PCCM or PCCM's compliance with §§438.604, 438.606, 438.608, 438.610, 438.230, and 438.808. As all of these sections are existing requirements, the only new burden is for states to update their policies and procedures, if necessary, to reflect revised regulatory text. We estimate a one-time state burden of 6 hr at \$53.32/hr for a business operations specialist to create and/or revise their policies. In aggregate, we estimate 252 hr (42 states x 6 hr) and \$13,436.64 (252 hr x \$53.32/hr).

Section 438.602(b) would require states to screen and enrollee MCO, PIHP, PAHP, PCCM and PCCM entity providers in accordance with 42 CFR part 455, subparts B and E. Given that states already comply with these subparts for their FFS programs, the necessary processes and procedures have already been implemented. Additionally, since some states require their managed care plan providers to enroll with FFS, the overlap that occurs in many states due to provider market conditions, and the exemption from this requirement for Medicare approved providers, we

believe the pool of managed care providers that will have to be newly screened and enrolled by the states is small. Since we do not have data on which to base our estimate, we seek comment from states on the quantity of managed care providers that would require screening and enrollment. We expect the MCOs, PIHPs, and PAHPs will need to create data files to submit new provider applications to the state for the screening and enrollment processes. As PCCMs and PCCM entities are already FFS providers, there would be no additional burden on them or the state. As such, we estimate a one-time private sector burden of 6 hr at \$73.60/hr for a computer programmer to create the necessary programs to send provider applications/data to the state. In aggregate, we estimate 3,408 hr (568 MCOs, PIHPs, and PAHPs x 6 hr) and \$250,828.80 (3,408 hr x \$73.60/hr). Once created, the report would likely be put on a production schedule and generate no additional burden.

Section 438.602(e) would require states to conduct or contract for audits of MCO, PIHP, and PAHP encounter and financial data once every 3 years. As validation of encounter data is also required in §438.818(a), we assume no additional burden. For the financial audits, states could use internal staff or an existing contractual resource, such as their actuarial firm. For internal staff, we estimate an annual state burden of 20 hr at \$63.10/hr for an accountant. In aggregate, we estimate 3,787 hr (568 MCOs, PIHPs, and PAHPs x 20 hr)/3 and \$238,959.70 (3,787 hr x \$63.10/hr).

Section 438.602(g) would require states to post the MCO's, PIHP's, and PAHP's contracts, data from §438.604, and audits from §438.602(e) on their website. As most of these activities will only occur no more frequently than annually, we estimate an annual state burden of 1 hr at \$73.60/hr for a computer programmer to post the documents. In aggregate, we estimate 40 hr (40 states x 1 hr) and \$2,944 (40 hr x \$73.60/hr).

37. ICRs Regarding Program Integrity Requirements (§438.608)

Section 438.608(a) would require that MCOs, PIHPs, and PAHPs have administrative and management arrangements or procedures that are designed to guard against fraud and abuse. The arrangements or procedures must include a compliance program as set forth under §438.608(a)(1), provisions for reporting under §438.608(a)(2), provisions for notification under §438.608(a)(3), provisions for verification methods under §438.608(a)(4), and provisions for written policies under §438.608(a)(5).

The compliance program must include: written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards and requirements under the contract; the designation of a Compliance Officer; the establishment of a Regulatory Compliance Committee on the Board of Directors; effective training and education for the organization's management and its employees; and provisions for internal monitoring and a prompt and effective response to noncompliance with the requirements under the contract.

While §438.608(a)(1) is an existing regulation, we expect all MCOs, PIHPs, and PAHPs review their policies and procedures to ensure that all of the above listed items are addressed. We estimate a one-time private sector burden of 2 hr at \$53.32/hr for a business operations specialist to review and (if necessary) revise their policies and procedures. In aggregate, we estimate 1,136 hr (568 MCOs, PIHPs, and PAHPs x 2 hr) and \$60,571.52 (1,136 hr x \$53.32/hr).

Section 438.608(a)(2) and (3) require reporting of improper payments and enrollee fraud. As these would be done via an email from the MCO, PIHP, or PAHP to the state and do not occur very often, we estimate an annual private sector burden of 2 hr at \$53.32/hr for a business operations specialist. In aggregate, we estimate 1,136 hr (568 MCOs, PIHPs, and PAHPs x 2 hr) and \$60,571.52 (1,136 hr x \$53.32/hr).

Section 438.608(a)(4) would require the MCO, PIHP, or PAHP to use a sampling methodology to verify receipt of services. Given that this is already required of all states in their FFS programs, many states already require their MCOs, PIHPs, and PAHPs to do this. Additionally, many health plans perform this as part of usual and customary business practice. Therefore, we estimate only approximately 200 MCOs, PIHPs, or PAHPs may need to implement this as a new procedure. As this typically involves mailing a letter or sending an email to the enrollee, we estimate that 200 MCOs, PIHPs, or PAHPs would mail to 100 enrollees each. We estimate an annual private sector burden of 1 min at \$26.40/hr for a mail clerk to send each letter. In aggregate, we estimate 333 hr (20,000 letters x 1 min/letter) and \$8,817.60 (333 hr x \$26.40/hr). This estimate will be significantly reduced as the use of email increases.

Section 438.608(b) reiterates the requirement in §438.602(b) whereby the burden is stated in section IV.B.36. of this proposed rule.

Section 438.608(c) and (d) would require states to include in all MCO, PIHP, and PAHP contracts, the process for the disclosure and treatment of certain types of recoveries and reporting of such activity. While the burden to amend the contracts is included in §438.3, we estimate a one-time private sector burden of 1 hr at \$73.60/hr for a computer programmer to create the report. In aggregate, we estimate 568 hr (568 MCOs, PIHPs, and PAHPs x 1 hr) and \$41,804.80 (568 hr x \$73.60/hr). Once developed, the report would be put on a production schedule and add no additional burden.

38. ICRs Regarding Disenrollment During Termination Hearing Process (§438.722)

After a state has notified an MCO, PIHP, PAHP or PCCM of its intention to terminate its contract, §438.722(a) would provide that the state may give the entity's enrollees written notice of the state's intent to terminate its contract. States already have the authority to terminate contracts

according to state law and they have already opted to provide written notice to MCO and PCCM enrollees.

We estimate that no more than 12 states may terminate 1 contract per year. We also estimate an annual state burden of 1 hr at \$53.32/hr for a business operations specialist to prepare the notice. In aggregate, we estimate a one-time state burden of 12 hr (12 states x 1 hr) and \$639.84 (12 hr x \$53.32/hr).

To send the notice, we estimate 1 min (per beneficiary) at \$26.40/hr for a mail clerk. We estimate an aggregate annual state burden of 18,075 hr (12 states x 90,378 enrollees/60 mins) and \$477,195 (18,075 hr x \$26.40/hr).

39. ICRs Regarding Enrollee Encounter Data (§438.818)

Section 438.818(a)(2) would require that the encounter data be validated prior to its submission. States can perform this validation activity themselves, contract it to a vendor, or contract it to their External Quality Review Organization (EQRO). In this regard, a state already using EQRO to validate its data at an appropriate frequency would incur no additional burden. Since approximately 10 states already use their EQRO to validate their data, only 27 states may need to take action to meet this requirement. The method selected by the state will determine the amount of burden incurred. We assume an equal distribution of states selecting each method, thus 9 states per method.

A state using EQRO to validate data on less than an appropriate frequency may need to amend their EQRO contract. In this case, we estimate 1 hr at \$53.32/hr for a business operations specialist. In aggregate, we estimate a one-time state burden of 9 hr (9 states x 1 hr) and \$479.88 (9 hr x \$53.32/hr).

A state electing to perform validation internally would need to develop processes and

policies to support implementation. In this case, we estimate 10 hr at \$53.32/hr for a business operations specialist to develop policy and 100 hr at \$73.60/hr for a computer programmer to develop, test, and automate the validation processes. In aggregate, we estimate a one-time state burden of 990 hr (9 states x 110 hr) and \$71,038.80 [9 states x ((10 hr x \$53.32/hr) + (100 hr x \$73.60/hr))].

For a state electing to procure a vendor, given the wide variance in state procurement processes, our burden is conservatively estimated at 150 hr for writing a proposal request, evaluating proposals, and implementing the selected proposal. We estimate 75 hr at \$53.32/hr for a business operations specialist to participate in the writing, evaluating, and implementing, 50 hr at \$53.32/hr for a business operations specialist to participate in the writing, evaluating, and implementing, and 25 hr at \$127.72/hr for a general and operations manager to participate in the writing, evaluating, and implementing. In aggregate, we estimate an annual state burden of 1,350 hr [9 states x (150 hr)] and \$88,722 [9 states x ((125 hr x \$53.32/hr) + (25 hr x \$127.72/hr))].

40. ICRs Regarding CHIP Component of the State Comprehensive Quality Strategy.

Per §457.760, states would address all delivery systems for their CHIP programs as a component of the state comprehensive quality strategy under part 431, subpart I. While the majority of the burden associated with the comprehensive quality strategy is captured in part 431, subpart I, we estimate an additional burden of 10 hr (every 3 years) at \$53.32/hr for a business operations specialist to address CHIP within the comprehensive quality strategy. In aggregate, we estimate an annualized burden of 110 hr [(33 states and territories x 10 hr) / 3 years] and \$5,864.61 (110 hr x \$53.32/hr).

41. ICRs Regarding Standard Contract Requirements (§§457.1201, 457.1205, 457.1207, 457.1208, 457.1210, 457.1212, 457.1218, 457.1220, 457.1222, 457.1224, 457.1226, 457.1228, 457.1230, 457.1233, 457.1240, 457.1250, 457.1260, 457.1270, and 457.1285)

Section 457.1201 would provide a list of standard requirements that must be included in MCO, PIHP, PAHP, and PCCM contracts. The following burden estimate addresses the effort to amend such contracts in addition to the contract amendments associated with §§457.1205, 457.1207, 457.1208, 457.1210, 457.1212, 457.1218, 457.1220, 457.1222, 457.1224, 457.1226, 457.1228, 457.1230, 457.1233, 457.1240, 457.1250, 457.1260, 457.1270, and 457.1285. We estimate a one-time state burden of 6 hr at \$53.32/hr for a business operations specialist to amend all contracts associated with the aforementioned requirements. In aggregate, we estimate 396 hr (66 contracts x 6 hr) and \$21,114.72 (396 hr x \$53.32/hr).

42. ICRs Regarding Medical Loss Ratio (§457.1205)

Section 457.1205 would apply the requirements of §438.8 to CHIP. Section 438.8(c) would require that MCOs, PIHPs, and PAHPs report to the state annually their total expenditures on all claims and non-claims related activities, premium revenue, the calculated MLR, and, if applicable under other authority, any remittance owed.

We estimate the total number of MLR reports that MCOs, PIHPs, and PAHPs would be required to submit to the state would amount to 62 contracts. We estimate a one-time burden of 168 hr for the initial administration activities. In the first year, we estimate that 60 percent of the time would be completed by a computer programmer (101 hr at \$73.60/hr), 30 percent would be completed by a business operations specialist (50 hr at \$53.32/hr), and 10 percent would be completed by a general and operations manager (17 hr at \$127.72/hr). The first year burden

amounts to 168 hr and \$12,270.84 ((101 hr x \$73.60) + (50 hr x \$53.32) + (17 hr x \$127.72)) per report or, in aggregate, 10,416 hr (62 reports x 168 hr) and \$760,792.086 (62 x \$12,270.84).

In subsequent years, since the programming and processes established in year 1 will continue to be used, the burden will be decrease from 168 hr to an ongoing burden of approximately 53 hr. Using the same proportions of labor allotment, we estimate 53 hr and \$3,865.18 ((31.8 hr x \$73.60) + (15.9 hr x \$53.32) + (5.3 hr x \$127.72)) per report and a total of 3,127 hr (53 hr x 59 reports) and \$228,045.62 (59 reports x \$3,865.18). We expect states to permit MCOs and PIHPs to submit the report electronically. Since the submission time is included in our reporting estimate, we are not setting out the burden for submitting the report.

43. ICRs Regarding Non-emergency Medical Transportation PAHPs (§457.1206)

Section 457.1206 would provide a list of standard requirements that must be included in NEMT PAHP contracts. The following burden estimate addresses the effort to amend such contracts in addition to the contract amendments associated with §§457.1205, 457.1207, 457.1210, 457.1212, 457.1220, 457.1222, 457.1224, 457.1226, 457.1230, and 457.1233. We estimate a one-time state burden of 4 hr at \$53.32/hr for a business operations specialist to amend all contracts associated with the aforementioned requirements. In aggregate, we estimate 12 hr (3 contracts x 4 hr) and \$639.84 (12 hr x \$53.32/hr).

44. ICRs Regarding Information Requirements (§457.1207)

Section 457.1207 would apply the requirements of §438.10 to CHIP. Section 438.10(c)(1) would require that states provide enrollment notices, informational materials, and instructional materials in an easily understood format. We anticipate that most states already do this and will only have to make minor revisions. We estimate an annual burden of 4 hr at \$53.32/hr for a

business operations specialist to make these revisions. In aggregate, we estimate 132 hr (33 states x 4 hr) and \$7,038.24 (132 hr x \$53.32/hr).

Section 438.10(c)(3) would require that states operate a website which provides the information set out under §438.10(f). Since all states already have websites for their Medicaid programs and most also include information about their managed care program, most states will probably only have to make minor revisions to their existing website. We estimate a one-time state burden of 6 hr at \$73.60/hr for a computer programmer to make the initial changes. In aggregate, we estimate 198 hr (33 states x 6 hr) and \$14,572.80 (198 hr x \$73.60/hr). We also estimate an annual burden of 3 hr at \$73.60/hr for a computer programmer to periodically add or update documents and links on the website. In aggregate, we estimate 99 hr (33 states x 3 hr) and \$7,286.40 (99 hr x \$73.60/hr).

Section 438.10(c)(4)(i) would recommend that states develop definitions for commonly used terms to enhance consistency of the information provided to enrollees. We estimate a one-time state burden of 6 hr at \$53.32/hr for a business operations specialist to develop these definitions. In aggregate, we estimate 198 hr (33 states x 6 hr) and \$10,557.36 (198 hr x \$53.32/hr).

Section 438.10(c)(4)(ii) would recommend that states create model enrollee handbooks and notices. Since many states already provide model handbooks and notices to their entities, we estimate that 15 states may need to take action to comply with this provision. We estimate a one-time state burden of 40 hr at \$53.32/hr for a business operations specialist to create these documents. In aggregate, we estimate 600 hr (15 states x 40 hr) and \$31,992.00 (600 hr x \$53.32/hr). We also estimate an annual state burden of 2 hr at \$53.32/hr for a business operations

specialist to maintain these documents. In aggregate, we estimate 30 hr (15 states x 2 hr) and \$1,599.60 (30 hr x \$53.32/hr).

Section 438.10(d)(1) would require that states identify prevalent non-English languages spoken in each managed care entity's service area. Given that states must already determine the prevalent non-English languages spoken in their entire Medicaid service area based on the policy guidance "Enforcement of Title VI of the Civil Rights Act of 1964 - National Origin Discrimination Against Persons With Limited English Proficiency" from the U.S. Department of Justice, we believe that dividing the information by plan service area requires only minimal IT programming. More specifically, we estimate a one-time state burden of 4 hr at \$73.60/hr for a computer programmer to create these reports. In aggregate, we estimate 132 hr (33 states x 4 hr) and \$9,715.20 (132 hr x \$73.60/hr) to create these reports. We estimate no additional burden for the running of these reports as they would be put into a production schedule, and putting a report into production adds no additional burden.

Section 438.10(d)(2)(i) would require that states add taglines to all printed materials for potential enrollees explaining the availability of translation and interpreter services as well as the phone number for choice counseling assistance. We estimate a one-time state burden of 2 hr at \$53.32/hr for a business operations specialist to create the taglines and another 4 hr to revise all document originals. In aggregate, we estimate 198 hr (33 states x 6 hr) and \$10,557.36 (198 hr x \$53.32/hr). As the prevalent languages within a state do not change frequently, we are not estimating burden for the rare updates that would be needed to these taglines.

Section 438.10(e)(1) would clarify that states can provide required information in paper or electronic format. As the amount and type of information that can be provided electronically will vary greatly among the states due to enrollee access and knowledge of electronic communication

methods, it is not possible to estimate with any accuracy the amount that will be able to be converted from written to electronic format. Therefore, we will use estimates for all written materials knowing that some of this burden will be alleviated as the states are gradually able to convert to electronic communication methods. In this regard, we estimate a one-time state burden of 40 hr at \$53.32/hr for a business operations specialist to create the materials. Many states already provide similar information to potential enrollees, so we anticipate that only 15 states would need to create these materials. We also estimate 1 min at \$29.92/hr for an office and administrative support worker to mail the materials annually. For existing states, we estimate 1 hr at \$53.32/hr for a business operations specialist to update or revise existing materials and 1 min at \$29.92/hr for a mail clerk to mail the materials to 5 percent of the enrollees that are new (306,937 enrollees). In aggregate, we estimate a one-time state burden of 600 hr (15 states x 40 hr) and \$31,992 (600 hr x \$53.32/hr) to create materials. We estimate a one-time state burden of 33 hr (33 states x 1 hr) and \$1,759.56 (33 hr x \$53.32/hr) to update or revise existing materials. The state will also need to mail the materials. We estimate an ongoing burden of 5,115.6 hr (306,937 enrollees x 1 min) and \$153,058.75 (5,115.6 hr x \$29.92/hr) to mail materials.

Although §438.10(g)(1) and (2) would require the provision of an enrollee handbook, Medicaid regulations have always required the provision of this information (although it did not specifically call it a “handbook”) so we do not anticipate that all entities would need to create a new handbook. Additionally, given the requirement in §438.10(c)(4)(ii) (which would be adopted in CHIP through §457.1207) for the state to provide a model template for the handbook, the burden on an entity is greatly reduced. We estimate approximately 5 new managed care entities per year using 10 hr at \$53.32/hr for a business operations specialist to create a handbook using their state’s model template. In aggregate, we estimate 50 hr (5 entities x 10 hr) and \$2,666 (50 hr

x \$53.32/hr). For existing MCOs, PIHPs, PAHPs, and PCCMs that already have a method for distributing the information, we believe that 20 entities will need to modify their existing handbook to comply with a new model provided by the state. We also estimate a one-time private sector burden of 4 hr at \$53.32/hr for a business operations specialist to update their entity's handbook. Once revised, we estimate 1 min at \$29.92/hr for an office and administrative support worker to send these handbooks to 3,069,371 enrollees (50 percent of total enrollment). In aggregate, we estimate 80 hr (20 entities x 4 hr) and \$4,265.60 (80 hr x \$53.32/hr) to update handbooks. To send the updated handbooks, we estimate 51,156.2 hr (3,069,371 enrollees x 1 min) and \$1,530,593.50 (51,156.2 hr x \$29.92/hr).

All new enrollees must receive a handbook within a reasonable time after receiving notice of the beneficiary's enrollment. We assume a 5 percent enrollee growth rate thus 306,937 enrollees (5 percent of 6,138,743) would need to receive a handbook each year. (Existing enrollees typically do not receive a new handbook annually unless significant changes have occurred so this estimate is for new beneficiaries only.) We estimate a private sector state burden of 1 min at \$29.92/hr for an office and administrative support worker to mail the handbook. In aggregate, we estimate 5,115.6 hr (306,937 enrollees x 1 min) and \$153,058.75 (5,115.6 hr x \$29.92/hr) to send handbooks to new enrollees.

All entities would need to keep their handbook up to date. In this regard, we estimate an annual private sector burden of 1 hr at \$53.32/hr for a business operations specialist to update the handbook. While the updates would need to be made as program changes occur, we estimate 1 hr since each change may only take a few minutes to make. In aggregate, we estimate 66 hr (66 entities x 1 hr) and \$3,519.12 (66 hr x \$53.32/hr).

Section 438.10(h) would require that MCOs, PIHPs, PAHPs, and PCCMs make a provider directory available in paper or electronic form. Producing a provider directory is a longstanding Medicaid requirement in §438.10 as well in the commercial health insurance market.

Additionally, given the time sensitive nature of provider information and the notorious high error rate in printed directories, most provider information is now obtained via website or by calling the customer service unit. Thus, the only new burden estimated would be the time for a computer programmer to add a few additional fields of data as appropriate, specifically, provider website addresses, additional disability accommodations, and adding behavioral and long-term services and support providers. We estimate a one-time private sector burden of 1 hr at \$73.60/hr for a computer programmer to update the existing directory. In aggregate, we estimate 66 hr (66 entities x 1 hr) and \$4,858 (66 hr x \$73.60/hr). Updates after creation of the original program would be put on a production schedule, which generates no additional burden.

45. ICRs Regarding Requirements that Apply to MCO, PIHP, PAHP, and PCCM Contracts Involving Indians, Indian Health Care Providers, and Indian Managed Care Entities (§457.1208)

Section 457.1208 would apply the requirements of §438.14 to CHIP. Section 438.14(c) would require states to make supplemental payments to Indian providers if the managed care entity does not pay at least the amount paid to Indian providers under the FFS program. There are approximately 25 states with separate CHIPs that have federally recognized tribes. We do not know how many managed care entities have Indian providers, but estimate that it is approximately 40 entities. This type of payment arrangement typically involves the managed care entity sending a report to the state, which then calculates and pays the amount owed to the Indian health care provider. We estimate it would take 1 hr at \$73.60/hr for a computer programmer to create the claims report and approximately 12 hr at \$53.32/hr for a state business operations specialist to

process the payments. We estimate that approximately 25 states will need to use this type of arrangement. In aggregate, we estimate a one-time private sector burden of 40 hr (40 entities x 1 hr) and \$2,944.00 (40 hr x \$73.60/hr). We also estimate an ongoing state burden of 300 hr (25 states x 12 hr) and \$15,996.00 (300 hr x \$53.32/hr).

After the MCO, PIHP, PAHP, and PCCM report is created, it will most likely run automatically at designated times and sent electronically to the state as the normal course of business operations; therefore, no additional burden is estimated after the first year.

(Note: this process is not necessary when the MCO, PIHP, PAHP, or PCCM entity pays the ICHP at least the full amount owed under this regulation.)

46. ICRs Regarding Managed Care Enrollment (§457.1210)

Section 457.1210(a) would require state to establish a process for prioritizing individuals for enrollment into managed care plans. Establishing a default enrollment process would require policy changes and require the state to send notices to enrollees once they have been enrolled in a plan. We estimate that states would need to use the default enrollment process specified in §457.1210(a) for 5 percent of enrollees (306,937), and that it would take 1 min at \$29.92/hr for a mail clerk to send the notice. In aggregate, we estimate 5,115.6 hr (306,937 beneficiaries x 1 min) and \$153,059.25 (5,115.6 hr x \$29.92/hr) to send the notices.

47. ICRs Regarding Disenrollment (§457.1212)

Section 457.1212 would apply the requirements of §438.56 to CHIP. To disenroll, §438.56(d)(1) would require that the beneficiary (or his or her representative) submit an oral or written request to the state agency (or its agent) or to the MCO, PIHP, PAHP, or PCCM, where permitted. We estimate that 5 percent of MCO, PIHP, PAHP, and PCCM enrollees will request

that they be disenrolled from an MCO, PIHP, PAHP, or PCCM each year. We also estimate approximately one-fourth of the enrollees will choose a written rather than an oral request.

We estimate an ongoing burden of 10 min for an enrollee to generate a written disenrollment request and 3 min per oral request. In aggregate, we estimate an annual burden (written requests) of 12,789 hr (76,734 enrollees x 10 min) and 11,510.1 hr (230,202 enrollees x 3 min) for oral requests.

48. ICRs Regarding Conflict of Interest Safeguards (§457.1214)

Section 457.1214 would apply the requirements of §438.58 to CHIP. Section 438.58 would require that states have in place safeguards against conflict of interest for employees or agents of the state who have responsibilities relating to the MCO, PIHP, or PAHP. We anticipate that most states already have such safeguards in place, and only 5 states would need to develop new standards to comply with this provision. We estimate a one-time state burden of 10 hr at \$53.32/hr for a business operations specialist to develop those standards. In aggregate, we estimate 50 hr (5 states x 10 hr) and \$2,666.00 (50 hr x \$53.32/hr).

49. ICRs Regarding Continued Services to Beneficiaries (§457.1216)

Section 457.1216 would apply the requirements of §438.62 to CHIP. Section 438.62(b)(1) would require that states have a transition of care policy for all beneficiaries moving from FFS CHIP into a MCO, PIHP, PAHP or PCCM, or when an enrollee is moving from one MCO, PIHP, PAHP, or PCCM to another and that enrollee would experience a serious detriment to health or be at risk of hospitalization or institutionalization without continued access to services. We estimate a one-time state burden of 10 hr at \$53.32/hr for a business operations specialist to develop the transition of care policy. In aggregate, we estimate 330 hr (33 states x 10 hr) and \$17,595.60 (330 hr x \$53.32/hr).

Section 438.62(b)(2) would require that MCOs, PIHPs, PAHPs, or PCCMs implement their own transition of care policy that meets the requirements of §438.62(b)(1). We estimate it would take 4 hr at \$73.60/hr for a computer programmer to create the program that gathers and sends the FFS data to the MCOs, PIHPs, PAHPs, or PCCMs. We also estimate each MCO, PIHP, PAHP, or PCCM will use 4 hr of a computer programmer time to create programs to receive and store data as well as gather and send data to other plans. We are not estimating additional burden for the routine running of these reports as they will be put into a production schedule. In aggregate, we estimate a one-time state burden of 132 hr (33 states x 4 hr) and \$9,715.20 (132 hr x \$73.60/hr) to create the program that gathers and sends the FFS data to the MCOs, PIHPs, PAHPs, or PCCMs. We also estimate a one-time private sector burden of 264 hr (66 MCOs, PIHPs, PAHPs, or PCCMs x 4 hr) and \$19,430.40 (264 hr x \$73.60/hr) to create programs to receive and store data as well as gather and send data to other plans.

Once a MCO, PIHP, PAHP, or PCCM receives a request or identifies a need to arrange for the transition of services, we estimate a registered nurse at the managed care plan may need 10 min, on average, to access the stored information and take appropriate action. We believe that an average of 25,000 beneficiaries will transition into managed care each year from FFS and 5,000 may switch between plans that would meet the state defined standards to qualify for the transition of care policy. In aggregate, we estimate an annual for private sector burden of 5,000 hr (30,000 beneficiaries x 10 min) and \$327,000.00 (5,000 hr x \$65.40/hr).

50. ICRs Regarding Network Adequacy Standards (§457.1218)

Section 457.1218 would apply the requirements of §438.68 to CHIP. Section 438.68(a) would require that states set network adequacy standards that each MCO, PIHP and PAHP must follow. Section 438.68(b) and (c) would require that states set standards that must include time

and distance standards for specific provider types and network standards for LTSS (if the MCO, PIHP or PAHP has those benefits covered through their contract).

We believe some states already comply with these requirements and that only 12 states would need to develop the standards. We estimate a one-time first year burden of 15 hr at \$53.32/hr for a business operations specialist to develop network standards meeting the specific provider types found in §438.68(b)(1). In aggregate, we estimate 180 hr (12 states x 15 hr) and \$9,597.60 (180 hr x \$53.32/hr).

Very few states include LTSS in CHIP, therefore we estimate only 5 states will need to develop related standards. We estimate a one-time burden of 10 additional hr at \$53.32/hr for a business operations specialist to develop those standards. In aggregate, we estimate 50 hr (5 states x 10 hr) and \$2,666.00 (50 hr x \$53.32/hr) for the development of LTSS standards. After network standards are established, we estimate that the maintenance of the network standards will be part of usual and customary business practices and therefore, we do not estimate any burden for states after the first year.

Section 438.68(d) would require that states: (1) develop an exceptions process for plans unable to meet the state's standards; and (2) review network performance for any MCO, PIHP or PAHP to which the state provides an exception. We estimate a one-time state burden of 3 hr at \$53.32/hr for a business operations specialist to establish an exceptions process. In aggregate, we estimate 99 hr (33 states x 3 hr) and \$5,278.68 (99 hr x \$53.32/hr).

The exception process should not be used very often as MCOs, PIHPs, and PAHPs meeting the established standards is critical to enrollee access to care. As such, after the exceptions process is established, we estimate that the occasional use of it will not generate any measurable burden after the first year.

51. ICRs Regarding Enrollee Rights (§457.1220)

Section 457.1220 would apply the requirements of §438.100 to CHIP. We do not anticipate a burden associated with implementing this section, because the proposed requirements to provide enrollees with treatment options and alternatives, allow enrollees to participate in decisions regarding health care, ensure that enrollees are free from restraint or seclusion, are standard practice in the field. The burden associated with providing information in accordance with 45 CFR 164.524 and 164.526 is accounted for in the collection of information associated with those regulations. The burden associated with modifying contracts to comply with this regulation are accounted for under §457.1202.

52. ICRs Regarding Provider-enrollee Communication (§457.1222)

Section 457.1222 would apply the requirements of §438.102 to CHIP. Section 438.102(a)(2) provides that MCOs, PIHPs, and PAHPs are not required to cover, furnish, or pay for a particular counseling or referral service if the MCO, PIHP, or PAHP objects to the provision of that service on moral or religious grounds and that written information on these policies is available to: (1) prospective enrollees, before and during enrollment; and (2) current enrollees, within 90 days after adopting the policy for an any particular service.

We believe the burden for providing written notice to current enrollees within 90 days of adopting the policy for a specific service, would affect no more than 3 MCOs or PIHPs annually since it would apply only to the services they discontinue providing on moral or religious grounds during the contract period. PAHPs are excluded from this estimate because they generally do not provide services that would be affected by this provision.

We estimate that each of the 3 MCOs or PIHPs would have such a policy change only once annually. We estimate that it would take 1 hr at \$53.32/hr for a business operations analyst to

update the policies. In aggregate, we estimate 3 hr (3 MCOs/PIHPs x 1 hr) and \$159.96 (3 hr x \$53.32/hr). We further estimate that it would take 4 hr at \$53.32/hr for a business operations specialist to create the notice and 1 min at \$29.92/hr for an office and administrative support worker to mail each notice. With an average MCO/PIHP enrollment of 78,000 enrollees, we estimate a total annual burden of 12 hr (3 MCOs/PIHPs x 4 hr/notice) and \$639.84 (12 hr x \$53.32/hr) to create the notice. To mail the notice we estimate 3,900 hr (3 MCOs/PIHPs x 78,000 enrollees x 1 min/notice) and \$116,688 (3,900 hr x \$29.92/hr).

53. ICRs Regarding Marketing Activities (§457.1224)

Section 457.1224 would apply the requirements of §438.104 to CHIP. Section 438.104(c) would require that the state review marketing materials submitted by managed care entities. We believe that each entity would revise its materials once every 3 years. We estimate a state burden of 3 hr at \$53.32/hr for a business operations specialist to review an entity's materials. In aggregate, we estimate an annual state burden of 75 hr [3 hr x 25 entities (one third of the total entities)] and \$3,999 (75 hr x \$53.32/hr).

We estimate that 5 entities may need to revise and submit updated materials. We estimate a private sector burden of 2 hr at \$53.32/hr for a business operations specialist to update and submit the materials. In aggregate, we estimate a one-time burden of 10 hr (5 entities x 2 hr) and \$533.20 (10 hr x \$53.32).

54. ICRs Regarding Access Standards (§457.1230)

Section 457.1230 would apply the requirements of §§438.206, 438.207, 438.208, and 438.210 to CHIP. Section 438.206(c)(3) through 457.1230(a), would require that MCOs, PIHPs, and PAHPs ensure that providers assure access, accommodations, and equipment for enrollees with physical and/or mental disabilities. We believe that MCOs, PIHPs, and PAHPs will need to

review and revise (possibly) their policies and procedures for network management to ensure compliance with this requirement.

We estimate a one-time private sector burden of 3 hr at \$53.32/hr for a business operations specialist to review and revise their network management policies and procedures. In aggregate, we estimate 189 hr (63 MCO/PIHP/PAHPs x 3 hr) and \$10,077.48 (189 hr x \$53.32/hr).

Section 438.207(b) through 457.1230(b) and 438.207(b) would require that each MCO, PIHP, and PAHP (where applicable) submit documentation to the state, in a format specified by the state, to demonstrate that it: (1) complies with specified requirements, and (2) has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care. Section 438.207(c) would require that the documentation be submitted to the state at least annually, at the time the MCO, PIHP, or PAHP enters into a contract with the state, and at any time there has been a significant change (as defined both by the state) in the MCO, PIHP, or PAHP's operations that would affect adequate capacity and services.

We estimate an annual private sector burden of 20 hr at \$53.32/hr for a business operations specialist to compile the information necessary to meet this requirement. In aggregate, we estimate 1,260 hr (63 entities x 20 hr) and \$67,183.20 (1,260 hr x \$53.32/hr).

After reviewing the documentation, §438.207(d) through 457.1230(a), would require that the state certify (to CMS) that the entity has complied with the state's requirements regarding the availability of services, as set forth at §438.68. We estimate an annual state burden of 1 hr/contract at \$53.32/hr for a business operations specialist to review documentation and submit the certification to CMS. In aggregate, we estimate 63 hr (63 entities x 1 hr) and \$3,359.16 (63 hr x \$53.32/hr).

Section 438.208(b)(2)(iii) through 457.1230(c), would require that MCOs, PIHPs and PAHPs coordinate service delivery with the services the enrollee receives in the FFS program (carved out services). This would involve using data from the state to perform the needed coordination activities. Since only a small percentage of enrollees receive carved out services and need assistance with coordination, we estimate 2 percent of all MCO, PIHP, and PAHP enrollees (122,775) will be affected.

We estimate an annual private sector burden of 10 min/enrollee at \$59.20/hr for a healthcare social worker. In aggregate, we estimate 20,463hr (122,775enrollees x 10 min) and \$1,211,380.00(20,463 hr x \$59.20/hr).

Section 438.208(b)(3) through 457.1230(c), would require that an MCO, PIHP or PAHP make its best effort to conduct an initial assessment of each new enrollee's needs within 90 days of the enrollment. We believe that most MCOs and PIHPs already meet this requirement and only 25 percent of the MCOs and PIHPs (15) would need to alter their processes; however, we do not believe this to be as common a practice among PAHPs and assume that all 3 PAHPs will be need to add this assessment to their initial enrollment functions.

We estimate a one-time private sector burden of 3 hr at \$53.32/hr for a business operations specialist to revise their policies and procedures. In aggregate, we estimate 54 hr [(15 MCOs and PIHPs + 3 PAHPs) x 3 hr] and \$2,879.28 (54 hr x \$53.32/hr).

We estimate that in a given year, approximately 10 percent of all enrollees are new to a managed care plan. Thus, 613,874 enrollees would be considered new and in need of an initial assessment. As PAHPs are typically a single entity within the state, we will only estimate that 5 percent of their enrollees (10,000 enrollees) would need an initial assessment. In general, we believe these assessments will take 10 min on average to complete by Call Center staff at

\$29.92/hr. In aggregate, we estimate an annual private sector burden of 102,312.33 hr (613,874 enrollees x 10 min) and \$3,061,185.01 (102,312.33 hr x \$29.92/hr).

Section 438.208(b)(4) through 457.1230(c), would require that MCOs, PIHPs, and PAHPs share with other MCOs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated. The burden associated with this requirement is the time it takes each MCO, PIHP or PAHP to disclose information on enrollees with special health care needs to the MCO, PIHP or PAHP providing a carved out service. This would most likely be accomplished by developing a report to collect the data and sending that report to the other MCO, PIHP, or PAHP.

We estimate a one-time private sector burden of 4 hr at \$73.60/hr for a computer programmer to develop the report. In aggregate, we estimate of 252 hr (63 MCOs, PIHP, and PAHPs x 4 hr) and \$18,547.20 (288 hr x \$73.60/hr). Once put into production on a schedule, no additional staff time would be needed, thus no additional burden is estimated.

Section 438.208(c)(2) and (3) through 457.1230(c), would require that the MCOs, PIHPs and PAHPs complete a comprehensive assessment and treatment plan for all enrollees that have special health care needs. The assessments and treatment plans should be completed by providers or MCO, PIHP or PAHP staff that meet the qualifications specified by the state. We believe the burden associated with this requirement is the time it takes to gather the information during the assessment. (Treatment plans are generally developed while the assessment occurs so we are not estimating any additional time beyond the time of the assessment.) We believe that only enrollees in MCOs and PIHPs will require this level of assessment as most PAHPs provide limited benefit packages that do not typically warrant a separate treatment plan.

We estimate that 1 percent of the total enrollment of 6,138,743 (61,387) are enrolled in either a MCO, PIHP or both, and would qualify as an individual with special health care needs. The time needed for the assessment and for treatment planning will, on average, take 1 hr at \$65.40/hr for a registered nurse to complete. In aggregate, we estimate an annual private sector burden of 61,387 hr (61,387 enrollees x 1 hr) and \$4,014,709.80 (61,387 hr x \$65.40/hr).

Section 438.210(c) through 457.1230(d), would require that each contract provide that the MCO, PIHP, or PAHP 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.

We estimate an annual private sector burden of 30 min at \$65.40/hr for a registered nurse to generate the notice. We estimate that each of 63 MCOs, PIHPs and PAHPs would process 20 denials/service reductions per 1,000 members. With average enrollment of 78,000, each entity is estimated to process a total of 1,560 denials and service reductions annually. In aggregate, we estimate 49,140 hr (63 entities x 1,560 denials or service reductions/entity x 30 min) and \$3,213,756.00 (49,140 hr x \$65.40/hr).

55. ICRs Regarding Structure and Operation Standards (§457.1233)

Section 457.1233 would apply the requirements of §§438.214, 438.230, 438.236, and 438.242 to CHIP. Section 438.214 would require that MCOs, PIHPs, and PAHPs have policies for the selection and retention of providers. As described in section IV.B.55. of this proposed rule, we believe that the requirements in §§438.214 are part of the usual course of business and will not add additional burden onto entities because the entities will have policies for selecting and retaining providers even in the absence of these regulations.

Section 438.230 through §457.1233(b), would require that MCOs, PIHPs, and PAHPs oversee subcontractors and would specify the subcontracted activities. We estimate 3 hr at \$53.32/hr for a business operations analyst to amend appropriate contracts. We estimate a one-time private sector burden of 189 (63 MCOs, PIHPs, and PAHPs x 3 hr) and \$10,077.48 (189 hr x \$53.32). Section 438.236(c) through §457.1233(c), would require that each MCO, PIHP, and PAHP disseminate guidelines to its affected providers and, upon request, to enrollees and potential enrollees. The burden associated with this requirement is the time required to disseminate the guidelines, usually by posting on their website. This is typically done annually. We estimate an annual private sector burden of 2 hr at \$53.32/hr for a business operations specialist. In aggregate, we estimate 124 hr (62 entities x 2 hr) and \$6,611.68 (124 hr x \$53.32/hr).

In §438.242(b)(2) through §457.1233(b), the state would be required to stipulate that each MCO and PIHP 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 such methods as may be specified by the state). We estimate a one-time private sector burden of 20 hr at \$73.60/hr for a computer programmer to extract this data from an entity's system and report to the state. In aggregate, we estimate 1,180 hr (59 entities x 20 hr) and \$86,848 (1,180 hr x \$73.60/hr). After the initial creation, the reports would be set to run and sent to the state at specified times as part of a production schedule.

56. ICRs Regarding Quality Measurement and Improvement (§457.1240)

Section 457.1240 would apply the requirements of §§438.330, 438.332, 438.334, and 438.340 to CHIP. Section 438.330(a)(2) through §457.1240(b), would authorize CMS to use a public notice and comment process to identify performance measures and PIP topics that states would include in their contracts with MCOs, PIHPs, and PAHPs. Should CMS use this process to

identify specific performance measures and PIP topics at least once every 3 years, we expect that states would need to program their MMIS systems to account for the specified performance measures and PIP topics. We estimate that MMIS programming changes would require 10 hr (every 3 years) at \$73.60/hr for a computer programmer. In aggregate, we estimate an ongoing annualized state burden of 110 hr [(33 states x 10 hr) / 3 years] and \$8,096 (110 hr x \$73.60/hr).

Section 438.330(a)(2)(i) through §457.1240(b), allows states to select performance measures and performance improvement projects (PIPs) in addition to those specified by CMS under §438.330(a)(2). Since this language continues the flexibility available to states today, we do not believe this creates any change in burden for states or the private sector.

Section 438.330(a)(2)(ii) allows states to apply for an exemption from the CMS-required performance measure and PIP topic requirements established under §438.330(a)(2). While we have no data on how many states would take advantage of this option, given that the performance measures and PIP topics under §438.330(a)(2) would be identified through a public notice and comment process, we estimate that 2 states would ask for an exemption every 3 years. We estimate that the exemption process would require 1 hr at \$53.32/hr for a business operations specialist. In aggregate, we estimate an ongoing annualized state burden of 0.67 hr [(2 states x 1 hr)/3 years] and \$36.72 (0.67 hr x \$53.32/hr).

Section 438.330(b)(3) would clarify that MCOs, PIHPs, and PAHPs must have an approach to evaluate and address findings regarding the underutilization and overutilization of services. Because utilization review in managed care has become commonplace in the commercial, Medicare, and Medicaid settings, we do not believe that this regulatory provision imposes any new burden on MCOs, PIHPs, or PAHPs.

In accordance with §438.310(c)(2), some PCCM entities (we estimate 3) will now be subject to the requirements of §438.330(b)(3). We estimate a one-time private sector burden of 10 hr at \$53.32/hr for a business operations specialist to establish the policies and procedures. In aggregate, we estimate 30 hr (3 PCCMs x 10 hr) and \$1,599.60 (30 hr x \$53.32/hr). We also estimate an ongoing burden of 10 hr to evaluate and address the findings. In aggregate, we estimate an annual burden of 30 hr (3 PCCMs x 10 hr) and \$1,599.60 (30 hr x \$53.32/hr) for program maintenance.

Section 438.330(c)(1) through (3) through §457.1240(b), would require that each MCO, PIHP, and PAHP annually measure its performance using standard measures required by the state and report its performance to the state. Because the use of performance measures in managed care has become commonplace in commercial, Medicare, and Medicaid managed care, we do not believe that this regulatory provision imposes any new burden on MCOs, PIHPs, or states.

In accordance with §438.310(c)(2) through §457.1240(b), some PCCM entities will now be subject to this requirement. We recognize that PAHPs and PCCM entities may not currently engage in performance measurement, and estimate that 7 entities might be impacted. We estimate that, in any given year, each PCCM entity and each PAHP would report to the state on at least 3 performance measures. We estimate an annual private sector burden of 4 hr per measure at \$53.32/hr for a business operations specialist to prepare a report for each performance measure. In aggregate, we estimate 84 hr [(3 PAHPs + 4 PCCMs) x 3 performance measures x 4 hr] and \$4,478.88 (84 hr x \$53.32/hr).

In §438.330(d)(1) through §457.1240(b), states would ensure that each MCO, PIHP and PAHP have an ongoing program of performance improvement projects (PIPs). In §438.330(d)(2) each MCO, PIHP, and PAHP would be required to report the status and results of each such

project to the state, as requested. We estimate that, in any given year, each of the 59 MCOs and PIHPs would conduct at least 3 PIPs and each of the 4 PAHPs would conduct at least 1 PAHP. We further expect that states will request the status and results of each entity's PIPs annually. Given that PAHPs may not currently conduct PIPs, we estimate a one-time private sector burden of 2 hr at \$53.32/hr for a business operations specialist to develop policies and procedures, for an aggregate burden of 8 hr (4 PAHPs x 2 hr) and \$426.56 (8 hr x \$53.32/hr). We estimate an annual burden of 8 hr to prepare a report on each PIP. In aggregate, we estimate 1,448 hr [(59 MCOs and PIHPs x 3 PIPs) + (4 PAHPs x 1 PIP)] x 8 hr] and \$77,207.36 (1,448 hr x \$53.32/hr) to prepare the report.

Per §438.310(c)(2), PCCM entities specified are also subject to the requirements in §438.330(e) through §457.1240(b). We estimate an annual state burden of 15 hr at \$53.32/hr for a business operations specialist to assess the performance of a single §438.3(r) PCCM entity. In aggregate, we estimate 45 hours (3 PCCM entities x 15 hr) and \$2,399.40 (45 hr x \$53.32/hr).

Section 438.330(e)(1)(ii) through §457.1240(b), would require that states include outcomes and trended results of each MCO, PIHP, and PAHP's PIPs in the state's annual review of quality assessment and performance improvement programs. We estimate a one-time state burden of 0.5 hr at \$53.32/hr for a business operations specialist to modify the state's policies and procedures. In aggregate, we estimate 16.5 hr (33 states x 0.5 hr) and \$879.78 (16.5 hr x \$53.32/hr). We also estimate an annual burden of 1 hr for the additional review. In aggregate, we estimate 33 hr (33 states x 1 hr) and \$1,759.56 (33 hr x \$53.32/hr). Section 438.330(e)(1)(iii) would set out a new requirement, related to §438.330(b)(5), requiring that the state must assess the rebalancing effort results for LTSS in its annual review. We do not know of any states that have an LTSS plan in CHIP, so there is no burden associated with the proposed provision.

Under §438.332(a) through §457.1240(c), states would review and approve the performance of all CHIP MCO, PIHP, and PAHP at least once every 3 years. We assume that no state would set up a separate review and approval process for CHIP, and would instead follow the same process used for Medicaid managed care plans. We estimate an annual state burden of 80 hr at \$53.32/hr for a business operations specialist, 5 hr at \$127.72/hr for a general and operations manager, and 5 hr at \$29.92/hr for an office and administrative support worker to assess a CHIP plan, which would occur at least once every 3 years. In aggregate, we estimate an annualized state burden of 1,980 hr (66 MCOs, PIHPs, and PAHPs x 90 hr / 3 years) and \$157,594.80 [(66 MCOs, PIHPs, and PAHPs x [(80 hr x \$53.32/hr) + (5 hr x \$127.72/hr) + (5 hr x \$29.92/hr)]) / 3 years] to review and approve CHIP MCOs, PIHPs, and PAHPs. We estimate an annualized private sector burden of 1,078 hr [(66 MCOs, PIHPs, and PAHPs x 49 hr / 3 years) and \$61,452.16 [(66 MCOs, PIHPs, and PAHPs x [(40 hr x \$53.32/hr) + (5 hr x \$29.92/hr) + (4 hr x \$127.72/hr)]) / 3 years] for CHIP MCOs, PIHPs, and PAHPs to provide the necessary information to the state for review and approval.

Section 438.332(b)(2) through §457.1240(c), would allow states to deem compliance with §438.332(a) for accredited MCOs, PIHPs, and PAHPs that authorize the private accrediting entity to release accreditation information to the state. The burden associated with operating this program at a state is captured in §438.332(b), were we assume that half of states will elect this option. We believe that approximately half of the CHIP MCOs, PIHPs, and PAHPs (17) in these states may already have received or are independently seeking accreditation, and thus would not face any additional burden associated with this requirement. The remaining 16 MCOs, PIHPs, and PAHPs (half the entities in half the states) would have to seek initial accreditation from a private accrediting entity. The burden for accreditation varies widely, depending on a number of factors

including the type of managed care entity, the size of its population, and the accrediting body. We estimate that initial accreditation costs \$70,700 per plan (given that private independent entities structure prices in terms of accreditation activities, not hours, an hourly burden estimate is not available) and must be renewed once every 3 years for the same cost. In aggregate, we estimate the one-time private sector burden for initial accreditation is \$1,131,200 (16 MCOs, PIHPs, and PAHPs x \$70,700), and the ongoing annualized private sector burden for accreditation renewal is \$377,066.67 [(16 MCOs, PIHPs, and PAHPs x \$70,700) / 3 years].

Section 438.332(c) through §457.1240(c), requires the state to document its determinations for all MCOs, PIHPs, and PAHPs on the state's website, the burden for which is included in §438.10.

Section 438.334 through §457.1240(d), would have states establish and operate a quality ratings system for MCOs, PIHPs, and PAHPs. We assume that states would utilize the same system and processes developed for CHIP managed care plans as was developed for Medicaid managed care plans. Using the assumptions developed for §438.332, we estimate that 25 states (with 47 MCOs, PIHPs, and PAHPs) will operate a quality rating systems as proposed in §438.334(a) and would rate plans each year. We estimate 20 hr at \$53.32/hr for a business operations specialist in a state to rate a MCO, PIHP, or PAHP. In aggregate, we estimate an annual state burden of 940 hr (47 MCOs, PIHPs, and PAHPs x 20 hr) and \$50,120.80 (940 hr x \$53.32/hr). We assume the remaining 8 states (with 16 MCOs, PIHPs, and PAHPs) will utilize the flexibility at §438.334(c) to continue to use their own quality rating system. As this would not be a change from the status quo, we estimate no additional burden in these states for the quality rating system.

Section 438.340 through §457.1240(e), would describe the additional comprehensive quality strategy elements that states contracting with MCOs, PIHPs, or PAHPs would include in their comprehensive quality strategies. To include the additional managed care-related items in their comprehensive quality strategies, we estimate a state burden of 10 hr at \$53.32/hr for a business operations specialist each time a state revises its comprehensive quality strategy (once every 3 years, per §431.504(b)). In aggregate, we estimate an annualized burden of 110 hr [(33 states x 10 hr) / 3 years] and \$5,865.20 (110 hr x \$53.32/hr).

57. ICRs Regarding External Quality Review (§457.1250)

Section 457.1250 would apply the requirements of §§438.350, 438.352, 438.354, 438.356, 438.358, and 438.364 to CHIP. Section 438.350 through §457.1250(a), would require that states include CHIP in their external quality review. We anticipate that most states would include CHIP in their Medicaid contract with the EQRO and that the burden for adding CHIP would be included in the burden for adding PAHPs to the EQRO contract. We anticipate that 5 states may contract separately for CHIP EQR services and that this would require states to procure a new vendor.

Given the wide variance in state procurement processes, the burden is conservatively estimated at 185 hr for writing an RFP, evaluating proposals, and implementing the selected proposal. More specifically, we estimate a one-time state burden of 125 hr at \$53.32/hr for a business operations specialist, 50 hr at \$73.60/hr for a computer programmer, and 10 hr at \$127.72/hr for a general and operations manager. In aggregate, we estimate 925 hr [(125 hr + 50 hr + 10 hr) x 5 states] and \$58,111.00 [((125 hr x \$53.32/hr) + (50 hr x \$73.60/hr) + (10 hr x \$127.72/hr) x 5 states)].

Section 438.356(a)(3) through §457.1250(a), would require that states submit their EQRO contracts to CMS for review and approval prior to implementation. We estimate a one-time state

burden of 2 hr at \$53.32/hr for a business operations specialist to submit the contract to CMS. In aggregate, we estimate 10 hr (5 states x 2 hr) and \$533.20 (10 hr x \$53.32/hr).

Section 438.358 through §457.1250(a), would require that the EQRO perform certain activities. The burden associated with this provision is the time for a state to conduct and document the findings of the four mandatory activities: (1) The annual validation of performance improvement projects conducted by the MCO/PIHP/PAHP; (2) the annual validation of performance measures calculated by the MCO/PIHP/PAHP; (3) once every 3 years, a review of MCO/PIHP/PAHP compliance with structural and operational standards; and (4) validation of MCO, PIHP, and PAHP network adequacy. Each of these activities would be conducted on the 5 MCOs/PIHPs/PAHPs that are currently providing CHIP services separately from Medicaid. The types of services provided by these managed care entities, the number of performance improvement projects conducted, and the performance measures calculated will vary. We assume that each MCO/PIHP will conduct at least 3 performance improvement projects, each PAHP will conduct at least 1 performance improvement project, and that each MCO/PIHP/PAHP will calculate at least 3 performance measures.

For a business operations specialist to conduct the mandatory EQR activities at \$53.32/hr, we estimate an annual state burden of 65 hr (performance improvement project validation), 53 hr (performance measure validation), 361 hr (compliance review; occurs once every 3 years), and 60 hr (validation of network adequacy activity). In aggregate, we estimate 2,671.67hr (5 x [(65 hr x 3 performance improvement projects) + (53 hr x 3 performance measures) + (361 hr/3) + 60 hr]) and \$142,453.27 (2,372 hr x \$53.32/hr).

In §438.358(b), the burden would include the time for an MCO/PIHP/PAHP to prepare the information necessary for the state to conduct the three mandatory activities. We estimate that it

will take each MCO/PIHP/PAHP 160 hr to prepare the documentation for these activities. We estimate that one-half of the time would be for preparing the information which will be performed by a business operations specialist at \$53.32/hr while the other half will be performed by office and administrative support worker at \$29.92/hr. In aggregate, we estimate a private sector burden of 800 hr (5 states x 160 hr) and \$33,296.00 [(5 states x 80 hr x \$53.32/hr) + (5 states x 80 hr x \$29.92/hr)].

Section 438.358(b)(1) through §457.1250(a), would stipulate that all of the PIPs required by the state and CMS be validated. We have added the reference to CMS-required PIPs to be consistent with our proposed provision at §438.330(a)(3). While current regulations do not specify the number of PIPs that must be validated in each state, the majority of states validate multiple PIPs for each MCO or PIHP.

Given current practice, we do not anticipate this will pose a burden on states or the private sector beyond the need to modify MCO, PIHP, PAHP, and EQRO contracts. We anticipate that most states would include CHIP in their Medicaid contract with the EQRO and that the burden for adding CHIP would be included in the burden under §438.350. The burden associated with amending MCO/PIHP/PAHP contracts is captured in §457.1202.

Section 438.358(c) through §457.1250(a), describes optional EQR-related activities. For the optional EQR activities, we have no data to estimate how long it would take to conduct these activities. We, therefore, estimate that it will take 350 hr to validate client level data and 50 hr to validate consumer or provider surveys. We estimate it will take three times as long to calculate performance measures as it takes on average to validate (159 hr) and three times as long to conduct performance improvement projects and focused studies as it takes on average to validate

performance improvement projects (195 hr). We also estimate that it will take three times as long to administer a consumer or provider survey than it takes to validate a survey (60 hr).

For a business operations specialist \$53.32/hr, we estimate: (1) 16,800 hr (350 hr × 48 MCOs/PIHPs) and \$895,776.00 (16,800hr x \$53.32/hr) to validate client level data; (2) 1500 hr (50 hr × 30 MCOs/PIHPs) and \$79,980.00 (1500 hr x \$53.32/hr) to validate consumer or provider surveys; (3) 3,180 hr (159 hr × 20 MCOs/PIHPs) and \$169,557.60 (3,180 hr x \$53.32/hr) to calculate performance measures; (4) 5,070 hr (195 hr × 26 MCOs/PIHPs) and \$270,332.40 (5,070 hr x \$53.32/hr) to conduct performance improvement projects; and (5) 8,268 hr (159 hr × 52 MCOs/PIHPs) and \$440,849.76 (8,268 hr x \$53.32/hr) to conduct focused studies. In aggregate, we estimate 34,818hr and \$1,856,495.76 for the optional EQR-related activities.

We do not have any data to estimate the amount of time to prepare data and information for the optional EQR activities for PAHPs. We also do not have data regarding how states will apply these optional activities to PAHPs. Therefore, at this time, we are unable to develop a burden estimate for optional EQR-related activities for PAHPs. We welcome comment to help us develop these estimates.

Section 438.364(a)(1) through §457.1250(a), specifies that information regarding the EQR activities may include information obtained from Medicare or private accreditation reviews in accordance with §438.360. Section 438.364(a)(1)(iii) would require that the EQR technical report include baseline and outcomes data regarding PIPs and performance measures. The burden of compiling this data for MCOs, PIHPs, and PAHPs is captured in §438.358.

Section 438.364(b)(1) through §457.1250(a), would clarify that the EQRO must produce and finalize the annual EQR-technical report and that states may not substantively revise the report without evidence of error or omission, or permission from CMS. The proposed April 30th deadline

for the finalization and submission of EQR technical reports is consistent with existing Medicaid sub-regulatory guidance. In an effort to ensure that the EQR process offers states timely and valuable insight into the quality of their managed care programs, we propose that the annual EQR technical report must address data collected in the previous 15 months.

We do not anticipate that these changes will pose a burden on states or the private sector. The burden associated with changing contracts for those programs that contract with EQROs with Medicaid is included under §438.364. States that contract with an EQRO separately for CHIP will include this requirement in the contract.

Section 438.364(b)(2) through §457.1250(a), would require that each state agency provide copies of technical reports, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO/PIHP/PAHP, beneficiary advocacy groups, and members of the general public. States would also be required to make the most recent EQR technical report publicly available in a manner specified by CMS. This will likely be accomplished by posting to the state's website, the burden for which is included in §457.1206. We believe that by making these reports available online, states would be able to significantly decrease the burden associated with responding to requests from the public for this information, as it will already be easily accessible. The burden associated with this requirement is the time for a state agency to disclose copies of a given technical report to interested parties.

We estimate an annual state burden of 5 min at \$15/hr for office and administrative support worker to disclose the required information per request. We also estimate that each state will receive 5 requests per MCO/PIHP/PAHP per year. In aggregate, we estimate 26 hr (62 MCOs/PIHPs/PAHPs x 5 requests x 5 min) and \$772.93 (26 hr x \$29.92/hr).

58. ICRs Regarding Grievances (§457.1260)

Section 457.1260 would apply subpart F of part 438 to CHIP. We anticipate that most states currently follow the Medicaid grievance procedures, so we adopt the burden associated with the proposed changes to the Medicaid regulation.

Section 438.400(b) through §457.1260, would update the definition of “Action” to “Adverse benefit determination,” clarify “appeal” and “grievance,” and add the definition of “grievance system.” We estimate a one-time state burden of 5 hr at \$53.32/hr for a business operations specialist to amend all relevant documents to the new nomenclature and definitions. In aggregate, we estimate 165 hr (5 hr x 33 states) and \$8,797.80 (165 hr x \$53.32/hr).

Aligning the definition of “adverse benefit determination” to include medical necessity, appropriateness, health care setting, or effectiveness would require that plans provide additional hearing resources to actions previously not included. We estimate 3 hr at \$53.32/hr for a business operations specialist and expect that each plan would provide 3 additional hearings per month (36 per year). In aggregate, we estimate an annual private sector burden of 6,696hr (62 MCOS, PIHPS, and PAHPS x 36 hearings x 3 hr) and \$357,030.72 (6,696hr x \$53.32/hr).

Section 438.402 through §457.1260, would specify the general requirements associated with the grievance system. More specifically, §438.402 would: (1) Require MCOs, PIHPS, and PAHPS to have a grievance system; (2) set out general requirements for the system; (3) establish filing requirements; and (4) provide that grievances and appeals may be filed either orally or in writing. The proposed provisions would apply to 62 entities. The burden for revising the contracts for these entities is included in §457.1201.

With regard to setting up a grievance system, we estimate it would take 100 hr (10 hr at \$127.72/hr for a general and operations manager, 75 hr at \$53.32/hr for a business operations specialist, and 15 hr at \$73.60/hr for a computer programmer) for each entity. We estimate that the

entities would receive 400 grievances per month. We estimate it will take a business operations specialist 30 min to process and handle each grievance and adverse benefit determinations.

We estimate a one-time private sector burden of 6,200 hr and \$395,572.40 [62 MCOs, PIHPs, and PAHPs x ((10 x \$127.72/hr) + (75 x \$53.32/hr) + (15 x \$73.60/hr)). We also estimate an annual burden of 148,800 hr [62 PAHPs x 400 grievances/month x 12 months x (0.5 hr/grievance x 12 months)] and \$7,934,016.00 (148,800 hr x \$53.32/hr) for processing each grievance and adverse benefit determination.

Section 438.404(a) through §457.1260, would add PAHPs as an entity that must give the enrollee timely written notice and would set forth the requirements of that notice. More specifically, the enrollee must be provided timely written notice if an MCO, PIHP, or PAHP intends to: (1) Deny, limit, reduce, or terminate a service; (2) deny payment; (3) deny the request of an enrollee in a rural area with one plan to go out of network to obtain a service; or (4) fails to furnish, arrange, provide, or pay for a service in a timely manner.

We estimate an annual private sector burden of 1 min at \$29.92/hr for an office and administrative support worker to provide written notice of the MCO, PIHP, or PAHP's intended action. We estimate that 5 percent (306,937) of the approximately 6 million MCO, PIHP, or PAHP enrollees will receive one notice of intended action per year from their MCO, PIHP, or PAHP. In aggregate, we estimate 5,116 hr (306,937 x 1 min) and \$153,059.25 (5,116 hr x \$29.92/hr).

In §438.416 through §457.1260, the state must require that MCOs, PIHPs and PAHPs maintain records of grievances and appeals. We estimate that approximately 6,139 enrollees (1 percent) of the approximately 6 million MCO and PIHP enrollees file a grievance or appeal with their MCO or PIHP. We estimate an annual private sector burden of 1 min (per request) at

\$29.92/hr for an office and administrative support worker to record and track grievances. In aggregate, we estimate 102 hr (6,139 grievances x 1 min) and \$3,061.31 (102 hr x \$29.92/hr).

59. ICRs Regarding Sanctions (§457.1270)

Section 457.1270 would apply subpart I of part 438 to CHIP. In §438.722(a) through §457.1270, states would be provided the option to give MCO, PIHP, PAHP, or PCCM enrollees written notice of the state's intent to terminate its MCO, PIHP, PAHP, or PCCM contract. Notice may be provided after the state has notified the entity of its intention to terminate their contract.

States already have the authority to terminate MCO, PIHP, PAHP or PCCM contracts according to state law and have been providing written notice to the MCO, PIHP, PAHP or PCCM enrollees. While it is not possible to gather an exact figure, we estimate that 8 states may terminate 1 contract per year.

We estimate an annual state burden of 1 hr at \$53.32/hr for a business operations specialist to prepare the notice to enrollees. In aggregate, we estimate 8 hr (1 hr x 8 states x 1 contract/yr.) and \$426.56 (8 hr x \$53.32/hr). We also estimate 1 hr at \$53.32/hr for a business operations specialist to prepare the notice. In aggregate, we estimate an annual state burden of 8 hr (8 states x 1 hr) and \$427 (8 hr x \$53.32/hr). To send the notice, we estimate an average enrollment of 30,000 beneficiaries and 1 min (per beneficiary) at \$26.40/hr for a mail clerk. In aggregate we estimate 500 hr (30,000 beneficiaries x 1 min) and \$13,200.00 (500 hr x \$26.40/hr).

Section 438.724 through §457.1270, would require that the state give the CMS Regional Office written notice whenever it imposes or lifts a sanction. The notice must specify the affected MCO, PIHP, PAHP, or PCCM, the kind of sanction, and the reason for the state's decision to impose or lift a sanction.

We anticipate that no more than 15 states would impose or lift a sanction each year and that it would take 30 min at \$53.32/hr for a business operations specialist to give the regional office notice. In aggregate, we estimate an annual burden of 7.5 hr (15 states x 30 min) and \$400 (7.5 hr x \$53.32/hr).

60. ICRs Regarding Conditions Necessary to Contract as an MCO, PIHP, or PAHP (§457.1280)

These requirements have not changed, they have been redesignated from another section of part 457, and so we do not estimate any additional burden.

61. ICRs Regarding Program Integrity Safeguards (§457.1285)

Section 457.1285 would apply most of subpart H of part 438 to CHIP. Section 438.602(a) through §457.1285, would detail state responsibilities for monitoring MCO, PIHP, PAHP, PCCM or PCCM's compliance with other sections of part 438, screening and enrollment of providers, reviewing ownership and control information, performing periodic audits, investigating based on whistleblower information, and imposing sanctions as appropriate. States would need to revise their policies and implement these activities, as needed. Once the policies are revised, the continuing performance would be part of usual and customary business operations.

We estimate 50 hr at \$53.32/hr for a business operations specialist to create and/or revise their policies for the above activities. In aggregate, we estimate a one-time state burden of 1,650 hr (33 states x 50 hr) and \$87,978.00 (1,650 hr x \$53.32/hr).

Section 438.602(b) through §457.1285, would require states to screen and enrollee MCO, PIHP, PAHP, PCCM and PCCM entity providers in accordance with 42 CFR part 455, subparts B and E. States are already required to screen and enroll providers in both FFS and managed care in their CHIP programs through 42 CFR §457.990, so there is no additional burden associated with this requirement.

Section 438.602(e) through §457.1285, would require states to conduct or contract for audits of MCO, PIHP, and PAHP encounter and financial data once every 3 years. Some states already use their EQRO to validate data. If they conduct this task at an appropriate frequency, it would incur no additional burden. We estimate 12 states already use their EQRO to validate their data, so only 21 states may need to take action to meet this requirement. The method selected by the state will determine the amount of burden incurred. We assume an equal distribution of states selecting each method, thus 7 states per method.

A state using EQRO to validate data on less than an appropriate frequency may need to amend their EQRO contract. In this case, we estimate 1 hr at \$53.32/hr for a business operations specialist. In aggregate, we estimate a one-time state burden of 7 hr (7 states x 1 hr) and \$373.24 (7 hr x \$53.32/hr).

A state electing to perform validation internally would need to develop processes and policies to support implementation. In this case, we estimate 10 hr at \$53.32/hr for a business operations specialist to develop policy and 100 hr at \$73.60/hr for a computer programmer to develop, test, and automate the validation processes. In aggregate, we estimate a one-time state burden of 770 hr (7 states x 110 hr) and \$55,252.40 [7 states x ((10 hr x \$53.32/hr) + (100 hr x \$73.60/hr))].

For a state electing to procure a vendor, given the wide variance in state procurement processes, our burden is conservatively estimated at 150 hr for writing a proposal request, evaluating proposals, and implementing the selected proposal. We estimate 125 hr at \$53.32/hr for a business operations specialist to participate in the writing, evaluating, and implementing, and 25 hr at \$127.72/hr for a general and operations manager to participate in the writing, evaluating, and implementing. In aggregate, we estimate an annual state burden of 1,050 hr [7 states x (150 hr)]

and \$69,006.00 [7 states x ((125 hr x \$53.32/hr) + (25 hr x \$127.72/hr))].

Section 438.602(g) through §457.1285, would require states to post the MCO's, PIHP's, and PAHP's contracts, data from §438.604, and audits from §438.602(e) on their website. As most of these activities will only occur no more frequently than annually, we estimate an annual state burden of 1 hr at \$73.60/hr for a computer programmer to post the documents. In aggregate, we estimate 33 hr (33 states x 1 hr) and \$2,428.80 (33 hr x \$73.60/hr).

Section 438.608(a) through §457.1285, would require that MCOs, PIHPs, and PAHPs have administrative and management arrangements or procedures that are designed to guard against fraud and abuse. The arrangements or procedures must include a compliance program as set forth under §438.608(a)(1), provisions for reporting under §438.608(a)(2), provisions for notification under §438.608(a)(3), provisions for verification methods under §438.608(a)(4), and provisions for written policies under §438.608(a)(5).

The compliance program must include: written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards and requirements under the contract; the designation of a Compliance Officer; the establishment of a Regulatory Compliance Committee on the Board of Directors; effective training and education for the organization's management and its employees; and provisions for internal monitoring and a prompt and effective response to noncompliance with the requirements under the contract.

We estimate that reviewing their policies and procedures to ensure that all of the above listed items are addressed. We estimate this would require 5 hr at \$53.32/hr for a business operations specialist to review and (if necessary) revise their policies and procedures. In

aggregate, we estimate a one-time private sector burden of 315 hr (63 MCOs, PIHPs, and PAHPs x 5 hr) and \$16,795.80 (315 hr x \$53.32/hr).

Section 438.608(a)(2) and (3) through §457.1285, require reporting of improper payments and enrollee fraud. As these would be done via an email from the MCO, PIHP, or PAHP to the state and do not occur very often, we estimate only 2 hr per year by a business operations specialist at \$53.32/hr. We estimate an annual burden of 126 hr (63 MCOs, PIHPs, and PAHPs x 2 hr) and \$6,718.32 (126 hr x \$53.32/hr).

Section 438.608(a)(4) through §457.1285, would require the MCO, PIHP, or PAHP to use a sampling methodology to verify receipt of services. This typically involves mailing a letter or sending an email to the enrollee, we estimate 33 states mail to 100 enrollees each (33 x 100 = 3,300 mailings) taking 1 min at \$29.92/hr for a mail clerk. We estimate a total annual aggregate burden for private sector of 55 hr (3,300 mailings x 1 min) and \$1,645.60 (55 hr x \$29.92/hr). This estimate will be significantly reduced as the use of email increases.

Section 438.608(c) and (d) through §457.1285, would require states to include in all MCO, PIHP, and PAHP contracts, the process for the disclosure and treatment of certain types of recoveries and reporting of such activity. The burden to amend the contracts is included in §457.1201. We estimate the burden to comply with the reporting to include 1 hr at \$73.60/hr for a computer programmer to create the report. In aggregate, we estimate a one-time private sector burden of 63 hr (63 MCOs, PIHPs, and PAHPs x 1 hr) and \$4,636.80 (63 hr x \$73.60/hr). Once developed, the report would be put on a production schedule and add no additional burden.

D. Summary of Proposed Burden Estimates

Table 2 sets out our proposed annual burden estimates. While the annual burden estimates (under Frequency) are unchanged, the one-time estimates have been annualized by dividing the

one-time hour and cost figures by 3 to account for OMB's 3-year approval period.

The burden associated with this proposed rule is divided amongst four Paperwork Reduction Act (PRA) packages. The burden proposed for part 431 subpart I will be contained in a new PRA package (CMS-10553). CMS-10108 will continue to contain all of part 438, except for those provisions related to external quality review (§§438.350, 438.352, 438.354, 438.356, 438.358, 438.360, 438.362, 438.364, and 438.370), which will remain in the separate CMS-R-305. The proposed CHIP managed care regulation burden will be in a new PRA package, CMS-10554.

TABLE 2: Summary of Proposed PRA-related Requirements and Burden

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
42 CFR 431											
431.502(a) Initial CQS	0938-New (CMS-10553)	19	19	70	1,330	53.32	3,732.40	70,915.60	once	443	23,638.53
431.502(a) Initial CQS		19	19	2	38	29.92	59.84	1,136.96	once	13	378.99
431.502(a) Initial CQS		19	19	15	285	53.32	799.80	15,196.20	once	95	5,065.40
431.502(a) Initial CQS		19	19	1	19	29.92	29.92	568.48	once	6	189.49
431.504(b) Revise CQS		18	18	25	150	53.32	1,333.00	7,998.00	annual	150	7,998.00
431.504(b) Revise CQS		18	18	2	12	29.92	59.84	359.04	annual	12	359.04
431.504(b) Revise CQS		18	18	5	30	53.32	266.60	1,599.60	annual	30	1,599.60
431.504(b) Revise CQS		18	18	1	6	29.92	29.92	179.52	annual	6	179.52
431.504(b) Update Policies		19	19	0.5	10	53.32	26.66	506.54	once	3	168.85
431.504(b) Revise CQS		19	19	25	158	53.32	1,333.00	8,442.33	annual	158	8,442.33
431.504(b) Revise CQS		19	19	2	13	29.92	59.84	378.99	annual	13	378.99
431.504(b) Revise CQS		19	19	5	32	53.32	266.60	1,688.47	annual	32	1,688.47
431.504(b) Revise CQS		19	19	1	6	29.92	29.92	189.49	annual	6	189.49
431.504(b) Revise QS to CQS		27	27	10	270	53.32	533.20	14,396.40	once	90	4,798.80
431.504(b)(1) Evaluate CQS		19	19	40	253	53.32	2,132.80	13,505.96	annual	253	13,505.96
431.504(c) Revise Policies		19	19	0.5	10	53.32	26.66	506.54	once	3	168.85

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
42 CFR 438											
438.3 Contracts	0938-0920 (CMS-10108)	42	602	6	3,612	53.32	319.92	192,591.84	once	1204	64,197.28
438.5 Rate Standards		39	50	10	500	92.00	920.00	46,000.00	annual	500	46,000.00
438.5Rate Standards		39	50	1	50	127.72	127.72	6,386.00	annual	50	6,386.00
438.7 Rate Certifications		39	70	1.50	105	92.00	138.00	9,660.00	annual	105	9,660.00
438.7 Rate Certifications		39	70	0.13	9	127.72	16.60	1,162.25	annual	9	1,162.25
438.7 Rate Certifications		39	70	0.73	51	73.60	53.73	3,760.96	annual	51	3,760.96
438.7 Rate Certifications		39	70	0.73	51	53.32	38.92	2,724.65	annual	51	2,724.65
438.7 Rate Certifications		39	70	0.26	18	29.92	7.78	544.54	annual	18	544.54
438.8(c) MLR		568	568	101	57,368	73.60	7,433.60	4,222,284.80	once	19123	1,407,428.27
438.8(c) MLR		568	568	50	28,400	53.32	2,666.00	1,514,288.00	once	9467	504,762.67
438.8(c) MLR		568	568	17	9,656	127.72	2,171.24	1,233,264.32	once	3219	411,088.11
438.8(c) MLR		568	568	32	18,176	73.60	2,355.20	1,337,753.60	annual	18176	1,337,753.60
438.8(c) MLR		568	568	16	9,088	53.32	853.12	484,572.16	annual	9088	484,572.16
438.8(c) MLR		568	568	5	2,840	127.72	638.60	362,724.80	annual	2840	362,724.80

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.10(c)(3) Information Requirements		42	42	6	252	73.60	441.60	18,547.20	once	84	6,182.40
438.10(c)(3) Information Requirements		42	42	3	126	73.60	220.80	9,273.60	annual	126	9,273.60
438.10(c)(4)(i) Information Requirements		42	42	6	252	53.32	319.92	13,436.64	once	84	4,478.88
438.10(c)(4)(ii) Information Requirements		20	20	20	400	53.32	1,066.40	21,328.00	once	133	7,109.33
438.10(c)(4)(ii) Information Requirements		20	20	2	40	53.32	106.64	2,132.80	annual	40	2,132.80
438.10(d)(2)(i) Information Requirements		42	42	6	252	53.32	319.92	13,436.64	once	84	4,478.88
438.10(e)(1) Information Requirements		42	42	1	42	53.32	53.32	2,239.44	once	14	746.48
438.10(e)(1) Information Requirements		42	2,069,259	0.0167	-30,512	26.40	0.44	-805,516.80	annual	-30512	-805,516.80
438.10(g) Information Requirements		100	100	4	400	53.32	213.28	21,328.00	once	133	7,109.33
438.10(g) Information Requirements		100	10,659,819	0.0167	177,699	26.40	0.44	4,691,258.42	once	59233	1,563,752.81
438.10(g) Information Requirements		100	2,069,259	0.0167	1,988	26.40	0.44	52,483.20	annual	1988	52,483.20
438.10(g) Information Requirements		577	577	1	577	53.32	53.32	30,765.64	annual	577	30,765.64

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.10(h) Information Requirements		577	577	1	577	73.60	73.60	42,467.20	once	192	14,155.73
438.14(c) Contracts		463	463	1	463	73.60	73.60	34,076.80	once	154	11,358.93
438.14(c) Contracts		25	25	12	300	53.32	639.84	15,996.00	annual	300	15,996.00
438.54(c)(2) Enrollment		15	15	2	30	73.60	147.20	2,208.00	once	10	736.00
438.54(c)(8) Enrollment		42	559,865	0.0167	9,350	26.40	0.44	246,833.28	annual	9350	246,833.28
438.62(b)(1) Transition of Care		42	42	5	210	53.32	266.60	11,197.20	once	70	3,732.40
438.62(b)(1) Transition of Care		568	568	1	568	53.32	53.32	30,285.76	once	189	10,095.25
438.62(b)(2) Transition of Care	568	568	4	2,272	73.60	294.40	167,219.20	once	757	55,739.73	
438.62(b)(2)Tr ansition of Care	42	42	4	168	73.60	294.40	12,364.80	once	56	4,121.60	
438.62(b)(2) Transition of Care	568	313,704	0	52,294	65.40	10.90	3,420,057.47	annual	52294	3,420,057.47	
438.66(a)-(b) State Monitoring	42	42	8	336	53.32	426.56	17,915.52	once	112	5,971.84	
438.66(c) State Monitoring	42	42	20	840	53.32	1,066.40	44,788.80	once	280	14,929.60	
438.66(d)(3) State Monitoring	20	20	5	100	127.72	638.60	12,772.00	annual	100	12,772.00	
438.66(d)(3) State Monitoring	20	20	30	600	53.32	1,599.60	31,992.00	annual	600	31,992.00	

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.66(d)(3) State Monitoring		20	20	5	100	73.60	368.00	7,360.00	annual	100	7,360.00
438.66(d)(3) State Monitoring		20	20	5	100	127.72	638.60	12,772.00	annual	100	12,772.00
438.66(d)(3) State Monitoring		20	20	30	600	53.32	1,599.60	31,992.00	annual	600	31,992.00
438.66(d)(3) State Monitoring		20	20	5	100	73.60	368.00	7,360.00	annual	100	7,360.00
438.66(e)(1-2) State Monitoring		42	42	6	252	53.32	319.92	13,436.64	annual	252	13,436.64
438.68(a)-(c) Network Adequacy		20	20	10	200	53.32	533.20	10,664.00	once	67	3,554.67
438.68(a)-(c) Network Adequacy		16	16	10	160	53.32	533.20	8,531.20	once	53	2,843.73
438.68(d) Network Adequacy		40	40	3	120	53.32	159.96	6,398.40	once	40	2,132.80
438.70(c) MLTSS Engagement		14	14	4	56	53.32	213.28	2,985.92	annual	56	2,985.92
438.71(a) Beneficiary Support System	20	20	125	2,500	53.32	6,665.00	133,300.00	once	833	44,433.33	
438.71(a) Beneficiary Support System	20	20	25	500	127.72	3,193.00	63,860.00	once	167	21,286.67	
438.71(b) Beneficiary Support System	42	42	3	126	53.32	159.96	6,718.32	once	42	2,239.44	

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.71(b) Beneficiary Support System		42	42	1	42	53.32	53.32	2,239.44	annual	42	2,239.44
438.110(a) Member Advisory Committee		14	14	6	84	53.32	319.92	4,478.88	annual	84	4,478.88
438.207(b)-(d) Adequate Capacity		568	568	1	568	73.60	53.32	30,285.76	once	189	10,095.25
438.207(b)-(d) Adequate Capacity		568	568	2	1,136	53.32	106.64	60,571.52	annual	1136	60,571.52
438.208(b)(2)(i ii) Care Coordination		568	2,746,476	0.1667	457,746	59.20	9.87	27,099,105.17	annual	457746	27,099,105.17
438.208(b)(3) Care Coordination		168	168	3	504	53.32	159.96	26,873.28	once	168	8,957.76
438.208(b)(3) Care Coordination		168	485,872	0.1667	80,980	29.68	4.95	2,403,494.90	annual	80980	2,403,494.90
438.208(b)(4) Care Coordination		568	568	4	-462,510	73.60	294.40	-34,040,736.00	once	80980	-11,346,912.00
438.208(c)(2)-(3) Care Coordination		568	428,128	1	428,128	65.40	65.40	27,999,571.20	annual	428128	27,999,571.20
438.208(c)(3)(v) Care Coordination		568	568	1	568	53.32	53.32	30,285.76	once	189	10,095.25
438.210(a)(4)(i i)(B) Authorization of Services		568	568	20	11,360	65.40	1,308.00	742,944.00	once	3787	247,648.00

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.210(c) Authorization of Services		61	61	1.0	61	53.32	53.32	3,252.52	once	20	1,084.17
438.230 Subcontracts		568	568	3.0	1,704	53.32	159.96	90,857.28	once	568	30,285.76
438.242(b)(2) Health Information		41	41	20	820	73.60	1,472.00	60,352.00	once	273	20,117.33
438.310(c)(2) State PCCM Assessment		10	10	2	20	53.32	106.64	1,066.40	once	7	355.47
438.330(a)(2) State QAPI Programming		40	40	10	133	73.60	736.00	9,810.88	annual	133	9,810.88
438.330(a)(2)(i) State QAPI Exemption		11	11	1	4	53.32	53.32	197.28	annual	4	197.28
438.330(b)(3) Create PCCM Utilization Review Policies		15	15	10	150	53.32	533.20	7,998.00	once	50	2,666.00
438.330(b)(3) Operate PCCM Utilization Review Policies		15	15	10	150	53.32	533.20	7,998.00	annual	150	7,998.00
438.330(c)(1)-(3) MCO/PIHP Performance Measures		511	1,533	0.1	153	53.32	5.33	8,173.96	annual	153	8,173.96
438.330(c)(1)-(3) PAHP/PCCM Performance Measures		56	168	4	672	53.32	213.28	35,831.04	annual	672	35,831.04

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.330(c)(4) MLTSS Performance Measures		179	358	4	1,432	53.32	213.28	76,354.24	annual	1432	76,354.24
438.330(d)(1)-(2) MCO/PIHP PIPs		511	1,533	8	12,264	53.32	426.56	653,916.48	annual	12264	653,916.48
438.330(d)(1)-(2) Create PAHP PIP Policies		41	41	2	82	53.32	106.64	4,372.24	once	27	1,457.41
438.330(d)(1)-(2) PAHP PIPs		41	41	8	328	53.32	426.56	17,488.96	annual	328	17,488.96
438.330(e) Assess PCCMs		15	15	15	225	53.32	799.80	11,997.00	annual	225	11,997.00
438.330(e)(1)(i) Update State Policies		40	40	0.5	20	53.32	26.66	1,066.40	once	7	355.47
438.330(e)(1)(i) State Review of Outcomes		40	40	1	40	53.32	53.32	2,132.80	annual	40	2,132.80
438.330(e)(1)(i) Update State Policies		16	16	0.5	8	53.32	26.66	426.56	once	3	142.19
438.330(e)(1)(i) State Assess LTSS		16	16	1	16	53.32	53.32	853.12	annual	16	853.12
438.332(a) State Purchase Accreditation Standards		20	20	N/A	N/A	N/A	20,000.00	133,333.33	annual	N/A	133,333.33
438.332(a) Develop State Standards	20	20	15	100	53.32	799.80	5,332.00	annual	100	5,332.00	

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.332(a) Develop State Standards		20	20	5	33	127.72	638.60	4,257.33	annual	33	4,257.33
438.332(a) State Review of Plans		20	276	80	7,360	53.32	4,265.60	392,435.20	annual	7360	392,435.20
438.332(a) State Review of Plans		20	276	5	460	127.72	638.60	58,751.20	annual	460	58,751.20
438.332(a) State Review of Plans		20	276	5	460	29.92	149.60	13,763.20	annual	460	13,763.20
438.332(a) Provide Plan Information		276	276	40	3,680	53.32	2,132.80	196,217.60	annual	3680	196,217.60
438.332(a) Provide Plan Information		276	276	5	460	29.92	149.60	13,763.20	annual	460	13,763.20
438.332(a) Provide Plan Information		276	276	4	368	127.72	510.88	47,000.96	annual	368	47,000.96
438.332(b) State Review Deeming Process		20	20	40	267	53.32	2,132.80	14,220.44	annual	267	14,220.44
438.332(b)(2) Initial Plan Accreditation		138	138	N/A	N/A	N/A	70,700.00	9,756,600.00	once	N/A	3,252,200.00
332(b)(2) Plan Accreditation Renewal		138	138	N/A	N/A	N/A	70,700.00	3,252,200.00	annual	N/A	3,252,200.00
438.334(a) Create State QRS		30	30	100	3,000	53.32	5,332.00	159,960.00	once	1000	53,320.00
438.334(a) Create State		30	30	40	1,200	73.60	2,944.00	88,320.00	once	400	29,440.00

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
QRS											
438.334(a) Create State QRS		30	30	15	450	127.72	1,915.80	57,474.00	once	150	19,158.00
438.334(a) Create State QRS		30	30	2	60	29.92	59.84	1,795.20	once	20	598.40
438.334(a) Create State QRS		30	30	15	450	53.32	799.80	23,994.00	once	150	7,998.00
438.334(b) State Rates Plans		30	414	20	8,280	53.32	1,066.40	441,489.60	annual	8280	441,489.60
438.334(c) State QRS Exemption		10	10	5	50	53.32	266.60	2,666.00	once	17	888.67
438.334(d) Use MA Rating		25	-25	20	-500	53.32	1,066.40	-26,660.00	annual	-500	-26,660.00
438.340 CQS Managed Care Elements		40	40	10	133	53.32	533.20	7,107.56	annual	133	7,107.56
438.340 Removal of 438.204(b)(2)		15	-15	80	-1,200	N/A	N/A	N/A	once	-400	
438.358(b)(1)-(3) MCO/PIHP Mandatory EQR-Related Activities		40	511	474.3	242,367	53.32	25,289.68	12,923,024.44	annual	242367	12,923,024.44
438.358(b)(1)-(3) PAHP Mandatory EQR-Related Activities		40	41	344.3	14,116	53.32	18,358.08	752,681.12	annual	14116	752,681.12

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.358(b)(1)-(4) Plan Information for Mandatory EQR-Related Activities		552	552	100	18,560	53.32	5,332.00	634,944.00	annual	18560	634,944.00
438.358(b)(1)-(4) Plan Information for Mandatory EQR-Related Activities		552	552	100	18,560	29.92	2,992.00	1,211,904.00	annual	18560	1,211,904.00
438.358(b)(4) MCO/PIHP/PA HP Mandatory EQR-Related Activity		40	552	60	33,120	53.32	3,199.20	1,765,958.40	annual	33120	1,765,958.40
438.358(c) MCO/PIHP Optional EQR-Related Activities		40	51	70	3,570	127.72	8,940.40	455,960.40	annual	3570	455,960.40
438.358(c) MCO/PIHP Optional EQR-Related Activities		40	51	87.5	4,463	73.60	6,440.00	328,440.00	annual	4463	328,440.00
438.358(c) MCO/PIHP Optional EQR-Related Activities		40	51	192.5	9,818	53.32	10,264.10	523,469.10	annual	9818	523,469.10
438.358(c) MCO/PIHP Optional EQR-Related Activities		40	25	30	750	127.72	3,831.60	95,790.00	annual	750	95,790.00

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	25	37.5	938	73.60	2,760.00	69,000.00	annual	938	69,000.00
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	25	82.5	2,063	53.32	4,398.90	109,972.50	annual	2063	109,972.50
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	26	10	260	127.72	1,277.20	33,207.20	annual	260	33,207.20
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	26	12.5	325	73.60	920.00	23,920.00	annual	325	23,920.00
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	26	27.5	715	53.32	1,466.30	38,123.80	annual	715	38,123.80
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	31.8	1,622	127.72	4,061.50	207,136.30	annual	1622	207,136.30
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	39.75	2,027	73.60	2,925.60	149,205.60	annual	2027	149,205.60
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	87.45	4,460	53.32	4,662.83	237,804.53	annual	4460	237,804.53

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	39	1,989	127.72	4,981.08	254,035.08	annual	1989	254,035.08
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	48.75	2,486	73.60	3,588.00	182,988.00	annual	2486	182,988.00
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	107.25	5,470	53.32	5,718.57	291,647.07	annual	5470	291,647.07
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	39	1,989	127.72	4,981.08	254,035.08	annual	1989	254,035.08
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	48.75	2,486	73.60	3,588.00	182,988.00	annual	2486	182,988.00
438.358(c) MCO/PIHP Optional EQR- Related Activities		40	51	107.25	5,470	53.32	5,718.57	291,647.07	annual	5470	291,647.07
438.358(c) PAHP Optional EQR-Related Activities		4	4	70	280	127.72	8,940.40	35,761.60	annual	280	35,761.60
438.358(c) PAHP Optional EQR-Related Activities		4	4	87.5	350	73.60	6,440.00	25,760.00	annual	350	25,760.00

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.358(c) PAHP Optional EQR-Related Activities		4	4	192.5	770	53.32	10,264.10	41,056.40	annual	770	41,056.40
438.358(c) PAHP Optional EQR-Related Activities		4	4	15	60	127.72	1,915.80	7,663.20	annual	60	7,663.20
438.358(c) PAHP Optional EQR-Related Activities		4	4	18.75	75	73.60	1,380.00	5,520.00	annual	75	5,520.00
438.358(c) PAHP Optional EQR-Related Activities		4	4	41.25	165	53.32	2,199.45	8,797.80	annual	165	8,797.80
438.358(c) PAHP Optional EQR-Related Activities		4	4	5	20	127.72	638.60	2,554.40	annual	20	2,554.40
438.358(c) PAHP Optional EQR-Related Activities		4	4	6.25	25	73.60	460.00	1,840.00	annual	25	1,840.00
438.358(c) PAHP Optional EQR-Related Activities		4	4	13.75	55	53.32	733.15	2,932.60	annual	55	2,932.60
438.358(c) PAHP Optional EQR-Related Activities		4	4	31.8	127	127.72	4,061.50	16,245.98	annual	127	16,245.98
438.358(c) PAHP Optional EQR-Related Activities		4	4	39.75	159	73.60	2,925.60	11,702.40	annual	159	11,702.40

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.358(c) PAHP Optional EQR-Related Activities		4	4	87.45	350	53.32	4,662.83	18,651.34	annual	350	18,651.34
438.358(c) PAHP Optional EQR-Related Activities		4	4	39	156	127.72	4,981.08	19,924.32	annual	156	19,924.32
438.358(c) PAHP Optional EQR-Related Activities		4	4	48.75	195	73.60	3,588.00	14,352.00	annual	195	14,352.00
438.358(c) PAHP Optional EQR-Related Activities		4	4	107.25	429	53.32	5,718.57	22,874.28	annual	429	22,874.28
438.358(c) PAHP Optional EQR-Related Activities		4	4	39	156	127.72	4,981.08	19,924.32	annual	156	19,924.32
438.358(c) PAHP Optional EQR-Related Activities		4	4	48.75	195	73.60	3,588.00	14,352.00	annual	195	14,352.00
438.358(c) PAHP Optional EQR-Related Activities		4	4	107.25	429	53.32	5,718.57	22,874.28	annual	429	22,874.28
438.360(b) MCO/PIHP Nonduplication Disclosure		51	51	2	102	53.32	106.64	5,438.64	annual	102	5,438.64
438.360(b) MCO/PIHP Nonduplication Disclosure		51	51	6	306	29.92	179.52	9,155.52	annual	306	9,155.52

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.360(b) PAHP Nonduplication Disclosure		4	4	2	8	53.32	106.64	426.56	annual	8	426.56
438.360(b) PAHP Nonduplication Disclosure		4	4	6	24	29.92	179.52	718.08	annual	24	718.08
438.360(b) Nonduplication Materials to EQRO		40	55	2	110	29.92	59.84	3,291.20	annual	110	3,291.20
438.360(b) State Nonduplication Offset - MCO/PIHP		40	-51	474.3	-24,189	53.32	25,289.68	-1,289,773.48	annual	-24189	-1,289,773.48
438.360(b) State Nonduplication Offset - PAHP		40	-4	344.3	-1,377	53.32	18,358.08	-73,432.30	annual	-1377	-73,432.30
438.360(b) MCO/PIHP/PA HP Nonduplication Offset		55	-55	75	-4,125	53.32	3,999.00	-219,945.00	annual	-4125	-219,945.00
438.360(b) MCO/PIHP/PA HP Nonduplication Offset		55	-55	75	-4,125	29.92	2,244.00	-123,420.00	annual	-4125	-123,420.00
438.362 Exemption		40	17	2	-126	53.32	106.64	-4,187.12	annual	-126	-4,187.12
438.362 Exemption		40	17	6	102	29.92	179.52	3,051.84	annual	102	3,051.84
438.364(a) Amend EQRO Contract		40	40	0.5	20	53.32	26.66	1,066.40	once	7	355.47

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.364(b)(1) Amend EQRO Contract		10	10	0.5	5	53.32	26.66	266.60	once	2	88.87
438.364(b)(2) Provide EQR Reports		40	2,760	0.0833	-91,370	29.92	2.49	-1,092,318.40	annual	-91370	-1,092,318.40
438.370(c) Update State Policies		12	12	0.5	6	53.32	26.66	319.92	once	2	106.64
438.370(c) Submit EQRO Contract		12	12	0.25	3	29.92	7.48	89.76	once	1	29.92
438.400(b) Definitions		507	507	5	2,535	53.32	266.60	135,166.20	once	845	45,055.40
438.400(b) Definitions		40	40	5	200	53.32	266.60	10,664.00	once	67	3,554.67
438.402(a) Grievance System		41	41	10	410	127.22	1,272.20	52,160.20	once	137	17,386.73
438.402(a) Grievance System		41	41	75	3,075	53.32	3,999.00	163,959.00	once	1025	54,653.00
438.402(a) Grievance System		41	41	15	615	73.60	1,104.00	45,264.00	once	205	15,088.00
438.402(a) Grievance System		41	410	36	14,760	53.32	1,919.52	787,003.20	annual	14760	787,003.20
438.404(a) Notices		41	240,000	0.0167	4,008	26.40	0.44	105,811.20	annual	4008	105,811.20
438.408(b) Appeals		200	200	1	200	53.32	53.32	10,664.00	once	67	3,554.67
438.416 Reporting		568	240,000	0.0167	4,008	29.92	0.50	119,919.36	annual	4008	119,919.36
438.416 Reporting		56	56	3	168	73.60	220.80	12,364.80	once	56	4,121.60

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.416 Reporting		56	856,257	0.0167	14,271	29.92	0.50	426,986.82	annual	14271	426,986.82
438.420(c)(4) Continuation of Benefits		507	507	4	2,028	53.32	213.28	108,132.96	once	676	36,044.32
438.602(a) Program Integrity		42	42	6	252	53.32	319.92	13,436.64	once	84	4,478.88
438.602(b) Program Integrity		568	568	6	3,408	73.60	441.60	250,828.80	once	1136	83,609.60
438.602(e) Program Integrity		42	568	20	3,787	63.10	1,262.00	238,959.70	annual	3787	238,959.70
438.602(g) Program Integrity		40	40	1	40	73.60	73.60	2,944.00	annual	40	2,944.00
438.608(a)(1) Program Integrity		568	568	2	1,136	53.32	106.64	60,571.52	once	379	20,190.51
438.608(a)(2)-(3) Program Integrity		568	568	2	1,136	53.32	106.64	60,571.52	annual	1136	60,571.52
438.608(a)(4) Program Integrity		200	20,000	0.0167	334	26.40	0.44	8,817.60	annual	334	8,817.60
438.608(c)-(d) Program Integrity		568	568	1	568	73.60	73.60	41,804.80	once	189	13,934.93
438.722 Disenrollment Notices		12	12	1	12	53.32	53.32	639.84	annual	12	639.84
438.722 Disenrollment Notices		12	1,084,536	0.0167	18,075	26.40	0.44	477,195	annual	18075	477,195
438.818(a)(2) Encounter Data		9	9	1	9	53.32	53.32	479.88	once	3	159.96
438.818(a)(2) Encounter Data		9	9	10	90	53.32	533.20	4,798.80	once	30	1,599.60

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
438.818(a)(2) Encounter Data		9	9	100	900	73.60	7,360.00	66,240.00	once	300	22,080.00
438.818(a)(2) Encounter Data		9	9	125	1,125	53.32	6,665.00	59,985.00	annual	375	59,985.00
438.818(a)(2) Encounter Data		9	9	25	225	127.72	3,193.00	28,737.00	annual	75	28,737.00
42 CFR 457											
457.760(a) Quality	0938-new (CMS-10554)	33	33	3.333	110	53.32	178	5,864.61	annual	110	5,864.61
457.1201 Contracts		66	66	6	396	53.32	320	21,114.72	once	132	7,038.24
457.1206 Contracts		3	3	4	12	53.32	213	639.84	once	4	213.28
457.1207 Information Requirements		33	33	4	132	53.32	213	7,038.24	annual	132	7,038.24
457.1207 Information Requirements		33	33	6	198	73.60	442	14,572.80	once	66	4,857.60
457.1207 Information Requirements		33	33	3	99	73.60	221	7,286.40	annual	99	7,286.40
457.1207 Information Requirements		33	33	6	198	53.32	320	10,557.36	once	66	3,519.12
457.1207 Information Requirements		15	15	40	600	53.32	2,133	31,992.00	once	200	10,664.00
457.1207 Information Requirements		15	15	2	30	53.32	107	1,599.60	annual	30	1,599.60
457.1207 Information Requirements		33	33	4	132	73.60	294	9,715.20	once	44	3,238.40

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
457.1207 Information Requirements		33	33	6	198	53.32	320	10,557.36	once	66	3,519.12
457.1207 Information Requirements		15	15	40	600	53.32	2,133	31,992.00	once	200	10,664.00
457.1207 Information Requirements		33	306937	0	5,116	29.92	0	153,059.25	once	1705	51,019.75
457.1207 Information Requirements		33	33	1	33	53.32	53	1,759.56	once	11	586.52
457.1208 Contracts		25	25	12	300	53.32	640	15,996.00	annual	300	15,996.00
457.1210(a) Enrollment		33	306937	0.01666667	5,116	29.92	0	153,059.25	annual	5116	153,059.25
457.1214 Conflict		5	5	10	50	53.32	533	2,666.00	once	17	888.67
457.1216 Continued services		33	33	10	330	53.32	533	17,595.60	once	110	5,865.20
457.1216 Continued services		33	33	4	132	73.60	294	9,715.20	once	44	3,238.40
457.1218 Network		12	12	15	180	53.32	800	9,597.60	once	60	3,199.20
457.1218 Network		5	5	10	50	53.32	533	2,666.00	once	17	888.67
457.1218 Network		33	33	3	99	53.32	160	5,278.68	once	33	1,759.56
457.1224 Marketing		25	25	3	75	53.32	160	3,999.00	annual	75	3,999.00
457.1260 Grievances		33	33	5	165	53.32	267	8,797.80	annual	165	8,797.80

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
457.1270 Sanctions		8	8	1	8	53.32	53	426.56	annual	8	426.56
457.1270 Sanctions		30000	30000	0.02	500	26.40	0	13,200.00	annual	500	13,200.00
457.1270 Sanctions		15	15	1/2	8	53.32	27	399.90	annual	8	399.90
457.1285 Program integrity		33	33	50	1,650	53.32	2,666	87,978.00	once	550	29,326.00
457.1285 Program integrity		7	7	1	7	53.32	53	373.24	once	2	124.41
457.1285 Program integrity		7	7	10	70	53.32	533	3,732.40	once	23	1,244.13
457.1285 Program integrity		7	7	100	700	73.60	7,360	51,520.00	once	233	17,173.33
457.1285 Program integrity		7	7	125	875	53.32	6,665.00	46,655.00	annual	875	46,655.00
457.1285 Program integrity		7	7	25	175	127.72	3,193.00	22,351.00	annual	175	22,351.00
457.1285 Program integrity		33	33	1	33	73.60	73.60	2,428.80	annual	33	2,428.80
457.1205 MLR		62	62	101	6,262	73.60	7,434	460,883.20	once	2087	153,627.73
457.1205 MLR		62	62	50	3,100	53.32	2,666	165,292.00	once	1033	55,097.33
457.1205 MLR		62	62	17	1,054	127.72	2,171	134,616.88	once	351	44,872.29
457.1205 MLR		62	62	31.8	1,972	73.60	2,340	145,109.76	annual	1972	145,109.76
457.1205 MLR		62	62	15.9	986	53.32	848	52,562.86	annual	938	52,562.86

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
457.1205 MLR		62	62	5.3	329	127.72	677	41,968.79	annual	329	41,968.79
457.1207 Information Requirements		5	5	10	50	53.32	533	2,666.00	once	17	888.67
457.1207 Information Requirements		20	20	4	80	53.32	213	4,265.60	once	27	1,421.87
457.1207 Information Requirements		66	3069371	0	51,156	29.92	0	1,530,593.01	once	17052	510,197.67
457.1207 Information Requirements		66	306937	0	5,116	29.92	0	153,059.25	annual	5116	153,059.25
457.1207 Information Requirements		66	66	1	66	53.32	53	3,519.12	once	22	1,173.04
457.1207 Information Requirements		66	66	1	66	73.60	74	4,857.60	once	22	1,619.20
457.1208 Contracts		40	40	1	40	73.60	74	2,944.00	once	13	981.33
457.1216 Continued services		66	66	4	264	73.60	294	19,430.40	once	88	6,476.80
457.1216 Continued services		30000	30000	1/6	5,000	65.40	11	327,000.00	annual	5000	327,000.00
457.1222 Communication		3	3	1	3	53.32	53	159.96	annual	3	159.96
457.1222 Communication		3	3	4	12	53.32	213	639.84	annual	12	639.84
457.1222 Communication		3	234,000	0	3,900	29.92	0	116,688.00	annual	3900	116,688.00
457.1224 Marketing		5	5	2	10	53.32	107	533.20	once	3	177.73

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
457.1260 Grievances		62	2232	3	6,696	53.32	160	357,030.72	annual	6696	357,030.72
457.1260 Grievances		62	62	10	620	127.72	1,277	79,186.40	once	207	26,395.47
457.1260 Grievances		62	62	75	4,650	53.32	3,999	247,938.00	once	1550	82,646.00
457.1260 Grievances		62	62	15	930	73.60	1,104	68,448.00	once	310	22,816.00
457.1260 Grievances		62	297,600	1/2	148,800	53.32	27	7,934,016.00	annual	148800	7,934,016.00
457.1260 Grievances		306937	306937	0	5,116	29.92	0	153,059.25	annual	5116	153,059.25
457.1260 Grievances		6139	6139	0	102	29.92	0	3,061.31	annual	102	3,061.31
457.1285 Program integrity		63	63	5	315	53.32	267	16,795.80	once	105	5,598.60
457.1285 Program integrity		63	63	2	126	53.32	107	6,718.32	annual	126	6,718.32
457.1285 Program integrity		33	3300	0	55	29.92	0	1,645.60	annual	55	1,645.60
457.1285 Program integrity		63	63	1	63	73.60	74	4,636.80	once	21	1,545.60
457.1230(a) Access Standards		63	63	3	189	53.32	160	10,077.48	once	63	3,359.16
457.1230(b) Access Standards		63	63	20	1,260	53.32	1,066	67,183.20	annual	1260	67,183.20
457.1230(b) Access Standards		63	63	1	63	53.32	53	3,359.16	annual	63	3,359.16
457.1230(c) Access Standards		122775	122775	1/6	20,463	59.20	10	1,211,380.00	annual	20463	1,211,380.00

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
457.1230(c) Access Standards		18	18	3	54	53.32	160	2,879.28	once	18	959.76
457.1230(c) Access Standards		613,874	613,874	1/6	102,312	29.92	5	3,061,185.01	annual	102312	3,061,185.01
457.1230(c) Access Standards		63	63	4	252	73.60	294	18,547.20	once	84	6,182.40
457.1230(c) Access Standards		61387	61387	1	61,387	65.40	65	4,014,709.80	annual	61387	4,014,709.80
457.1230(d) Access Standards		63	98280	0.5	49,140	65.40	33	3,213,756.00	annual	49140	3,213,756.00
457.1233(b) Structure and Operations		63	63	3	189	53.32	160	10,077.48	once	63	3,359.16
457.1233(c) Structure and Operations		62	62	2	124	53.32	107	6,611.68	annual	124	6,611.68
457.1233(d) Structure and Operations		59	59	20	1,180	73.60	1,472	86,848.00	once	393	28,949.33
457.1240(b) Quality		33	33	3.33333333	110	73.60	245	8,096.00	once	37	2,698.67
457.1240(b) Quality		2	2	0.33	1	53.32	18	35.19	annual	1	35.19
457.1240(b) Quality		3	3	10	30	53.32	533	1,599.60	annual	30	1,599.60
457.1240(b) Quality		7	21	4	84	53.32	213	4,478.88	annual	84	4,478.88
457.1240(b) Quality		4	4	2	8	53.32	107	426.56	once	3	142.19
457.1240(b) Quality		59	177	8	1,416	53.32	427	75,501.12	annual	1416	75,501.12
457.1240(b) Quality		4	4	8	32	53.32	427	1,706.24	annual	32	1,706.24

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
457.1240(b) Quality		3	3	15	45	53.32	800	2,399.40	annual	45	2,399.40
457.1240(b) Quality		33	33	0.5	17	53.32	27	879.78	once	6	293.26
457.1240(b) Quality		33	33	1	33	53.32	53	1,759.56	annual	33	1,759.56
457.1240(c) Quality		66	66	80	1,760	53.32	4,265.60	93,843.20	annual	1760	93,843.20
457.1240(c) Quality		66	66	5	110	127.72	638.60	14,049.20	annual	110	14,049.20
457.1240(c) Quality		66	66	5	110	29.92	149.60	3,291.20	annual	110	3,291.20
457.1240 Quality		66	66	40	880	53.32	2,132.80	46,921.60	annual	880	46,921.60
457.1240 Quality		66	66	5	110	29.92	149.60	3,291.20	annual	110	3,291.20
457.1240 Quality		66	66	4	88	127.72	510.88	11,239.36	annual	88	11,239.36
457.1240 Quality		66	66	30	1,980	53.32	1,600	105,573.60	annual	1980	105,573.60
457.1240 Quality		66	66	5	330	127.72	639	42,147.60	annual	330	42,147.60
457.1240 Quality		66	66	5	330	29.92	150	9,873.60	annual	330	9,873.60
457.1240(c) Quality		16	16	N/A	N/A	N/A	70,700.00	1,131,200.00	once		377,066.67
457.1240(c) Quality		16	16	N/A	N/A	N/A	70,700.00	377,066.67	annual		377,066.67
457.1240(d) Quality		47	47	20	940	53.32	1,066.40	50,120.80	annual	940	50,120.80
457.1240(d) Quality		33	33	3.33333333	110	53.32	177.73	5,865.20	once	37	1,955.07
457.1250(a) EQR		5	5	125	625	53.32	6,665	33,325.00	once	208	11,108.33

CFR Section	OMB control Number	# Respondents	# responses	Burden per response (hours)	Total Annual Hours	Labor Rate (\$/hr)	Cost (\$) per Response	Total cost (\$)	Frequency	Annualized hours*	Annualized costs (\$)
457.1250(a) EQR		5	5	50	250	73.60	3,680	18,400.00	once	83	6,133.33
457.1250(a) EQR		5	5	10	50	127.72	1,277	6,386.00	once	17	2,128.67
457.1250(a) EQR		5	5	2	10	53.32	107	533.20	once	3	177.73
457.1250(a) EQR		5	15	65	975	53.32	3,466	51,987.00	annual	975	51,987.00
457.1250(a) EQR		5	15	53	795	53.32	2,826	42,389.40	annual	795	42,389.40
457.1250(a) EQR		5	5	120.333333	602	53.32	6,416	32,080.87	annual	602	32,080.87
457.1250(a) EQR		5	5	60	300	53.32	3,199	15,996.00	annual	300	15,996.00
457.1250(a) EQR		5	5	80	400	53.32	4,266	21,328.00	annual	400	21,328.00
457.1250(a) EQR		5	5	80	400	29.92	2,394	11,968.00	annual	400	11,968.00
457.1250(a) EQR		48	48	350	16,800	53.32	18,662	895,776.00	annual	16800	895,776.00
457.1250(a) EQR		30	30	50	1,500	53.32	2,666	79,980.00	annual	1500	79,980.00
457.1250(a) EQR		20	20	159	3,180	53.32	8,478	169,557.60	annual	3180	169,557.60
457.1250(a) EQR		26	26	195	5,070	53.32	10,397	270,332.40	annual	5070	270,332.40
457.1250(a) EQR		52	52	159	8,268	53.32	8,478	440,849.76	annual	8268	440,849.76
457.1250(a) EQR		52	310	0	26	29.92	2	772.93	annual	26	772.93
TOTAL					1,803,056	--		108,439,506.50	---	--	111,623,115.30

E. Exempt ICRs

1. Administrative Actions

While the requirements under §§431.220(a)(5) and (6), 431.220(b), 438.710(b)(2), 438.730(b), and 457.1270(a), (b), and (c) are subject to the PRA, since the information collection requirements are associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), they are exempt from the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.)

Section 431.220(a)(5) and (6) would add PAHP enrollees as eligible for a state fair hearing as permitted in subpart B of 42 CFR part 438. Section 431.220(b) prescribes procedures for an opportunity for a hearing if the state agency or non-emergency transportation PAHP takes action to suspend, terminate, or reduce services, or an MCO, PIHP or PAHP takes action under subpart.

Before imposing any of the sanctions specified in subpart I, §438.710(a) would require that the state give the affected MCO, PIHP, PAHP or PCCM written notice that explains the basis and nature of the sanction. Section 438.710(b)(2) states that before terminating an MCO's, PIHP's, PAHP's or PCCM's contract, the state would be required to: (1) give the MCO or PCCM written notice of its intent to terminate, the reason for termination, the time and place of the hearing; (2) give the entity written notice (after the hearing) of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and (3) give enrollees of the MCO or PCCM notice (for an affirming decision) of the termination and information, consistent with §438.10, on their options for receiving Medicaid services following the effective date of termination.

Section 438.730(b) would require that if CMS accepts a state agency's recommendation for a sanction, the state agency would be required to give the MCO written notice of the proposed sanction. Section 438.730(c) would require that if the MCO submits a timely response to the notice of sanction, the state agency must give the MCO a concise written decision setting forth the

factual and legal basis for the decision. If CMS reverses the state's decision, the state must send a copy to the MCO.

Section 457.1270 would apply subpart I (Sanctions) of part 438 to CHIP. Within subpart I, §438.710(a) would require that the state provide the affected entity with timely written notice of the basis of the sanction. Section 438.710(b) would require that the state provide an entity a pre-termination hearing. If we accept a state agency's recommendation for a sanction, §438.730(b) would require that the agency provide the MCO, PIHP or PAHP written notice of the proposed sanction. If the MCO submits a timely response to the notice of sanction, §438.730(c) would require that the state agency provide the MCO, PIHP or PAHP with a concise written decision setting forth the factual and legal basis for the decision. If we reverse the state's decision, the state must send a copy to the affected MCO, PIHP or PAHP.

2. Fewer than 10 Respondents

While the requirements under §§438.8(m), 438.70(a), 438.102(a)(2), 438.350(a)(1) and (2), 438.360(c), 438.724, and 438.818(d) are subject to the PRA, in each instance we estimate fewer than 10 respondents. Consequently, the information collection requirements are exempt (5 CFR 1320.3(c)) from the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

Section 438.8(m) would require the MCO, PIHP, or PAHP to recalculate its MLR for any year in which a retroactive capitation change is made. As such retroactive adjustments are not a common practice, we only estimate that no more than three plans per year may have to recalculate their MLR.

Section 438.70(a) would require that states have a process to solicit and address viewpoints from beneficiaries, providers, and other stakeholders as part of the design, implementation, and oversight of the managed LTSS program. We estimate no more than 3 states per year would elect

to move to a managed LTSS program.

Section 438.102(a)(2) specifies that MCOs, PIHPs, and PAHPs are not required to cover, furnish, or pay for a particular counseling or referral service if the MCO, PIHP, or PAHP objects to the provision of that service on moral or religious grounds; and that written information on these policies is made available to: prospective enrollees, before and during enrollment; and current enrollees, within 90 days after adopting the policy for an any particular service. We believe the burden associated with this requirement affects no more than 3 MCOs or PIHPs annually since it applies only to the services they discontinue providing on moral or religious grounds during the contract period. PAHPs are excluded from this estimate because they generally do not provide services that would be affected by this provision.

Section §438.350 would add PAHPs to the list of affected entities in §438.350(a)(1) and (2). The addition of PAHPs to the EQR process would require the nine states with PAHPs and existing EQRO contracts to modify their existing EQRO contracts. The estimated 3 states with PAHPs that do not currently have an EQRO contract would need to enter into a contract with an EQRO.

Section 438.360(c) would require states to document, in the comprehensive quality strategy required at §431.502, which mandatory EQR-related activities it will apply the non-duplication provisions to, and why it believes these activities would be duplicative. Given that this is already standard practice for the 37 states that currently contract with MCOs and/or PIHPs, only the 3 states that contract only with PAHPs would have to revise their policies and procedures to include this in their comprehensive quality strategy.

Section 438.724 would require that the state provide written notice to their CMS Regional Office whenever it imposes or lifts a sanction on a PCCM or PCCM entity. Given the limited scope of benefits provided by a PCCM or PCCM entity, we anticipate that no more than 3 states

may impose or lift a sanction on a PCCM or PCCM entity in any year.

Section 438.818(d) would require states new to managed care and not previously submitting encounter data to MSIS to submit an Implementation plan. There are currently only 8 states that do not use MCOs thus these would be the only states that may have to submit an Implementation plan should they adopt managed care in the future.

3. Usual and Customary Business Practices

Section 433.138(e)(1) would make a technical correction addressing state Medicaid agencies' review of claims with trauma codes, to identify instances where third party liability (TPL) may exist for expenditures for medical assistance covered under the state plan. The correction would remove references to the International Classification of Disease, 9th edition, Clinical Modification Volume 1 (ICD-9-CM) by replacing the references with a general description of the types of medical diagnoses indicative of trauma. States would use the International Classification of Disease that they are using at the time of claims processing. There is no additional cost to the state related to the proposed changes to §433.138(e) because the proposed changes do not require any action by the state, if the state wishes to retain their usual and customary editing for the same types of traumatic injuries currently identified with ICD-9-CM.

While the requirements under §§438.10(c)(7), 438.208(b)(2), 438.208(b)(2)(i) and (iv), 438.208(b)(5), 438.210(b), 438.214, 438.360(c), 438.406(b)(5), 438.408(b)(2) and (3), 438.408(f)(1) and (2), and 438.416(b) and (c) are subject to the PRA, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with the aforementioned requirements would be incurred by persons during the normal course of their activities and, therefore, should be considered usual and customary business practices.

Section 438.10(c)(7) would add PAHPs and PCCMs to the managed care entities that must

have mechanisms in place to help enrollees and potential enrollees understand the requirements and benefits of managed care.

Section 438.208(b)(2) would require that MCOs, PIHPs and PAHPs coordinate an enrollee's care between settings or with services received through a different MCO, PIHP, PAHP and FFS. Section 438.208(b)(2)(i) would require discharge planning which has been a long standing industry practice since managed care plans consistently require authorization for all inpatient and facility care.

Section 438.208(b)(5) would require providers to maintain a record according to medical industry accepted professional standards.

Section 438.210(b) would require contracts with MCOs, PIHPs, or PAHPs and its subcontractors to have written policies and procedures for the processing of requests for initial and continuing authorizations of services. The burden associated with this requirement is the time required to develop the policies and procedures which is standard industry practice for managed care plans.

In §438.214, each state must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for the selection and retention of providers. Since all managed care programs utilize provider networks, this is industry standard practice.

Section 438.360(c) would require states to document, in the comprehensive quality strategy required at §431.502, which mandatory EQR-related activities it will apply the non-duplication provisions to, and why it believes these activities would be duplicative. Given that this is already standard practice for the 37 states that currently contract with MCOs and/or PIHPs, only the three states that contract only with PAHPs would have to revise their policies and procedures to include this in their comprehensive quality strategy.

Section 438.406(b)(5) would modify the language for evidence standards for appeals to

mirror the private market evidence standards. This aligns the text with commercial requirements but does not alter the meaning.

Section 438.408(b)(2) would change the timeframe an entity has to reach a determination from 45 days to 30 days to align with Medicare. Most insurers offer more than one line of business, and therefore we believe this timeframe will allow MCOs, PIHPs, and PAHPs to be consistent with their usual and customary business practices and reduce their burden. Section 438.408(b)(3) would change the timeframe an entity has to reach a determination in an expedited appeal from 3 days to 72 hr to align with Medicare and the private market. Most insurers offer more than one line of business, and therefore we believe this timeframe will make Medicaid consistent with usual and customary business practices and reduce their burden. Section 438.408(f)(1) and (2) would require that an enrollee exhaust the appeals process before proceeding to the state fair hearing process, and change the timeframe in which a beneficiary must request a state fair hearing to 120 days. MCOs, PIHPs, and PAHPs would no longer have to maintain an appeal and a fair hearing simultaneously which will decrease administrative burdens. The changing of the timeframe to request a state fair hearing from “not less than 20 or in excess of 90 days” to 120 days aligns with the private market. Many insurers offer more than one line of business, and therefore we believe aligning these timeframes will make Medicaid consistent with their usual and customary business practices and reduce their burden.

Section 438.416(b) and (c) would set forth a standard for the minimum types of information an entity must record during the appeals process and how that information must be stored. This standard aligns with the standards in the private market. Most insurers offer more than one line of business, and therefore, we believe aligning record keeping standards will make Medicaid consistent with usual and customary business practices.

F. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS' website at www.cms.hhs.gov/Paperwork@cms.hhs.gov, or call the Reports Clearance Office at 410-786-1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the ADDRESSES section of this proposed rule.

Comments must be received on/by July 27, 2015.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule modernizes the Medicaid managed care regulations recognizing changes in the usage of managed care delivery systems since the release of the final rule in 2002. As Medicaid managed care programs have developed and matured in the intervening years, states have taken various approaches to implementing part 438. This has resulted in inconsistencies and, in some cases, less than optimal results. To improve consistency and adopt policies and practices

from states that have proven the most successful, we propose revisions in this rule to strengthen beneficiary protections, support alignment with rules governing managed care in other public and private sector programs, strengthen actuarial soundness and the accountability of rates paid in the Medicaid managed care program, and implement statutory provisions issued since 2002.

According to the 2013 Actuarial Report on the Financial Outlook for Medicaid, total Medicaid outlays in federal FY 2012 exceeded \$431 billion; \$250 billion, or 58 percent represented federal spending, and \$181 billion, or 42 percent represented state spending.¹⁹ States have continued to expand the use of managed care in the past decade, not only to new geographic areas but to more complex populations, including seniors, persons with disabilities, and those who need long-term services and supports. Today, the predominant form of managed care in Medicaid is capitated risk-based arrangements – virtually identical in structure and payment to arrangements in the private insurance market in many ways. Coordination and alignment with the private insurance market will improve operational efficiencies for states and health plans and improve the experience of care for individuals moving between insurance coverage options. Total Medicaid managed care spending (federal and state) exceeded \$132 billion in 2013²⁰, with expenditures rising annually as new beneficiaries and programs move into a managed care delivery system. It is CMS' responsibility to make sure these dollars are spent wisely, ensuring that there is adequate funding to support the delivery of required services to beneficiaries without wasting state and federal tax dollars. Additionally, the prevalence of MLTSS being delivered through a risk-based capitated system has increased significantly since the regulations were last published. Beneficiaries using MLTSS are among the most vulnerable, and often require enhanced protections to preserve health and welfare. This regulation would codify these necessary

¹⁹ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2013.pdf>

²⁰ CMS, Financial Management Report—Base Payments, 2013.

beneficiary protections in MLTSS. The changes we propose in this rule for rate setting, medical loss ratio, encounter data, and reporting, would support and reflect the increased efforts of states and health plans to provide more comprehensive, coordinated, and effective care while achieving better health outcomes.

Congress established CHIP in 1997 through the passage of the Balanced Budget Act (BBA) and reauthorized it in 2009 with the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA). Since CHIP was established, participation has grown steadily, and the rate of uninsured children has been reduced by half. The most recent data indicate that more than 87 percent of eligible children are enrolled in CHIP or Medicaid. Managed care has always been a large part of CHIP, because the program was established in an era of increased use of managed care in all health care sectors and the flexibility granted to states in administering the program. Many states enroll all or nearly all of their CHIP population in managed care plans. At the same time, CHIP has historically had few regulations related to the use of managed care.

When Congress reauthorized CHIP in 2009 in section 403 of CHIPRA, it applied a number of the Medicaid managed care provisions in section 1932 of the Act to CHIP. In response, we released two State Health Official (SHO) letters 09-008 and 09-013, issued on August 31, 2009 and October 21, 2009, respectively, which provided initial guidance on the implementation of section 403 of CHIPRA. (SHO #09-008 is available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109a.pdf>. SHO #09-013 is available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO102109.pdf>.) This proposed rule builds on that guidance. It would align CHIP managed care standards with those of the Marketplace and Medicaid, where practical, ensuring consistency across programs. Consistency has the benefit of creating efficiencies for both plans and beneficiaries, including operational efficiencies for plans from using similar rules and

smoother transitions between programs for beneficiaries.

The BBA established quality standards for Medicaid managed care programs: a quality assessment and improvement strategy, and an external, independent review. While these standards initially applied only to MCOs, the application of several of them has spread to PIHPs (via the regulations at part 438, subparts D (Quality Assessment and Performance Improvement, effective on August 13, 2002 (67 FR 40989)) and E (External Quality Review, effective on March 25, 2003 (68 FR 3586)) and to CHIP managed care programs (per the CHIPRA). States that use a combination of managed care and other delivery systems are encouraged to use their quality strategies to develop a comprehensive quality plan across all delivery systems (as described in State Health Official letter entitled Quality Considerations in Medicaid and CHIP (SHO #13-007, available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf>)). Changes, in both MA and the private sector, related to performance measurement, quality rating systems, and private accreditation help to improve the health of beneficiaries while also controlling health care costs. Statewide comprehensive quality strategies, along with improvements to Medicaid and CHIP managed care quality, will give states additional tools to evaluate and improve the care received by beneficiaries.

For all of these reasons, the current regulatory framework is no longer the most appropriate or efficient to achieve program goals. We believe that it is necessary to modernize the Medicaid and CHIP managed care and quality regulations to support health care delivery system reform, improve population health outcomes, and improve the beneficiary experience in a cost effective and consistent manner in all states.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving

Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). We estimate that this rule is “economically significant” as measured by the \$100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that to the best of our ability presents the costs and benefits of this rule. The numbers presented in this RIA are rounded depending on the level of precision in the data used to generate them. Specifically, all COI costs are rounded to \$0.1 million while transfers are rounded to the nearest \$100 million. This

difference also allows us to display the smaller numbers in the COI costs, which would reflect zero if rounded to the nearest \$100 million.

Tables 3 and 4 show the overall estimates of the financial impact of this proposed rule in comparison to the status quo under the current regulatory framework. These tables and analyses use administrative burden estimates from the Paperwork Reduction Act documentation as well as any other quantifiable and qualitative benefits and costs when available. Table 3 divides the overall cost estimates into federal costs, state costs, and private sector costs with high and low estimates as appropriate. Table 4 divides the overall transfer estimates into federal and state transfers with high and low estimates as appropriate. Utilizing burden estimates from section IV of this proposed rule (COI) and estimated transfers, federal, state, and private sector costs and transfers were derived by applying the appropriate FMAP and the corresponding burdens in section IV of this proposed rule. For the revisions in part 438, we applied a weighted FMAP of 58.44 percent (weighted for enrollment) to estimate the federal share of private sector costs. This was done to account for private sector costs that are passed to the federal government through the managed care capitation rates. For part 457, we applied an enhanced FMAP of 93.9 for 2016 through 2019 and an enhanced FMAP of 71.5 for 2020 for both state and private sector costs. These represent the average CHIP FMAP in the respective years under current law. Federal CHIP funding is capped and is currently appropriated through 2017; therefore federal CHIP expenditures will not exceed the total allotments described in section 2104(a) of the Act.

Table 3 separates the overall costs by part 431, which represents comprehensive quality strategies; part 438, which represents Medicaid managed care; and part 457, which represents CHIP. As shown in Table 3, the total cost associated with this proposed rule is a cumulative \$0.1 million in the first year for the revisions to part 431, a cumulative \$86 million in the first year for revisions to part 438, and a cumulative \$25.6 million in the first year for revisions to part 457, for a

total cost of a cumulative \$111.7 million for all revisions in the first year. Table 4 represents the overall transfer estimates for part 438 only, as parts 431 and 457 have no estimated transfers. As shown in Table 4, the total estimated transfers associated with this proposed rule range from a potential -\$1 billion to a potential \$300 million in the first year.

The COI costs estimated for some of the provisions are based on the number of enrollees. As such, as enrollment grows each year, the cost for these provisions will grow accordingly. For this analysis, we used the projected average enrollment growth rate for Medicaid of 3.3 percent²¹ for Medicaid managed care enrollment to trend cost burdens. Recognizing the success that states have had enrolling eligible children in CHIP (more than 87 percent of eligible children enrolled in CHIP or Medicaid²²) and the current prevalence of managed care in the program, we used a 3 percent growth rate for CHIP managed care enrollment. The burdens estimated for the quality components (proposed amendments to part 431 and part 438 subpart E) are not associated with enrollment, and therefore do not display any variable costs.

This RIA includes the administrative costs (wage and labor) related to implementing and operating a Medicaid managed care delivery system as well as non-administrative benefit and cost estimates when available. The burden estimates presented in section IV of this proposed rule provide the detail supporting the summary COI burden estimates presented in this RIA. As part of the costs considered outside of the COI, we included information technology and information systems costs, such as small system modifications or upgrades. However, we believe these costs are minimal and consistent with the nature of business in contracting and providing services to Medicaid and CHIP managed care enrollees. We also believe that many of these costs would fall

²¹ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2013.pdf>

²² Genevieve M. Kenney, Nathaniel Anderson, Victoria Lynch. Medicaid/CHIP Participation Rates Among Children: An Update. September 2013. Available at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412901-Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf>.

under routine IT maintenance and upgrades. Therefore, we believe that these costs would have a negligible impact consistent with normal business practices.

TABLE 3: Overall Federal, State, and Private Costs for Parts 431, 438, and 457 (in millions of dollars)

Part 431												
	2016		2017		2018		2019		2020		2016-2020	
	Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Federal	\$0.05	\$0.05	\$0.05	\$0.05	\$0.05	\$0.05	\$0	\$0	\$0	\$0	\$0.15	\$0.15
State	\$0.05	\$0.05	\$0.05	\$0.05	\$0.05	\$0.05	\$0	\$0	\$0	\$0	\$0.15	\$0.15
Private	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Part 431	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0	\$0	\$0	\$0	\$0.3	\$0.3
Part 438												
	2016²		2017		2018		2019		2020		2016-2020	
	Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Federal¹	\$51.7	\$51.7	\$54.1	\$54.1	\$54.9	\$54.9	\$50.9	\$50.9	\$51.7	\$51.7	\$263.3	\$263.3
State	\$6.4	\$6.4	\$6.7	\$6.7	\$6.8	\$6.8	\$6.2	\$6.2	\$6.4	\$6.4	\$32.5	\$32.5
Private	\$27.9	\$27.9	\$29.1	\$29.1	\$29.6	\$29.6	\$27.4	\$27.4	\$27.9	\$27.9	\$141.9	\$141.9
Total Part 438	\$86	\$86	\$89.9	\$89.9	\$91.3	\$91.3	\$84.5	\$84.5	\$86	\$86	\$437.7	\$437.7
Part 457												
	2016		2017		2018		2019		2020		2016-2020	
	Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Federal³	\$24	\$24	\$24	\$24	\$24.1	\$24.1	\$22.6	\$22.6	\$17.3	\$17.3	\$112	\$112
State	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2	\$0.8	\$0.8	\$1.6	\$1.6
Private	\$1.4	\$1.4	\$1.4	\$1.4	\$1.4	\$1.4	\$1.3	\$1.3	\$6.0	\$6.0	\$11.5	\$11.5
Total Part 457	\$25.6	\$25.6	\$25.6	\$25.6	\$25.6	\$25.6	\$24.1	\$24.1	\$24.2	\$24.2	\$125.1	\$125.1
Total Costs for Parts 431, 438, and 457												
	2016		2017		2018		2019		2020		2016-2020	
	Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Total Part 431	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1	\$0	\$0	\$0	\$0	\$0.3	\$0.3
Total Part 438	\$86	\$86	\$89.9	\$89.9	\$91.3	\$91.3	\$84.5	\$84.5	\$86	\$86	\$437.7	\$437.7
Total Part 457	\$25.6	\$25.6	\$25.6	\$25.6	\$25.6	\$25.6	\$24.1	\$24.1	\$24.2	\$24.2	\$125.1	\$125.1
Grand Total	\$111.7	\$111.7	\$115.6	\$115.6	\$117	\$117	\$108.6	\$108.6	\$110.2	\$110.2	\$563.1	\$563.1

¹Includes federal costs based on a weighted FMAP of 58.44 percent.

²Estimates based on 2012 data.

³Includes federal costs based on an average FMAP of 93.9 for 2016-2019 and an average FMAP of 71.5 for 2020.

TABLE 4: Overall Federal and State Transfers for Part 438 (in millions of dollars)

*Parts 431 and 457 do not have transfers

Part 438												
	2016		2017		2018		2019		2020		2016-2020	
	Low	High	Low	High								
Federal	-\$600	\$200	-\$1,400	\$400	-\$2,000	\$400	-\$2,100	\$500	-\$2,300	\$500	-\$8,400	\$2,000
State	-\$400	\$100	-\$800	\$300	-\$1,200	\$400	-\$1,300	\$400	-\$1,400	\$400	-\$5,100	\$1,600
Total Part 438	-\$1,000	\$300	-\$2,200	\$700	-\$3,200	\$800	-\$3,400	\$900	-\$3,700	\$900	-\$13,500	\$3,600

All state Medicaid programs receive a federal matching rate of at least 50 percent for administrative expenses and 50 to 73 percent (determined individually by state) for covered service expenses, with exceptions for certain services and eligibility groups. State CHIP programs receive a higher federal funding rate, ranging from 88 to 100 percent for 2016 through 2019 and ranging from 65 to 82 percent for 2020; states receive the same federal funding rate for administrative expenses, but they are capped at 10 percent of a state's total CHIP expenditures. The Medicaid managed care plans are paid actuarially sound capitation rates to cover the costs of fulfilling their obligations under their contract. These rates are included in the expenditures by the state and subsequently submitted to CMS for federal matching payments at the state's assigned rate. This is reflected in Table 3 in the "Private Sector" row. State expenditures for external quality review (EQR) and EQR-related activities performed by EQROs for MCOs with contracts under section 1903(m) of the Act are eligible for a federal matching rate of 75 percent; EQR on other types of managed care entities or EQR-related activities conducted by non-EQROs are eligible for a 50 percent federal matching rate. CHIP EQR activities are considered administrative activities, which receive the CHIP federal funding rate, and count towards the administrative cap.

Table 5 shows the estimate of the impact for the COI costs of this proposed rule, divided into fixed and variable costs. Fixed costs are those which do not change with the number of enrollees while variable costs change with the number of enrollees.

TABLE 5: Overall Fixed and Variable Costs for Parts 431, 438, and 457 (in millions of dollars)

	Part 431				
	2016²	2017	2018	2019	2020
Fixed costs	\$0.1	\$0.1	\$0.1	\$0	\$0
Variable costs	N/A	N/A	N/A	N/A	N/A
Part 431 Subtotal	\$0.1	\$0.1	\$0.1	\$0	\$0
	Part 438				
	2016²	2017	2018	2019	2020
Fixed costs	\$24.9	\$24.9	\$24.9	\$16.7	\$16.7
Variable costs¹	\$61.1	\$65	\$66.4	\$67.8	\$69.3
Part 438 Subtotal	\$86	\$89.9	\$91.3	\$84.5	\$86
	Part 457				
	2016²	2017	2018	2019	2020
Fixed costs	\$24.7	\$24.7	\$24.6	\$23.1	\$23.2
Variable costs³	\$0.9	\$1	\$1	\$1	\$1
Part 457 Subtotal	\$25.6	\$25.6	\$25.6	\$24.1	\$24.2
Total for Parts 431, 438, and 457	\$111.7	\$115.6	\$117	\$108.6	\$110.2

¹Utilizes the average enrollment growth rate as established in the 2013 Actuarial Report on the Financial Outlook for Medicaid: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf>.

²Estimates based on 2012 data.

³Utilizes a 3 percent growth rate.

1. Cost Estimates by Guiding Principles

The principles discussed below guided the policy development and changes proposed in this rule. These guiding principles and proposed regulatory changes support the coordination and integration of health care, promote effective forms of information sharing, and require transparency on cost and quality information to support greater overall accountability in the Medicaid and CHIP programs. Detailed COI burden estimates can be found in section IV of this

proposed rule. This section details the significant COI costs and transfers related to benefits and costs associated with this proposed rule.

2. Setting Actuarially Sound Rates and Other Payment and Accountability Improvements.

This guiding principle seeks to provide more data, analytical rigor, documentation, and transparency in the managed care rate-setting process and includes setting actuarially sound capitation rates and program integrity. The estimated first-year COI costs associated with the provisions under this guiding principle account for a cumulative \$1 million of the total estimated first-year burden for the revisions to part 438 and part 457 (detailed burden estimates can be found in the COI section of this proposed rule at sections IV.D.4 and IV.D.5 for rates and IV.D.36 and IV.D.37 for program integrity).

The rule also proposes new requirements related to setting actuarially sound capitation rates in sections §438.4 through §438.7. Many of these requirements would codify current policy on developing capitation rates for Medicaid managed care plans. Other requirements set standards for actuaries developing the capitation rates, specify requirements for data and information that must be included in the actuarial certification of the rates, or describe the CMS process for reviewing and approving the rates. As such, we believe that many of these provisions are unlikely to have a direct effect on the actual capitation rates or future Medicaid expenditures. To the extent that these new standards or requirements do have an effect on capitation rates or Medicaid expenditures, we believe this could lead to increases in some cases and decreases in other cases in the capitation payment rates and Medicaid expenditures.

In particular, we believe that the combination of the new proposed requirements related to actuarial soundness and the proposed change to no longer allow states to certify rate ranges and to require states to certify specific capitation rates may have some financial impact. Currently, 40 states and the District of Columbia have at least one managed care program as part of their

Medicaid program. Of these, 26 states and the District of Columbia currently certify rate ranges instead of rates for at least one managed care program in the state (Arkansas; California; Colorado; Delaware; District of Columbia; Georgia; Idaho; Indiana; Iowa; Kansas; Kentucky; Louisiana; Maryland; Massachusetts; Minnesota; Missouri; Nebraska; New Mexico; New York; North Carolina; North Dakota; Oregon; Pennsylvania; Tennessee; Utah; Virginia; and West Virginia). The certified rate ranges in many cases can be large. Based on our review of the most recent actuarial certifications in states that use rate ranges, the width of the rate range is 10 percent or smaller in 14 states (that is, the low end and the high end of the range are within 5 percent of the midpoint of the range), but in some states the ranges may be as wide as 30 percent (that is, the low end and the high end are within 15 percent of the midpoint of the range). In addition, most states tend to set the contracted capitation payment rates toward the lower end of the rate range.

For states that currently use relatively narrower rate ranges (which we would generally define as 10 percent or less), we believe that the states would be able to meet the proposed requirements and reasonably set rates that would be equivalent to those at the low end of the rate ranges (if the states were still able to certify a rate range). For states with relatively wider rate ranges (those that are greater than 10 percent), we believe that the states may not be able to set rates equivalent to the current low end of the rate range. In general, our opinion is that in cases where the rates would be more than 5 percent below the midpoint of the rate ranges it would be more difficult for a state to certify that rate as actuarially sound (and at the same time meet all of the other actuarial soundness requirements).

To estimate the high end of the range of the potential financial impact, we assumed that in states that had rate ranges wider than 10 percent and set rates at the low end of the rate range, that future Medicaid MCO, PIHP, and PAHP premiums would increase 2.5 percent (that is, roughly the average across all states of how much the low end of the rate range would need to increase to bring

the width of the rate range to about 10 percent). We also included states for which the rate certification provided no information about the actual contracted capitation payment rates. For states with wide rate ranges but that paid rates at different points within the rate ranges, we assumed that the rates would increase by 1.25 percent (that is, half of the increase in rates for states that paid at the low end of the rate range). We assumed no impact on states with relatively narrower rate ranges (10 percent or less).

These changes increased projected Medicaid managed care expenditures by \$3.6 billion from 2016 to 2020, or about 0.4 percent overall of about \$1.3 trillion in projected Medicaid expenditures on MCOs, PIHPs, and PAHPs over the 5-year period. These estimates would be an increase of about 1.5 percent in costs in states assumed to be affected by this change. We believe that these estimates are a reasonable upper bound on the projected effect of these proposed changes.

In addition, we believe that there may be cases where these changes would reduce capitation rates and Medicaid expenditures. In particular, there are some states that make significant retroactive changes to the contracted rates at or after the end of the rating period. We do not believe that these changes are made to reflect changes in the underlying assumptions used to develop the rates (for example, the utilization of services, the prices of services, or the health status of the enrollee), but are used to provide additional reimbursements to the plans or to some providers. We believe that the proposed requirements for actuarial soundness and certifying the capitation rates would limit these types of changes and may result in some reduction in Medicaid expenditures.

To estimate the high end of the range of the potential financial impact, we assumed that in states that we are aware of that make these types of changes to the capitation rates, that an amount equal to 50 percent of the difference between paying MCOs, PIHPs, and PAHPs at the low end and

the high end of the rate ranges would not be paid to the plans. These changes decreased projected Medicaid managed care expenditures by \$11.0 billion from 2016 to 2020, or about 0.9 percent of about \$1.3 trillion in projected expenditures on MCOs, PIHPs, and PAHPs over those 5 years. We believe that these estimates are a reasonable upper bound on the projected effect of these proposed changes.

Thus, we believe that the effects of these changes to Medicaid managed care actuarial soundness requirements and the requirement to certify the capitation rates could increase expenditures as much as \$3.6 billion from 2016 to 2020 and could decrease expenditures as much as \$11.0 billion from 2016 to 2020. We believe that these estimates reflect reasonable upper and lower bounds on the potential effect of these changes in the proposed regulation. Assuming that these changes in the regulation are effective mid-way through 2016, we estimate that the proposed changes related to actuarial soundness requirements and certifying the capitation rates would have the following effects as shown in Table 6.

TABLE 6: Projected Financial Effects (Transfers) of Actuarial Soundness Requirements, FY 2016-2020 (in millions of dollars)

Payer	2016	2017	2018	2019	2020	2016-2020
Low estimate						
Federal government	-\$600	-\$1,400	-\$1,500	-\$1,600	-\$1,700	-\$6,800
States	-\$400	-\$800	-\$900	-\$1,000	-\$1,100	-\$4,200
Total	-\$1,000	-\$2,200	-\$2,400	-\$2,600	-\$2,800	-\$11,000
High estimate						
Federal government	\$200	\$400	\$400	\$500	\$500	\$2,000
States	\$100	\$300	\$400	\$400	\$400	\$1,600
Total	\$300	\$700	\$800	\$900	\$900	\$3,600

It is possible that the impacts could be more or less than estimated here. More or fewer states may need to adjust capitation rates than we have assumed here. In particular, it is possible that states with relatively narrower ranges may decide that the capitation rates would still need to be higher than what would have been the low end of the rate range previously. We believe that states that use rate ranges as wide as 10 percent may still be affected by these changes. In addition, states may adjust their capitation rates to a greater or less extent than we have assumed here. These changes may also affect states that do not use rate ranges. While we believe that the proposed changes related to rate setting may be more likely to affect states that currently use relatively wide rate ranges, it is also possible that this may affect other states, including those that do not use rate ranges at all.

In addition, for states that historically have made significant changes to capitation rates within the rate ranges at the end or after the end of the rating period, those states may adjust their rate setting approaches as well. The payments might be closer to or farther from the final payments than we have estimated. Finally, these projections rely on the data, assumptions, and methodology used to develop the President's FY 2016 Budget projections for Medicaid. Changes in enrollment, health care costs, and the use of managed care plans within Medicaid may differ from these projections and may lead to greater or lesser Medicaid MCO, PIHP, and PAHP expenditures.

3. Program Integrity

Another aspect of this rule that we evaluated under this principle was enhancements to program integrity. We believe that many of these program integrity activities are currently already being performed by states and MCOs, PIHPs, and PAHPs. For program integrity activities that would be new or expanded under the proposed changes, there is very limited information on the effect that program integrity activities in general have on Medicaid expenditures. The lack of

information is especially true for specific program integrity activities. While we believe these new activities may lead to some additional recoveries from plans, providers, or other individuals and may also deter entities from committing fraud or violating program requirements, it is difficult to determine the financial impacts of these activities and we believe that any financial impact is unknown. Therefore, we assume that the proposed changes are likely to have a negligible financial impact on future Medicaid expenditures. We invite comment on possible ways to quantify the costs and/or benefits associated with these proposed provisions.

4. Alignment with other Insurers.

This guiding principle seeks to align Medicaid and CHIP managed care requirements with the Marketplace or MA to better streamline the beneficiary experience and to reduce operational burdens on health plans across publicly-funded programs and the commercial market. This guiding principle covers the regulatory topics of marketing, appeals and grievances, medical loss ratio, and standard contract provisions. As shown in Table 7, the COI costs associated with the provisions under this principle account for a cumulative \$6 million in the first year for the revisions to part 438.

TABLE 7: Costs of Alignment with Insurers for Part 438 (in millions of dollars)

Medical Loss Ratio Standards¹	2016	2017	2018	2019	2020
Federal	\$2.6	\$2.6	\$2.6	\$1.2	\$1.2
State	\$0	\$0	\$0	\$0	\$0
Private	\$1.9	\$1.9	\$1.9	\$0.9	\$0.9
Appeals and Grievances²					
Federal	\$0.9	\$0.9	\$0.9	\$0.9	\$0.9
State	\$0	\$0	\$0	\$0	\$0
Private	\$0.6	\$0.7	\$0.7	\$0.6	\$0.6
Total					
Federal	\$3.5	\$3.6	\$3.6	\$2.1	\$2.1
State	\$0	\$0	\$0	\$0	\$0
Private	\$2.5	\$2.5	\$2.5	\$1.5	\$1.5
Grand Total	\$6	\$6.1	\$6.1	\$3.6	\$3.6

¹§438.8²§§438.400-438.416

Similarly, as shown in Table 8, the COI costs associated with implementing the provisions under this principle account for a cumulative \$11.6 million in the first year for the revisions to part 457.

TABLE 8: Costs of Alignment with Insurers for Part 457 (in millions of dollars)

Medical Loss Ratio Standards¹	2016	2017	2018	2019	2020
Federal	\$0.5	\$0.5	\$0.5	\$0.2	\$0.1
State	\$0	\$0	\$0	\$0	\$0
Private	\$0	\$0	\$0	\$0	\$0.1
Appeals and Grievances²					
Federal	\$10.4	\$10.4	\$10.4	\$10.3	\$7.9
State	\$0	\$0	\$0	\$0	\$0
Private	\$0.7	\$0.7	\$0.7	\$0.7	\$3.1
Total					
Federal	\$10.9	\$10.9	\$10.9	\$10.5	\$8
State	\$0	\$0	\$0	\$0	\$0
Private	\$0.7	\$0.7	\$0.7	\$0.7	\$3.2
Grand Total	\$11.6	\$11.6	\$11.6	\$11.2	\$11.2

¹§457.1205²§457.1260

5. Medical Loss Ratio

As an increasing and more diverse set of Medicaid services are being delivered through managed care, good measurement systems are increasingly important to ensure that Medicaid funding is used prudently and that capitation rates are sufficiently based on the expenses associated with services. The implementation of a MLR is an integral part of the overall financial accountability aspects of the proposal and would align Medicaid and CHIP with the private health insurance market, as well as with MA. MLR reporting is a valuable tool to ensure that capitation rates for MCOs, PIHPs, and PAHPs are actuarially sound and adequately based on reasonable expenditures for covered services. Acknowledging that basis for proposing an MLR requirement,

there are four benefits to having a common national standard for the calculation, reporting and use of MLR as we have proposed: (1) It will provide greater transparency for the use of Medicaid funding; (2) it will allow comparability across states and facilitate better rate setting; (3) it will facilitate better comparisons to MLRs in MA and the private health market; and (4) it will reduce the administrative burden on health plans by providing a consistent approach to ensuring financial accountability for managed care plans working in multiple product lines and/or operating in multiple states. The proposed provisions in §§438.4, 438.5, 438.8, 457.1203 and 457.1205 require MCOs, PIHPs, and PAHPs to calculate, report, and use a MLR in the development of capitation rates. The estimated first-year COI cost for the proposed provisions in part 438 is a cumulative \$4.5 million (detailed burden estimates can be found in the COI section of this proposed rule at section IV.D.6 for MLR). The total estimated first-year COI cost associated with implementing the proposed MLR provisions of part 457 is a cumulative \$0.5 million.

This rule proposes new requirements that would require the states to calculate and report the medical loss ratios (MLRs) for Medicaid MCOs, PIHPs, and PAHPs in §438.4 and §438.5, and to add new §438.8 and §438.74, as well as incorporate an MLR assumption in the rate setting process. These changes, however, do not require that states assess any financial penalties on MCOs, PIHPs, and PAHPs that do not meet a minimum MLR. We will encourage states to adopt minimum MLRs or to develop similar financial arrangements to incentivize better plan performance; however, as states are already permitted to implement a minimum MLR or similar standards and some choose not to do so, we believe that this rule is unlikely to encourage more states to do so and therefore is unlikely to have any direct financial impact on Medicaid expenditures for MCOs, PIHPs, and PAHPs; however, we believe that there is the potential for some financial impacts when considering the proposed MLR requirements and the actuarial soundness standards requirements.

We do not collect data or information on the MLRs of Medicaid MCOs, PIHPs, and PAHPs, nor do we collect the data or information necessary to calculate the loss ratios. Milliman has published a series of annual research papers that review Medicaid MCO performance, including data on MLRs. We have reviewed the most recent research papers covering 2011, 2012, and 2013 for our review of the potential impacts of the proposed regulation related to MLRs (“Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2011,” Palmer and Pettit, July 2012; “Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2012,” Palmer and Pettit, June 2013; and “Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2013,” Palmer and Pettit, June 2014). These studies provide an analysis of Medicaid managed care plans, including loss ratios, covering 35 states and territories, including the District of Columbia and Puerto Rico, and up to 167 managed care plans.

From 2011 to 2013, the mean MLR varied between 85.5 percent and 87.9 percent, with an average of 87.0 percent over the 3-year period (weighted by the number of plans reporting each year). A significant percentage of plans experienced loss ratios below the 85-percent target noted in this proposed rule. In each year, 10 percent of plans experienced loss ratios below 78.0 percent to 79.4 percent, and 25 percent of plans experienced loss ratios below 82.6 percent to 83.6 percent. Thus, we would expect a substantial number of plans would likely not meet a minimum loss ratio of 85 percent each year.

We fit a normal distribution to the MLRs based on the average loss ratios at each percentile shown in the Milliman reports (10th, 25th, 50th, 75th, and 90th) for 2011, 2012, and 2013. This suggested that between 37 percent and 39 percent of plans would have loss ratios equal to or less than 85 percent over this period. Assuming that the distribution of loss ratios is not affected by the size of the MCO or the MCO’s total revenue (in general, the Milliman reports did not suggest any apparent correlation), we calculate that if all states enforced a minimum MLR of 85 percent and if

MCOs with smaller loss ratios had to return revenue such that the effective loss ratio would be equal to 85 percent, that MCOs on average would return 1.5 percent to 1.9 percent of total revenue. (This does not account for any impact of the credibility adjustment proposed in the regulation.) To the extent that smaller MCOs, PIHPs, and PAHPs would receive a credibility adjustment and thus effectively lower the minimum MLR standard for those plans, the percentage of total revenue returned may be less than estimated.

In 2013, the sum of MCO, PIHP, and PAHP payments was \$132 billion (CMS, Financial Management Report—Base Payments)²³; therefore, we estimate that if a minimum MLR had been enforced for each MCO, PIHP or PAHP in all states in 2013, that between \$2.0 billion and \$2.5 billion would have been returned by MCOs, PIHPs, and PAHPs to the federal government and the states in that year.

As of 2013, we found, based on an internal review, 12 states that had requirements about a minimum MLR; of those, 6 enforced financial penalties for MCOs or other plans that did not have loss ratios at least equal to the minimum MLR. Those 6 states accounted for about 11 percent of Medicaid MCO, PIHP, and PAHP expenditures in 2013. Relatedly, a study by the Kaiser Family Foundation found that as of 2010 there were 11 states that had a minimum MLR requirement for Medicaid MCOs, PIHPs, or PAHPs (“A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey,” Gifford, Smith, Snipes, and Paradise, September 2011).

There is significant variation in the standards currently in place, as states may have different methods of calculating the MLRs (for example, whether or not they include certain costs as medical expenses or losses, and whether or not they make certain adjustments to plans’ revenues) and have different minimum MLRs (although all such minimums fell between 80 percent and 88 percent). In addition, many states that implemented the eligibility expansion under

²³ CMS, Financial Management Report—Base Payments, 2013.

the Affordable Care Act to all adults up to age 65 with household incomes of 138 percent or less included a minimum MLR requirement or a similar risk-sharing arrangement in its contracts with MCOs, PIHPs, and PAHPs for 2014. These currently existing requirements and standards may have some effect on the potential impact of the proposed changes.

For the purpose of illustrating the potential impact of these changes in the regulation, we have developed estimates assuming that all states would require a minimum MLR. If all states implemented the 85 percent minimum MLR requirement that is required to be calculated in the proposed regulation, we estimate that the federal government would collect about \$7 billion to \$9 billion between 2018 and 2020 and the states would collect about \$4 billion to \$5 billion over the 3-year period (although we note (1) the loss ratio in Medicaid would not be measured over 3 years like the MLR for QHPs; and (2) the first year an MCO, PIHP, or PAHP would have to refund Medicaid would be 2018). This calculation also accounts for states that already have a minimum loss ratio requirement in place. This amount would account for about 1.3 percent to 1.7 percent of projected MCO, PIHP, and PAHP expenditures.

We assume that this rule would not lead more states to implement an enforceable, minimum MLR; we therefore conclude that there would be no direct financial impact of the MLR provisions of the proposed rule.

Considering the proposed MLR requirements and the proposed changes to the requirements for actuarial soundness in §438 (a)(7) that requires rates to be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve an MLR of at least 85 percent for the rate year, we believe it is possible that collecting and reporting MLRs for each MCO, PIHP, or PAHP and additional oversight of the rate setting process may lead states to make adjustments to setting capitation rates in the future. For example, if this additional information led a state to realize that the loss ratios for the MCOs, PIHPs, or PAHPs were consistently higher than or lower than

expected, the state may adjust future rates lower or higher. We believe that there may be cases that lead to rate increases and other cases that lead to rate decreases relative to what the rates otherwise would have been.

Because the minimum MLR would not be enforced with a penalty under this proposed rule, the financial impacts would likely be significantly less than the estimates provided earlier. We believe that it is likely that any encouragement or oversight by CMS that would lead states to adjust rates would be less effective than implementing financial requirements on MCOs, PIHPs, and PAHPs that do not meet the minimum MLR. In addition, we believe that in many states there may only be one plan or a few plans which would not meet the minimum MLR in a given year (or conversely, one plan or a few plans which would have unusually high MLRs). In those cases, relatively low or high MLRs may be due in large part to the plans' own ability to manage costs (including their ability to manage utilization and costs), and not necessarily the result of the capitation rates being set too high or too low overall. Furthermore, some plans may only have MLRs below the minimum in a single year instead of more regularly; in those cases, while there would be a financial recovery if the minimum MLR was required, it is less likely that there would be longer-term changes to the capitation rates as a result of that one year's experience.

Using a similar methodology as described previously to estimate the potential impact if all states were to require a minimum MLR of 85 percent, we have estimated what the effects of reporting the MLR and the other actuarial soundness requirements would be on Medicaid payments for MCOs, PIHPs, and PAHPs. Instead of calculating the amount of payments that would be returned if a minimum MLR of 85 percent was required, we have measured the amount of payments that would be returned for plans with MLRs below 82 percent, and assumed that the indirect effects of these proposed changes would be equal to 50 percent of that amount. We have assumed for plans with MLRs somewhat below 85 percent (which we defined here to be between

82 and 85 percent) that the states may not need to make significant adjustments to rate setting. For plans with MLRs further below 85 percent (82 percent or less), we assumed that these proposed changes would likely lead to decreases in future rates and payments below what would have otherwise occurred; however, we also assumed that the rates and payments would still have been adjusted by the states, as they would have a financial incentive not to significantly overpay the managed care plans. The percentage of all MCO, PIHP, and PAHP payments that would be paid from the plans to the federal government and the states for plans under these assumptions is estimated to be between 0.35 and 0.5 percent.

Similarly, we calculated the amount of additional payments that would need to be made for plans with high MLRs, which we assumed to be 95 percent or greater. In these cases, we believe that the plans may have a higher likelihood of experiencing a loss. The Milliman reports found that between 2011 and 2013 that 25 percent of all plans had MLRs above 90.0 to 91.9 percent, and that 10 percent of plans had MLRs above 96.6 to 97.3 percent. We believe that in the cases that the states may adjust future capitation rates and payments to be higher than they otherwise would have been, and assumed that these adjustments would equal 50 percent of the difference between a MLR of 95 percent and the actual MLR. We estimated that the percentage of all MCO, PIHP, and PAHP payments would be increased between 0.1 and 0.2 percent due to these changes.

The net effect of these changes is estimated to be a decrease in MCO, PIHP, and PAHP payments of about 0.2 to 0.3 percent. Between 2018 and 2020, a 0.3-percent decrease in MCO, PIHP, and PAHP expenditures is projected to be a reduction of \$1.6 billion in federal expenditures and of \$0.9 billion in state expenditures. We believe that this is a reasonable lower bound of the effect of these proposed changes. We believe that a reasonable upper bound of these estimates would be \$0, assuming that the changes led to no financial impact. These estimates are shown in Table 9 below.

TABLE 9: Projected Financial Effects (Transfers) of Medical Loss Ratio and Actuarial Soundness Requirements, FY 2016-2020 (in millions of dollars)

Payer	2016	2017	2018	2019	2020	2016-2020
Low estimate						
Federal government	-\$0	-\$0	-\$500	-\$500	-\$600	-\$1,600
States	-\$0	-\$0	-\$300	-\$300	-\$300	-\$900
Total	-\$0	-\$0	-\$800	-\$800	-\$900	-\$2,500
High estimate						
Federal government	\$0	\$0	\$0	\$0	\$0	\$0
States	\$0	\$0	\$0	\$0	\$0	\$0
Total	\$0	\$0	\$0	\$0	\$0	\$0

There is a significant amount of uncertainty in these estimates beyond whether or not states would elect to implement an enforceable minimum MLR requirement. We have not accounted for the impact of the credibility adjustment. States and plans may also adjust their behavior as a result of the minimum MLR requirements; for example, states may set capitation payment rates differently to target certain loss ratios, and plans may make changes to how they manage health care costs and utilization for their enrollees. These changes may lead to differences in future expenditures for MCO, PIHP, and PAHP expenditures, and thus the actual experience may differ from our estimates.

In addition, it is not clear that the reports we relied on measure MLR the same way as is proposed in the regulation. To the extent that there are differences, the actual range and distribution of MLRs among MCOs, PIHPs, and PAHPs that would be measured under the proposed regulation may be different than as shown in the studies (for example, if there are expenditures that would be considered medical losses under the proposed regulation but were not

considered medical losses in the Milliman studies). This could lead to the actual effects of the MLR and actuarial soundness requirements being different than estimated here. In addition, it is possible that the effects of the proposed actuarial soundness and certification requirements may capture some of the same effects as estimated here; however, we have not made any adjustments to reflect any potential interaction between the two sets of changes.

Moreover, the extent of and the effectiveness of CMS' and states' efforts to adjust future capitation rates to target certain MLRs are difficult to predict. How CMS and the states respond to these changes would likely have a large bearing on the effect that these sections of the proposed regulation have on future Medicaid expenditures. Finally, these projections rely on the data, assumptions, and methodology used to develop the President's FY 2016 Budget projections for Medicaid. Changes in enrollment, health care costs, and the use of managed care plans within Medicaid may differ from these projections and may lead to greater or lesser Medicaid MCO, PIHP, and PAHP expenditures.

6. Appeals and Grievances

Proposed changes to the appeals and grievances provisions in §§438.400 through 438.416 and §457.1260 focus on creating state and health plan processes that are consistent across product lines (that is, MA, Medicaid, CHIP, and qualified health plans). Medicaid currently differs from MA and the qualified health plans in several key ways and these differences hinder a streamlined grievance and appeals process across the public and commercial managed care sectors, and creates unnecessary administrative complexity for health issuers participating across product lines. Our proposed revisions will allow enrollees to better understand the grievance processes and receive a resolution of their grievances and appeals more quickly. We believe this will be a tremendous benefit to families that have some family members eligible for Medicaid and other family members eligible for marketplace coverage; enrollees that change between Medicaid and the

qualified health plans due to life changes that affect eligibility; and enrollees that are dually eligible for Medicaid and Medicare. We believe consistency and quicker resolution of issues will not only make the enrollee more comfortable using the grievance system, but also confident that there is benefit in utilizing these systems when needed. Health plans have indicated that alignment of these provisions would reduce operational burden for those that operate across product lines and in different states as it would enable them to create and implement one set of uniform processes and procedures. A significant portion of the burden associated with this principle is the result of the proposal that Medicaid non-NEMT PAHPs comply with the same standards as MCOs and PIHPs. This proposed change will require non-NEMT PAHPs to develop a compliant grievance system, which will generate some one-time burdens, but we believe it is important for enrollees to have an avenue within these entities to raise and receive resolution to their grievances and appeals. The total estimated first-year COI costs for requiring Medicaid non-NEMT PAHPs to meet the same standards as MCOs and PIHPs and provide due process to beneficiaries through provisions in part 438 is a cumulative \$1.5 million (detailed burden estimates can be found in the COI section of this proposed rule at sections IV.D.31 through IV.D.35 for appeals and grievances). We are also proposing to apply most of the Medicaid grievance regulations to CHIP MCOs, PIHPs, and PAHPs. The total estimated first-year COI costs associated with implementing the proposed grievance provisions of part 457 under this principle is a cumulative \$11.1 million.

7. Allowing Payment for Institution of Mental Disease for Inpatient Psychiatric Services as an In Lieu of Service

The proposed regulation would allow MCOs and PIHPs, to pay institutions of mental disease (IMDs) using funds received from Medicaid to provide services to their beneficiaries as an in lieu of service, and sets requirements about how to consider the utilization and costs of covered services rendered in an IMD in developing the capitation rates. At this time, we do not have sufficient data to develop an estimate of the impact of these changes in the proposed regulation.

We do not know how many states currently allow plans to use IMDs to provide inpatient psychiatric services as an in lieu of service, nor do we collect data on the utilization and cost of such arrangements paid by Medicaid MCOs and PIHPs. We are aware that some states allow MCOs or PIHPs to use an IMD as a substitute provider for covered services. However, we do not know how many states currently permit this practice. The information cannot be determined from the contracts between the states and MCOs or PIHPs. States cannot require a managed care plan to use in lieu of services, and consequently, contracts do not include specific provisions for these services through an IMD. Likewise, we do not collect data on the utilization and cost of IMD services paid by MCOs or PIHPs.

There are two key potential financial impacts related to these changes. First, to the extent that inpatient psychiatric services rendered in an IMD are more cost-effective than the inpatient acute hospital setting, there is the potential for some reduction in expenditures; however, as the proposed regulation allows states to cover inpatient services in an IMD, while the preamble explains that prices for covered inpatient services rendered in an IMD cannot be used to determine the capitation rates, we believe that any reduction in expenditures for the federal government and the states is likely to be negligible. Second, these changes may encourage more states to cover mental health and substance abuse in IMDs as in lieu of services within the managed care plans. Because federal Medicaid payments are otherwise not permitted for persons in IMDs, allowing IMDs as a substitute setting for covered services may lead to an increase in federal Medicaid expenditures; as federal Medicaid outlays are not permitted for adults in IMDs, this change may lead to more costs eligible for federal matching funds that would have otherwise been deferred. It is not clear how much this proposed provision would incentivize states to allow plans to provide services in IMDs as in lieu of services. Similarly, it is unknown the extent to which this provision would lead states to move mental health and substance abuse services from the FFS program to

managed care, although we do not believe that this provision would be the primary impetus for states to make a change from FFS to managed care. Given the lack of data and program information, it is not possible to develop credible estimates of the impacts of either of these effects or to determine if a net increase or a net decrease in expenditures is more likely.

8. Beneficiary Protections.

This guiding principle seeks to protect beneficiaries from harm and includes enrollment and disenrollment; beneficiary support system; continuation of benefits pending appeal; authorization of services; continued services and coordination of care; managed long-term services and supports; and stakeholder engagement. As the use of managed care to deliver Medicaid benefits has grown, so has the inclusion of more vulnerable populations into managed care. These new populations include persons with disabilities, individuals with behavioral health needs, and beneficiaries needing long-term services and supports. The unique needs and vulnerability of these newer populations heightens the need for added beneficiary protections and thus, prompted the proposed revisions to the regulations. As shown in Table 10, the COI costs associated with the provisions under this principle account for a cumulative \$50.2 million in the first year for the revisions to part 438 (detailed burden estimates can be found in the COI section of this proposed rule at sections IV.D.10 and IV.D.17 for coordination/continuity of care and IV.D.18 for authorization of services).

TABLE 10: Costs of Beneficiary Protections for Part 438 (in millions of dollars)

Coordination/Continuity of Care¹	2016	2017	2018	2019	2020
Federal	\$28.9	\$29.6	\$30.4	\$31.1	\$31.9
State	\$0.9	\$0.9	\$0.9	\$0.9	\$1
Private	\$19.9	\$20.4	\$20.9	\$21.5	\$22
Authorization of Services²					
Federal	\$0.1	\$0.1	\$0.1	\$0	\$0
State	\$0	\$0	\$0	\$0	\$0
Private	\$0.1	\$0.1	\$0.1	\$0	\$0
Other³					
Federal	\$0.2	\$0.2	\$0.2	\$0.1	\$0.2
State	\$0.1	\$0.2	\$0.2	\$0.1	\$0.1
Private	\$0	\$0	\$0	\$0	\$0
Total					
Federal	\$29.2	\$29.9	\$30.7	\$31.2	\$32.1
State	\$1	\$1.1	\$1.1	\$1	\$1.1
Private	\$20	\$20.5	\$21	\$21.5	\$22
Grand Total	\$50.2	\$51.5	\$52.8	\$53.7	\$55.2

¹§438.62, §438.208²§438.210³§438.54, §438.70, §438.71, §438.110

Similarly, as shown in Table 11, the COI costs associated with implementing the provisions under this principle account for a cumulative \$12.1 million in the first year for the revisions to part 457.

TABLE 11: Costs of Beneficiary Protections for Part 457 (in millions of dollars)

Continued services to enrollees¹	2016	2017	2018	2019	2020
Federal	\$0.4	\$0.5	\$0.5	\$0.2	\$0.3
State	\$0	\$0	\$0	\$0	\$0
Private	\$0	\$0	\$0	\$0	\$0.1
Coordination/Continuity of Care²					
Federal	\$7.8	\$7.8	\$7.8	\$7.8	\$5.9
State	\$0	\$0	\$0	\$0	\$0.1
Private	\$0.5	\$0.5	\$0.5	\$0.5	\$2.3
Authorization of Services³					
Federal	\$3	\$3.1	\$3.2	\$3.3	\$2.6
State	\$0	\$0	\$0	\$0	\$0
Private	\$0.2	\$0.2	\$0.2	\$0.2	\$1
Enrollment⁴					
Federal	\$0.2	\$0.2	\$0.2	\$0.2	\$0.1
State	\$0	\$0	\$0	\$0	\$0.1
Private	\$0	\$0	\$0	\$0	\$0.1
Total					
Federal	\$11.4	\$11.6	\$11.7	\$11.5	\$8.9
State	\$0	\$0	\$0	\$0	\$0.2
Private	\$0.7	\$0.7	\$0.7	\$0.7	\$3.5
Grand Total	\$12.1	\$12.3	\$12.4	\$12.2	\$12.6

¹§457.1216

²§457.1230(c)

³§457.1230(d)

⁴§457.1210

9. Coordination and Continuity of Care

The provisions for coordination and continuity of care are in §438.62 and §438.208. Under current regulations, these sections focus only on primary and acute medical care, which is not appropriate or consistent with the needs of people with disabilities, frail elders, and other LTSS populations. These populations rely heavily on less traditional services, such as support services for work, community activity access, and assistance with activities of daily living. For example, people with dementia may prefer and be able to live in the community with personal care assistance, memory aids, and alerting systems, but may not be able to identify and notify a care coordinator in situations of neglect or abuse. A young adult with an intellectual disability may be able to work with supports in place, but be at risk of harm if transportation falls through or a support worker does not show up for a scheduled time. These populations often require heightened levels of monitoring and oversight by the care coordinator to ensure that they are able to fully access the services and supports needed to thrive in the community and to be sure that risks of harm or abuse are mitigated. Additionally, many of the providers for LTSS are small businesses and unaccustomed to working with managed care plans and care coordinators can be the bridge to establishing and building a productive relationship with these providers to best meet enrollees' needs.

The proposed regulations would address these enhanced care coordination needs by proposing provisions to strengthen the role of care coordinators who help beneficiaries transition from providers and services available through their current delivery system to providers and services available through a managed care plan. Care coordinators can help enrollees with finding specialty providers, understanding how the managed care program works, setting appointments, verifying delivery of services, and reminding enrollees of their appointments. The proposed regulations would also be strengthened to ensure that individuals with LTSS needs complete an accurate and timely person-centered assessment and service planning process with more frequent

monitoring to assist beneficiaries in fully utilizing services. The proposed changes to these provisions are designed to enable people with disabilities and LTSS enrollees to live, work, and participate in the setting of their choice more safely, effectively, and with fewer lapses in care. Additionally, we propose to enhance existing requirements for coordination and continuity of care when enrollees move between plans or programs. While this has always been a requirement in part 438, we are aware of gaps in some states' and health plans' implementation for the LTSS population.

Behavioral health, substance use disorders, and institutional services are the most common services that managed care enrollees receive through FFS; coordinating these services with the managed care services is crucial to comprehensive care management. Enrollees receiving behavioral health or substance use treatment on a frequent, sometimes daily, basis are at high risk for emergency department visits or setbacks to their recovery if they experience a disruption in their services. The added protections provided by the proposed changes would ensure that enrollees, particularly those with complex health needs, experience smoother transitions, have fewer incidents of abuse or neglect, are able to retain the ability to live in their communities and have fewer emergency department visits or admissions. For enrollees receiving on-going care and LTSS, lapses in care can trigger acute events and even be life threatening. Putting additional protections in place to prevent such occurrences is critical to enrollees' health outcomes. Care coordinators can help enrollees in these situations with finding appropriate providers, understanding how the managed care program works, setting appointments, and ensuring that appropriate authorizations are in the system to facilitate claims payment.

While we believe that the benefits of care coordination have a significant positive impact on the quality of life, consumer experience, and health outcomes for enrollees, we acknowledge that the activities that would bring about these positive impacts will likely generate costs. From an

administrative perspective, the proposed provisions in §438.62 have an estimated first-year COI cost of a cumulative \$3.5 million, and the proposed provisions in §438.208 have an estimated first-year COI cost of a cumulative \$46.2 million (detailed burden estimates can be found in the COI section of this proposed rule at sections IV.D.10 and IV.D.17, respectively). In general, we expect that most of the activities that would be required under the proposed regulation are already being provided in some form by the state Medicaid program or by their MCOs, PIHPs, and PAHPs. We anticipate little to no new impacts in practice or in expenditures on activities already occurring with existing populations and benefits. However, we believe there is a greater likelihood that the proposed changes in the regulation specific to MLTSS could lead to new or additional care coordination expenditures. There are currently 20 states that use MLTSS. Unfortunately, there is very limited data available to determine the potential impact of this section of the proposed regulation. We do not collect consistent or validated cost data on Medicaid managed care encounters or administrative costs and, therefore, it is not possible to determine the amount of new expenditures for MCOs, PIHPs, and PAHPs to provide particular services or to serve particular enrollees. In any managed care program, we would generally expect care coordination expenditures to be a notable portion of MCO, PIHP, and PAHP administrative costs. Milliman has published studies²⁴ on the financial performance of Medicaid managed care plans that contains data on administrative costs for plans. These studies provide an analysis of Medicaid managed care plans covering 35 states and territories, including the District of Columbia and Puerto Rico, and up to 167 managed care plans. According to these studies, the average ratio of administrative expenditures to plan revenues ranged from 11.4 percent to 12.1 percent between 2011 and 2013. We believe that care coordination costs would likely be some fraction of that percentage, but are

²⁴ “Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2011,” Palmer and Pettit, July 2012; “Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2012,” Palmer and Pettit, June 2013; and “Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2013,” Palmer and Pettit, June 2014

not able to determine the specific proportion. Given that administrative costs may cover a range of activities, we believe that it is most likely that care coordination costs are likely between 1 and 3 percent of plan revenue.

Unfortunately, there is also little data or research available on the amount of care coordination expenditures provided by MCOs, PIHPs, or PAHPs and the effectiveness of care coordination. Some studies have found that care coordination may lead to reductions in preventable inpatient readmissions and costs related to screening, testing, and evaluation. Studies²⁵ of transitional care models have found that they may reduce hospital readmissions while other demonstrations have found that care coordination has had some success in reducing hospitalizations and specialist visits²⁶). Conversely, there are other studies²⁷ that have shown that care coordination may not have a significant effect on health care expenditures; for example, a study of one Medicare demonstration showed that most care coordination programs did not have a significant effect on the costs or the quality of care, and even successful programs were not able to achieve savings large enough to offset care coordination costs.

It should be noted that these studies and most other studies available have examined the effects of care coordination on hospitalizations and utilization of physician services on general Medicaid and/or Medicare populations; we are not aware of any studies or research that focuses specifically on the impact of care coordination on beneficiaries who are using long-term services and supports. To the extent that care coordination may be more likely to affect hospital and physician service costs and that many Medicaid enrollees receiving long-term services and

²⁵ ("Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles," Thorpe 2011)

²⁶ ("Effects of Primary Care Coordination on Public Hospital Patients," Schillinger, Bibbins-Domingo, Vranizan, Bacchetti, Luce, and Bindman, *Journal of General Internal Medicine*, December 2001)

²⁷ ("Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries," Peikes, Chen, Schore, and Brown, *The Journal of the American Medical Association*, February 2009; "Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Readmissions of High-Risk Patients," Brown, Peikes, Peterson, Schore, and Razafindrakoto, *Health Affairs*, June 2012)

supports are also enrolled in Medicare, any financial impact of care coordination may be more likely to affect Medicare rather than Medicaid.

While we do not collect the amount of managed care capitation payments or expenditures in such a way that the amount paid for managed long-term care services can be determined, we estimate about 38 percent of total Medicaid managed care expenditures were provided for aged and disabled enrollees in 2013 (\$50 billion of \$132 billion), and we expect a significant amount of those expenditures covered acute care services. Thus, the potential amount of expenditures on long-term services and supports under Medicaid managed care programs is expected to be relatively small compared to the rest of the program. At this time we believe a reasonable estimate of the financial impact of the proposed changes to care coordination requirements under the regulation is that there would be a net impact of \$0. We believe that the expected increase in care coordination costs is likely to be small and that the effect of those activities on overall health benefit expenditures would be limited. The effect on overall expenditures would vary significantly depending on how successfully the managed care plans implement and/or enhance their current coordination efforts. We expect that provisions proposed in this rule related to setting actuarially sound rates, performance reporting, and encounter data reporting would enable more robust analysis of the effects of care coordination and transition efforts on expenditures in the future. We invite comment on possible ways to further quantify the costs and/or benefits associated with these proposed provisions.

We propose to apply some of the Medicaid beneficiary protections to CHIP, specifically the requirements in §438.62, §438.208, and §438.210. We believe these protections will ensure that enrollees, particularly those with complex health needs, experience smoother transitions, and have fewer emergency department visits or admissions. The proposed provisions in §438.62,

§438.208, and §438.210 associated with implementing the beneficiary protection provisions of part 457 have an estimated first-year COI cost of a cumulative \$12.1 million.

10. Modernizing Regulatory Requirements.

This guiding principle seeks to incorporate the numerous advancements in state activities, health plan practices, and federal oversight interests since the inception of part 438. This guiding principle covers the regulatory topics of network adequacy and accessibility of services; quality measurement and improvement; state monitoring standards; information standards; primary care case management; choice of managed care plans; non-emergency transportation; and state plan standards. As shown in Table 12, the COI costs associated with the provisions under this principle account for a cumulative \$28.3 million in the first year for the revisions to part 438 (detailed burden estimates can be found in the COI section of this proposed rule at section IV.D.7 for information standards and sections IV.D.21 through IV.D.30 for quality framework).

TABLE 12: Costs of Modernizing Regulatory Requirements for Part 438 (in millions of dollars)

Information Standards¹	2016	2017	2018	2019	2020
Federal	\$0.5	\$2	\$2.1	\$1.2	\$1.2
State	\$0	\$0	\$0	\$0	\$0
Private	\$0.4	\$1.4	\$1.5	\$0.8	\$0.9
Quality Measurement and Improvement²					
Federal	\$14.4	\$14.4	\$14.4	\$12.6	\$12.6
State	\$9.1	\$9.1	\$9.1	\$8	\$8
Private	\$3.7	\$3.7	\$3.7	\$3.3	\$3.3
Other³					
Federal	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1
State	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1
Private	\$0	\$0	\$0	\$0	\$0
Total					
Federal	\$15	\$16.5	\$16.6	\$13.9	\$13.9
State	\$9.2	\$9.2	\$9.2	\$8.1	\$8.1
Private	\$4.1	\$5.1	\$5.2	\$4.1	\$4.2
Grand Total	\$28.3	\$30.8	\$31	\$26.1	\$26.2

¹§438.10²Subpart E, Quality Framework and External Quality Review³§438.66, §438.68, §438.207

Similarly, as shown in Table 13, the COI costs associated with implementing the provisions under this principle account for a cumulative \$0.1 million in the first year for the revisions to part 431.

TABLE 13: Costs of Modernizing Regulatory Requirements for Part 431 (in millions of dollars)

Quality Measurement and Improvement¹	2016	2017	2018	2019	2020
Federal	\$0.05	\$0.05	\$0.05	\$0	\$0
State	\$0.05	\$0.05	\$0.05	\$0	\$0
Private	\$0	\$0	\$0	\$0	\$0
Grand Total	\$0.1	\$0.1	\$0.1	\$0	\$0

¹Subpart I, Part 321

Similarly, as shown in Table 14, the COI costs associated with implementing the provisions under this principle account for a cumulative \$4.1 million in the first year for the revisions to part 457.

TABLE 14: Costs of Modernizing Regulatory Requirements for Part 457 (in millions of dollars)

Information Standards¹	2016	2017	2018	2019	2020
Federal	\$0.7	\$0.7	\$0.8	\$0.2	\$0.1
State	\$0	\$0	\$0	\$0	\$0
Private	\$0	\$0	\$0	\$0	\$0.1
Quality Measurement and Improvement²					
Federal	\$3.1	\$3.1	\$3.1	\$2.6	\$2
State	\$0.1	\$0.1	\$0.1	\$0.1	\$0.5
Private	\$0.1	\$0.1	\$0.1	\$0.1	\$0.3
Other³					
Federal	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1
State	\$0	\$0	\$0	\$0	\$0
Private	\$0	\$0	\$0	\$0	\$0
Total					
Federal	\$3.9	\$3.9	\$4	\$2.9	\$2.2
State	\$0.1	\$0.1	\$0.1	\$0.1	\$0.5
Private	\$0.1	\$0.1	\$0.1	\$0.1	\$0.4
Grand Total	\$4.1	\$4.1	\$4.2	\$3.1	\$3.1

¹§457.1207²§457.1240, §457.1250³§457.1218, §457.1230(b)

The provision of information to potential enrollees by the state and to enrollees by the managed care plans has always been a requirement in §438.10. However, we have proposed changes to this section to better organize and clarify the standards for states and managed care plans. These changes are necessary, and important, since the information provided to potential and current enrollees is critical in aiding them to make informed decisions when selecting a health plan and to sufficiently understand the managed care program to maximize the benefits and rights

available to them. For example, without information presented in an easily understood way, an enrollee may choose a health plan that does not have their existing providers in the network, which may force the enrollee to change their providers. This is particularly challenging for enrollees with disabilities or receiving LTSS, because these individuals often receive services that assist with activities of daily living in their home. Disruption in services from their usual providers can cause numerous problems and may prevent them from living safely and effectively in their chosen setting.

We propose changes to the content and delivery methods for notices, handbooks, and provider directories to facilitate the dissemination of timely and complete information that potential enrollees and enrollees need. Current §438.10 pertaining to information requirements do not reflect current technology advances that enable states and managed care plans to provide access to information more quickly, accurately, and less expensively. As more consumers understand and rely on electronic information, not revising this section and continuing to mandate that all information be provided by mailing paper would be unrealistic, unnecessarily costly, and not in the beneficiaries' or managed care plans' best interest. Many states and managed care plans have been providing required information in both electronic and paper form for several years. The revisions will eliminate this duplication. Since the transition to electronic communication will be gradual and at varying rates, we expect the burden for providing the information required in §438.10 to diminish over time. The proposed provisions in §438.10 have an estimated first-year COI cost of a cumulative \$0.9 million (detailed burden estimates can be found in the COI section of this proposed rule at section IV.D.7 for information standards). As required by section 2103(f)(3) of the Act, added by section 403 of CHIPRA, and consistent with the requirements of section 2101(a) to provide coverage in an effective and efficient manner, we also propose to apply the standards of §438.10 to CHIP in §457.1207. The total estimated first-year COI costs

associated with implementing the information requirements in part 457 is a cumulative \$0.7 million.

11. Quality Measurement and Improvement

There are several items that are driving the new burden associated with the proposed quality revisions. Given that some PAHPs may provide clinical services, such as dental or behavioral health services, we propose to apply the quality standards in part 438 subpart E to PAHPs. This will ensure that they are subject to the same approach to measuring and improving quality as are MCOs and PIHPs, which will allow for better oversight and accountability. Revisions proposed for the quality assessment and performance improvement (QAPI) program at §438.330 reflect the expansion of managed care to LTSS. By specifically addressing LTSS within their QAPI program, MCOs, PIHPs, and PAHPs will have tools that can be used to provide accountability for the care provided to this vulnerable population. The proposed new EQR-related activity (that is, validation of network adequacy) and state review and approval of MCOs, PIHPs, and PAHPs will also support state oversight of managed care plans, and help to ensure that consumers have access to high-quality plans. Similarly, state-based quality rating systems for MCOs, PIHPs, and PAHPs will assist consumers in identifying the plan that best meets their needs. The total estimated first-year COI costs associated with the modifications to the managed care quality components of the regulations is a cumulative \$27.2 million (detailed burden estimates can be found in the COI section of this proposed rule at section IV.D.21 through IV.D.30 for quality framework).

States contracting with MCOs or PIHPs currently maintain a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Regardless of delivery system, it is important to have a strategy for measuring performance to understand what is working and what needs to be improved. Because of this, we propose adding a new

subpart I to part 431 which would extend the comprehensive quality strategy to all state Medicaid programs. States that contract with MCOs, PIHPs, or PAHPs would have to address managed care-specific elements described in §438.340 within the comprehensive quality strategy. The proposed provisions in part 431 subpart I have an estimated first-year COI cost of a cumulative \$0.1 million, with the creation and periodic evaluation and revision of the comprehensive quality strategy accounting for the complete cost. As required by section 2101(f)(3) of the Act, added by section 403 of CHIPRA, and consistent with the requirements of section 2101(a) to provide coverage in an effective and efficient manner, we also propose to apply the quality standards of 438 subpart E and 431 subpart I to CHIP in §457.760, §457.1240, and §457.1250. The total estimated first-year COI costs associated with implementing the quality standards in part 457 is a cumulative \$3.3 million.

The proposed regulation makes a number of changes related to Medicaid quality of care, primarily for Medicaid managed care programs, including requirements for comprehensive quality strategies, quality assessment and performance improvement, quality rating systems, state review and approval of performance of managed care plans by states, and external quality reviews. While these changes may lead to improvements in the quality of care delivered by states and Medicaid managed care plans, it is difficult to determine whether or not these changes would have any financial impacts on Medicaid expenditures. We would expect some activities would be unlikely to have a financial impact (such as state review and approval requirements), while other activities may lead to some small increases or decreases in expenditures. For example, some activities may require managed care plans to increase expenditures to improve the quality of care and meet certain quality standards associated with some of the proposed changes in the regulation, while other activities may improve the quality of care and lead to a net decrease in benefit expenditures. We believe that it is not possible to estimate the potential financial impacts of these proposed

changes and believe that any impacts on net Medicaid expenditures would be negligible. We invite comment on possible ways to quantify the costs and/or benefits associated with these proposed provisions.

12. Network Adequacy

We propose a new §438.68, to establish minimum standards in the area of network adequacy. This proposed section aims to maintain state flexibility while modernizing the current regulatory framework to reflect the maturity and prevalence of Medicaid managed care delivery systems, promote processes for ensuring access to care, and align, where feasible, with other private and public health care coverage programs. Therefore, we propose to set standards to ensure ongoing state assessment and certification of MCO, PIHP, and PAHP networks, set threshold standards for the establishment of network adequacy measures for a specified set of providers, establish criteria for developing network adequacy standards for MLTSS programs, and ensure the transparency of network adequacy standards. As many states currently have some network standards in place, we estimate only a small administrative burden to states to implement these provisions. In general, we would expect strengthening network adequacy standards could increase expenditures, as some plans would likely need to add more providers to in their networks and, in doing so, may need to increase provider reimbursement rates. In addition, adding more providers to plan networks could potentially lead to more use of health care services among the providers added, whether primary care physicians, specialists, or other providers. However, the proposed changes in the regulation are limited and only set requirements about setting and reporting network adequacy standards. The proposed regulation does not establish network adequacy standards. Thus, while a state may need to adapt its network adequacy standards to include criteria specified in the proposed regulation or to provide additional reports and information about those standards, we do not assume that these changes would likely lead to

significant changes to the standards currently in place in states. Therefore, we believe that these proposed changes are likely to have no financial impact on future Medicaid expenditures. To the extent that these proposed changes do lead to some states changing their current network adequacy standards, it is possible that future expenditures would increase if plans increase provider reimbursement rates to attract new providers to their networks or if greater access to care leads to more utilization of health care services. We invite comment on possible ways to quantify the costs and/or benefits associated with these proposed provisions.

13. Implementing Statutory Provisions.

This guiding principle seeks to implement the statutory provisions impacting Medicaid and CHIP managed care that have passed since the Balanced Budget Act of 1997 (BBA). This principle covers the regulatory topics of incorporating provisions for encounter data and health information systems requirements established in the Affordable Care Act and requirements for contracts involving Indians established in the American Recovery and Reinvestment Act (ARRA). The total estimated first-year COI costs associated to the provisions under this principle account for a cumulative \$0.1 million (provisions in §§438.14, 438.242, and 438.818) (detailed COI burden estimates can be found in the COI section of this proposed rule at sections IV.D.8 and IV.D.20 for encounter data and health information systems and IV.D.8 for contracts involving Indians). No additional quantifiable benefits or costs were identified for these provisions.

14. Other Provisions.

Changes proposed in Subpart F of part 438 that include references to part 431 require minor changes to §431.220 and §431.244. Without these changes, the sections would be inconsistent with the changes proposed in part 438. There is no burden associated with this change as it is a technical correction and any related burden is included in §438.408(f).

In §433.138, technical corrections are being proposed to remove a soon-to-be obsolete

reference to “ICD-9” and replace it with text that does not alter the meaning nor need to be updated as newer versions of the International Classification of Diseases are published in the future. There is no burden associated with this change as states are not mandated to make any changes to their policies or procedures as a result of this revised text.

C. Anticipated Effects

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that some PAHPs, PCCMs, and PCCM entities are likely to be small entities as that term is used in the RFA. For purposes of the RFA, we estimate that most MCOs and PIHPs are not small entities as that term is used in the RFA. For purposes of the RFA and according to the Small Business Administration (SBA) and the Table of Small Business Size Standards, small entities include small businesses in the health care sector that are direct health and medical insurance carriers with average annual receipts of less than \$38.5 million and offices of physicians or health practitioners with average annual receipts of less than \$11 million. For purposes of the RFA, individuals and state governments are not included in the definition of a small entity.

As of 2012, there are 331 MCOs, 176 PIHPs, 41 PAHPs, 20 NEMT PAHPs, 25 PCCMs, and 9 PCCM entities participating in the Medicaid managed care program. We estimate that there are an additional 66 entities that serve only CHIPs, including approximately 59 MCOs and PIHPs, 3 PAHPs, and 4 PCCMs. We believe that only a few of these entities qualify as small entities. Specifically, we believe that 10 to 20 PAHPs, 8 to 15 PCCMs, and 2 to 5 PCCM entities are likely to be small entities. We believe that the remaining MCOs and PIHPs have average annual receipts from Medicaid and CHIP contracts and other business interests in excess of \$38.5 million. In analyzing the scope of the impact of these regulations on small entities, we examined the United States Census Bureau’s Statistics of U.S. Businesses for 2010. According to the 2010 data, there

are 4,414 direct health and medical insurance carriers with less than 20 employees and 158,607 offices of physicians or health practitioners with less than 20 employees. For purposes of the RFA, we believe that we are impacting less than 1 percent of the small entities that we have identified.

The primary impact on small entities will be through the standards proposed to be placed on PAHPs, PCCMs, and PCCM entities through the following requirements: (1) adding PCCMs and PCCM entities, where appropriate, to the information standards in §438.10 and §457.1207 regarding enrollee handbooks, provider directories, and formularies; (2) adding PAHPs, PCCMs, and PCCM entities in §438.62 to implement their own transition of care policies and PAHPs in §438.208 to perform initial assessments and care coordination activities and applying these standards to CHIP in §§457.1216 and 457.1230(c); (3) adding PAHPs in §438.242 to collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system or other such methods and applying these standards to CHIP in §457.1230(d); (4) adding PCCM entities to the quality assessment and performance improvement program standards in §438.330 and applying these standards to CHIP in §457.1240; (5) adding PAHPs in §438.350 to the list of affected entities regarding the EQR process and applying these standards to CHIP in §457.1250; and (6) adding PAHPs to the types of entities subject to the standards of subpart F to establish a grievances and appeals system and process and applying these standards to CHIP in §457.1260. We do not believe that the remaining impacts or burdens of the provisions of this proposed rule are great on the small entities that we have identified.

For purposes of the RFA, all cost estimates were derived from the Collection of Information calculations in section IV of this proposed rule. The estimated costs associated with the impacts on small entities listed above are primarily attributable to the transition of care policies for PAHPs, PCCMs, and PCCM entities, initial assessments and care coordination activities for

PAHPs, and the establishment of a grievances and appeals system and process for PAHPs. The transition of care policies, initial assessments, and care coordination activities for PAHPs account for approximately \$2.4 million of the cumulative \$4.5 million annual impact on the 41 PAHPs (detailed burden estimates can be found in the COI section of this proposed rule at sections IV.D.10 and IV.D.17 for coordination/continuity of care). The establishment of a grievances and appeals system and process accounts for approximately \$1.1 million of the cumulative \$4.5 million annual impact on the 41 PAHPs (detailed burden estimates can be found in the COI section of this proposed rule at sections IV.D.31 through IV.D.35 for grievances and appeals). The total estimated annual burden per PAHP is less than \$0.1 million, or less than 1 percent of the \$38.5 million threshold. The transition of care policies for PCCMs and PCCM entities account for approximately \$0.4 million of the cumulative \$0.6 million annual impact on the 34 PCCMs and PCCM entities (detailed burden estimates can be found in the COI section of this proposed rule at sections IV.D.10 and IV.D.17 for coordination/continuity of care). The total estimated annual burden per PCCM or PCCM entity is less than \$0.1 million, or less than 1 percent of the \$11 million threshold.

These small entities must meet certain standards as identified in the provisions of this proposed rule; however, we believe these are consistent with the nature of their business in contracting with state governments for the provision of services to Medicaid and CHIP managed care enrollees. Therefore, based on the estimates in the COI (section IV of this proposed rule), we have determined, and the Secretary certifies, that this proposed rule will not have a significant economic impact on a substantial number of small entities. We invite comment on our proposed analysis of the impact on small entities and on possible alternatives to provisions of the proposed rule that would reduce burden on small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis

for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds.

We do not anticipate that the provisions in this proposed rule will have a substantial economic impact on most hospitals, including small rural hospitals. Provisions include some proposed new standards for State governments, MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities but no direct requirements on individual hospitals. The impact on individual hospitals will vary according to each hospital's current and future contractual relationships with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities, but any additional burden on small rural hospitals should be negligible. We invite comment on our proposed analysis of the impact on small rural hospitals regarding the provisions of this proposed rule.

We have determined that we are not preparing analysis for either the RFA or section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals in comparison to total revenues of these entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2015, that is approximately \$144 million. This proposed rule does not contain any federal mandate costs resulting from (A) imposing enforceable duties on state, local, or tribal governments, or on the private sector, or (B) increasing the stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs. We have determined that this proposed

rule does not impose any mandates on state, local, or tribal governments, or the private sector that will result in an annual expenditure of \$144 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. We believe this proposed regulation gives states appropriate flexibility regarding managed care standards (for example, setting network adequacy standards, setting credentialing standards, EQR activities), while also aligning Medicaid and CHIP managed care standards with those for plans in the Marketplace and MA to better streamline the beneficiary experience and to reduce administrative and operational burdens on states and health plans across publicly-funded programs and the commercial market. We have determined that this proposed rule would not significantly affect states' rights, roles, and responsibilities.

1. Effects on Other Providers

The providers directly affected by the provisions of this rule are the MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities under contract to a state Medicaid or CHIP agency. As detailed in the sections above, the effect of the proposed rule varies by entity type and amount of burden. Setting actuarially sound rates and MLR are the areas with the largest impact on the managed care plans. We believe that many of the proposed rate setting provisions are unlikely to have a direct effect on the actual capitation rates or future Medicaid expenditures. To the extent that these new standards or requirements do have an effect on capitation rates or Medicaid expenditures, we believe that generally it is likely that this could lead to increases in some cases and decreases in other cases in the capitation payment rates and Medicaid expenditures. The sum of the estimated financial impacts of these changes could increase expenditures as much as \$3.6 billion from 2016 to 2020 and could decrease expenditures as much as \$11.0 billion from 2016 to 2020.

The regulation proposes new requirements that would require the states to calculate and report the medical loss ratios (MLRs) for Medicaid MCOs, PIHPs, and PAHPs in §438.4 and §438.5, and to add new §438.8 and §438.74. These changes, however, do not require that states assess any financial penalties on MCOs, PIHPs, and PAHPs that do not meet a minimum MLR. The net effect of these changes is estimated to range from zero impact to a decrease in MCO, PIHP, and PAHP payments of about 0.2 to 0.3 percent. Between 2018 and 2020, a 0.3-percent decrease in MCO, PIHP, and PAHP expenditures is projected to be a reduction of \$1.6 billion in federal expenditures and of \$0.9 billion in state expenditures.

Many other proposed changes in this rule will have small COI costs for MCOs, PIHPs, and PAHPs; however, they are negligible. All COI costs are described in section IV of this proposed rule.

2. Effects on the Medicare and Medicaid Programs.

This rule has may have some positive effect on Medicare, but that effect is not quantifiable. Sections 438.62 and 438.208 propose enhanced care planning, transition, and coordination activities. Many of these activities will affect dually eligible enrollees. If, as expected, those efforts generate savings from more efficient and appropriate use of services, then Medicare as the primary payer may recognize some benefit.

The provisions of proposed part 431 subpart I will apply to Medicaid programs in all states and territories. The total estimated first-year COI cost for states is a cumulative \$0.1 million, with 50 percent eligible for federal matching funds. This rule will help states to measure and improve the quality of care provided to all beneficiaries in the state, regardless of delivery system.

The provisions of proposed part 438 will apply to all states using a managed care delivery system for the Medicaid program. Federal matching rates are discussed more fully in section V.B, Overall Impact. This rule will help states fulfill the goals and mission of the Medicaid program

through better oversight and accountability of their programs and will enable them to detect deficiencies and implement corrective action more quickly and consistently.

D. Alternatives Considered

One alternative considered was leaving part 438 as it is today. While it has been the guiding regulation for Medicaid managed care since its finalization in 2002, many questions and issues have arisen in the intervening 13 years due to the current version's lack of clarity or detail in some areas. The proposed revisions to the topics of rate setting and enrollment are good examples of this. With no guidance in these areas, states have created various standards, leading to inconsistency and, in some cases, less than optimal program performance. Additionally, many issues have arisen from the evolution of managed care in the last twelve years that have rendered parts of parts 438 nearly obsolete. For example, the existing version gives little acknowledgement to the use of electronic means of communication and no recognition to the recently created health care coverage options offered through the federal and state marketplaces. This creates gaps that leave states and managed care plans with unclear, non-existent, or confusing guidance and standards for program operation. We believe that with consistent standards and clearly defined flexibilities for states, programs can develop in ways that not only transform the healthcare delivery system and fulfill the mission of the Medicaid program, but can improve the health and wellness of Medicaid enrollees. For these reasons, we believe that leaving part 438 as it is now is not a viable option.

Another option was to align completely with standards applicable to plans in Medicare and/or the Marketplace. Given the high rate of cross program participation among the managed care plans in some states, we believe it is important to allow managed care plans to take advantage of operational efficiencies by aligning part 438 with Medicare and the private insurance market wherever possible by creating and implementing uniform policies and procedures. Alignment also

adds consistency and ease of understanding for enrollees as they move between healthcare coverage programs as their life circumstances change. For each regulatory area where a comparable Medicare or Marketplace practice or policy existed, staff evaluated the information against existing Medicaid regulations. When differences were identified, they were evaluated to determine the benefits and drawbacks to adopting and the degree of impact the change would have on the Medicaid population, which is often significantly different from Medicare and the Marketplace populations. Additionally, as Medicaid is a federal-state partnership, we wanted to preserve the flexibility historically provided to states in the design and administration of their programs. As such, complete alignment was only an option in some provisions, while partial alignment was selected in others to recognize and accommodate the unique aspects of the Medicaid program.

Regarding quality measurement and improvement (part 438 subpart E) and comprehensive quality strategies (part 431 subpart I), two alternatives were considered: (1) leaving the language as it exists today, and (2) revising the regulatory text for only states that contract with MCOs, PIHPs, and PAHPs. While our regulatory language has remained unchanged since 2002, there have been significant improvements regarding quality measurement and improvement for Medicaid. Under the authority of CHIPRA and the Affordable Care Act, we have developed and issued a set of performance measures to assess the quality of care received by adults and children in the Medicaid and CHIP programs. The National Quality Strategy and CMS Quality Strategy now offer national guidance regarding how we move forward as a nation to offer better health care, improved affordability, and support healthy people and healthy communities. At a state level, Medicaid managed care programs have undergone shifts both in terms of populations and benefits since 2002. Given these changes, we believe that it is necessary and appropriate to revise our regulatory language to address needs of the Medicaid programs both today and into the future.

While the role of managed care in both Medicaid has grown since 2002, we cannot forget that many individuals still receive care through a FFS delivery model, and that certain services are still provided FFS to individuals otherwise enrolled in managed care programs. We believe that, regardless of delivery system, it is important for states to measure performance to develop a plan to strengthen and improve the quality of care. It is also important that managed care quality regulations support the programs as they exist today and into the future. Therefore, we determined that the most appropriate course of action would be to revise the Medicaid and CHIP managed care quality regulations, and to have states establish a comprehensive quality strategy for all delivery systems within their Medicaid programs.

For CHIP, we considered two alternatives: (1) not regulating; or (2) adopting additional Medicaid requirements. CHIPRA applied several of the Medicaid managed care standards to CHIP. In response, we released two SHOs conveying those requirements to states, but have not provided additional guidance. As a result, states do not have clear understanding of the expectations of the federal requirements for CHIP managed care, and CMS does not have needed information about state oversight of managed care plans. Therefore, we determined that regulations were appropriate. When deciding whether to adopt all of the Medicaid regulations, or only the subset proposed in this regulation, we have worked to balance the need for information about state oversight of CHIP managed care plans against the administrative burden of complying with the proposed regulations. To that end, we propose to only apply the rules that are most important for aligning CHIP managed care with Marketplace and Medicaid managed care rules. The scope of the CHIP proposed regulations is narrower than the proposed revisions and amendments to the Medicaid managed care regulations.

E. Accounting Statement and Table

The estimates that appear in the Transfers section of Table 15 combine both cost savings

and transfers between members of society. To the extent that the proposed rule changes provision of medical care, the impacts represent cost savings. Otherwise, the rule’s impacts represent transfers to the federal and state governments from MCOs, PIHPs and PAHPs.

TABLE 15: Economic Data: Costs and Benefits Statement

Category	Primary Estimate	Low Estimate	High Estimate	Units			Notes
				Year Dollars	Discount Rate	Period Covered	
Benefits							
Non-Quantified	Improved health outcomes; reduced unnecessary services; improved beneficiary experience; improved access; and improved program transparency which facilitates better decision making.						
Costs							
Annualized Monetized \$ millions/year	112.8			2013	7%	2016-2020	
	112.7			2013	3%	2016-2020	
Non-Quantified	Costs of activities (other than information collection as defined in the Paperwork Reduction Act) that would be necessary for generating benefits listed above.						
Transfers							
Federal Annualized Monetized \$ millions/year		-390.4	1623.9	2016	7%	2016-2020	
		-395.8	1655.6	2016	3%	2016-2020	
From/To	From: MCOs, PIHPS & PAHPs			To: Federal Government			
Other Annualized Monetized \$ millions/year		-310.3	985.8	2016	7%	2016-2020	
		-315.8	1005.2	2016	3%	2016-2020	
From/To	From: MCOs, PIHPS & PAHPs			To: State Governments			

List of Subjects42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 438

Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 440

Grant programs-health, Medicaid.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

42 CFR Part 495

Administrative practice and procedure, Electronic health records, Health facilities, Health professions, Health maintenance organizations (HMO), Medicaid, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

2. Section 431.200 is amended by revising paragraph (b) to read as follows:

§431.200 Basis and Scope.

* * * * *

(b) Prescribes procedures for an opportunity for a hearing if the State agency or non-emergency transportation PAHP (as defined in §438.9(a) of this chapter) takes action, as stated in this subpart, to suspend, terminate, or reduce services, or an MCO, PIHP or PAHP takes action under subpart F of part 438 of this chapter; and

* * * * *

3. Section 431.220 is amended by revising paragraphs (a)(5) and (a)(6) to read as follows:

§431.220 When a hearing is required.

(a) * * *

(5) Any MCO, PIHP, or PAHP enrollee who is entitled to a hearing under subpart F of part 438 of this chapter.

(6) Any enrollee in a Non-Emergency Medical Transportation PAHP (as that term is defined in §438.9 of this chapter) who has an action as stated in this subpart.

* * * * *

4. Section 431.244 is amended by—

a. Revising paragraphs (f)(1) and (f)(2) introductory text.

b. Removing paragraph (f)(3).

The revisions read as follows:

§431.244 Hearing decisions.

* * * * *

(f) * * *

(1) Ordinarily, within 90 days from the date the enrollee filed an MCO, PIHP, or PAHP appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing.

(2) As expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, from the MCO, PIHP, or PAHP, the case file and information for any appeal of a denial of a service that, as indicated by the MCO, PIHP, or PAHP—

* * * * *

5. Subpart I is added to part 431 to read as follows:

Sec.

Subpart I—General Provisions

431.500 Basis and scope.

431.502 State comprehensive quality strategy.

431.504 State comprehensive quality strategy development, evaluation, and revision.

431.506 Applicability to Medicaid managed care programs.

Subpart I—General Provisions

§431.500 Basis and scope.

(a) Statutory basis. This part is based on sections 1932(c), 1902(a)(4), 1902(a)(6), 1902(a)(19), and 1902(a)(22) of the Act.

(b) Scope. This part sets forth specifications for a comprehensive quality strategy that all States must implement to ensure the delivery of quality health care to all Medicaid beneficiaries.

§431.502 State comprehensive quality strategy.

(a) General rule. Each State must draft and implement a written, comprehensive quality strategy for assessing and improving the quality of health care and services furnished to all Medicaid beneficiaries.

(b) Elements of the State comprehensive quality strategy. At a minimum, the State's comprehensive quality strategy must include the following:

(1) The State's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of all populations served by the Medicaid program.

(2) Specific quality metrics and performance targets for measuring improvement and performance, including the identification of which quality metrics and performance outcomes the State will publish at least annually on the State's public Medicaid website.

§431.504 State comprehensive quality strategy development, evaluation, and revision.

In drafting and revising the comprehensive quality strategy, the State must:

(a) Obtain the input of the Medical Care Advisory Committee, required by §431.12, beneficiaries, and other stakeholders (including Tribal consultation, as appropriate) in the development of the comprehensive quality strategy (and any revisions) and make the strategy available for public comment before submitting the strategy to CMS for review.

(b) Review and update the comprehensive quality strategy as needed, but no less than once every 3 years.

(1) This review must include an evaluation of the effectiveness of the comprehensive quality strategy conducted within the previous 3 years.

(2) The State must make the results and findings of the effectiveness evaluation of the comprehensive quality strategy available on the State's public Medicaid website.

(c) Submit to CMS the following:

(1) A copy of the initial strategy for CMS comment and feedback before adopting it in final.

(2) A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's Medicaid program. The State must include its definition of "significant changes" within each revised comprehensive quality strategy.

(d) The State must make the final comprehensive quality strategy available on the State's public Medicaid website.

§431.506 Applicability to Medicaid managed care programs.

Each State contracting with an MCO, PIHP, or PAHP as defined in §438.2 of this chapter or with a PCCM entity as described in §438.3(r) of this chapter must also address, within the comprehensive quality strategy, the requirements described in §438.340 of this chapter.

PART 433—STATE FISCAL ADMINISTRATION

6. The authority citation for part 433 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

7. Section 433.138 is amended by revising paragraph (e) to read as follows:

§433.138 Identifying liable third parties.

* * * * *

(e) Diagnosis and trauma code edits. Except as specified under paragraph (l) of this section, the agency must take action to identify those paid claims for Medicaid beneficiaries that contain diagnosis codes that are indicative of trauma, or injury, poisoning, and other consequences of external causes, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f).

* * * * *

8. Part 438 is revised to read as follows:

PART 438—MANAGED CARE

Sec.

Subpart A--General Provisions

438.1 Basis and scope.

438.2 Definitions.

438.3 Standard contract requirements.

438.4 Actuarial soundness.

438.5 Rate development standards.

438.6 Special contract provisions related to payment.

438.7 Rate certification submission.

438.8 Medical loss ratio (MLR) standards.

438.9 Provisions that apply to non-emergency medical transportation PAHPs.

438.10 Information requirements.

438.12 Provider discrimination prohibited.

438.14 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs).

Subpart B—State Responsibilities

438.50 State Plan requirements.

438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities.

438.54 Managed care enrollment.

438.56 Disenrollment: Requirements and limitations.

438.58 Conflict of interest safeguards.

438.60 Prohibition of additional payments for services covered under MCO, PIHP or PAHP contracts.

438.62 Continued services to enrollees.

438.66 State monitoring requirements.

438.68 Network adequacy standards.

438.70 Stakeholder engagement when LTSS is delivered through a managed care program.

438.71 Beneficiary support system.

438.74 State oversight of the minimum MLR requirement.

Subpart C—Enrollee Rights and Protections

438.100 Enrollee rights.

438.102 Provider-enrollee communications.

438.104 Marketing activities.

438.106 Liability for payment.

438.108 Cost sharing.

438.110 Member advisory committee.

438.114 Emergency and poststabilization services.

438.116 Solvency standards.

Subpart D—MCO, PIHP and PAHP standards

438.206 Availability of services.

438.207 Assurance of adequate capacity and services.

438.208 Coordination and continuity of care.

438.210 Coverage and authorization of services.

438.214 Provider selection.

438.224 Confidentiality.

438.228 Grievance systems.

438.230 Subcontractual relationships and delegation.

438.236 Practice guidelines.

438.242 Health information systems.

Subpart E—Quality Measurement and Improvement; External Quality Review

438.310 Basis, scope, and applicability.

438.320 Definitions.

438.330 Quality assessment and performance improvement program.

438.332 State review and approval of MCOs, PIHPs and PAHPs.

438.334 Medicaid managed care quality rating system.

438.340 Managed care elements of the State comprehensive quality strategy.

438.350 External quality review.

438.352 External quality review protocols.

438.354 Qualifications of external quality review organizations.

438.356 State contract options for external quality review.

438.358 Activities related to external quality review.

438.360 Nonduplication of mandatory activities.

438.362 Exemption from external quality review.

438.364 External quality review results.

438.370 Federal financial participation (FFP).

Subpart F—Grievance System

438.400 Statutory basis and definitions.

438.402 General requirements.

438.404 Timely and adequate notice of adverse benefit determination.

438.406 Handling of grievances and appeals.

438.408 Resolution and notification: Grievances and appeals.

438.410 Expedited resolution of appeals.

438.414 Information about the grievance system to providers and subcontractors.

438.416 Recordkeeping requirements.

438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending.

438.424 Effectuation of reversed appeal resolutions.

Subpart G—[Reserved]

Subpart H—Additional Program Integrity Safeguards

438.600 Statutory basis.

438.602 State responsibilities.

438.604 Data, information, and documentation that must be submitted.

438.606 Source, content, and timing of certification.

438.608 Program integrity requirements under the contract.

438.610 Prohibited affiliations.

Subpart I—Sanctions

438.700 Basis for imposition of sanctions.

438.702 Types of intermediate sanctions.

438.704 Amounts of civil money penalties.

438.706 Special rules for temporary management.

438.708 Termination of an MCO, PCCM, or PCCM entity contract.

438.710 Notice of sanction and pre-termination hearing.

438.722 Disenrollment during termination hearing process.

438.724 Notice to CMS.

438.726 State plan requirement.

438.730 Sanction by CMS: Special rules for MCOs.

Subpart J—Conditions for Federal Financial Participation (FFP)

438.802 Basic requirements.

438.806 Prior approval.

438.807 Deferral and/or disallowance of FFP for non-compliance with Federal requirements.

438.808 Exclusion of entities.

438.810 Expenditures for enrollment broker services.

438.812 Costs under risk and nonrisk contracts.

438.816 Expenditures for independent consumer support services for enrollees using LTSS.

438.818 Enrollee encounter data.

Subpart K—[Reserved]

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—General Provisions

§438.1 Basis and scope.

(a) Statutory basis. This part is based on the following statutory sections:

(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(i)(25) prohibits payment to a State unless a State provides enrollee encounter data required by CMS.

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

(4) 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.

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

(6) 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.

(vii) Specifies rules for Indian enrollees, Indian health care providers, and Indian managed care entities.

(viii) 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, PCCMs and PCCM entities. 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—

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Capitation payment means a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Choice counseling means the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care health plans and primary care providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP.

Comprehensive risk contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

- (1) Outpatient hospital services.
- (2) Rural health clinic services.
- (3) Federally Qualified Health Center (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.

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

Enrollee encounter data means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a MCO, PIHP, or PAHP that is subject to the requirements of §§438.242 and 438.818.

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 a provider, if coverage for the physician's or provider's services is under the managed care contract.

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(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act of 2008).

Long-term services and supports (LTSS) means services and supports provided to

beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

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 by the Secretary to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

(ii) Meets the solvency standards of §438.116.

Managed care program means a managed care delivery system operated by a State as authorized under section 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

Material adjustment means an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

Network provider means any health care professional, group of health care professionals, or entity that receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP.

Nonrisk contract means a contract between the State and a PIHP or PAHP under which the

contractor—

(1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in §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.

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

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

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

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

(3) Does not have a comprehensive risk contract.

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

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

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

(3) Does not have a comprehensive risk contract.

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, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in

which the practitioner furnishes them.

Primary care case management means a system under which:

(1) A PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or

(2) A PCCM entity contracts with the State to provide a defined set of functions.

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

(2) Development of enrollee care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.

(4) Provision of payments to FFS providers on behalf of the State.

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports systems/providers.

Primary care case manager (PCCM) means a physician, a physician group practice or, at State option, any of the following:

- (1) A physician assistant.
- (2) A nurse practitioner.
- (3) A certified nurse-midwife.

Rate cells means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, and region or geographic area. Each enrollee should be categorized in one of the rate cells and no enrollee should be categorized in more than one rate cell.

Risk contract means a contract between the State and an MCO, PIHP or PAHP under which the contractor—

- (1) Assumes risk for the cost of the services covered under the contract; and
- (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

State means the Single State agency as specified in §431.10 of this chapter.

§438.3 Standard contract requirements.

(a) CMS review. The CMS 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. Proposed final contracts must be submitted in the form and manner established by CMS. For States seeking approval of contracts prior to a specific effective date, proposed final contracts must be submitted to CMS for review no later than 90 days prior to the effective date of the contract.

(b) Entities eligible for comprehensive risk contracts. A State 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 amended by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990).

(c) Payment. The final capitation rate for each MCO, PIHP or PAHP must be specifically identified in the applicable contract submitted for CMS review and approval. The final capitation rates must be based only upon services covered under the State plan and additional services deemed by the State to be necessary to comply with the Mental Health Parity and Addiction Equity Act, and represent a payment amount that is adequate to allow the MCO, PIHP or PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

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

(1) The MCO, PIHP, PAHP, PCCM or PCCM entity accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), 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, PCCM or PCCM entity 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, PCCM or PCCM entity will not discriminate against

individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

(e) Services that may be covered by an MCO, PIHP, or PAHP. An MCO, PIHP, or PAHP may cover, for enrollees, services that are in addition to those covered under the State plan as follows:

(1) Any services that the MCO, PIHP or PAHP voluntarily agree to provide, although the cost of these services cannot be included when determining the payment rates under paragraph (c) of this section.

(2) [Reserved]

(f) Compliance with applicable laws and conflict of interest safeguards. All contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities must:

(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; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

(2) Comply with the conflict of interest safeguards described in §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

(g) Provider-preventable condition requirements. All contracts with MCOs, PIHPs and PAHPs must comply 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 chapter. MCOs, PIHPs, and PAHPs, must report all identified provider-preventable conditions in a form and frequency as specified by the State.

(h) Inspection and audit of records and access to facilities. All contracts must provide that the State, CMS, and the Office of the Inspector General may, at any time, inspect and audit any records or documents of the MCO, PIHP, PAHP, PCCM or PCCM entity or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

(i) 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 “MA organization,” “CMS,” and “Medicare beneficiaries” must be read as references to “MCO, PIHP, or PAHP,” “State,” and “Medicaid beneficiaries,” respectively.

(j) 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.

(k) Subcontracts. All subcontracts must fulfill the requirements of this part for the service or activity delegated under the subcontract in accordance with §438.230.

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

(m) Audited financial reports. The contract must require MCOs, PIHPs, and PAHPs to submit audited financial reports on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

(n) [Reserved]

(o) LTSS contract requirements. Any contract with an MCO, PIHP or PAHP that includes LTSS as a covered benefit must require that any services covered under the contract that could be authorized through a waiver under section 1915(c) of the Act or a State plan amendment authorized through sections 1915(i) or 1915(k) of the Act be delivered in settings consistent with §441.301(c)(4) of this chapter.

(p) 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.

(q) 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 PCCM'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 in accordance with §438.56(c).

(r) Additional rules for contracts with PCCM entities. In addition to the requirements in paragraph (q) of this section, States must submit PCCM entity contracts to CMS for review and approval to ensure compliance with the provisions of this paragraph; §438.10; and if the State's contract with the PCCM entity provides for shared savings, incentive payments or other financial reward for improved quality outcomes, §438.330(b)(3), (c) and (e) and §438.340, and §438.350.

(s) Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs. MCOs, PIHPs or PAHPs that are contractually obligated to provide coverage of covered outpatient drugs must include the following requirements:

(1) The MCO, PIHP or PAHP provides coverage of covered outpatient drugs as defined in section 1927(k)(2) of the Act, that meets the standards for such coverage imposed by section 1927 of the Act as if such standards applied directly to the MCO, PIHP, or PAHP.

(2) The MCO, PIHP, or PAHP reports drug utilization data that is necessary for States to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the MCO, PIHP, or PAHP.

(3) The MCO, PIHP or PAHP establishes procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from the reports required under paragraph (s)(2) of this section.

(4) The MCO, PIHP or PAHP must operate a drug utilization review program that complies with the requirements described in section 1927(g) of the Act, as if such requirement applied to the MCO, PIHP, or PAHP instead of the State.

(5) The MCO, PIHP or PAHP must provide a detailed description of its drug utilization review program activities to the State on an annual basis.

(6) The MCO, PIHP or PAHP must conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the Act, as if such requirements applied to the MCO, PIHP, or PAHP instead of the State.

(t) Requirements for MCOs, PIHPs or PAHPs responsible for coordinating benefits for dually eligible individuals. In a State that enters into a Coordination of Benefits Agreement with Medicare for FFS, an MCO, PIHP or PAHP contract that includes responsibility for coordination of benefits for individuals dually eligible for Medicaid and Medicare must require the MCO, PIHP or PAHP to enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

(u) Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease. The State may make a monthly capitation payment to an MCO or PIHP for an enrollee receiving inpatient treatment in an Institution for Mental Diseases, as defined in §435.1010 of this chapter, so long as the facility is an inpatient hospital facility or a sub-acute facility providing crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment.

(v) Recordkeeping requirements. MCOs, PIHPs, and PAHPs must retain, and require

subcontractors to retain, as applicable, the following information: enrollee grievance and appeal records in §438.416, base data in §438.5(c), MLR reports in §438.8(k), and the data, information, and documentation specified in §438.604, §438.606, §438.608, and §438.610 for a period of no less than 6 years.

§438.4 Actuarial soundness.

(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.

(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must do all of the following:

(1) Have been developed in accordance with standards specified in §438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must not be based on the Federal financial participation percentage associated with the covered populations.

(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.

(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§438.206, 438.207, and 438.208.

(4) Be specific to payments for each rate cell under the contract. Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.

(5) Be certified by an actuary as meeting the applicable requirements of this part, including

§438.3(c) and (e).

(6) Meet any applicable special contract provisions as specified in §438.6.

(7) Be provided to CMS in a format and within a timeframe that meets requirements in §438.7.

(8) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under §438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under §438.8, as long as the capitation rates are adequate for necessary and reasonable administrative costs.

§438.5 Rate development standards.

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

Budget neutral means a standard for any risk sharing mechanism that recognizes both higher and lower expected costs among contracted MCOs, PIHPs, or PAHPs and does not create a net aggregate gain or loss across all payments.

Prospective risk adjustment means a methodology to account for anticipated variation in risk levels among contracted MCOs, PIHPs, or PAHPs that is derived from historical experience of the contracted MCOs, PIHPs, or PAHPs and applied to rates for the rating period for which the certification is submitted.

Retrospective risk adjustment means a methodology to account for variation in risk levels among contracted MCOs, PIHPs, or PAHPs that is derived from experience concurrent with the rating period of the contracted MCOs, PIHPs, or PAHPs subject to the adjustment and calculated at the expiration of the rating period.

Risk adjustment is a methodology to account for the health status of enrollees when predicting or explaining costs of services covered under the contract for defined populations or for

evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the State.

(b) Process and requirements for setting actuarially sound capitation rates. In setting actuarially sound capitation rates, the State must follow the steps below in accordance with this section, or explain why they are not applicable:

(1) Consistent with paragraph (c) of this section, identify and develop the base utilization and price data.

(2) Consistent with paragraph (d) of this section, develop and apply trend factors, including cost and utilization, to base data that are developed from actual experience of the Medicaid population or a similar population in accordance with generally accepted actuarial practices and principles.

(3) Consistent with paragraph (e) of this section, develop the non-benefit component of the rate to account for reasonable expenses related to MCO, PIHP, or PAHP administration; taxes; licensing and regulatory fees; contribution to reserves; profit margin; cost of capital; or other operational costs associated with the MCO's, PIHP's, or PAHP's provision of State plan services to Medicaid enrollees.

(4) Consistent with paragraph (f) of this section, make appropriate and reasonable adjustments to account for changes to the base data, programmatic changes, non-benefit components, and any other adjustment necessary to establish actuarially sound rates.

(5) Take into account the MCO's, PIHP's, or PAHP's past medical loss ratio, as calculated and reported under §438.8, in the development of the capitation rates, and consider the projected medical loss ratio in accordance with §438.4(b)(7).

(6) Consistent with paragraph (g) of this section, select a risk adjustment methodology that uses generally accepted models and apply it in a budget neutral manner across all MCOs, PIHPs, or PAHPs in the program to calculate adjustments to the payments as necessary.

(c) Base data. (1) States must provide all the validated encounter data, FFS data (as appropriate), and audited financial reports (as defined in §438.3(m)) that demonstrate experience for the populations to be served by the MCO, PIHP, or PAHP to the actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.

(2) States and their actuaries must use the most appropriate data, with the basis of the data being no older than from the three most recent and complete years prior to the rating period, for setting capitation rates. Such base data must be derived from the Medicaid population, or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population. Data must be in accordance with actuarial standards for data quality and an explanation of why that specific data is used must be provided in the rate certification.

(3) Exception. (i) States that are unable to base their rates on data meeting the qualifications in paragraph (c)(2) of this section that the basis of the data be no older than from the three most recent and complete years prior to the rating period may request approval for an exception; the request must describe why an exception is necessary and describe the actions the state intends to take to come into compliance with those requirements.

(ii) States that request an exception from the base data standards established in this section must set forth a corrective action plan to come into compliance with the base data standards no later than 2 years from the rating period for which the deficiency was identified.

(d) Trend. Each trend must be reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend must be developed from actual experience of the Medicaid population or from a similar population.

(e) Non-benefit component of the rate. The development of the non-benefit component of the rate must include appropriate and reasonable expenses related to MCO, PIHP, or PAHP

administration, taxes, licensing and regulatory fees, contribution to reserves, profit margin, cost of capital, or other operational costs, consistent with §438.3(c).

(f) Adjustments. Each adjustment must reasonably support the development of an accurate base data set for purposes of rate-setting, address appropriate programmatic changes, the health status of the enrolled population, or reflect non-benefit costs, and be developed in accordance with generally accepted actuarial principles and practices.

(g) Risk adjustment. Prospective or retrospective risk adjustment methodologies must be developed in a budget neutral manner consistent with generally accepted actuarial principles and practices.

§438.6 Special contract provisions related to payment.

(a) Definitions. As used in this part, the following terms have the indicated meanings:

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.

Risk corridor means a risk sharing mechanism in which States and contractors may share in profits or losses under the contract outside of a predetermined threshold amount.

Withhold arrangement means any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract.

(b) Basic requirements. (1) If used in the payment arrangement between the State and the MCO, PIHP, or PAHP, all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be described in the contract.

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

(i) For a fixed period of time.

(ii) Not to be renewed automatically.

(iii) Made available to both public and private contractors under the same terms of performance.

(iv) Not conditioned on intergovernmental transfer agreements.

(v) Necessary for the specified activities, targets, performance measures, and quality-based outcomes that support program initiatives.

(3) Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's, PIHP's or PAHP's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required under §438.7(b)(6). For all withhold arrangements, the contract must provide that the arrangement is—

(i) For a fixed period of time.

(ii) Not to be renewed automatically.

(iii) Made available to both public and private contractors under the same terms of performance.

(iv) Not conditioned on intergovernmental transfer agreements.

(v) Necessary for the specified activities, targets, performance measures, and quality-based outcomes that support program initiatives.

(4) 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.

(c) Delivery system and provider payment initiatives under MCO, PIHP, or PAHP contracts—(1) General rule. Except as specified in paragraphs (c)(1)(i) through (iii) of this section, the State may not direct the MCO's, PIHP's or PAHP's expenditures under the contract.

(i) The State may require the MCO, PIHP or PAHP to implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services.

(ii) The State may require MCOs, PIHPs, or PAHPs to participate in a multi-payer delivery system reform or performance improvement initiative.

(iii) The State may require the MCO, PIHP or PAHP to:

(A) Adopt a minimum fee schedule for all providers that provide a particular service under the contract; or

(B) Provide a uniform dollar or percentage increase for all providers that provide a particular service under the contract.

(2) Process for approval. (i) All contract arrangements that direct the MCO's, PIHP's or PAHP's expenditures must have written approval prior to implementation. To obtain written approval, a state must demonstrate, in writing, that the arrangement —

(A) Is based on the utilization and delivery of services;

(B) Directs expenditures equally, and using the same terms of performance, for all public and private providers providing the service under the contract;

(C) Expects to advance at least one of the goals and objectives in the comprehensive quality strategy in §438.340;

(D) Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the comprehensive quality strategy in §438.340;

(E) Does not condition provider participation on intergovernmental transfer agreements; and

(F) Not to be renewed automatically.

(ii) Any contract arrangements that direct the MCO's, PIHP's or PAHP's expenditures under paragraphs (c)(1)(i) or (c)(1)(ii) must also demonstrate, in writing, that the arrangement —

(A) Must make participation in the value-based purchasing initiative, delivery system reform or performance improvement initiative available, using the same terms of performance, to all public and private providers providing services under the contract related to the reform or improvement initiative;

(B) Must use a common set of performance measures across all of the payers and providers;

(C) May not set the amount or frequency of the expenditures; and

(D) Does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

§438.7 Rate certification submission.

(a) CMS review and approval of the rate certification. States must submit to CMS for review and approval, all MCO, PIHP, and PAHP rate certifications concurrent with the review and approval process for contracts as specified in §438.3(a).

(b) Documentation. The rate certification must contain the following information:

(1) Base data. A description of the base data used in the rate setting process (including the base data requested by the actuary, the base data that was provided by the State, and an explanation of why any base data requested was not provided by the State) and of how the actuary determined which base data set was appropriate to use for the rating period.

(2) Trend. Each trend factor, including trend factors for changes in the utilization and price of services, applied to develop the capitation rates must be adequately described with enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can understand and evaluate the following:

(i) The calculation of each trend used for the rating period and the reasonableness of the trend for the enrolled population.

(ii) Any meaningful difference in how a trend differs between the rate cells, service categories, or eligibility categories.

(3) Non-benefit component of the rate. The development of the non-benefit component of the rate must be adequately described with enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense.

(4) Adjustments. All adjustments used to develop the capitation rates must be adequately described with enough detail so that CMS, or an actuary applying generally accepted actuarial principles and practices, can understand and evaluate all of the following:

(i) How each material adjustment was developed and the reasonableness of the material adjustment for the enrolled population.

(ii) The cost impact of each material adjustment and the aggregate cost impact of non-

material adjustments.

(iii) Where in the rate setting process the adjustment was applied.

(iv) A list of all non-material adjustments used in the rate development process.

(5) Risk adjustment. (i) All prospective risk adjustment methodologies must be adequately described with sufficient detail so that CMS or an actuary applying generally accepted actuarial principles and practices can understand and evaluate the following:

(A) The data, and any adjustments to that data, to be used to calculate the adjustment.

(B) The model, and any adjustments to that model, to be used to calculate the adjustment.

(C) The method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations.

(D) The magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP.

(E) An assessment of the predictive value of the methodology compared to prior rating periods.

(F) Any concerns the actuary has with the risk adjustment process.

(ii) All retrospective risk adjustment methodologies must be adequately described with sufficient detail so that CMS or an actuary applying generally accepted actuarial principles and practices can understand and evaluate the following:

(A) The party calculating the risk adjustment.

(B) The data, and any adjustments to that data, to be used to calculate the adjustment.

(C) The model, and any adjustments to that model, to be used to calculate the adjustment.

(D) The timing and frequency of the application of the risk adjustment.

(E) Any concerns the actuary has with the risk adjustment process.

(6) Special contract provisions. A description of any of the special contract provisions related to payment in §438.6 that are applied in the contract.

(c) Rates paid under risk contracts. The State, through its actuary, must certify the final rate paid under each risk contract and document the underlying data, assumptions and methodologies supporting that specific rate.

(1) The State may pay each MCO, PIHP or PAHP a capitation rate under the contract that is different than the capitation rate paid to another MCO, PIHP or PAHP, so long as the rate that is paid is independently developed and set in accordance with this part.

(2) If the State determines that a retroactive adjustment to the capitation rate is necessary, the retroactive adjustment must be supported by a rationale for the adjustment and the data, assumptions and methodologies used to develop the magnitude of the adjustment must be described in sufficient detail to allow CMS or an actuary to determine the reasonableness of the adjustment. These retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment to be approved by CMS. All such adjustments are also subject to Federal timely filing requirements.

(d) Provision of additional information. The State must, upon CMS' request, provide additional information, whether part of the rate certification or additional supplemental materials, if CMS determines that information is pertinent to the approval of the certification under this part. The State must identify whether the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.

§438.8 Medical loss ratio (MLR) standards.

(a) Basic rule. The State must ensure, through its contracts starting on or after January 1, 2017, that each MCO, PIHP, and PAHP calculate and report a MLR in accordance with this section. For multi-year contracts that do not start in 2017, the State must require the MCO, PIHP, or PAHP to calculate and report a MLR for the rating period that begins in 2017.

(b) Definitions. As used in this section, the following terms have the indicated meanings:

Credibility adjustment means an adjustment to the medical loss ratio for a partially credible MCO, PIHP, or PAHP to account for a difference between the actual and target medical loss ratios that may be due to random statistical variation.

Full credibility means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a medical loss ratio with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. An MCO, PIHP, or PAHP that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its medical loss ratio.

Member months mean the number of months an enrollee or a group of enrollees is covered by an MCO, PIHP, or PAHP over a specified time period, such as a year.

MLR reporting year means a period of 12 months selected by the State, for which a MCO's, PIHP's, or PAHP's MLR experience is reported. This could be the contract year, calendar year, State fiscal year or Federal fiscal year, but must be consistent with the rating period used to develop the capitation rates paid to the MCO, PIHP, or PAHP.

No credibility means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be insufficient for the calculation of a medical loss ratio. An MCO, PIHP, or PAHP that is assigned no credibility (or is non-credible) will not be measured against any medical loss ratio requirements.

Non-claims cost means those expenses for administrative services that are not: incurred claims (as defined in paragraph (e)(1) of this section); expenditures on quality improving activities (as defined in paragraph (e)(2) of this section); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of this section).

Partial credibility means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a medical loss ratio but with a non-negligible

chance that the difference between the actual and target medical loss ratios is statistically significant. An MCO, PIHP, or PAHP that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its medical loss ratio.

(c) MLR requirement. If a State elects to mandate a minimum MLR for its MCOs, PIHPs, or PAHPs, that minimum MLR must be equal to or higher than 85 percent (the standard used for projecting actuarial soundness under §438.4(b)) and the MLR must be calculated and reported for each MLR reporting year by the MCO, PIHP, or PAHP consistent with this section.

(d) Calculation of the MLR. (1) The MLR experienced for each MCO, PIHP, or PAHP in a MLR reporting year is the ratio of the numerator (as defined in paragraph (e) of this section) to the denominator (as defined in paragraph (f) of this section). A MLR may be increased by a credibility adjustment, in accordance with paragraph (h) of this section.

(2) [Reserved]

(e) Numerator. (1) The numerator of an MCO's, PIHP's, or PAHP's MLR for a MLR reporting year is the sum of the MCO's, PIHP's, or PAHP's incurred claims (as defined in (e)(2) of this section); the MCO's, PIHP's, or PAHP's expenditures for activities that improve health care quality (as defined in paragraph (e)(3) of this section); and activities compliant with §438.608(a)(1) through (5), (7), (8) and (b) (subject to paragraph (e)(4) of this section).

(2) Incurred claims. (i) Incurred claims must include the following:

(A) Direct claims that the MCO, PIHP, or PAHP paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and medical services meeting the requirements of §438.3(e) provided to enrollees.

(B) Unpaid claims reserves for the MLR reporting year, including claims reported in the process of adjustment.

(C) Withholds from payments made to network providers.

- (D) Claims that are recoverable for anticipated coordination of benefits.
- (E) Claims payments recoveries received as a result of subrogation.
- (F) Incurred but not reported claims based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.
- (G) Changes in other claims-related reserves.
- (H) Reserves for contingent benefits and the medical claim portion of lawsuits.
- (ii) Amounts that must be deducted from incurred claims include the following:
 - (A) Overpayment recoveries received from health care professionals.
 - (B) Prescription drug rebates received by the MCO, PIHP, or PAHP.
 - (C) State subsidies based on a stop-loss payment methodology.
- (iii) Expenditures that must be included in incurred claims include the following:
 - (A) Payments made by an MCO, PIHP, or PAHP to mandated solvency funds.
 - (B) The amount of incentive and bonus payments made to network providers.
 - (C) The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses shall not include activities specified in §438.8(e)(4).
- (iv) Amounts that must either be included in or deducted from incurred claims include the following:
 - (A) Respectively, net payments or receipts related to risk adjustment and risk corridor programs developed in accordance with §438.5 or §438.6.
 - (B) [Reserved]
- (v) Amounts that must be excluded from incurred claims:
 - (A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(1) Amounts paid to third party vendors for secondary network savings.

(2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

(3) Amounts paid, including amounts paid to a health care professional, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in §438.3(e) and provided to an enrollee.

(4) Fines and penalties assessed by regulatory authorities.

(B) Amounts paid to the State as remittance under paragraph (j) of this section.

(vi) Incurred claims paid by one MCO, PIHP, or PAHP that is later assumed by another entity must be reported by the assuming MCO, PIHP, or PAHP for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding MCO, PIHP, or PAHP.

(3) Activities that improve health care quality. Activities that improve health care quality must be in one of the following categories:

(i) An MCO, PIHP, or PAHP activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).

(ii) An MCO, PIHP, or PAHP activity related to any EQRO activity as described in §438.358(b) and (c).

(iii) Any MCO, PIHP, or PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in paragraph (e)(2) of this section.

(4) Activities compliant with §438.608. MCO, PIHP, or PAHP expenditures on activities related to the program integrity requirements in §438.608(a)(1) through (5), (7), (8) and (b), limited to 0.5 percent of premium revenue. Expenditures under this paragraph shall not include

expenses for fraud reduction efforts in §438.8(e)(2)(iii)(C).

(f) Denominator. (1) For a MLR reporting year the denominator of the MLR must equal the adjusted premium revenue. The adjusted premium revenue is the MCO's, PIHP's, or PAHP's premium revenue (as defined in paragraph (f)(2) of this section) minus the MCO's, PIHP's, or PAHP's Federal and State taxes and licensing and regulatory fees (as defined in paragraph (f)(3) of this section) and is aggregated in accordance with paragraph (i) of this section.

(2) Premium revenue. Premium revenue includes the following for the MLR reporting year:

(i) State capitation payments, developed in accordance with §438.4, to the MCO, PIHP, or PAHP for all enrollees under a risk contract approved under §438.3(a).

(ii) State-developed one time payments, for specific life events of enrollees.

(iii) Other payments to the MCO, PIHP, or PAHP under the contract approved under §438.6, such as incentive arrangement payments or withhold payments.

(iv) Unpaid cost-sharing amounts that the MCO, PIHP, or PAHP could have collected from enrollees under the contract, except those amounts the MCO, PIHP, or PAHP can show it made a reasonable, but unsuccessful, effort to collect.

(v) All changes to unearned premium reserves.

(3) Federal and State taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees for the MLR reporting year include:

(i) Statutory assessments to defray the operating expenses of any State or Federal department.

(ii) Examination fees in lieu of premium taxes as specified by State law.

(iii) Federal taxes and assessments allocated to MCOs, PIHPs, and PAHPs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

(iv) State taxes and assessments including:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly.

(B) Guaranty fund assessments.

(C) Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(D) State income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

(E) State premium taxes plus State taxes based on reserves, if in lieu of premium taxes.

(v) Payments made by an MCO, PIHP, or PAHP, which is otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:

(A) Three percent of earned premium; or

(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's, PIHP's, or PAHP's earned premium in the State.

(4) The total amount of the denominator for a MCO, PIHP, or PAHP which is later assumed by another entity must be reported by the assuming MCO, PIHP, or PAHP for the entire MLR reporting year and no amount under this paragraph for that year may be reported by the ceding MCO, PIHP, or PAHP.

(g) Allocation of expense—(1) General requirements. (i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

(2) Methods used to allocate expenses. (i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(iii) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

(h) Credibility adjustment. (1) A MCO, PIHP, or PAHP may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the State as described in paragraph (j) of this section.

(2) A MCO, PIHP, or PAHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(3) If a MCO's, PIHP's, or PAHP's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this section.

(4) On an annual basis, CMS will publish base credibility factors for MCOs, PIHPs, and PAHPs that are developed according to the following methodology:

(i) CMS will use the most recently available and complete managed care encounter data or FFS claims data, and enrollment data, reported by the states to CMS. This data may cover more than 1 year of experience.

(ii) CMS will calculate the credibility adjustment so that a MCO, PIHP, or PAHP receiving a capitation payment that is estimated to have a medical loss ratio of 85 percent would be expected

to experience a loss ratio less than 85 percent 1 out of every 4 years, or 25 percent of the time.

(iii) The minimum number of member months necessary for a MCO's, PIHP's, or PAHP's medical loss ratio to be determined at least partially credible will be set so that the credibility adjustment would not exceed 10 percent for any partially credible MCO, PIHP, or PAHP. Any MCO, PIHP, or PAHP with enrollment less than this number of member months will be determined non-credible.

(iv) The minimum number of member months necessary for an MCO's, PIHP's, or PAHP's medical loss ratio to be determined fully credible will be set so that the minimum credibility adjustment for any partially credible MCO, PIHP, or PAHP would be greater than 1 percent. Any MCO, PIHP, or PAHP with enrollment greater than this number of member months will be determined fully credible.

(v) A MCO, PIHP, or PAHP with a number of enrollee member months between the levels established for non-credible and fully credible plans will be deemed partially credible, and CMS will develop adjustments, using linear interpolation, based on the number of enrollee member months.

(vi) CMS may adjust the number of enrollee member months necessary for a MCO's, PIHP's, or PAHP's experience to be non-credible, partially credible, or fully credible so that the standards are rounded for the purposes of administrative simplification. The number of member months will be rounded to 1,000 or a different degree of rounding as appropriate to ensure that the credibility thresholds are consistent with the objectives of this regulation.

(i) Aggregation of data— (1) Aggregation by covered population. MCOs, PIHPs, or PAHPs will aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

(2) [Reserved]

(j) Remittance to the State if Specific MLR is not met. If required by the State, a MCO, PIHP, or PAHP must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher if set by the State as described in paragraph (c) of this section.

(k) Reporting requirements. (1) The State, through its contracts, must require each MCO, PIHP, or PAHP to submit a report to the State that includes at least the following information for each MLR reporting year:

- (i) Total incurred claims.
- (ii) Expenditures on quality improving activities.
- (iii) Expenditures related to activities compliant with §438.608(a)(1) through (5), (7), (8) and (b).
- (iv) Non-claims costs.
- (v) Premium revenue.
- (vi) Taxes, licensing and regulatory fees.
- (vii) Methodology for allocation of expenditures.
- (viii) Any credibility adjustment applied.
- (ix) The calculated MLR.
- (x) Any remittance owed to the State, if applicable.
- (xi) A reconciliation of the information reported in this paragraph with the audited financial report required under §438.3(m).
- (xii) A description of the aggregation method used under paragraph (i) of this section.
- (xiii) The number of member months.

(2) A MCO, PIHP, or PAHP must submit the report required in paragraph (k)(1) of this

section in a timeframe and manner determined by the State, which must be within 12 months of the end of the MLR reporting year.

(3) MCOs, PIHPs, or PAHPs must require any third party vendor supplying Medicaid services to its enrollees to provide all underlying data associated with MLR reporting to that MCO, PIHP, or PAHP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCO, PIHP, or PAHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(l) Newer experience. A State, in its discretion, may exclude a MCO, PIHP, or PAHP that is newly contracted with the State from the requirements in this section for the first year of the MCO's, PIHP's, or PAHP's operation. Such MCOs, PIHPs, or PAHPs must be required to comply with the requirements in this section during the next MLR reporting year in which the MCO, PIHP, or PAHP is in business with the State, even if the first year was not a full 12 months.

(m) Recalculation of MLR. In any instance where a State makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the State, the MCO, PIHP, or PAHP must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements in paragraph (k) of this section.

(n) Attestation. MCOs, PIHPs, and PAHPs must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under paragraph (k) of this section.

§438.9 Provisions that apply to non-emergency medical transportation PAHPs.

(a) For purposes of this section, Non-Emergency Medical Transportation (NEMT) PAHP means an entity that provides only NEMT services to enrollees under contract with the State, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.

(b) Unless listed in this paragraph, a requirement of this part does not apply to NEMT PAHPs, NEMT PAHP contracts, or States in connection with a NEMT PAHP. The following requirements and options apply to NEMT PAHPs, NEMT PAHP contracts, and States in connection with NEMT PAHPs, to the same extent that they apply to PAHPs, PAHP contracts, and States in connection with PAHPs.

(1) All contract provisions in §438.3 except requirements for:

(i) Physician Incentive plans.

(ii) Advance directives.

(iii) LTSS requirements.

(iv) MHPAEA.

(2) The actuarial soundness requirements in §438.4.

(3) The information requirements in §438.10.

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

(5) The State responsibility provisions in §§438.56, 438.58, 438.60, and 438.62(a).

(6) The provisions on enrollee rights and protections in subpart C of this part except for §§438.110 and 438.114.

(7) The PAHP standards in §§438.206(b)(1), 438.210, 438.214, 438.224, 438.230, and 438.242.

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

(9) Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in §438.610.

§438.10 Information requirements.

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

Prevalent means a non-English language determined to be spoken by a significant number

or percentage of potential enrollees and enrollees that are limited English proficient and consistent with standards used by the Office for Civil Rights in enforcing anti-discrimination provisions.

Readily accessible means electronic information and services which comply with modern accessibility standards such as Section 508 guidelines or guidelines that provide greater accessibility to individuals with disabilities.

(b) Applicability. The provisions of this section apply to all managed care programs which operate under any authority in the Act.

(c) Basic rules. (1) Each State, enrollment broker, MCO, PIHP, PAHP, PCCM, and PCCM entity must provide all required information in this section to enrollees and potential enrollees in a manner and format that may be easily understood and readily accessible by such enrollees and potential enrollees.

(2) The State must utilize its beneficiary support system required in §438.71.

(3) The State must operate a website that provides the content specified in paragraphs (g) and (h) of this section, §438.68(e), §438.364(b)(2), and §438.602(g), either directly or by linking to individual MCO, PIHP, PAHP or PCCM entity websites.

(4) For consistency in the information provided to enrollees, the State must develop and require each MCO, PIHP, PAHP and PCCM entity to use:

(i) Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services, skilled nursing care, specialist,

and urgent care; and

(ii) Model member handbooks and member notices.

(5) The State must ensure, through its contracts, that each MCO, PIHP, PAHP and PCCM entity provides the required information in this section to each enrollee.

(6) Enrollee information required in this section may not be provided electronically by the State, MCO, PIHP, PAHP, PCCM or PCCM entity unless all of the following are met:

(i) The format is readily accessible.

(ii) The information is placed in a location on the State, MCO, PIHP, PAHP, or PCCM entity website that is prominent and readily accessible.

(iii) The information is provided in an electronic form which can be electronically retained and printed.

(iv) The information is consistent with the content and language requirements of this section.

(v) The State, MCO, PIHP, PAHP, and PCCM entity informs the enrollee that the information is available in paper form without charge upon request and provides it upon request within 5 calendar days.

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

(d) Language and format. The State must:

(1) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area.

(2) Make available oral and written information in each prevalent non-English language.

All written materials for potential enrollees must include taglines in each prevalent non-English

language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by §438.71(a). Large print means printed in a font size no smaller than 18 pt.

(3) Require each MCO, PIHP, PAHP, and PCCM entity to make its written materials, including, at a minimum, provider directories, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services, available in the prevalent non-English languages in its particular service area. Written materials must also be made available in alternative formats and auxiliary aids and services should be made available upon request of the potential enrollee or enrollee at no cost.

(i) All written materials for enrollees, including provider directories, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services, must include taglines in each prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's, PIHP's, PAHP's or PCCM entity's member/customer service unit. Large print means printed in a font size no smaller than 18 pt.

(ii) [Reserved]

(4) Make interpretation services available to each potential enrollee and require each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American sign language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.

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

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

(ii) That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and

(iii) How to access those services.

(6) Provide, and require MCOs, PIHPs, PAHPs, PCCMs or PCCM entities to provide, all written materials for potential enrollees and enrollees consistent with the following:

(i) Use easily understood language and format.

(ii) Use a font size no smaller than 12 point.

(iii) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

(iv) Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 pt.

(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, either in paper or electronic form 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, PCCMs, or PCCM entities.

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

(i) Information about the potential enrollee's right to disenroll consistent with the

requirements of §438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance.

(ii) The basic features of managed care.

(iii) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program.

(iv) The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity.

(v) Covered benefits including

(A) Which benefits are provided by the MCO, PIHP, or PAHP; and

(B) Which, if any, benefits are provided directly by the State.

(C) For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.

(vi) The provider directory information required in paragraph (h) of this section.

(vii) Any cost-sharing that will be imposed by the MCO, PIHP, PAHP, PCCM or PCCM entity consistent with those set forth in the State plan.

(viii) The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in §438.68.

(ix) MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care.

(x) To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

(f) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: General requirements. (1) The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a

good faith effort to give written notice of termination of a contracted provider, within 15 calendar 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.

(2) The State must notify all enrollees of their right to disenroll consistent with the requirements of §438.56 at least annually. Such notification must clearly explain the process for exercising this disenrollment right, as well as the alternatives available to the enrollee based on their specific circumstance. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 calendar days before the start of each enrollment period.

(3) The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in §438.3(i).

(g) Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities – Enrollee handbook. (1) Each MCO, PIHP, PAHP and PCCM entity must provide each enrollee an enrollee handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).

(2) The content of the member handbook must include information that enables the enrollee to understand how to effectively use the managed care program. This information must include at a minimum:

(i) Benefits provided by the MCO, PIHP, PAHP or PCCM entity.

(ii) How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided.

(A) In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered.

(B) The MCO, PIHP, PAHP, or PCCM entity must inform enrollees how they can to obtain information from the State about how to access those services.

(iii) 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.

(iv) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

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

(A) What constitutes an emergency medical condition and emergency services.

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

(C) 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.

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

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

(viii) Cost sharing, if any is imposed under the State plan.

(ix) Enrollee rights and responsibilities, including the elements specified in §438.100.

(x) The process of selecting and changing the enrollee's primary care provider.

(xi) Grievance, appeal, and fair hearing procedures and timeframes, consistent with subpart F of this part, in a State-developed or State-approved description. Such information must include:

(A) The right to file grievances and appeals.

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

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

(D) The right to request a State fair hearing after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee.

(E) The fact that, when requested by the enrollee benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or State Fair Hearing is pending if the final decision is adverse to the enrollee.

(xii) How to exercise an advance directive, as set forth in §438.3(j). For PAHPs, information must be provided only to the extent that the PAHP includes any of the providers described in §489.102(a) of this chapter.

(xiii) How to access auxiliary aids and services, including additional information in in alternative formats or languages.

(xiv) The toll-free telephone number for member services medical management and any other unit providing services directly to enrollees.

(xv) Information on how to report suspected fraud or abuse;

(xvi) Any other content required by the State.

(3) Information required by this paragraph to be provided by a MCO, PIHP, PAHP or PCCM entity will be considered to be provided if the MCO, PIHP, PAHP or PCCM entity:

(i) Mails a printed copy of the information to the enrollee's mailing address;

(ii) Provides the information by email after obtaining the enrollee's agreement to receive the information by email;

(iii) Posts the information on the website of the MCO, PIHP, PAHP or PCCM entity and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address provided that enrollees with disabilities who cannot access

this information online are provided auxiliary aids and services upon request at no cost; or

(iv) Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

(4) The MCO, PIHP, PAHP, or PCCM entity must give each enrollee notice of any change that the State defines as significant in the information specified in this paragraph (g), at least 30 days before the intended effective date of the change.

(h) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities – Provider Directory. (1) Each MCO, PIHP, PAHP, and when appropriate, the PCCM entity, must make available in electronic or paper form, the following information about its network providers:

(i) The provider's name as well as any group affiliation.

(ii) Street address(es).

(iii) Telephone number(s).

(iv) Website URL as appropriate.

(v) Specialty, if appropriate.

(vi) Whether the provider will accept new enrollees.

(vii) The provider's cultural and linguistic capabilities, including languages spoken by the provider or by skilled medical interpreter at the provider's office.

(viii) Whether the provider's office/facility is accessible for people with physical disabilities, including offices, exam room(s) and equipment.

(2) The provider directory must include the information in paragraph (h)(1) of this section for each of the following provider types covered under the contract:

(i) Physicians including specialists.

(ii) Hospitals.

(iii) Pharmacies.

(iv) Behavioral health providers.

(v) LTSS providers.

(3) Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 3 business days after the MCO, PIHP, PAHP or PCCM entity receives updated provider information.

(4) Provider directories must be made available on the MCO's, PIHP's, PAHP's, or, if applicable, PCCM entity's website in a machine readable file and format as specified by the Secretary.

(i) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Formulary. Each MCO, PIHP, PAHP, and when appropriate, PCCM entity, must make available in electronic or paper form, the following information about its formulary:

(1) Which medications are covered (both generic and name brand).

(2) What tier each medication is on.

(3) Formulary drug lists must be made available on the MCO's, PIHP's, PAHP's, or, if applicable, PCCM entity's website in a machine readable file and format as specified by the Secretary.

§438.12 Provider discrimination prohibited.

(a) General rules. (1) An MCO, PIHP, or PAHP may not discriminate in 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 provider 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.

§438.14 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs).

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

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

(i) Is a member of a Federally recognized Indian tribe.

(ii) Resides in an urban center and meets one or more of the four criteria:

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations promulgated by the Secretary;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose;

(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian health care provider (IHCP) under 42 CFR 447.51 means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Indian managed care entity (IMCE) under section 1932(h)(4)(B) of the Act means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(b) Network requirements. All contracts between a State and a MCO, PIHP, PAHP, PCCM, and PCCM entity, to the extent that the PCCM or PCCM entity has a provider network, which enroll Indians must:

(1) Require the MCO, PIHP, PAHP, PCCM entity to demonstrate that there are sufficient IHCPs participating in the provider network of the MCO, PIHP, PAHP, or PCCM entity to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.

(2) Require that IHCPs, whether participating or not, be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:

(i) At a rate negotiated between the MCO, PIHP, PAHP, PCCM, or PCCM entity, and the IHCP, or

(ii) In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO, PIHP, PAHP, or PCCM entity would make for the services to a participating provider which is not an IHCP; and

(iii) Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under §§447.45 and 447.46 of this chapter.

(3) Permit any Indian who is enrolled in a MCO, PIHP, PAHP, PCCM or PCCM entity that is not an IMCE and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.

(4) Permit Indian enrollees to obtain services covered under the contract between the State and the MCO, PIHP, PAHP, PCCM, or PCCM entity from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

(5) In a State where timely access to covered services cannot be ensured due to few or no IHCPs, an MCO, PIHP, PAHP and PCCM will be considered to have met the requirement in paragraph (b)(1) of this section if--

(i) Indian enrollees are permitted by the MCO, PIHP, PAHP, or PCCM entity to access out-of-State IHCPs; or

(ii) If this circumstance is deemed to be good cause for disenrollment from both the MCO, PIHP, PAHP, or PCCM entity and the State's managed care program in accordance with §438.56(c).

(c) Payment requirements. (1) When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the MCO, PIHP, PAHP and PCCM entity, it must be paid an amount equal to the amount the MCO, PIHP, PAHP, or PCCM entity would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the State to make up the

difference between the amount the MCO, PIHP, PAHP or PCCM entity pays and what the IHCP FQHC would have received under FFS.

(2) When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, PIHP, PAHP and PCCM entity or not, it has the right to receive the same amount it would be paid if the services provided to the Indian enrollee were provided under the State plan in a FFS payment methodology or the applicable encounter rate published annually in the **Federal Register** by the Indian Health Service.

(3) Where the amount a IHCP receives from a MCO, PIHP, PAHP, or PCCM entity is less than the amount required by paragraph (c)(2) of this section, the State must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, PCCM, or PCCM entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

(d) Enrollment in IMCEs. An IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians, without being in violation of the requirements in §438.3(d).

Subpart B—State Responsibilities

§438.50 State Plan requirements.

(a) General rule. A State plan that requires Medicaid beneficiaries to enroll in MCOs, PCCMs, or PCCM 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 FFS or capitation).

(3) Whether it contracts on a comprehensive risk basis.

(4) The process the State uses to involve the public in both design and initial implementation of the managed care 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 or PCCM entity 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, PCCMs, and PCCM entities.

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

(6) Section 438.4, 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, PCCM or PCCM entity:

(1) Beneficiaries who are also eligible for Medicare.

(2) Indians as defined in §438.14(a), except as permitted under §438.14(d).

(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.

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

(a) General rule. Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid beneficiaries to:

(1) Enroll in an MCO, PIHP, or PAHP must give those beneficiaries a choice of at least two MCOs, PIHPs, or PAHPs.

(2) Enroll in a primary care case management system must give those beneficiaries a choice from at least two primary care case managers employed or contracted with the State.

(3) Enroll in a PCCM entity may limit a beneficiary to a single PCCM entity. Beneficiaries must be permitted to choose from at least two primary care case managers employed by or contracted with the PCCM entity.

(b) Exception for rural area residents. (1) Under any managed care program authorized by any of the following, 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, or PAHP:

(i) A State 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) To comply with this paragraph, a State, must permit the beneficiary—

(i) To choose from at least two primary care providers; 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, or PAHP 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, or PAHP 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 calendar 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 (b), “rural area” is any county designated as “micro,” “rural,” or “County with Extreme Access Criteria (CEAC)” in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year.

(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).

§438.54 Managed care enrollment.

(a) Applicability. The provisions of this section apply to all Medicaid managed care programs which operate under any authority in the Act.

(b) General rule. The State must have an enrollment system for both voluntary and mandatory managed care programs.

(1) Voluntary managed care programs are those where one or more groups of beneficiaries as enumerated in section of 1905(a) of the Act have the option to either enroll in a MCO, PIHP, PAHP, PCCM or PCCM entity, or remain enrolled in FFS to receive Medicaid covered benefits.

(2) Mandatory managed care programs are those where one or more groups of beneficiaries as enumerated in section 1905(a) of the Act must enroll in a MCO, PIHP, PAHP, PCCM or PCCM entity to receive covered Medicaid benefits.

(c) Voluntary managed care programs. (1) States must have an enrollment system for a voluntary managed care program. That system may provide an enrollment choice period with the ability to make an active choice for managed care programs or may employ a passive enrollment process in which the State selects a MCO, PIHP, PAHP, PCCM or PCCM entity for a potential enrollee in a MCO, PIHP, PAHP, PCCM or PCCM entity but provides a period of time for the potential enrollee to decline the MCO, PIHP, PAHP, PCCM or PCCM entity selected for them before being enrolled in the MCO, PIHP, PAHP, PCCM or PCCM entity.

(2) A State must provide potential enrollees at least 14 calendar days of FFS coverage to provide the potential enrollee the opportunity to actively elect to receive covered services through

the managed care or FFS delivery system. If the potential enrollee elects to receive covered services through the managed care delivery system, the potential enrollee must then also select a MCO, PIHP, PAHP, PCCM, or PCCM entity.

(i) If the State does not use a passive enrollment process and the potential enrollee does not make an active choice during the choice period, the potential enrollee will be enrolled in a MCO, PIHP, PAHP, PCCM, or PCCM entity by the State using its default process. The enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity will become effective after the end of the choice period.

(ii) If the State used a passive enrollment process, the potential enrollee must select either to accept the MCO, PIHP, PAHP, PCCM, or PCCM entity selected for them by the State's passive enrollment process or select a different MCO, PIHP, PAHP, PCCM, or PCCM entity. If the potential enrollee does not make an active choice during the choice period, the MCO, PIHP, PAHP, PCCM, or PCCM entity selected for them by the passive enrollment process will become effective. The enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity will become effective after the end of the choice period.

(3) The State must develop informational notices that clearly explain the implications to the potential enrollee of not making an active choice between managed care and FFS and declining the MCO, PIHP, PAHP, PCCM, or PCCM entity selected by the State, if relevant to the State's managed care program. These notices must:

(i) Comply with the information requirements in §438.10.

(ii) Have a postmark or electronic date stamp that is at least 3 calendar days prior to the first day of the election period identified in paragraph (c)(2) of this section.

(4) Priority for enrollment. The State's enrollment system must provide that beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM or PCCM entity are given priority to continue

that enrollment if the MCO, PIHP, PAHP, PCCM or PCCM entity does not have the capacity to accept all those seeking enrollment under the program.

(5) If a State elects to use a passive enrollment process, the process must assign beneficiaries to a qualified MCO, PIHP, PAHP, PCCM or PCCM entity. To be a qualified MCO, PIHP, PAHP, PCCM or PCCM entity, it must:

(i) Not be subject to the intermediate sanction described in §438.702(a)(4).

(ii) Have capacity to enroll beneficiaries.

(6) A passive enrollment process must seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries.

(i) An “existing provider-beneficiary relationship” is one in which the provider was the main source of Medicaid services for the beneficiary during the previous year. This may be established through State records of previous managed care enrollment or FFS experience, encounter data, or through contact with the beneficiary.

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

(7) If the approach in paragraph (c)(6) of this section is not possible, the State must distribute the beneficiaries equitably among the MCOs, PIHPs, PAHPs, PCCMs and PCCM entities.

(i) The State may not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered.

(ii) The State may consider additional criteria to conduct the passive enrollment process, including the enrollment preferences of family members, previous plan assignment of the beneficiary, quality assurance and improvement performance, procurement evaluation elements, accessibility of provider offices for people with disabilities (when appropriate), and other

reasonable criteria that support the objectives of the managed care program.

(8) If a passive selection process is used, the State must send a confirmation of the enrollee's managed care enrollment to the enrollee within 5 calendar days of the MCO, PIHP, PAHP, PCCM or PCCM entity enrollment being processed by the State. The confirmation must clearly explain the enrollee's right to disenroll within 90 days from the effective date of the enrollment.

(d) Mandatory managed care programs. (1) States must have an enrollment system for a mandatory managed care program that includes the elements specified in paragraphs (d)(2) through (7) of this section.

(2) A State must provide potential enrollees at least 14 calendar days of FFS coverage to provide the potential enrollee the opportunity to actively select their MCO, PIHP, PAHP, PCCM, or PCCM entity.

(3) A State must provide informational notices to each potential enrollee that explain the process for enrolling in a MCO, PIHP, PAHP, PCCM or PCCM entity including the choice of MCOs, PIHPs, PAHPs, PCCMs or PCCM entities available, how to make the enrollee's selection of a MCO, PIHP, PAHP or PCCM known to the State, and enrollee's right to disenroll within 90 days from the effective date of the enrollment. These notices must:

(i) Comply with the information requirements in §438.10.

(ii) Have a postmark or electronic date stamp that is at least 3 calendar days prior to the first day of the election period identified in paragraph (d)(2) of this section.

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

(5) Enrollment by default. For potential enrollees that do not select an MCO, PIHP, PAHP, PCCM or PCCM entities during the enrollment period specified in paragraph (d)(2) of this section, the State must have a default enrollment process for assigning those beneficiaries to qualified MCOs, PIHPs, PAHPs, PCCMs and PCCM entities. To be a qualified MCO, PIHP, PAHP, PCCM or PCCM entity, it must:

(i) Not be subject to the intermediate sanction described in §438.702(a)(4).

(ii) Have capacity to enroll beneficiaries.

(6) The process must seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries.

(i) An “existing provider-beneficiary relationship” is one in which the provider was the main source of Medicaid services for the beneficiary during the previous year. This may be established through State records of previous managed care enrollment or FFS experience, encounter data, or through contact with the beneficiary.

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

(7) If the approach in paragraph (d)(6) of this section is not possible, the State must distribute the beneficiaries equitably among the MCOs, PIHPs, PAHPs, PCCMs and PCCM entities available to enroll them.

(i) The State may not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered; and

(ii) The State may consider additional criteria to conduct the default enrollment process, including the enrollment preferences of family members, previous plan assignment of the beneficiary, quality assurance and improvement performance, procurement evaluation elements, and other reasonable criteria related to a beneficiary’s experience with the Medicaid program.

§438.56 Disenrollment: Requirements and limitations.

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

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

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

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

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

(c) Disenrollment requested by the enrollee. If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, PCCM and PCCM entity contracts must provide that a beneficiary may request disenrollment as follows:

(1) For cause, at any time.

(2) Without cause, at the following times:

(i) During the 90 days following the date of the beneficiary's initial enrollment into a MCO, PIHP, PAHP, PCCM or PCCM entity, or the date the State sends the beneficiary notice of the

enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

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

(iv) When the State imposes the intermediate sanction specified in §438.702(a)(4).

(d) Procedures for disenrollment—(1) Request for disenrollment. The beneficiary (or his or her representative) must submit an oral or written request, as required by the State —

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

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

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

(i) The enrollee moves out of the MCO's, PIHP's, PAHP's, PCCM's or PCCM entity'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 provider 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) For enrollees that use MLTSS services, the enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO, PIHP or PAHP.

(v) Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care

needs.

(3) MCO, PIHP, PAHP, PCCM, or PCCM entity action on request. (i) When the MCO's, PIHP's, PAHP's, PCCM's or PCCMs entity's contract with the State permits the MCO, PIHP, PAHP, PCCM or PCCM entity to process disenrollment requests, the MCO, PIHP, PAHP, PCCM or PCCM entity may either approve a request for disenrollment by or on behalf of an enrollee or the MCO, PIHP, PAHP, PCCM or PCCM entity must refer the request to the State.

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

(4) State agency action on request. For a request received directly from the beneficiary, or one referred by the MCO, PIHP, PAHP, PCCM, or PCCM entity, 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, PCCM, or PCCM entity at the agency's request.

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

(5) Use of the MCO's, PIHP's, PAHP's, PCCM's or PCCMs entity's grievance procedures.

(i) The State agency may require that the enrollee seek redress through the MCO's, PIHP's, PAHP's, PCCM's or PCCM entity'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 paragraph (e)(1) of this section.

(iii) If, as a result of the grievance process, the MCO, PIHP, PAHP, PCCM or PCCM entity approves the disenrollment, the State agency is not required to make a determination in accordance with paragraph (d)(4) of this section.

(e) 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 requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State.

(2) If the MCO, PIHP, PAHP, PCCM, PCCM entity, 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 for the effective date that would have been established had the State or MCO, PIHP, PAHP, PCCM, PCCM entity complied with paragraph (e)(1) of this section.

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

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

§438.58 Conflict of interest safeguards.

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 enrollment processes specified in §438.54(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).

§438.60 Prohibition of additional payments for services covered under MCO, PIHP or PAHP contracts.

The State agency must ensure that no payment is made to a network provider other than by the MCO, PIHP, or PAHP for services covered under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are specifically required to be made by the State in Title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract to account for payments for graduate medical education, in accordance with §438.6(b)(4).

§438.62 Continued services to enrollees.

(a) The State agency must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of an MCO, PIHP, PAHP, PCCM or PCCM entity the contract of which is terminated and for any Medicaid enrollee who is disenrolled from an MCO, PIHP, PAHP, PCCM or PCCM entity for any reason other than ineligibility for Medicaid.

(b) The State must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to a MCO, PIHP, PAHP, PCCM or PCCM entity or transition from one MCO, PIHP, PAHP, PCCM or PCCM entity to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

(1) The transition of care policy must include the following:

(i) The enrollee has access to services consistent with the access they previously had, and is

permitted to retain their current provider for a period of time if that provider is not in the MCO, PIHP or PAHP network.

(ii) The enrollee is referred to appropriate providers of services that are in the network.

(iii) The State, in the case of FFS, PCCM, or PCCM entity, or the MCO, PIHP or PAHP that was previously serving the enrollee, fully and timely complies with requests for historical utilization data from the new MCO, PIHP, PAHP, PCCM, or PCCM entity in compliance with Federal and State law.

(iv) Consistent with Federal and State law, the enrollee's new provider(s) are able to obtain copies of the enrollee's medical records, as appropriate.

(v) Any other necessary procedures as specified by the Secretary to ensure continued access to services to prevent serious detriment to the enrollee's health or reduce the risk of hospitalization or institutionalization.

(2) The State must require by contract that MCOs, PIHPs, and PAHPs implement a transition of care policy consistent with the requirements in paragraph (b)(1) of this section and at least meets the State defined transition of care policy.

(3) The State must make its transition of care policy publicly available and provide instructions to enrollees and potential enrollees on how to access continued services upon transition. At a minimum the transition of care policy must be described in the comprehensive quality strategy, as required by §438.340, and explained to individuals in the materials to enrollees and potential enrollees, in accordance with §438.10.

§438.66 State monitoring requirements.

(a) General requirement. The State agency must have in effect a monitoring system for all managed care programs.

(b) The State's system must address all aspects of the managed care program, including the

performance of each MCO, PIHP, PAHP and PCCM entity (if applicable) in at least the following areas:

- (1) Administration and management.
- (2) Appeal and grievance systems.
- (3) Claims management.
- (4) Enrollee materials and customer services.
- (5) Finance, including medical loss ratio reporting.
- (6) Information systems, including encounter data reporting.
- (7) Marketing.
- (8) Medical management, including utilization management and case management.
- (9) Program integrity.
- (10) Provider network management.
- (11) Availability and accessibility of services.
- (12) Quality improvement.
- (13) Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1)

through (12) of this section as applicable to the managed care program.

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

(c) The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum:

- (1) Enrollment and disenrollment trends in each MCO, PIHP, or PAHP.
- (2) Member grievance and appeal logs.
- (3) Provider complaint and appeal logs.
- (4) Findings from the State's External Quality Review process.
- (5) Results from any enrollee satisfaction survey conducted by the State or MCO, PIHP or

PAHP.

- (6) Performance on required quality measures.
- (7) Medical management committee reports and minutes.
- (8) The annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity.
- (9) Audited financial and encounter data submitted by each MCO, PIHP or PAHP.
- (10) The medical loss ratio summary reports required by §438.8.
- (11) Customer service performance data submitted by each MCO, PIHP or PAHP.
- (12) Any other data related to the provision of LTSS not otherwise included in paragraphs

(c)(1) through (11) of this section as applicable to the managed care program.

(d)(1) The State must assess the readiness of each MCO, PIHP, PAHP or PCCM entity with which it contracts as follows:

(i) Prior to the State implementing a managed care program, whether the program is voluntary or mandatory.

(ii) When the specific MCO, PIHP, PAHP or PCCM entity has not previously contracted with the State.

(iii) When any MCO, PIHP, PAHP or PCCM entity currently contracting with the State will provide or arrange for the provisions of covered benefits to new eligibility groups.

(iv) When any MCO, PIHP, PAHP or PCCM entity currently contracting with the State will provide a new set of benefits to current or new eligibility groups; or

(v) When any MCO, PIHP, PAHP or PCCM entity currently contacting with the State will expand coverage to new geographic areas.

(2) The State must conduct a readiness review of each MCO, PIHP, PAHP, or PCCM entity with which it contracts as follows:

- (i) Started at least 3 months prior to the effective date of the events described in paragraph

(d)(1) of this section.

(ii) Completed in sufficient time to ensure smooth implementation of an event described in paragraph (d)(1) of this section.

(iii) Submitted to CMS in order for CMS to make a determination that the contract or contract amendment associated with an event described in paragraph (d)(1) of this section is approved under §438.3.

(3) Readiness reviews must include both a desk review of documents and on-site reviews of each MCO, PIHP, PAHP or PCCM entity. On-site reviews must include interviews with MCO, PIHP, PAHP or PCCM entity staff and leadership that manage key operational areas.

(4) A State's readiness review must assess the ability and capacity of the MCO, PIHP, PAHP and PCCM entity (if applicable) to perform satisfactorily for the following areas:

(i) Operations/Administration, including--

(A) Administrative staffing and resources.

(B) Delegation and oversight of MCO, PIHP, PAHP or PCCM entity responsibilities.

(C) Enrollee and provider communications.

(D) Grievance and appeals.

(E) Member services and outreach.

(F) Provider Network Management.

(G) Program Integrity/Compliance.

(ii) Service delivery, including--

(A) Case management/care coordination/Service planning.

(B) Quality improvement.

(C) Utilization review.

(iii) Financial management, including--

(A) Financial reporting and monitoring.

(B) Financial solvency.

(iv) Systems management, including--

(A) Claims management.

(B) Encounter data and enrollment information management.

(e)(1) The State must submit to CMS no later than 150 days after each contract year, a report on each managed care program administered by the State, regardless of the authority under which the program operates. For States that operate their managed care program under section 1115 of the Act authority, submission of an annual report that may be required by the Special Terms and Conditions of the demonstration program will be deemed to satisfy the requirement of this paragraph provided that the report includes the information specified in paragraph (e)(2) of this section.

(2) The program report must provide information on and an assessment of the operation of the managed care program and include, at a minimum, the following:

(i) Financial performance of each MCO, PIHP and PAHP.

(ii) Encounter data reporting by each MCO, PIHP or PAHP.

(iii) Enrollment and service area expansion (if applicable) of each MCO, PIHP, PAHP and PCCM entity.

(iv) Modifications to, and implementation of, MCO, PIHP, or PAHP benefits covered under the contract with the State.

(v) Grievance, appeals and State fair hearings for the managed care program.

(vi) Availability and accessibility of covered services within the MCO, PIHP, or PAHP contracts.

(vii) Evaluation of MCO, PIHP, or PAHP performance on quality measures, including as

applicable, consumer report card, surveys, or other reasonable measures of performance.

(viii) Results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP or PCCM entity to improve performance.

(ix) Any other factors in the delivery of LTSS not otherwise addressed in (e)(2)(i) – (viii) of this section as applicable.

(3) The program report required in this section must be:

(i) Posted on the website required under §438.10.

(ii) Provided to the Medical Care Advisory Committee, required under §431.12 of this chapter.

(iii) Provided to the stakeholder consultation group specified in §438.70, to the extent that the managed care program includes LTSS.

§438.68 Network adequacy standards.

(a) General rule. A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section.

(b) Provider-specific network adequacy standards. (1) At a minimum, a State must develop time and distance standards for the following provider types, if covered under the contract:

(i) Primary care, adult and pediatric.

(ii) OB/GYN.

(iii) Behavioral health.

(iv) Specialist, adult and pediatric.

(v) Hospital.

(vi) Pharmacy.

(vii) Pediatric dental.

(viii) Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards.

(2) LTSS. States with MCO, PIHP or PAHP contracts which cover LTSS must develop:

(i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and

(ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.

(3) Scope of network adequacy standards. Network standards established in accordance with paragraphs (b)(1) and (b)(2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.

(c) Development of network adequacy standards. (1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:

(i) The anticipated Medicaid enrollment.

(ii) The expected utilization of services.

(iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.

(iv) The numbers and types (in terms of training, experience, and specialization) of network health care professionals required to furnish the contracted Medicaid services.

(v) The numbers of network health care professionals who are not accepting new Medicaid patients.

(vi) The geographic location of health care professionals and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees.

(vii) The ability of health care professionals to communicate with limited English proficient enrollees in their preferred language.

(viii) The ability of healthcare professionals to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

(2) States developing standards consistent with paragraph (b)(2) of this section must consider the following:

(i) All elements in paragraphs (c)(1)(i) through (viii) of this section.

(ii) Elements that would support an enrollee's choice of provider.

(iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.

(iv) Other considerations that are in the best interest of the enrollees that need LTSS.

(d) Exceptions process. (1) To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:

(i) Specified in the MCO, PIHP or PAHP contract.

(ii) Based, at a minimum, on the number of health care professionals in that specialty practicing in the MCO, PIHP, or PAHP service area.

(2) States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under §438.66.

(e) Publication of network adequacy standards. States must publish the standards developed in accordance with paragraphs (b)(1) and (b)(2) of this section on the website required by §438.10. Upon request, network adequacy standards must also be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.

§438.70 Stakeholder engagement when LTSS is delivered through a managed care program.

The State must ensure the views of beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of a State's managed LTSS program. The composition of the stakeholder group and frequency of meetings must be sufficient to ensure meaningful stakeholder engagement.

§438.71 Beneficiary support system.

(a) General requirement. The State must develop and implement a beneficiary support system that provides support to beneficiaries both prior to and after enrollment in a MCO, PIHP, PAHP, PCCM or PCCM entity.

(b) Elements of the support system. (1) A State beneficiary support system must include at a minimum:

(i) Choice counseling for all beneficiaries.

(ii) Training for network providers as specified in paragraph (d) of this section

(iii) Assistance for enrollees in understanding managed care.

(iv) Assistance for enrollees who use, or express a desire to receive, LTSS as specified in paragraph (e) of this section.

(2) The beneficiary support system must perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.

(c) Choice counseling. (1) Choice counseling, as defined in §438.2, must be provided to all

potential enrollees and enrollees who disenroll from a MCO, PIHP, PAHP, PCCM or PCCM entity for reasons specified in §438.56(b) and(c).

(2) If an individual or entity provides choice counseling on the State's behalf under a memorandum of agreement or contract, it is considered an enrollment broker as defined in §438.810(a) and must meet the independence and freedom from conflict of interest standards in §438.810(b)(1) and (2).

(d) Training. The beneficiary support system must provide training to MCOs, PIHPs, PAHPs, PCCMs, PCCM entities and network providers on community-based resources and supports that can be linked with covered benefits.

(e) Functions specific to LTSS activities. At a minimum, the beneficiary support system must provide the following support to enrollees who use, or express a desire to receive, LTSS:

(1) An access point for complaints and concerns about MCO, PIHP, PAHP, PCCM, and PCCM entity enrollment, access to covered services, and other related matters.

(2) Education on enrollees' grievance and appeal rights within the MCO, PIHP or PAHP; the State fair hearing process; enrollee rights and responsibilities; and additional resources outside of the MCO, PIHP or PAHP.

(3) Assistance, upon request, in navigating the grievance and appeal process within the MCO, PIHP or PAHP, as well as appealing adverse benefit determinations by the MCO, PIHP, or PAHP to a State fair hearing. The system may not provide representation to the enrollee at a State fair hearing but may refer enrollees to sources of legal representation.

(i) An entity that receives non-Medicaid funding to represent beneficiaries at hearings, may, subject to approval by CMS, establish firewalls to provide choice counseling as an independent function.

(ii) [Reserved]

(4) Review and oversight of LTSS program data to provide guidance to the State Medicaid Agency on identification, remediation and resolution of systemic issues.

§438.74 State oversight of the minimum MLR requirement.

(a) State reporting requirement. (1) The State must annually submit to CMS a summary description of the report(s) received from the MCO(s), PIHP(s), and PAHP(s) under contract with the State under §438.8(k) with the actuarial certification described in §438.7.

(2) The summary description must include, at a minimum, the amount of the numerator, denominator, MLR experienced, the number of member months, and any remittances owed by each MCO, PIHP, or PAHP for that MLR reporting year.

(b) Repayment of Federal share of remittances. (1) If a State requires a MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State, the State must reimburse CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in Federal matching rate.

(2) If a remittance is owed according to paragraph (b)(1) of this section, the State must submit a report describing the methodology used to determine the State and Federal share of the remittance with the report required in paragraph (a) of this section.

Subpart C—Enrollee Rights and Protections

§438.100 Enrollee rights.

(a) General rule. The State must ensure that:

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

(2) Each MCO, PIHP, PAHP, PCCM and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect 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, PCCM or PCCM entity 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(g)(2)(ii)(A) and (B).
- (iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.
- (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) 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.

(3) An enrollee of an MCO, PIHP, or PAHP 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, PCCM or PCCM entity and its network 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, PCCM and PCCM entity complies with any other applicable Federal and State laws (including: 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; and Titles II and III of the Americans with Disabilities Act).

§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 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.

(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.

(B) To enrollees, within 90 days after adopting the policy for 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(g)(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(g)(2)(ii)(A) and (B), 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.

(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.

(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.

§438.104 Marketing activities.

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

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

Marketing means any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's,

PAHP's, PCCM's or PCCM entity's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.

Marketing materials means materials that—

- (1) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, or PCCM; and
- (2) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM or PCCM entity to potential enrollees.

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

Private insurance does not include a qualified health plan, as defined in 45 CFR 155.20.

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

- (1) Provide that the entity—
 - (i) Does not distribute any marketing materials without first obtaining State approval.
 - (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.
 - (v) Does not, directly or indirectly, engage in door-to-door, telephone, e-mail, texting, or other cold-call marketing activities.
- (2) Specify the methods by which the entity ensures 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, PCCM or PCCM entity to obtain benefits or to not lose benefits; or

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

(c) State agency review. 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.

§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.

(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 furnished 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 covered 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 447.82 of this chapter.

§438.110 Member advisory committee.

(a) General rule. When LTSS are covered under a risk contract between a State and an MCO, PIHP, or PAHP, the contract must provide that each MCO, PIHP or PAHP establish and maintain a member advisory committee.

(b) Committee composition. The committee required in paragraph (a) of this section must include at least a reasonably representative sample of the LTSS populations covered under the contract with the MCO, PIHP, or PAHP.

§438.114 Emergency and poststabilization services.

(a) Definitions. As used in this section—

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, for 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.

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.

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

enrollee's condition.

(b) 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 State, for managed care programs that contract with PCCMs or PCCM entities

(c) 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, PCCM or PCCM entity; 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, PCCM or PCCM entity instructs the enrollee to seek emergency services.

(2) A PCCM or PCCM entity must 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.

(d) 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.

(e) 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 “MA organization” and “financially responsible” must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the States.

(f) 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—MCO, PIHP and PAHP Standards

§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 in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68.

(b) Delivery network. The State must ensure, through its contracts, that each MCO, PIHP and PAHP, consistent with the scope of its contracted services, 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 for all enrollees, including those with limited English proficiency or physical or mental disabilities.

(2) Provides female enrollees with direct access to a women's health specialist within the

provider network for covered care necessary to provide women's routine and preventive health care 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) Provides for a second opinion from a qualified health care professional within the provider network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

(4) If the provider 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's provider network is unable to provide them.

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

(6) Demonstrates that its network providers are credentialed as required by §438.214.

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

(1) Timely access. Each MCO, PIHP, and PAHP must do the following:

(i) Meet and require its network 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 FFS, 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 network providers.
- (v) Monitor network providers regularly to determine compliance.
- (vi) Take corrective action if there is a failure to comply by a network provider.

(2) Access and 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 limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

(3) Accessibility considerations. Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

§438.207 Assurances of adequate capacity and services.

(a) Basic rule. The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides 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.

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

(1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.

(2) 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.

(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) On an annual basis.
- (3) 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 the adequacy of capacity and services, including—
 - (i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; 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 submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the State's requirements for availability of services, as set forth in §438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP or PAHP related to its provider network.
 - (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 paragraphs (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, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, 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 Advantage Organization, the State determines to what extent the MCO must meet the identification, assessment, and treatment planning provisions of paragraph (c) of this section for dually eligible individuals.

(ii) The State bases its determination on the needs of the population it requires the MCO to serve.

(b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees. Each MCO, PIHP, and PAHP must implement procedures to deliver care to and coordinate services 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 care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee.

(2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee:

(i) Between settings of care including appropriate discharge planning for short term and long-term hospital and institutional stays;

(ii) With the services the enrollee receives from any other MCO, PIHP, or PAHP; and

(iii) With the services the enrollee receives in FFS Medicaid.

(3) Provide that the MCO, PIHP or PAHP, within 90 days of the effective date of enrollment for all new enrollees, makes a best effort to conduct an initial assessment of each enrollee's needs, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.

(4) Share with the State or other MCOs, PIHPs, and PAHP serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities.

(5) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.

(6) 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.

(c) Additional services for enrollees with special health care needs or who need LTSS. (1) Identification. The State must implement mechanisms to identify persons who need LTSS or 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 comprehensive quality strategy in §438.340.

(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 comprehensively 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 needing LTSS or having special health care needs 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 or individuals meeting LTSS service coordination requirements of the State or the MCO, PIHP, or PAHP as appropriate.

(3) Treatment/service plans. If the State requires MCOs, PIHPs, or PAHPs to produce a treatment or service plan for enrollees who require LTSS or with special health care needs that are

determined through assessment to need a course of treatment or regular care monitoring, the treatment or service plan must be—

(i) Developed by the enrollee's provider or individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any other health care professionals caring for the enrollee.

(ii) Developed by a person trained in person centered planning using a person-centered process and plan as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans.

(iii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP.

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

(v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per section §441.301(c)(3) of this chapter.

(4) Direct access to specialists. For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with paragraph (c)(2) of this section) 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 between a State and 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 FFS Medicaid, as set forth in §440.230 of this chapter.

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

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably 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.

(4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service—

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

(ii) For the purpose of utilization control, provided that

(A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

(B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and

(C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20.

(5) 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;

(ii) Meets the requirements for providing early and periodic screening and diagnosis of beneficiaries under age 21 to ascertain physical and mental defects, and treatment to correct or

ameliorate defects and chronic conditions found (EPSDT); and

(iii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that address:

(A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

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

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

(D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living.

(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) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.

(3) 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 expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

(c) Notice of adverse benefit determination. 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, PIHPs, and PAHPs the notice must meet the requirements of §438.404.

(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 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, 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 72 hours after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 72 hour 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 between a State and

MCO, PIHP, or PAHP must provide that, consistent with §438.3(i), 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.

§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, at a minimum, meet the requirements of this section.

(b) Credentialing and recredentialing requirements. (1) Each State must establish a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate, and require each MCO, PIHP and PAHP to follow those policies.

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

(d) Excluded providers. (1) 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.

§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.

§438.228 Grievance systems.

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

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

§438.230 Subcontractual relationships and delegation.

(a) Applicability. The requirements of this section apply to any contract or written arrangement that an MCO, PIHP, or PAHP has with any individual or entity that relates directly or indirectly to the performance of the MCO's PIHP's or PAHP's obligations under its contract with the State.

(b) General rule. The State must ensure, through its contracts with MCOs, PIHPs, and PAHPs, that—

(1) Notwithstanding any relationship(s) that the MCO, PIHP, or PAHP may have with any other individual or entity, the MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and

(2) All contracts or written arrangements between the MCO, PIHP, or PAHP and any individual or entity that relates directly or indirectly to the performance of the MCO's PIHP's or

PAHP's activities or obligations under its contract with the State must meet the requirements of paragraph (c) of this section.

(c) Each contract or written arrangement described in paragraph (b)(2) of this section must specify that:

(1) If any of the MCO's, PIHP's, or PAHP's activities or obligations under its contract with the State are delegated to another individual or entity –

(i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.

(ii) The individual or entity agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's or PAHP's contract obligations.

(iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the individual or entity has not performed satisfactorily.

(2) The individual or entity agrees to comply with all applicable Medicaid laws, regulations, subregulatory guidance, and contract provisions;

(3) The individual or entity agrees that—

(i) The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems of the individual or entity, or of the individual's or entity's contractor or subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the contract with the State, if the reasonable possibility of fraud is determined to exist by any of these entities.

(ii) The individual or entity will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, and

records relating to its Medicaid enrollees.

(iii) The right to audit under paragraph (c)(3)(i) of this section will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(iv) If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the individual or entity at any time.

§438.236 Practice guidelines.

(a) Basic rule. The State must ensure, through its contracts, that each MCO, 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.

(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.

(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.

§438.242 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 part. The systems must provide information on areas including, but not limited to, utilization, claims, 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) Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.

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

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

(i) Verifying the accuracy and timeliness of reported data, including data from network providers the MCO, PIHP, or PAHP is compensating on the basis of capitation payments.

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

(iii) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

(4) Make all collected data available to the State and upon request to CMS, as required in this part.

(c) Enrollee encounter data. Contracts between a State and a MCO, PIHP, or PAHP must provide for:

(1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.

(2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS.

(3) Submission of all enrollee encounter data that the State is required to report to CMS under §438.818.

(4) Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

Subpart E—Quality Measurement and Improvement; External Quality Review

§438.310 Basis, scope, and applicability.

(a) Statutory basis. This subpart is based on sections 1932(c)(1), 1932(c)(2), 1903(a)(3)(C)(ii), 1902(a)(4), and 1902(a)(19) of the Act.

(b) Scope. This subpart sets forth:

(1) Specifications for a quality assessment and performance improvement program that States must require each contracting managed care organization (MCO), prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) to implement and maintain.

(2) Requirements for the state review and approval of all contracting MCOs, PIHPs, and PAHPs.

(3) Specifications for a Medicaid managed care quality rating system for all States contracting with MCOs, PIHPs, and PAHPs.

(4) Specifications for managed care elements of the comprehensive quality strategy that States must implement to ensure the delivery of quality health care.

(5) Requirements for annual external quality reviews of each contracting MCO, PIHP, and PAHP including—

(i) Criteria that States must use in selecting entities to perform the reviews.

(ii) Specifications for the activities related to external quality review.

(iii) Circumstances under which external quality review may use the results of Medicare quality reviews or private accreditation reviews.

(iv) Requirements for making the results of the reviews publicly available.

(c) Applicability. (1) The provisions of this subpart apply to MCOs, PIHPs, and PAHPs.

For purposes of this subpart, HIOs that are not expressly exempt by statute are required to comply with this subpart as an MCO.

(2) PCCM entities. Notwithstanding paragraphs (b) and (c)(1) of this section, the State must assess the performance of each PCCM entity consistent with the requirements of §438.3(r). That assessment must, at a minimum, include the elements described in §438.330(b)(3), (c), and (e).

§438.320 Definitions.

As used in this subpart—

Access, as it pertains to external quality review, means the timely use of services to achieve the best outcomes possible, as evidenced by successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).

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, or 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 holds a contract with a State to perform 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, or PAHP increases the likelihood of desired health outcomes of its enrollees through:

(1) Its structural and operational characteristics.

(2) The provision of services that are consistent with current professional, evidenced-based knowledge.

(3) Positive trends in performance measures and clinically significant results from interventions for performance improvement.

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.

§438.330 Quality assessment and performance improvement program.

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

(2) CMS, through a public notice and comment process in consultation with States and other stakeholders, may specify performance measures for collection in accordance with paragraph

(c) of this section, a methodology for calculating quality ratings, and topics with performance indicators for performance improvement projects in accordance with paragraph (d) of this section to be required by States in their contracts with MCOs, PIHPs, and PAHPs.

(i) In addition to those required by CMS under paragraph (a)(2) of this section, States may select their own performance improvement projects topics and performance measures to satisfy the requirements of paragraphs (b)(1) and (b)(2) of this section.

(ii) A State may apply for an exemption from collecting and reporting on the performance measures or performance improvement projects established under (a)(2) of this section, by submitting a request, in writing, to CMS which details the reason for such an exemption.

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

(1) Conduct performance improvement projects in accordance with paragraph (d) of this section.

(2) Collect and submit performance measurement data in accordance with paragraph (c) of this section.

(3) Have in effect mechanisms to detect both underutilization and overutilization of services.

(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State.

(5) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including assessment of care between care settings and a comparison of services received with those set forth in the enrollee's treatment plan.

(6) Participate in efforts by the State to prevent, detect, and remediate critical incidents that

are based, at a minimum, on the requirements on the State for home and community-based waiver programs.

(c) Performance measurement. Annually each MCO, PIHP, and PAHP must—

(1) Measure and report to the State its performance, using standard measures required by the State, including those performance measures specified by CMS under paragraph (a)(2) of this section.

(2) Submit to the State data, as specified by the State, that enables the State to measure the MCO's, PIHP's, or PAHP's performance; or

(3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.

(4) LTSS performance measurement. The State must require, through its contracts, each MCO, PIHP, and PAHP that provides LTSS services to include, as a part of its performance measurement activities under this paragraph and in addition to other measures required of all MCOs, PIHPs, and PAHPs, measures that assess the quality of life of beneficiaries and the outcomes of the MCO, PIHP, or PAHP's rebalancing and community integration activities for beneficiaries receiving LTSS.

(d) Performance improvement projects. (1) MCOs, PIHPs, and PAHPs must have an ongoing program of performance improvement projects that focuses on both clinical and nonclinical areas. 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.

Each project must include the following elements:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of interventions to achieve improvement in the access to and quality of

care.

(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 topics specified by CMS under paragraph (a)(3) of this section. 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) Option for MCOs, PIHPs, or PAHPs serving only dual eligibles. At State option, MCOs, PIHPs, or PAHPs exclusively serving dual eligibles may substitute a MA Organization quality improvement project conducted under §422.152(d) of this chapter for a performance improvement project required under this paragraph (d)(1) of this section.

(e) Program review by the State. (1) The State must review, at least annually, the impact and effectiveness of each MCO's, PIHP's, 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 measures on which it is required to report.

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

(iii) The results of any efforts by the MCO, PIHP, or PAHP to support community integration for enrollees using LTSS.

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

§438.332 State review and approval of MCOs, PIHPs, and PAHPs.

(a) General requirement. (1) To enter into a contract with the State under this part, MCOs, PIHPs, and PAHPs must be reviewed and approved by the State on the basis of performance in accordance with standards that are at least as stringent as the standards used by a private accreditation entity recognized by CMS under 45 CFR 156.275(c) or approved under §422.157 of this chapter.

(2) Following initial approval, the State must review and reapprove each MCO, PIHP, and PAHP in accordance with paragraph (a)(1) of this section at least once every 3 years.

(3) Upon obtaining initial State approval in accordance with paragraph (a)(1) of this section, MCOs, PIHPs, and PAHPs must perform consistent with the level required for approval so long as they participate in the State's Medicaid managed care program.

(b) Compliance deemed on the basis of accreditation by a private independent entity. (1) The State may elect to use proof of MCO, PIHP, or PAHP accreditation by a private independent entity recognized by CMS under 45 CFR 156.275(c) or approved under §422.157 of this chapter to satisfy the requirement described in paragraph (a) of this section.

(2) If the State chooses to exercise this option, the MCO, PIHP, or PAHP must authorize the private accreditation entity to release to the State a copy of its most recent accreditation survey, including:

(i) Accreditation status, survey type, or level (if applicable).

(ii) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.

(iii) Expiration date of accreditation.

(c) The State must make the final approval status, whether based on State review or private accreditation, for all MCOs, PIHPs, and PAHPs available on the State's Medicaid website required

under §438.10(c)(3).

§438.334 Medicaid managed care quality rating system.

(a)(1) Each State contracting with an MCO, PIHP, or PAHP must establish a quality rating system for Medicaid managed care plans that meets the requirements of this section.

(2) The quality rating system must be based on the following three components:

(i) Clinical quality management.

(ii) Member experience.

(iii) Plan efficiency, affordability, and management.

(3) The quality rating system must measure and report on the performance of each MCO, PIHP, or PAHP on measures identified by CMS, under §438.330(a)(2). Such measures will be categorized within each of the components listed in paragraph (a)(1) of this section. The quality rating system may also measure and report on additional measures identified by the State.

(b) Each State must collect data from each MCO, PIHP, and PAHP with which it contracts, which includes, at a minimum, data evidencing the MCO's, PIHP's, or PAHP's performance on the measures described in paragraph (a)(2) of this section. The State must apply the methodology established by CMS, under §438.330(a)(2), to these performance measures to determine a quality rating or ratings for each MCO, PIHP, or PAHP.

(c) Alternative quality rating system. Upon CMS approval, a State may opt to use an alternative quality rating system that utilizes different components than those described in paragraph (a)(2) of this section, incorporates the use of different performance measures than those described in paragraph (a)(3) of this section, or applies a different methodology from that described in paragraph (b) of this section.

(d) Option for MCOs, PIHPs, or PAHPs serving only dual eligibles. The State may opt to utilize the MA five-star rating for MCOs, PIHPs, or PAHPs exclusively serving dual eligible in

place of the quality rating system established under this section.

(e) The State must prominently display on its website the quality rating of each MCO, PIHP, or PAHP in a manner that complies with the standards in §438.10(d).

§438.340 Managed care elements of the State comprehensive quality strategy.

In addition to the requirements set forth in part 431, subpart I of this chapter, any State contracting with an MCO, PIHP, or PAHP must also address the following elements in the State's comprehensive quality strategy:

(a) The State-defined MCO, PIHP, and PAHP network adequacy and availability of services standards required by §§438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires its MCOs, PIHPs, and PAHPs to adopt in accordance with §438.236.

(b) The State's goals and objectives for continuous quality improvement must be developed in accordance with §431.502(b)(1) of this chapter and must incorporate a description of:

(1) Quality metrics and performance targets for measuring improvement and performance regarding MCOs, PIHPs, and PAHPs, and include, at a minimum, performance measures to be reported in accordance with §438.330(c); and

(2) Performance improvement projects to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to achieve improvement in access, quality, or timeliness of care for enrollees in MCOs, PIHPs, and PAHPs.

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

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

(e) A description of how the State will assess the performance and quality outcomes

achieved by each PCCM entity, consistent with the requirements in §438.3(r).

§438.350 External quality review.

(a) Each State that contracts with MCOs, PIHPs, or PAHPs must ensure that—

(1) Except as provided in §438.362, a qualified EQRO performs an annual EQR for each contracting MCO, PIHP, and PAHP.

(2) The EQRO has sufficient information to use in performing the review.

(3) The information used to carry out the review must be obtained from the EQR-related activities described in §438.358 or from a Medicare or private accreditation review as described in §438.360.

(4) For each EQR-related activity, the information gathered for use in the EQR must include the elements described in §438.364(a)(1)(i) through (iv).

(5) The information provided to the EQRO in accordance with paragraph (a)(2) of this section is obtained through methods consistent with the protocols established under §438.352.

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

(b) A State may require that a qualified EQRO performs an annual EQR for each PCCM entity consistent with the requirements of §438.3(r). If an EQR is performed, the requirements in paragraphs (a)(2) through (6) of this section apply.

§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 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, or 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 if either the EQRO or the MCO, PIHP, or PAHP exerts control over the other (as used in this paragraph, “control” has the meaning given the term in 48 CFR 19.101) 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;

(iv) Conduct or have conducted within the previous 3 years, an accreditation review on any contracting MCO, PIHP, or PAHP; or

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

§438.356 State contract options for external quality review.

(a) The State—

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

(2) May contract with additional EQROs or other entities 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 with an EQRO described in paragraph (a) of this section, the State must follow an open, competitive procurement process that is in accordance with State law and regulations. In addition, the State must comply with 45 CFR part 75 as it applies to State procurement of Medicaid services.

§438.358 Activities related to external quality review.

(a) General rule. (1) 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.

(2) The data obtained from the mandatory and optional EQR-related activities in this section must be used as described in §438.350(a)(3).

(b) Mandatory activities. For each MCO, PIHP, and PAHP, the following EQR-related activities must be performed:

(1) Validation of performance improvement projects, required by the State and CMS to comply with requirements set forth in §438.330(b)(1), that were underway during the preceding 12 months.

(2) Validation of MCO, PIHP, or PAHP performance measures reported (as required by the State and CMS) or MCO, PIHP, or PAHP performance measures calculated by the State during the preceding 12 months to comply with requirements set forth in §438.330(b)(2).

(3) A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D and the quality assessment and performance improvement requirements described in §438.330.

(4) Validation of MCO, PIHP, and PAHP network adequacy during the preceding

12 months to comply with requirements set forth in §438.68.

(c) Optional activities. For each MCO, PIHP, and PAHP, the following activities may be performed by using information derived during the preceding 12 months:

(1) Validation of encounter data reported by an MCO, PIHP, or PAHP.

(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 of performance improvement projects in addition to those conducted by an 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 described in this section that provide information for the EQR and the resulting EQR technical report.

§438.360 Nonduplication of mandatory activities.

(a) General rule. To avoid duplication, the State may use information about an 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) of this section are met.

(b) MCOs, PIHPs, or PAHPs reviewed by Medicare or private accrediting organizations. For information about an MCO's, PIHP's, or PAHP's performance for the validation of performance improvement projects (as required by §438.358(b)(1)) or performance measures (as required by §438.358(b)(2)) or compliance with the standards in subpart D of this part (as required

by §438.358(b)(3)), the State may use information from a Medicare or private accreditation review if the following conditions are met:

(1) The MCO, PIHP, or PAHP is in compliance with the standards established by CMS for Medicare or has obtained accreditation from a private accrediting organization recognized by CMS. The Medicare or private accreditation review standards must be substantially comparable to the mandatory activities set forth in §§438.358(b)(1) through (b)(3).

(2) The MCO, PIHP, or PAHP provides to the State all the reports, findings, and other results of the Medicare or private accreditation review related to the mandatory activities set forth in §438.358(b)(1), (b)(2), and (b)(3) and the State provides the information to the EQRO. The EQRO must include an analysis and aggregation of this information in the final EQR technical report as described in §438.364.

(c) In its comprehensive quality strategy, the State must identify the mandatory activities for which it has exercised this option and explain 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 from EQR if the following conditions are met:

(1) The MCO 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 has been subject to EQR under this part, and found to be performing acceptably for the quality, timeliness, and access to health care services it provides to Medicaid beneficiaries.

(b) Information on exempted MCOs. 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 that it exempts from EQR the most recent Medicare review findings reported on the MCO including—

(i) All data, correspondence, information, and findings pertaining to the MCO'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 performance.

(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 MA Organization deeming. (i) If an exempted MCO has been reviewed by a private accrediting organization, the State must require the MCO 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 results in an annual detailed technical report that summarizes findings on access and quality of care, including:

(1) A description of 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 EQR-related activity conducted in accordance with §438.358:

(i) Objectives.

(ii) Technical methods of data collection and analysis.

(iii) Description of data obtained, including performance measurement data for each activity conducted in accordance with §438.358(b)(1) and (2).

(iv) Conclusions drawn from the data.

(2) An assessment of each MCO's, PIHP's, or PAHP's strengths and weaknesses for 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, including how the State can target goals and objectives in the comprehensive quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

(4) Methodologically appropriate, comparative information about all MCOs, PIHPs, and 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 contract with a qualified EQRO to produce and submit to the State an annual EQR technical report in accordance with paragraph (a)

of this section. The annual technical report must be finalized no later than April 30th of each year. States may not substantively revise the content of the final EQR technical report without evidence of error or omission.

(2) The State must provide copies of the information specified in paragraph (a) of this section, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, or PAHP, beneficiary advocacy groups, and members of the general public. The State must make the most recent copy of the annual EQR technical report publicly available on the State's website required under §438.10(c)(3).

(3) The State must make the information specified in paragraph (a) of this section available in alternative formats for persons with disabilities, when requested.

(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 (FFP).

(a) FFP at the 75 percent rate is available in expenditures for EQR (including the production of EQR results) and the EQR-related activities set forth in §438.358 performed on MCOs and 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, and for EQR (including the production of EQR results) and EQR-related activities performed by an EQRO on entities other than MCOs.

(c) Prior to claiming FFP at the 75 percent rate in accordance with paragraph (a) of this section, the State must submit each EQRO contract to CMS for review and approval.

Subpart F—Grievance System

§438.400 Statutory basis and definitions.

(a) Statutory basis. This subpart is based on the following statutory sections:

(1) Section 1902(a)(3) of the Act 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) of the Act 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) of the Act 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:

Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, health care setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (b)(2) regarding the standard disposition of grievances and standard disposition and resolution of appeals; or

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

Appeal means a review by a MCO, PIHP, or PAHP of an adverse benefit determination.

Grievance means an expression of dissatisfaction about any matter other than an adverse

benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Grievance system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

§438.402 General requirements.

(a) The grievance system. Each MCO, PIHP, and PAHP must have a grievance system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in §438.9, are not subject to subpart F.

(b) Level of appeals. Each MCO, PIHP and PAHP may have only one level of appeal for enrollees.

(c) Filing requirements. (1) Authority to file. (i) An enrollee may file a grievance and an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld.

(ii) A provider, acting on behalf of the enrollee, 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—(i) Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.

(ii) Appeal. Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee or the provider has 60 calendar days in which to file an appeal.

(3) Procedures—(i) Grievance. 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, PIHP, or PAHP.

(ii) Appeal. The enrollee or a provider may file an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.

§438.404 Timely and adequate notice of adverse benefit determination.

(a) Notice. The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of adverse benefit determination in writing consistent with the requirements below and in §438.10.

(b) Content of notice. The notice must explain the following:

(1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make.

(2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's claim for benefits. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

(3) The enrollee's and the provider's right to file an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination.

(4) The procedures for exercising the rights specified in this paragraph (b).

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The enrollee's right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

(c) Timing of notice. The MCO, PIHP, or PAHP 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, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), 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 benefit determination), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).

§438.406 Handling of grievances and appeals.

(a) General requirements. In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(b) Special requirements. An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:

(1) Acknowledge receipt of each grievance and appeal.

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(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 condition or disease.

(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.

(iii) That takes into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution.

(5) Provide the enrollee and his or her representative (free of charge and sufficiently in

advance of the resolution timeframe for appeals as specified in §438.408(b) and (c)) the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination.

(6) 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.

§438.408 Resolution and notification: Grievances and appeals.

(a) Basic rule. Each MCO, PIHP, or PAHP 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 calendar days from the day the MCO, PIHP, or PAHP 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 calendar days from the day the MCO, PIHP, or PAHP 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 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) Extension of timeframes. (1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO, PIHP, or PAHP 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.

(2) Requirements following extension. If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:

(i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.

(ii) Within 2 calendar days 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.

(iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(d) Format of notice. (1) Grievances. The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the disposition of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10.

(2) Appeals. (i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of disposition in a format and language that, at a minimum, meet the standards described at §438.10.

(ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.

(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 and receive benefits while the hearing is pending, and how to make

the request.

(iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.

(f) Requirements for State fair hearings. (1) Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP or PAHP is upholding the adverse benefit determination.

(2) The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.

(3) Parties. The parties to the State fair hearing include the MCO, PIHP, or PAHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

§438.410 Expedited resolution of appeals.

(a) General rule. Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP 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 not 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) Follow the requirements in §438.408(c)(2).

§438.414 Information about the grievance system to providers and subcontractors.

The MCO, PIHP, or PAHP must provide information specified in §438.10(g)(2)(xi) about the grievance system to all providers and subcontractors at the time they enter into a contract.

§438.416 Recordkeeping requirements.

(a) The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

(b) The record of each grievance or appeal must contain, at a minimum, all of the following information:

- (1) A general description of the reason for the appeal or grievance.
- (2) The date received.
- (3) The date of each review or, if applicable, review meeting.
- (4) Resolution at each level of the appeal or grievance, if applicable.
- (5) Date of resolution at each level, if applicable.
- (6) Name of the covered person for whom the appeal or grievance was filed.

(c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.

§438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending.

(a) Definitions. As used in this section--

Timely filing means filing on or before the later of the following:

(i) Within 10 calendar days of the MCO, PIHP, or PAHP mailing the notice of adverse benefit determination.

(ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit

determination.

(b) Continuation of benefits. The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur:

- (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.
- (5) 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.
- (3) A State fair hearing office issues a hearing decision adverse to the enrollee.

(d) Enrollee responsibility for services furnished while the appeal and state fair hearing is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may recover the cost of the services furnished to the enrollee while the appeal and state fair hearing was 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. The ability of the MCO, PIHP or PAHP to recoup the costs of services from the enrollee must be specified in the contract. Such

practices must be consistently applied within the State under managed care and FFS delivery systems.

§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, PIHP, or PAHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(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, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations.

Subpart G—[Reserved]

Subpart H— Additional Program Integrity Safeguards

§438.600 Statutory basis.

This subpart is based on the following statutory sections:

(a) Section 1128 of the Act provides for the exclusion of certain individuals and entities from participation in the Medicaid program.

(b) Section 1128J(d) of the Act requires that persons who have received an overpayment under Medicaid report and return the overpayment within 60 days after the date on which the overpayment was identified.

(c) Section 1902(a)(4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(d) Section 1902(a)(19) of the Act 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.

(e) Section 1902(a)(27) of the Act requires States to enroll persons or institutions that provide services under the State plan.

(f) Section 1902(a)(68) of the Act requires that any entity receiving annual payments under the State plan of at least \$5,000,000 must establish certain minimum written policies relating to the Federal False Claims Act.

(g) Section 1902(a)(77) of the Act requires that States comply with provider and supplier screening, oversight, and reporting requirements described in section 1902(kk)(1) of the Act.

(h) Section 1902(a)(80) of the Act prohibits payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

(i) Section 1902(kk)(7) of the Act requires States to enroll physicians or other professionals that order or refer services under the State plan.

(j) Section 1903(i) of the Act prohibits FFP for amounts expended by MCOs or PCCMs for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services.

(k) Section 1903(m) of the Act establishes conditions for payments to the State for contracts with MCOs.

(l) Section 1932(d)(1) of the Act prohibits MCOs and PCCMs from knowingly having certain types of relationships with individuals and entities debarred under Federal regulations from participating in specified activities, or with affiliates of those individuals.

§438.602 State responsibilities.

(a) Monitoring contractor compliance. Consistent with §438.66, the State must monitor the MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's compliance, as applicable, with

§438.604, §438.606, §438.608, §438.610, §438.230, and §438.808.

(b) Screening and enrollment and revalidation of providers. The State must screen and enroll, and periodically revalidate, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E of this chapter. This requirement extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the State to provide services to FFS beneficiaries. This provision does not require the network provider to render services to FFS beneficiaries.

(c) Ownership and control information. The State must review the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors, subject to the requirements in §438.230, in accordance with subpart B of part 455 of this chapter.

(d) Federal database checks. Consistent with the requirements at §455.436 of this chapter, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. This includes the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State or Secretary may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. If the state determines a match, it must promptly notify the MCO, PIHP, PAHP, PCCM, or PCCM entity and take action consistent with §438.610(c).

(e) Periodic audits. The State must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP.

(f) Whistleblowers. The State must receive and investigate information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part.

(g) Transparency. The State must post on its website or make available upon request the following documents and reports:

(1) The MCO, PIHP, PAHP, or PCCM entity contract.

(2) The data submitted under §438.604.

(3) The results of any audits under paragraph (e) of this section.

(h) Contracting integrity. The State must have in place conflict of interest safeguards described in §438.58 and must comply with the requirement described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

(i) Entities located outside of the U.S. The State must ensure that the MCO, PIHP, PAHP, PCCM, or PCCM entity with which the State contracts under this part is not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates.

§438.604 Data, information, and documentation that must be submitted.

(a) Specified data, information, and documentation. The State must require any MCO, PIHP, PAHP, PCCM or PCCM entity to submit to the State the following data:

(1) Encounter data in the form and manner described in §438.818.

(2) Data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO, PIHP or PAHP under §438.3, including base data described in §438.5(c) that is generated by the MCO, PIHP or PAHP.

(3) Data on the basis of which the State determines the compliance of the MCO, PIHP, or

PAHP with the medical loss ratio requirement described in §438.8.

(4) Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under §438.116.

(5) Documentation described in §438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in §438.206.

(6) Information on ownership and control described in §455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by §438.230.

(7) The annual report of overpayment recoveries as required in §438.608(d)(3).

(b) Additional data, documentation, or information. In addition to the data, documentation, or information specified in paragraph (a) of this section, an MCO, PIHP, PAHP, PCCM or PCCM entity must submit any other data, documentation, or information relating to the performance of the entity's obligations under this part required by the State or the Secretary.

§438.606 Source, content, and timing of certification.

(a) Source of certification. For the data, documentation, or information specified in §438.604, the State must require that the data, documentation or information the MCO, PIHP, PAHP, PCCM or PCCM entity submits to the State be certified by either the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer.

(b) Content of certification. The certification provided by the individual in paragraph (a) of this section must attest that the MCO, PIHP, PAHP, PCCM, or PCCM entity has conducted a reasonably diligent review of the data, documentation, and information specified in §438.604(a) and (b), and that the data documentation, and information is accurate, complete, and truthful.

(c) Timing of certification. The State must require the MCO, PIHP, PAHP, PCCM. or PCCM entity to submit the certification concurrently with the submission of the data,

documentation, or information required in §438.604(a) and (b).

§438.608 Program integrity requirements under the contract.

(a) Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. The State, through its contract with the MCO, PIHP or PAHP, must require that the MCO, PIHP, or PAHP, or subcontractor to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims under the contract between the State and the MCO, PIHP, or PAHP, implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

(1) A compliance program that includes, at a minimum, all of the following elements:

(i) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.

(ii) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.

(iii) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

(iv) A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.

(v) Effective lines of communication between the compliance officer and the

organization's employees.

(vi) Enforcement of standards through well-publicized disciplinary guidelines.

(vii) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

(2) Provision for prompt reporting of all improper payments identified or recovered, specifying the improper payments due to potential fraud, to the State or law enforcement.

(3) Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following:

(i) Changes in the enrollee's residence or notification of an enrollee's mail that is returned as undeliverable.

(ii) Changes in the enrollee's income.

(iii) The death of an enrollee.

(4) Provision for notification to the State when it receives information about a change in a provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP.

(5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

(6) In the case of MCOs, PIHPs, or PAHPs that receive annual payments under the contract

of at least \$5,000,000, written policies for all employees of the entity, and of any contractor or agent, providing detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers are in place.

(7) Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

(8) Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with §455.23 of this chapter.

(b) Provider screening and enrollment requirements. The State, through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter. This provision does not require the network provider to render services to FFS beneficiaries.

(c) Disclosures. The State must ensure, through its contracts, that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors:

(1) Provides written disclosure of any prohibited affiliation under §438.610.

(2) Provides written disclosures of information on ownership and control required under §455.104.

(3) Reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

(d) Treatment of recoveries made by the MCO, PIHP or PAHP of overpayments to providers. (1) Contracts with a MCO, PIHP, or PAHP must specify that the MCO, PIHP or PAHP

retains the following:

(i) Payments made to a network provider that was otherwise excluded from participation in the Medicaid program, and subsequently recovered from that network provider, by an MCO, PIHP or PAHP.

(ii) Payments made to a network provider due to fraud, waste or abuse, and subsequently recovered from that network provider, by an MCO, PIHP or PAHP.

(2) Each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment.

(3) Each MCO, PIHP, or PAHP must report annually to the State on their recoveries of overpayments.

(4) The State must use the results of the report in paragraph (d)(3) of this section for setting actuarially sound capitation rates for each MCO, PIHP, or PAHP consistent with the requirements in §438.4.

(5) For purposes of paragraph (d) of this section, an overpayment is any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under title XIX of the Act.

§438.610 Prohibited affiliations.

(a) An MCO, PIHP, PAHP, PCCM, or PCCM entity may not knowingly have a relationship of the type described in paragraph (c) of this section with the following:

(1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from

participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) An MCO, PIHP, PAHP, PCCM, or PCCM entity may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

(c) The relationships described in paragraph (a) of this section, are as follows:

(1) A director, officer, or partner of the MCO, PIHP, PAHP, PCCM, or PCCM entity.

(2) A subcontractor of the MCO, PIHP, PAHP, PCCM, or PCCM entity, as governed by §438.230.

(3) A person with beneficial ownership of 5 percent or more of the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's equity.

(4) A network provider or persons with an employment, consulting or other arrangement with the MCO, PIHP, PAHP, PCCM, or PCCM entity for the provision of items and services that are significant and material to the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's obligations under its contract with the State.

(d) Effect of noncompliance. If a State finds that an MCO, PIHP, PAHP, PCCM, or PCCM entity 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, PIHP, PAHP, PCCM, or PCCM entity unless the Secretary directs otherwise.

(3) May not renew or otherwise extend the duration of an existing agreement with the MCO, PIHP, PAHP, PCCM, or PCCM entity unless the Secretary provides to the State and to

Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

(4) Nothing in this section must be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

(e) Consultation with the Inspector General. Any action by the Secretary described in paragraphs (d)(2) or (d)(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 must, and each State that contracts with a PCCM or PCCM entity may, establish intermediate sanctions (which may include those 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 acts or fails to act as follows:

(1) Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.

(2) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

(3) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(4) Misrepresents or falsifies information that it furnishes to CMS or to the State.

(5) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

(6) 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, PCCM or PCCM entity 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 has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

(2) A PCCM or PCCM entity has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act, or 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 date the Secretary or the State notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.

(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. If the State imposes civil monetary penalties as provided under §438.702(a)(1), the maximum civil money penalty the State may impose varies depending on the nature of the MCO's, PCCM or PCCM entity's action or failure to act, as provided in this section.

(b) Specific limits. (1) The limit is \$25,000 for each determination under §438.700(b)(1), (b)(5), (b)(6), and (c).

(2) The limit is \$100,000 for each determination under §438.700(b)(3) or (b)(4).

(3) The limit is \$15,000 for each beneficiary the State determines was not enrolled because of a discriminatory practice under §438.700 (b)(3). (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 \$25,000 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. If the State imposes temporary management under §438.702(a)(3), the State may do so only if it finds (through onsite surveys, enrollee or other

complaints, financial status, or any other source) any of the following:

(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.

(2) There is substantial risk to enrollees' health.

(3) The sanction is necessary to ensure the health of the MCO's enrollees—

(i) While improvements are made to remedy violations under §438.700.

(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 sections 1903(m) or 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, PCCM or PCCM entity contract.

A State has the authority to terminate an MCO, PCCM or PCCM entity contract and enroll that entity's enrollees in other MCOs, PCCMs or PCCM entities, or provide their Medicaid benefits through other options included in the State plan, if the State determines that the MCO, PCCM or PCCM entity has failed to do either of the following:

(a) Carry out the substantive terms of its contract.

(b) Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.

§438.710 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 appeal rights that the State elects to provide.

(b) Pre-termination hearing. (1) General rule. Before terminating an MCO, PCCM or PCCM entity contract under §438.708, the State must provide the entity a pre-termination hearing.

(2) Procedures. The State must do all of the following:

(i) Give the MCO, PCCM or PCCM entity 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.

(iii) For an affirming decision, give enrollees of the MCO, PCCM or PCCM entity 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, PCCM or PCCM entity 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.

§438.724 Notice to CMS.

(a) The State must give CMS written notice whenever it imposes or lifts a sanction for one

of the violations listed in §438.700.

(b) The notice must adhere to all of the following requirements:

(1) Be given no later than 30 days after the State imposes or lifts a sanction.

(2) Specify the affected MCO, the kind of sanction, and the reason for the State's decision to impose or lift a sanction.

§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 §438.730(e).

§438.730 Sanction by CMS: Special rules for MCOs.

(a) Basis for sanction. A State 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's determination becomes CMS' determination for purposes of section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days.

(2) When the State decides to recommend imposing the sanction described in paragraph (e) of this section, this recommendation becomes CMS' 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's determination becomes CMS' determination under paragraph (b)(2) of this section, the State takes all of 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.

(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--

(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.

(iii) Forwards the decision to CMS.

(2) The State's decision under paragraph (d)(1)(ii) of this section becomes CMS' 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 decision, the agency sends the MCO a copy of CMS' 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 MCO 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' denial of payment for new enrollees automatically results in a denial of agency payments to the MCO 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 (c) 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) of this section, the sanction is effective on the date specified in CMS' reconsideration notice.

(ii) If CMS, in consultation with the State, 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 (d)(1)(ii) of this section.

(g) CMS' role. (1) CMS retains the right to independently perform the functions assigned to the State under paragraphs (a) through (d) of this section.

(2) At the same time that the State sends notice to the MCO under paragraph (c)(1) 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. 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 (FFP)**§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.

§438.806 Prior approval.

(a) Comprehensive risk contracts. FFP is available under a comprehensive risk contract only if all of the following apply:

(1) CMS 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 §438.3.

(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 provisions of 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.

§438.807 Deferral and/or disallowance of FFP for non-compliance with Federal requirements.

CMS may defer and/or disallow FFP under a contract subject to approval under this part,

payment amounts associated with services under a MCO contract, in accordance with the requirements in §430.40 and §430.42 of this chapter, respectively, if the Administrator finds that—

(a) The contract, as submitted for approval or as administered by the State, is non-compliant with the requirements of section 1903(m)(2)(A) of the Act, the applicable requirements of section 1932 of the Act, or the provisions of this part for the service or services; or

(b) The final capitation rates as developed and described in the rate certification are noncompliant with the requirements in §§438.4 through 438.7 for the service or services.

§438.808 Exclusion of entities.

(a) General rule. FFP is available in payments under MCO contracts or PIHP, PAHP, PCCM, or PCCM entity contracts under a section 1915(b)(1) of the Act waiver 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 or an individual described in §438.610(a).

(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 described in §438.610(a).

(ii) Any individual or entity that would provide those services through an individual or entity described in §438.610(a).

§438.810 Expenditures for enrollment broker services.

(a) Definitions. As used in this section—

Enrollment activities means activities such as distributing, collecting, and processing

enrollment materials and taking enrollments by phone, in person, or through electronic methods of communication.

Enrollment broker means an individual or entity that performs choice counseling or enrollment activities, or both.

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, PCCM entity 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, PCCM entity or other health care provider in the State;

(ii) Is owned or controlled by an MCO, PIHP, PAHP, PCCM, PCCM entity or other health care provider in the State; or

(iii) Owns or controls an MCO, PIHP, PAHP, PCCM, PCCM entity 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.

§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.

§438.816 Expenditures for independent consumer support services for enrollees using LTSS.

State expenditures for the person or entity providing the services outlined in §438.71(e) are considered necessary for the proper and efficient operation of the State plan and thus eligible for FFP only if all of the following conditions are met:

(a) Costs must be supported by an allocation methodology that appears in the State's approved Public Assistance Cost Allocation Plan in §433.34 of this chapter.

(b) The costs do not duplicate payment for activities that are already being offered or should be provided by other entities or paid by other programs.

(c) The person or entity providing the services must meet the requirements in §438.810(b)(1) and (2).

(d) The initial contract or MOA for services performed has been reviewed and approved by CMS.

§438.818 Enrollee encounter data.

(a) FFP is available for expenditures under an MCO, PIHP, or PAHP contract only if the State meets the following conditions for providing sufficient and timely enrollee encounter data to CMS:

(1) Enrollee encounter data reports must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards and be submitted in the format required by the Medicaid Statistical Information System or format required by any successor system to the Medicaid Statistical Information System.

(2) States must ensure that enrollee encounter data is validated for accuracy and completeness before each data submission. States may use the external quality review activity required in §438.358 for the validation of encounter data to meet this requirement.

(3) States must cooperate with CMS to fully comply with all encounter data reporting requirements of the Medicaid Statistical Information System or any successor system.

(b) CMS will assess a State's submission to determine if it complies with current criteria for accuracy and completeness.

(c) If, after being notified of compliance issues under paragraph (b) of this section the State is unable to make a data submission compliant, CMS will take appropriate steps to defer and/or disallow FFP on all or part of an MCO, PIHP, or PAHP contract in a manner based on the enrollee and specific service type of the noncompliant data.

(d) States must, within 90 days of the effective date of this requirement, submit to CMS a detailed plan of their procedures and processes to ensure that complete and accurate enrollee encounter data are being submitted timely.

Subpart K – [Reserved]

PART 440—SERVICES: GENERAL PROVISIONS

9. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

10. Section 440.262 is added to read as follows:

§440.262 Access and cultural considerations.

The State must have methods to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that beneficiaries have access to covered services that are delivered in a manner that meet their unique needs.

PART 457—ALLOTMENTS AND GRANTS TO STATES

11. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

12. Section 457.10 is amended by revising the definition of “fee-for-service entity” and adding the definitions of “actuarially sound principles”, “comprehensive risk contract”, “external quality review”, “external quality review organization”, “managed care organization”, “prepaid ambulatory health plan”, “prepaid inpatient health plan”, “primary care case management”, “primary care case management entity”, “primary care case manager”, and “risk contract” in alphabetical order to read as follows:

§457.10 Definitions and use of terms.

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Actuarially sound principles means generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board.

* * * * *

Comprehensive risk contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

- (1) Outpatient hospital services.
- (2) 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.

* * * * *

External quality review (EQR) 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, or PAHP, or their contractors furnish to CHIP beneficiaries.

External quality review organization (EQRO) means an organization that meets the competence and independence requirements set forth in §438.354 of this chapter, and holds a contract with a State to perform external quality review, other EQR-related activities as set forth in §438.358 of this chapter, or both.

* * * * *

Fee-for-service entity means any individual or entity that furnishes services under the program on a fee-for-service basis, including health insurance services.

* * * * *

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 CHIP enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other CHIP beneficiaries within the area served by the entity.

(ii) Meets the solvency standards of §438.116 of this chapter.

* * * * *

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

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

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

(3) Does not have a comprehensive risk contract.

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

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

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

(3) Does not have a comprehensive risk contract.

* * * * *

Primary care case management means a system under which:

(1) A PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to CHIP beneficiaries;

or

(2) A PCCM entity contracts with the State to provide a defined set of functions to CHIP beneficiaries.

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

(2) Development of enrollee care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of fee-for-service providers in the fee-for-service program.

(4) Provision of payments to fee-for-service providers on behalf of the State.

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports systems/providers.

Primary care case manager (PCCM) means a physician, a physician group practice or, at State option, any of the following in addition to primary care case management services:

(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.

(2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

* * * * *

13. Section 457.204 is amended by revising paragraph (a) to read as follows:

§457.204 Withholding of payment for failure to comply with Federal requirements.

(a) Basis for withholding. CMS withholds payments to the State, in whole or in part, only if, after giving the State notice, a reasonable opportunity for correction, and an opportunity for a hearing, the Administrator finds—

(1) That the State plan is in substantial noncompliance with the requirements of title XXI of the Act or the regulations in this part. Substantial non-compliance includes, but is not limited to, failure to comply with requirements that significantly affect federal or state oversight or state reporting; or

(2) That the State is conducting its program in substantial noncompliance with either the State plan or the requirements of title XXI of the Act or the regulations in this part. Substantial

non-compliance includes, but is not limited to, failure to comply with requirements that significantly affect federal or state oversight or state reporting. (Hearings are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions. These efforts may be continued even if a date and place have been set for the hearing.)

* * * * *

14. Section 457.700 is amended by redesignating paragraphs (a)(1) and (a)(2) as paragraphs (a)(3) and (a)(4), and adding new paragraphs (a)(1) and (a)(2) to read as follows:

§457.700 Basis, scope, and applicability.

(a) * * *

(1) Section 2101(a) of the Act, which provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner; and

(2) Section 2103(f)(3) of the Act, which required compliance with managed care requirements, including quality assurance standards; and

* * * * *

15. Section 457.760 is added to subpart G to read as follows:

§457.760 CHIP component of the State comprehensive quality Strategy.

(a) General rule. As a component of the State comprehensive quality strategy required under part 431, subpart I of this chapter, each state must address how it will assess and improve the quality of health care and services furnished to all CHIP enrollees.

(b) Under the CHIP component of the State comprehensive quality strategy, the State must:

(1) Address all elements set forth in §431.502 of this chapter; and

(2) Follow the development, evaluation, and revision requirements as provided in §431.504 of this chapter.

(c) Each State contracting with an MCO, PIHP, or PAHP as defined in §457.10 of this chapter must also address, within the comprehensive quality strategy in paragraph (a), the requirements described in §457.1240 of this chapter.

§457.902 [Removed]

16. Section 457.902 is removed.

17. Section 457.940 is revised to read as follows:

§457.940 Procurement standards.

(a) A State must submit to CMS a written assurance that title XXI services will be provided in an effective and efficient manner. The State must submit the assurance—

(1) With the initial State plan; or

(2) For States with approved plans, with the first request to amend the approved plan.

(b) A State must provide for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services in accordance with the procurement requirements of 45 CFR 74.43 or 45 CFR 92.36, as applicable.

(c) All contracts under this part must include provisions that define a sound and complete procurement contract, as required by 45 CFR part 74 or 45 CFR part 92, as applicable.

18. Section 457.950 is amended by revising paragraph (a) to read as follows:

§457.950 Contract and payment requirements including certification of payment-related information.

(a) MCOs, PAHPs, PIHPs, PCCMs, and PCCM entities. The contract requirements for MCOs, PAHPs, PIHPs, PCCMs, and PCCM entities are provided in §457.1201.

* * * * *

19. Subpart L is added to part 457 to read as follows:

Subpart L—Managed Care

Sec.

GENERAL PROVISIONS

457.1200 Basis, scope, and applicability.

457.1201 Standard contract requirements.

457.1203 Rate development standards.

457.1205 Medical loss ratio.

457.1206 Non-emergency medical transportation PAHPs.

457.1207 Information requirements.

457.1208 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care provider (IHCP), and Indian managed care entities (IMCE).

STATE RESPONSIBILITIES

457.1210 Managed care enrollment.

457.1212 Disenrollment.

457.1214 Conflict of interest safeguards.

457.1216 Continued services to enrollees.

457.1218 Network adequacy standards.

ENROLLEE RIGHTS AND PROTECTIONS

457.1220 Enrollee rights.

457.1222 Provider-enrollee communication.

457.1224 Marketing activities.

457.1226 Liability for payment.

457.1228 Emergency and poststabilization services.

MCO, PIHP, AND PAHP STANDARDS

457.1230 Access standards.

457.1233 Structure and operation standards.

QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW

457.1240 Quality measurement and improvement.

457.1250 External quality review.

GRIEVANCE SYSTEM

457.1260 Grievance system.

SANCTIONS

457.1270 Sanctions.

Subpart L—Managed Care

GENERAL PROVISIONS

§457.1200 Basis, scope, and applicability.

(a) Statutory basis. This subpart implements the following sections of the Act:

(1) Section 2101(a), which provides that the purpose of Title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

(2) Section 2103(f)(3) and 2107(e)(1)(M) of the Act, which apply certain provisions of Title XIX related to Medicaid managed care to CHIP.

(3) Sections 2107(b) and 2107(e)(2) of the Act, which relate to program integrity.

(b) Scope. This subpart sets forth requirements for the provision of services through managed care organizations, prepaid ambulatory health plans, prepaid inpatient health plans, and primary care case management entities, as defined in §457.10.

(c) Applicability. The requirements of this subpart apply to child health assistance provided under a separate child health program operating a managed care delivery system. Regulations

relating to managed care that are applicable to a Medicaid expansion program are found at part 438 of this chapter.

§457.1201 Standard contract requirements.

(a) CMS review. The State must submit all MCO, PAHP, PIHP, PCCM, and PCCM entity contracts for review in accordance with standards specified by the Secretary.

(b) Entities eligible for comprehensive risk contracts. The State 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.

(c) Payment. The final contract rates per contracted MCO, PIHP, or PAHP must be specifically identified in the applicable contract submitted for CMS review. The final contract rates must be based only upon services covered under the State plan and additional services deemed by the State to be necessary to comply with the Mental Health Parity and Addiction Equity Act, follow the requirements in §457.1203 and represent a payment amount that is adequate to allow the MCO, PIHP or PAHP to efficiently deliver high quality services to CHIP-eligible individuals in a manner compliant with contractual requirements.

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

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

(3) The MCO, PAHP, PIHP, PCCM or PCCM entity will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability.

(e) Compliance with applicable laws and conflict of interest safeguards. All contracts with MCOs, PAHPs, PIHPs, PCCMs or PCCM entities 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; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

(2) Comply with the conflict of interest safeguards described in §457.1214.

(f) Inspection and audit of records and access to facilities. Risk contracts must provide that the State, CMS, and the Office of the Inspector General may inspect and audit any records or documents of the MCO, PAHP, PIHP, PCCM or PCCM entity or its subcontractors, and may inspect the premises, physical facilities, and equipment related to its CHIP enrollees.

(g) Physician incentive plans. (1) MCO, PAHP, and PIHP 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 “MA organization,” “CMS,” and “Medicare beneficiaries” must be read as references to “MCO, PAHP, or PIHP,” “State,” and “CHIP beneficiaries,” respectively.

(h) Subcontracts. All subcontracts must fulfill the requirements of this part for the service or activity delegated under the subcontract in accordance with §457.1233(b).

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

(j) Audited financial reports. The contract must require MCOs, PAHPs, and PIHPs to submit audited financial reports on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

(k) [Reserved]

(l) 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 PCCM'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.

(m) Additional rules for contracts with PCCM entities. In addition to the requirements in paragraph (l) of this section, the State must submit PCCM entity contracts to CMS for review to ensure compliance with the provisions of paragraph (l) of this section; §457.1206; and if the State's contract with the PCCM entity provides for shared savings, incentive payments, or other financial reward for improved quality outcomes, §457.1240(b), §457.1240(e) and 457.1240(f) if

the State's contract with the PCCM entity provides for shared savings, incentive payments or other financial reward for improved quality outcomes.

(n) Attestations. Contracts with MCO, PAHP, PIHP, PCCM or PCCM entities must include an attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.

(o) Guarantee not to avoid costs. Contracts with MCO, PAHP, PIHP, PCCM or PCCM entities must include a guarantee that the MCO, PAHP, PIHP, PCCM or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources.

(p) Recordkeeping requirements. MCOs, PIHPs, and PAHPs, must retain, and require subcontractors to retain, as applicable, the following information: enrollee grievance and appeal records in §457.1260, MLR reports in §457.1205, and the data, information, and documentation specified in §457.1270 for a period of no less than 6 years.

§457.1203 Rate development standards.

(a) A state must use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at §457.10.

(b) A State may establish higher rates than permitted under paragraph (a) of this section if such rates are necessary to ensure sufficient provider participation, provider access, or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

(c) The rates must be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under §438.8 of this chapter, of at least 85 percent for the rate year. In addition, the rates must be developed in such a way to achieve a medical loss ratio standard, as calculated under §438.8, that provides for reasonable

administrative costs.

(d) The State must provide to CMS, if requested, a description of the manner in which rates were developed in accordance with the requirements of paragraphs (a), (b), or (c) of this section.

§457.1205 Medical loss ratio.

(a) The state must comply with the requirements related to medical loss ratios as provided in §438.74 of this chapter, except that the description of the reports received from the MCO,s PIHPs and PAHPs pursuant to §438.8(k) will not be submitted with the actuarial certification described in §438.7.

(b) The state must ensure, through its contracts, that each MCO, PIHP, and PAHP complies with the requirements §438.8 of this chapter.

§457.1206 Non-emergency medical transportation PAHPs.

(a) For purposes of this section Non-Emergency Medical Transportation (NEMT) PAHP means an entity that provides only NEMT services to enrollees under contract with the State, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.

(b) Unless listed in this paragraph, a requirement of this part does not apply to NEMT PAHPs, NEMT PAHP contracts, or States in connection with a NEMT PAHP. The following requirements and options apply to NEMT PAHPs, NEMT PAHP contracts, and States in connection with NEMT PAHPs, to the same extent that they apply to PAHPs, PAHP contracts, and States in connection with PAHPs.

(1) All contract provisions in §457.1202 except requirements for:

- (i) Physician Incentive plans;
- (ii) Audited Financial Reports; and
- (iii) MHPAEA.

- (2) The rate development standards in §457.1203.
- (3) The information requirements in §457.1207.
- (4) The provision against provider discrimination in §457.1208.
- (5) The State responsibility provisions in §§457.1212, 457.1214, and 438.62(a) of this chapter, as cross referenced by §457.1216.
- (6) The provisions on enrollee rights and protections in §§457.1220, 457.1222, 457.1224, and 457.1226.
- (7) The PAHP Standards in §438.206(b)(1) of this chapter, as cross-referenced by §§457.1230(a); 457.1230(d); and 457.1233(a) through (c).
- (8) An enrollee's right to a State review under subpart K of this chapter.
- (9) Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in §457.1285.

§457.1207 Information requirements.

The State must provide, or ensure its contracted MCO, PAHP, PIHP, PCCM and PCCM entities provide all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees as provided in §438.10 of this chapter.

§457.1208 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care provider (IHCP), and Indian managed care entities (IMCE).

The State must follow, and ensure through its contracts, that each MCO, PIHP, PAHP, PCCM, and PCCM entity follows, the requirements related to Indians, IHCPs, and IMCEs as provided in §438.14 of this chapter.

STATE RESPONSIBILITIES

§457.1210 Managed care enrollment.

(a) If a state uses a default enrollment process to assign beneficiaries to a MCO, PIHP, PAHP, PCCM, or PCCM entity, the process must:

(1) Assign beneficiaries to a qualified MCO, PIHP, PAHP, PCCM or PCCM entity. To be a qualified, the MCO, PIHP, PAHP, PCCM or PCCM entity must:

- (i) Not be subject to the intermediate sanction described in §438.702(a)(4) of this chapter.
- (ii) Have capacity to enroll beneficiaries.

(2) Seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served CHIP beneficiaries.

(i) An “existing provider-beneficiary relationship” is one in which the provider was the main source of CHIP services for the beneficiary during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience, encounter data, or through contact with the beneficiary.

(ii) A provider is considered to have “traditionally served” CHIP beneficiaries if it has experience in serving the CHIP population.

(3) If the approach in paragraph (a)(2) of this section is not possible, the State must distribute the beneficiaries equitably among the MCOs, PIHPs, PAHPs, PCCMs and PCCM entities.

(i) The State may not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered.

(ii) The State may consider additional criteria to conduct the default enrollment process, including the enrollment preferences of family members, previous plan assignment of the beneficiary, quality assurance and improvement performance, procurement evaluation elements, accessibility of provider offices for people with disabilities (when appropriate), and other reasonable criteria that support the objectives of the managed care program.

(4) The State must send a confirmation of the enrollee's managed care enrollment to the enrollee within 5 calendar days of the MCO, PIHP, PAHP, PCCM or PCCM entity enrollment being processed by the State. The confirmation must clearly explain the enrollee's right to disenroll within 90 days from the effective date of the enrollment.

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

§457.1212 Disenrollment.

The State must follow and ensure, through its contracts, that each MCO, PAHP, PIHP, PCCM and PCCM entity follows, the disenrollment requirements as provided in §438.56 of this chapter, except that references to fair hearings should be read to refer to reviews as described in subpart K of this chapter.

§457.1214 Conflict of interest safeguards.

The State must have in effect safeguards against conflict of interest as provided in §438.58 of this chapter.

§457.1216 Continued services to enrollees.

The State must follow the requirements related to continued services to enrollees as provided in §438.62 of this chapter.

§457.1218 Network adequacy standards.

The State must develop network adequacy standards as provided in §438.68 of this chapter, and, ensure through its contracts, that each MCO, PAHP, and PIHP meets such standards. In addition to developing standards provided in §438.68 of this chapter, the state must develop time and distance standards for dental providers and pediatric specialists, if covered under the contracts.

ENROLLEE RIGHTS AND PROTECTIONS

§457.1220 Enrollee rights.

The State must ensure, through its contracts, that each MCO, PIHP, PAHP, PCCM, and PCCM entity follow the enrollee rights requirements as provided in §438.100 of this chapter.

§457.1222 Provider-enrollee communication.

The State must ensure, through its contracts, that each MCO, PIHP, and PAHP protects communications between providers and enrollees as provided in §438.102 of this chapter.

§457.1224 Marketing activities.

The State must ensure, through its contracts, that each MCO, PIHP, PAHP, PCCM, and PCCM entity follows the requirements related to marketing activities as provided in §438.104 of this chapter.

§457.1226 Liability for payment.

The State must ensure, through its contracts, that enrollees of MCOs, PIHPs, and PAHPs are not held liable for services or debts of the MCO, PIHP, or PAHPs as provided in §438.106 of this chapter.

§457.1228 Emergency and poststabilization services.

The State must ensure that emergency services, as defined in §457.10, are available and accessible to enrollees as provided in §438.114 of this chapter.

MCO, PIHP, AND PAHP STANDARDS

§457.1230 Access standards.

(a) Availability of services. The State must ensure that the services are available and accessible to enrollees as provided in §438.206 of this chapter.

(b) Assurances of adequate capacity and services. The State must ensure, through its contracts, that each MCO, PIHP and PAHP has adequate capacity to serve the expected enrollment as provided in §438.207 of this chapter.

(c) Coordination and continuity of care. The State must ensure, through its contracts, that each MCO, PIHP and PAHP complies with the coordination and continuity of care requirements as provided in §438.208 of this chapter.

(d) Coverage and authorization of services. The State must ensure, through its contracts, that each MCO, PIHP or PAHP complies with the coverage and authorization of services requirements as provided in §438.210 of this chapter, except:

(1) Section 438.210(a)(5) related to medically necessary services does not apply;

(2) Notice of adverse benefit determination must meet the requirements of §457.1260;

(3) The time frames set forth in §438.210(d) do not apply. For the timeframe for decisions, each MCO, PIHP, or PAHP contract must provide for the decisions and notices in accordance with §457.1160.

§457.1233 Structure and operation standards.

(a) Provider selection. The State must ensure, through its contracts, that each MCO, PIHP or PAHP complies with the provider selection requirements as provided in §438.214 of this chapter.

(b) Subcontractual relationships and delegation. The State must ensure, through its contracts, that each MCO, PIHP and PAHP complies with the subcontractual relationships and delegation requirements as provided in §438.230 of this chapter.

(c) Practice guidelines. The state must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP, complies with the practice guidelines requirements as provided in §438.236 of this chapter.

(d) Health information systems. The State must ensure, through its contracts, that each MCO, PIHP, and PAHP complies with the health information systems requirements as provided in §438.242 of this chapter.

QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW

§457.1240 Quality measurement and improvement.

(a) Scope. This section sets forth requirements related to quality assessment and performance improvement that each State contracting with an MCO, PIHP, or PAHP must meet.

(b) Quality assessment and performance improvement program. The State must require, through its contracts, that each MCO, PIHP, and PAHP must establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in §438.330, except that the terms of §438.330(d)(3) of this chapter (for dual eligibles) do not apply.

(c) State review and approval of MCOs, PIHPS, and PAHPs. The State must review and approve the performance of each MCO, PIHP, and PAHP in accordance with the requirements as set forth in §438.332 of this chapter.

(d) Managed Care quality rating system. The State must collect data and apply the methodology established by CMS under the process described in §438.330(a)(2) to determine a quality rating or ratings for each MCO, PIHP, and PAHP in accordance with the requirements set forth in §438.334, except that the terms of 438.334(d) of this chapter (for dual eligible) do not apply.

(e) Managed care elements of the State comprehensive quality strategy. In addition to the requirements set forth in §457.760, any State contracting with an MCO, PIHP, or PAHP must also address the managed care elements described in §438.340 of this chapter.

§457.1250 External quality review.

(a) Each State that contracts with MCOs, PIHPs, or PAHPs must follow all applicable external quality review requirements as set forth in §§438.350, 438.352, 438.354, 438.356, 438.358, and 438.364 of this chapter.

(b) Exceptions. (1) The following provisions do not apply to the CHIP external quality review process for States contracting with MCOs, PIHPs, or PAHPs;

(i) Nonduplication of mandatory activities (as set forth in §438.360 of this chapter.)

(ii) Exemption from external quality review (as set forth in §438.362 of this chapter.)

(2) A State may amend an existing EQRO contract to include the performance of EQR-related activities and/or EQR in accordance with paragraph (a) of this section, provided that the existing contract meets the requirements in §438.356 of this chapter.

GRIEVANCE SYSTEM

§457.1260 Grievance system.

The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the grievance and appeals requirements and procedures as provided in subpart F of part 438 of this chapter, except that the terms of §438.420 do not apply and that references to fair hearings should be read to refer to reviews as described in subpart K of this chapter.

SANCTIONS

§457.1270 Sanctions.

The State must comply, and ensure that its contracted MCOs comply, with the sanctions requirements as provided in subpart I of part 438 of this chapter.

20. Add a new undesignated center heading to subpart K after §457.1190 to read as follows:

PROGRAM INTEGRITY

§457.955 [Redesignated as §457.1280]

21. Section 457.955 is redesignated as new §457.1280 in subpart K.

22. Newly redesignated §457.1280 is amended by revising the section heading and paragraphs (a), (b)(1), (b)(2), (b)(3), and (d) to read as follows:

§457.1280 Conditions necessary to contract as an MCO, PAHP, or PIHP.

(a) The State must assure that any entity seeking to contract as an MCO, PAHP, or PIHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse.

(b) * * *

(1) Enforce MCO, PAHP, and PIHP compliance with all applicable Federal and State statutes, regulations, and standards.

(2) Prohibit MCOs, PAHPs, and PIHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity.

(3) Include a mechanism for MCOs, PAHPs, and PIHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PAHP, or PIHP and other individuals.

* * * * *

(d) The State may inspect, evaluate, and audit MCOs, PIHPs, and PAHPs at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent and abusive activity.

23. Section 457.1285 is added to subpart K to read as follows:

§457.1285 Program integrity safeguards.

The state must comply with the program integrity safeguards as provided in subpart H of part 438, except that the terms of §438.604(a)(2) of this chapter do not apply.

**PART 495—STANDARDS FOR THE ELECTRONIC HEALTH RECORD
TECHNOLOGY INCENTIVE PROGRAM**

24. The authority citation for part 495 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§495.332 [Amended]

25. In §495.332, amend paragraph (d)(2) by removing the reference “§438.6(v)(5)(iii)” and add in its place the reference “§438.6(b)(2)”.

§495.366 [Amended]

26. In §495.366, amend paragraph (e)(7) by removing the reference “§438.6(c)(5)(iii)” and add in its place the reference “§438.6(b)(2)”.

CMS-2390-P

Dated: March 11, 2015.

Andrew M. Slavitt,
Acting Administrator,
Centers for Medicare & Medicaid Services.

Dated: May 21, 2015.

Sylvia M. Burwell,
Secretary,
Department of Health and Human Services.

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