ATTACHMENT C

Sample Documentation and Reporting Tool

for Recording MCO/PIHP Compliance with Medicaid Managed Care Regulatory Provisions

This sample documentation and reporting tool illustrates how results of monitoring activities could be recorded. Entities conducting compliance reviews may find it helpful to use this tool, modify this tool, or use a tool of their own design. Whatever tool is used, all entities conducting compliance reviews must use some approach that documents, in writing, their findings with respect to MCO/PIHP compliance with individual regulatory provisions. Reviewers will use their personal notes recorded during or immediately following data gathering activities to complete this data reporting tool.

This tool contains three components:

1) First, it presents each of the applicable regulatory provisions of subparts C, D and F (Enrollee Rights, Quality Assessment and Performance Improvement, and the Grievance System, respectively) as well as supporting notes and definitions. Regulatory provisions have been divided into distinct parts to facilitate compliance determination. For ease of use, whenever subparts C, D or F contain a cross-reference to a regulatory provision that is not in subparts C, D, or F, these provisions are included with the regulatory provision that contains the cross reference.

2) Next to each regulatory provision is space for indicating the extent to which an MCO/PIHP is in compliance with the provision. Three possible compliance designations are presented: Met, Partially Met, and Not Met. These designations should be amended to reflect whatever compliance categories are specified by the State (See Protocol Activity 6, pp. 62-64).

3) Below each grouping of regulatory provisions, space is provided to allow reviewers to reference documentation or other evidence supporting the compliance designations.

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
§438.100 Enrollee rights. **(a)** ***General rule.*** The State must ensure that-- **(1)** Each MCO and each PIHP has written policies regarding the enrollee rights specified in this section; and **(2)** Each MCO, PIHP, . . . complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.			
Documentation for 438.100(a)			
§438.100 Enrollee rights. **(b)** ***Specific rights.*** **(1)** ***Basic requirement.*** The State must ensure that . . . **(2)** An enrollee of an MCO, PIHP, . . . has . . .; The right to-- **(i)** Receive information in accordance with §438.10. ***[Section 438.10 is stated below.]***			
§438.10 Information requirements. **(b)** ***Basic rule.*** Each . . . MCO, PIHP, . . . must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.			
Documentation for 438.10(b)			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
§438.10 Information requirements. **(c) *Language.*** The State must…: **(3)** Require each MCO, PIHP, . . . to make its written information available in the prevalent, non-English languages in its particular service area.			
Documentation for 438.10(c)(3)			
§438.10 Information requirements. **(c) *Language.*** The State must…: **(4)** . . . require each MCO, PIHP, . . . to make those services [i.e., oral interpretation services] available free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent. **(5)** . . . require each MCO, PIHP, . . . to notify its enrollees-- **(i)** That oral interpretation is available for any language and written information is available in prevalent languages; and **(ii)** How to access those services.			
Documentation for 438.10(c)(4) and (5)			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
§438.10 Information requirements. **(d)** ***Format.*** **(1)** Written material must-- **(i)** Use easily understood language and format;			
Documentation for 438.10(d)(1)(i)			
§438.10 Information requirements. **(d)** ***Format.*** **(1)** Written material must-- **(ii)** Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. **(2)** All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.			
Documentation for 438.10(d)(1)(ii) and (2)			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
§438.10 Information requirements. **(f) G*eneral information for all enrollees of MCOs, PIHPs, . . .*** Information must be made available to MCO, PIHP, . . . enrollees as follows: **(2)** The State, its contracted representative, or the MCO, PIHP, . . . must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section, and if applicable, paragraphs (g)…of this section, at least once a year. **(3)** The State, its contracted representative, or the MCO, PIHP, . . . must furnish to each of its enrollees the information listed in paragraph (f)(6) of this section, and, if applicable, paragraphs (g)… of this section, within a reasonable time after the MCO, PIHP, . . . receives, from the State or its contracted representative, notice of the recipient's enrollment. **(4)** … the MCO, PIHP, . . . must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraph (f)(6) of this section, and, if applicable, paragraphs (g)… of this section, at least 30 days before the intended effective date of the change. **(5)** The MCO, PIHP, . . . must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. **(6)** … the MCO, or PIHP,… must provide the following information to all enrollees: **(i)** Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs,… this includes, at a minimum, information on primary care physicians, specialists, and hospitals. **(ii)** Any restrictions on the enrollee's freedom of choice among network providers. [Related provisions addressing the free choice of providers for family planning services are included herein:] ********** **431.51 Free choice of providers** **(a) Statutory basis. ***** (4) Section 1902(a)(23) of the Act provides that a recipient enrolled in a … Medicaid managed care organization			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
(MCO) may not be denied freedom of choice of qualified providers of family planning services. (5) Section 1902(e)(2) of the Act provides that an enrollee who, while completing a minimum enrollment period, is deemed eligible only for services furnished by or through the MCO… may as an exception to the deemed limitation, seek family planning services from any qualified provider. (6) Section 1932(a) of the Act permits a State to restrict the freedom of choice required by section 1902(a)(23), under specified circumstances, for all services except family planning services. ********** **(iii)** Enrollee rights and responsibilities, as specified in §438.100 **(iv)** Information on grievance and fair hearing procedures, and the information specified in §438.10(g)(i)… **(v)** The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled. **(vi)** Procedures for obtaining benefits, including authorization requirements. **(vii)** The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers. **(viii)** The extent to which, and how, after-hours and emergency coverage are provided, including**:** **(A)** What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in §438.114 (a). [Section 438.114 definitions listed below:]			
********** **438.114 Emergency and post-stabilization 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) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
child) in serious jeopardy. (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. *Emergency services* means covered inpatient or outpatient services that are as follows: (1) Furnished by a provider qualified to furnish these services under this title. (2) Needed to evaluate or stabilize an emergency medical condition. *Post-stabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition." ********** **(B)** The fact that prior authorization is not required for emergency services. **(C)** The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent. **(D)**The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract. **(E)** The fact that, subject to the provisions of this section, the enrollee has the right to use any hospital or other setting for emergency care. **(ix)** The post-stabilization care service rules set forth at 422.113(c) of this chapter. ***[Section 422.113(c) is stated below.]*** ********** **422.113(c) Maintenance care and post-stabilization care services.** **(1)** Definition. [This is the same as shown above.] **(2)** M+C organization financial responsibility. The M+C organization— **(i)** Is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the M+C organization that re pre-approved by a plan provider or other M+C organization representative; **(ii)** Is financially responsible for post-stabilization care			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
services obtained within or outside the M+C organization that are not pre-approved by a plan provider or other M+C organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the M+C organization for pre-approval of further post-stabilization care services; **(iii)** Is financially responsible for post-stabilization care services obtained within or outside the M+C organization that are not pre-approved by a plan provider or other M+C organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if— **(A)** The M+C organization does not respond to a request for pre-approval within 1hour; **(B)** The M+C organization cannot be contacted; or **(C)** The M+C organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the M+C organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and **(iv)** Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the M+C organization. **(3)** End of M+C organization's financial responsibility. The M+C organization's financial responsibility for post-stabilization care services it has not approved ends when— **(i)** A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care; **(ii)** A plan physician assumes responsibility for the enrollee's care through transfer; **(iii)** An M+C organization representative and the treating physician reach an agreement concerning the enrollee's care; or			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
(iv) The enrollee is discharged. ********** **(x)**Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider. **(xi)** Cost sharing, if any. **(xii)** How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP… does not cover because of moral or religious objections, the MCO, PIHP… need not furnish information on how and where to obtain the service. The State must furnish information about how and where to obtain the service.			
Documentation for 438.10(f)			
(g) ***Specific information requirements for enrollees of MCOs and PIHPs.*** In addition to the requirements in §438.10(f),… the MCO and PIHP must provide the following information to their enrollees: **(1)** Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§438.400 through 438.424, in a State-developed or State-approved description, that must include the following: **(i)** For State fair hearing-- **(A)** The right to hearing; **(B)** The method for obtaining a hearing; and **(C)** The rules that govern representation at the hearing**.** **(ii)** The right to file grievances and appeals. **(iii)**The requirements and timeframes for filing a grievance or appeal. **(iv)** The availability of assistance in the filing process. **(v)** The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone. **(vi)** The fact that, when requested by the enrollee--			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
(A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and **(B)** The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee. **(vii)** Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service. **(2)** Advance directives, as set forth in §438.6(i)(2). [Compliance with requirements for advance directives are addressed as part of the provisions of §438.100(b)(2)(iv) pertaining to enroll participation in treatment decisions.] **(3)** Physician incentive plans as set forth in §438.6(h) of this chapter. [Section 438.6(h) is stated below]. ********** **438.6(h) Physician incentive plans** **(1)** MCO, PIHP,… contracts must provide for compliance with the requirements set forth in §§ 422.208 and 422.210 of this chapter. **(2)** In applying the provision of §§ 422.208 and 422.210 of this chapter, references to "M+C organization", "CMS', and "Medicare beneficiaries" must be read as references to "MCO, PIHP,…", "State agency" and "Medicaid recipients", respectively. **********			
Documentation for 438.10(g)			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
(i) *Special rules: States with mandatory enrollment under state plan authority.--* ***(1) Basic rule.*** If the State plan provides for mandatory enrollment under §438.50, the State or its contracted representative must provide information on MCOs,… (as specified in paragraph (i)(3) of this section), either directly or through the MCO…. ***(2) When and how the information must be furnished.*** The information must be furnished as follows: **(i)** For potential enrollees, within the timeframe specified in §438.10(e)(1). **(ii)** For enrollees, annually and upon request. **(iii)** In a comparative, chart-like format. **(3) *Required* information**. Some of the information is the same as the information required for potential enrollees under paragraph (e) of this section and for enrollees under paragraph (f) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (i)(2) of this section, and includes the following for each contracting MCO… in the potential enrollee and enrollee's service area: **(i)** The MCO's. . . service area. **(ii)** The benefits covered under the contract. **(iii)** Any cost sharing imposed by the MCO…[Related provisions addressing cost sharing are included below.] ********** **438.106 Liability for payment** Each MCO, PHIP… must provide that its Medicaid enrollees are not held liable for any of the following: (a) The MCO's, PIHP'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 (2) The State, or the MCO, PIHP,… does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement. (c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP … provided the services directly.			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
438.108 Cost sharing The contract must provide that any cost sharing imposed on Medicaid enrollees is in accordance with 447.50 through 447.60 of this chapter. ********** **(iv)** To the extent available, quality and performance indicators, including but not limited to, disenrollment rates as defined by the State, and enrollee satisfaction.			
Documentation for 438.10(h)			
§438.100 Enrollee rights (cont.) **(b)** ***Specific rights.*** **(1)** ***Basic requirement.*** The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraph (b)(2) and (b)(3) of this section. **(2)** An enrollee of an MCO, PIHP,… has the following rights: The right to-- **(ii)** Be treated with respect and with due consideration for his or her dignity and privacy;			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
§438.100 Enrollee rights (cont.) **(b)** ***Specific rights.*** **(1)** ***Basic requirement.*** The State must ensure that each managed care enrollee . . . **(2)** . . . has . . . The right to-- **(iii)** Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(f)(6)(xii). ***Note to reviewers:*** See related §438.102 and its exception clause, below: ********** **§438.102 Provider-enrollee communications** **(a)** General rules. **(1)** An MCO, PIHP. . . may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: (i) The enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered. (ii) Any information the enrollee needs in order to decide among all relevant treatment options. (iii) The risks, benefits, and consequences of treatment or nontreatment. (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. **(2)** Subject to the information requirements of paragraph (b) of this section, an MCO, PIHP… 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, . . . objects to the service on moral or religious grounds. **(b)** Information requirements: MCO, PIHP. . . responsibility**.** **(1)** An MCO, PIHP…that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows:			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
(i) To the State-- **(A)** With its application for a Medicaid contract; and **(B)** Whenever it adopts the policy during the term of the contract. **(ii)** Consistent with the provisions of §438.10— **(A)** To potential enrollees, before and during enrollment; and **(B)** To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle the MCO, PIHP . . . to the option provided in paragraph (a)(2) of this section, the overriding rule in § 438.10(f)(4) requires the MCO, PIHP,. . . to furnish the information at least 30 days before the effective date of the policy.) **(3)** As specified in § 438.10(f), the information that MCOs, PIHPs, . . must furnish to enrollees does not include how and where to obtain the service excluded under paragraph (a)(2) of this section. **********			
Documentation for 438.100(b)(2)(iii)			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
§438.100 Enrollee rights (cont.) **(b)** ***Specific rights.*** **(1)** ***Basic requirement.*** The State must ensure that. . . **(2)** An enrollee of an MCO, PIHP, . . . has the . . . right to-- **(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. **Note: Section 438.10(g)(2) requires that MCO and PIHP enrollees receive information on advance directives. Because of the relationship of advance directives to decisions regarding health care, these provisions are discussed in this section.** 438.10(g) states that, ". . .MCOs and PIHPs must provide to their enrollees, information on 2) Advance Directives, as set forth in §438.6(i)(2). [Section 438.6(i)(2) is stated below.] ********** **438.6(i)Advance Directives** **(1)** All MCO and PIHP contracts must provide for compliance with the requirements of §422.128 of this chapter for maintaining written policies and procedures with respect to advance directives. ***(Note: Section* 422.128(a) *requires that each organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. Section 489.102(d) requires adherence to §417.436 requirements which are stated below.)*** **(2)** The MCO or PIHP must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law. **(3)** 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. --- **417.436(d)** ***Advance directives.*** (1) An HMO or CMP must maintain written policies and procedures concerning advance directives, as defined in §489.100 of this chapter[1],			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
with respect to all adult individuals receiving medical care by or through the HMO or CMP and are required to: (i) Provide written information to those individuals concerning- (A) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individuals option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Such information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law; and (B) The HMO's or CMP's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the HMO or CMP cannot implement an advance directive as a matter of conscience. At a minimum, this statement should: *(1)* Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians; *(2)* Identify the state legal authority permitting such objection; and *(3)* Describe the range of medical conditions or procedures affected by the conscience objection. (ii) Provide the information specified in paragraphs (d)(1)(i) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the HMO or CMP may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law.			

[1] Section 489.100 states, "*Advance directive* means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated."

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
The HMO or CMP is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time. (iii) Document in the individual's medical record whether or not the individual has executed an advance directive; (iv) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; (v) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives; (vi) Provide for the education of staff concerning its policies and procedures on advance directives; and (vii) Provide for community education regarding advance directives that may include material required in paragraph (d)(1)(i)(A) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the HMO or CMP. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An HMO or CMP must be able to document its community education efforts. (2) The HMO or CMP - (i) Is not required to provide care that conflicts with an advance directive. (ii) Is not required to implement an advance directive if, as a matter of conscience, the HMO or CMP cannot implement an advance directive and State law allows any health care provider or any agent of such provider to conscientiously object. (3) The HMO or CMP must inform individuals that complaints concerning non-compliance with the advance directive may be filed with the State survey and certification agency.			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
Documentation for 438.100(b)(2)(iv) and (v)			
§438.100 Enrollee rights (cont.) **(b)** ***Specific rights.*** **(3)** An enrollee of an MCO, PIHP,… has the right to be furnished health care services in accordance with §§438.206 through 438.210.			
Documentation for 438.100(b)(3)			

Subpart C Regulations: Enrollee Rights and Protections	Met	Partially Met	Not Met
§438.100 Enrollee rights (cont.) **(d)** ***Compliance with other Federal and State laws.*** The State must ensure that each MCO, PIHP,. . . complies with any other applicable Federal or State laws (such as the 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; and other laws regarding privacy and confidentiality).			
Documentation for 438.100(d)			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.206 Availability of services **(b)** ***Delivery network.*** The State must ensure, through its contracts, that each MCO, and each PIHP… consistent with the scope of the PIHP's… 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. In establishing and maintaining the network, the MCO must consider the following: **(i)** The anticipated Medicaid enrollment. **(ii)** The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP,… **(iii)** The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. **(iv)** The number of network providers who are not accepting new Medicaid patients. **(v)**The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.			
Documentation for 438.206(b)(1)(i-v) Availability of services:			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.206(b). . . Each MCO, and each PIHP… consistent with the scope of the PIHP's… contracted services, meets the following requirements: **(2)** Provides female enrollees with direct access to a women's health specialist within the 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.			
Documentation for 438.206(b)(2):			
438.206(b). . . Each MCO, and each PIHP… consistent with the scope of the PIHP's… contracted services, meets the following requirement: **(3)** Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.			
Documentation for 438.206(b)(3):			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.206(b). . . Each MCO, and each PIHP… consistent with the scope of the PIHP's… contracted services, meets the following requirements: **(4)** If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP,… must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP,… is unable to provide them.			
Documentation for 438.206(b)(4):			
438.206(b). . . Each MCO, and each PIHP… consistent with the scope of the PIHP's… contracted services, meets the following requirements: **(5)** Requires out-of-network providers to coordinate with the MCO, PIHP,… with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.			
Documentation for 438.206(b)(5):			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.206(c) ***Furnishing of services.*** **(1)** ***Timely access.*** Each MCO, PIHP,… must-- **(i)** Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services; **(ii)** Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. **(iii)** Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. **(iv)**Establish mechanisms to ensure compliance by providers. **(v)** Monitor providers regularly to determine compliance. **(vi)**Take corrective action if there is failure to comply.			
Documentation for 438.206(c)(1)(i) through (vi): Timely access			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.206(c)(2) ***Cultural considerations.*** Each MCO, PIHP,… 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.			
Documentation for 438.206(c)(2) Cultural considerations:			
438.208 ***Coordination and continuity of care.*** **(b) Primary care and coordination of health care services for all MCO, PIHP,… enrollees.** Each MCO, PIHP, … must implement procedures to deliver primary care to and coordinate health care services for all MCO, PIHP, … enrollees. These procedures must meet State requirements and must do the following: **(1)** Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. **(2)** Coordinate the services the MCO, PIHP,… furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP. **(3)** Share with other MCOs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities. **(4)** Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to extent that they are applicable.			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
Documentation for 438.208(b) Primary care and coordination of health care services:			
Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.208 ***Coordination and continuity of care.*** ***(c) Additional services for enrollees with special health care needs.*** **(1) Identification.** The State must implement mechanisms to identify persons with special health care needs to MCOs, PIHPs,… as those persons are defined by the State. These identification mechanisms— **(ii)** May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs,…			
Documentation for 438.208(c)(1) Identification:			
438.208 ***Coordination and continuity of care.*** **(c)** ***Additional services for enrollees with special health care needs.*** **(2) Assessment.** Each MCO, PIHP,… must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanisms specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP,… by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health			

care professionals.			
Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
Documentation for 438.208(c)(2) *Assessment*:			
Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.208 *Coordination and continuity of care.* ***(c) Additional services for enrollees with special health care needs.*** **(3) Treatment plans.** If the State requires MCOs, PIHPs,… to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be— **(i)** Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; **(ii)** Approved by the MCO, PIHP,… in a timely manner, if this approval is required by the MCO, PIHP,… and **(iii)** In accord with any applicable State quality assurance and utilization review standards.			
Documentation for 438.208(c)(3) Treatment plans:			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.208 ***Coordination and continuity of care.*** ***(c) Additional services for enrollees with special health care needs.*** **(4) Direct access to specialists.** For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with §438.208(c)(2)) to need a course of treatment or regular care monitoring, each MCO, PIHP,… 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.			
Documentation for 438.208(c)(3) Treatment plans:			
438.210 ***Coverage and authorization of services.*** **(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,… and its subcontractors have in place and follow, written policies and procedures. **(2)**That the MCO, PIHP,… -- **(i)** Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and **(ii)** Consult with the requesting provider when appropriate. **(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 clinical expertise in			

treating the enrollee's condition or disease.			
Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
Documentation for 438.210(b) A*uthorization of services*:			
438.210 *Coverage and authorization of services.* **(c)** ***Notice of adverse action***. Each contract must provide for the MCO,PIHP,… to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP,… to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of § 438.404, except that the notice to the provider need not be in writing.			
Documentation for 438.210(c) *Notice of adverse action:*			
438.210 *Coverage and authorization of services.* **(d)** ***Timeframe for decisions.*** Each MCO, PIHP,… contract must provide for the following decisions and notices: ***(1) Standard authorization decisions.*** For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— **(i)** The enrollee, or the provider, requests extension; or **(ii)** The MCO, PIHP,… justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
(2) Expedited authorization decisions. **(i)** For cases in which a provider indicates, or the MCO, PIHP,… determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability attain, maintain, or regain maximum function, the MCO, PIHP,… must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. **(ii)** The MCO, PIHP,… may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP,… justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.			
Documentation for 438.210(d) ***Timeframe for decisions*****:**			
438.210 ***Coverage and authorization of services.*** **(e)** ***Compensation for utilization management activities.*** Each contract must provide that, consistent with §438.6(h), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.			
Documentation for 438.210(e) ***Compensation for utilization management decisions:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.114 Emergency and post-stabilization 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 possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in- **(1)** Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. **(2)** Serious impairment to bodily functions. **(3)** Serious dysfunction of any bodily organ or part. *Emergency services* means covered inpatient or outpatient services that are— **(1)** Furnished by a provider that is qualified to furnish these services under this title. **(2)** Needed to evaluate or stabilize an emergency medical condition. *Poststabilization care services* means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition. **(b)** ***Coverage and payment: General rule.*** The following entities are responsible for coverage and payment of emergency services and post-stabilization care services. **(1)** The MCO, PIHP,… **(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 entity that furnishes the services has a contract with the MCO, PIHP,… and **(ii)** May not deny payment for treatment obtained under either of the following circumstances: (cont.)			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
(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,. . . instructs the enrollee to seek emergency 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,… 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 "M+C organization" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section. **(f)** ***Applicability to PIHPs . . .*** To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP. . . is responsible, the rules under this section apply.			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
Documentation for 438.114 ***Emergency and pos-stabilization services:***			
438.214 Provider selection **(a)** ***General rules.*** The State must ensure, through its contracts, that each MCO, PIHP,… implements written policies and procedures for selection and retention of providers and that those written policies and procedures include, at a minimum the requirements of this section. ***(b) Credentialing and recredentialing requirements.*** **(1)** Each State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP,… must follow. **(2)** Each MCO, PIHP,… must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO, PIHP,...			
Documentation for 438.214(a) and (b) ***General rules*** **and** ***Credentialing and recredentialing requirements:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.214 Provider selection. ***(c) Nondiscrimination.*** MCO, PIHP,… provider selection policies and procedures, consistent with §438.12 ***(below)*** do not discriminate against particular practitioners that serve high risk populations, or specialize in conditions that require costly treatment. 438.12 Provider discrimination prohibited. **(a)** ***General rules.*** **(1)** An MCO, PIHP,… may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO, PIHP,… declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. **(2)** In all contracts with health care professionals, an MCO, PIHP,… 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,… to contract with providers beyond the number necessary to meet the needs of its enrollees; **(2)** Preclude the MCO, PIHP,… from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or **(3)** Preclude the MCO, PIHP,… from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.			
Documentation for 438.214(c) and 438.12 Nondiscrimination and Provider discrimination prohibited:			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.214: Provider selection **(d)** ***Excluded providers.*** MCOs, PIHPs,… may not employ or contract with providers excluded from participation in Ffederal health care programs under either section 1128 or section 1128A of the Act.			
Documentation for 438.214(d) Excluded providers:			
438.214: Provider selection **(e)** ***State requirements.*** Each MCO, PIHP,… must comply with any additional requirements established by the State.			
Documentation for 438.214(e) State requirements:			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.226 Enrollment and disenrollment: The State must ensure that each MCO, PIHP,… contract complies with the enrollment and disenrollment requirements and limitations set forth in 438.56. *(relevant sections of 438.56 included below)*.			
438.56 Disenrollment: Requirements and limitations. **(b)** ***Disenrollment requested by the MCO, PIHP,. . .*** All MCO, PIHP,… contracts must-- **(1)** Specify the reasons for which the MCO, PIHP,… may request disenrollment of an enrollee; **(2)** Provide that the MCO, PIHP, . . .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,. . . seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); and **(3)** Specify the methods by which the MCO, PIHP,… assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.			
Documentation for 438.226 and 438.56(b)(1) - (3) ***Disenrollment requested by the MCO, PIHP:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.56 Disenrollment: Requirements and limitations. ***(c) Disenrollment requested by the enrollee.*** If the State chooses to limit disenrollment, MCO, PIHP,… contracts must provide that a recipient 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 recipient's initial enrollment with the MCO, PIHP,… or the date the State sends the recipient notice of the enrollment, whichever is later. **(ii)** At least once every 12 months thereafter. **(iii)** Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity. **(iv)** When the State imposes the intermediate sanction specified in §438.702(a)(3).			
Documentation for 438.56(c) *Disenrollment requested by the enrollee:*			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.56 Disenrollment: Requirements & limitations. **(d)** ***Procedures for disenrollment.*** **(1)** ***Request for disenrollment.*** The recipient (or his or her representative) must submit an oral or written request-- **(i)** To the State agency (or its agent); or **(ii)** To the MCO, PIHP,… if the State permits MCOs, PIHPs,. . . to process disenrollment requests. **(2)** ***Cause for disenrollment.*** The following are cause for disenrollment: **(i)** The enrollee moves out of the MCO, PIHP,… service area. **(ii)**The plan does not, because of moral or religious objections, cover the service the enrollee seeks. **(iii)**The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. **(iv)** Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs. **(3)** ***MCO, PIHP,. . . action on request.*** **(i)** An MCO, PIHP,… may either approve a request for disenrollment or refer the request to the State. **(ii)**If the MCO, PIHP, . . . or State agency (whichever is responsible) fails to make a disenrollment determination so that the recipient can be disenrolled within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved. **(4)** ***State agency action on request.*** For a request received directly from the recipient, or one referred by the MCO, PIHP,… 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,… at the agency's request. **(iii)** Any of the reasons specified in paragraph (d)(2) of this section.			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
(5) ***Use of the MCO, PIHP,. . . grievance procedures.*** **(i)** The State agency may require that the enrollee seek redress through the MCO, PIHP,… grievance system before making a determination on the enrollee's request. **(ii)** The grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in §438.56(e)(1). **(iii)** If, as a result of the grievance process, the MCO, PIHP,… approves the disenrollment, the State agency is not required to make a determination.			
Documentation 438.56(d) ***Procedures for disenrollment:***			
438.56 Disenrollment: Requirements and limitations. **(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 or the MCO, PIHP,. . . files the request. **(2)** If the MCO, PIHP, . . . or the State agency (whichever is responsible) fails to make the determination within the timeframes specified in paragraphs(e)(1) of this section, the disenrollment is considered approved.			
Documentation 438.56(e) ***Timeframe for disenrollment determinations:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.228 Grievance systems. **(a)** The State must ensure, through its contracts, that each MCO and PIHP has in effect a grievance system that meets the requirements of subpart F of this part**.** **(b)** If the State delegates to the MCO or PIHP responsibility for notice of action under subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCO and PIHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.			
Documentation for 438.228 ***Grievance systems:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
§438.230 Subcontractual relationships and delegation. **(a)** ***General rule***. The State must ensure, through its contracts, that each MCO, PIHP,… -- **(1)** Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor, and **(2)** Meets the conditions of paragraph (b) of this section. **(b)** ***Specific conditions.*** **(1)** Before any delegation, each MCO, PIHP,… evaluates the prospective subcontractor's ability to perform the activities to be delegated. **(2)** There is a written agreement that -- **(i)** Specifies the activities and report responsibilities designated to the subcontractor; and **(ii)** Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. **(3)** The MCO, PIHP,… monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations. **(4)** If any MCO, PIHP,… identifies deficiencies or areas for improvement, the MCO, PIHP,… and the subcontractor take corrective action.			
Documentation for 438.230 (a) and (b) ***Subcontractual relationships and delegation:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.236 Practice guidelines. **(a)** ***Basic rule.*** The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP… meets the requirements of this section. ***(b) Adoption of practice guidelines.*** Each MCO and, when applicable, each PIHP,… 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,… enrollees. **(3)** Are adopted in consultation with contracting health care professionals. **(4)** Are reviewed and updated periodically, as appropriate.			
Documentation for 438.236(b)(1-4) ***Adoption of practice guidelines*****:**			
438.236 Practice guidelines. **(c)** ***Dissemination of guidelines.*** Each MCO, PIHP,… disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.			
Documentation for 438.236(c) ***Dissemination of [practice] guidelines:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.236 Practice guidelines. **(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.			
Documentation for 438.236(d) ***Application of [practice] guidelines.***			
438.240 Quality assessment and performance improvement program. **(a)** ***General rules.*** **(1)** The State must require, through its contracts, that each MCO and PIHP has an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.			
Documentation for 438.240(a)(1) Quality assessment and performance improvement program - ***General rules:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.240 Quality assessment and performance improvement program. **(b)** ***Basic elements of MCO and PIHP quality assessment and performance improvement programs***. At a minimum, the State must require that each MCO and PIHP comply with the following requirements-- **(1)** Conduct performance improvement projects as described in paragraph (d) of this section *[Note: Paragraph (d) is included below]*. These projects must 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. ********** **(d)** ***Performance improvement projects.*** **(1)** MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following: **(i)** Measurement of performance using objective quality indicators. **(ii)** Implementation of system interventions to achieve improvement in quality. **(iii)** Evaluation of the effectiveness of the interventions. **(iv)** Planning and initiation of activities for increasing or sustaining improvement. **(2)** Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of §438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
Documentation for 438.240(b)(1) *Basic elements of MCO and PIHP quality assessment and performance improvement programs,* and 438.240(d) *Performance improvement projects*:			
438.240 Quality assessment and performance improvement program. **(b) *Basic elements of MCO and PIHP quality assessment and performance improvement programs*.** At a minimum, the State must require that each MCO and PIHP comply with the following requirements-- **(2)** Submit performance measurement data as described in paragraph (c) of this section. [Note: Paragraph (c) is included below.] ********** **438.240(c) *Performance measurement.*** Annually, each MCO and PIHP must— **(1)** Measure and report to the State its performance, using standard measures required by the State, including those that incorporate the requirements of §438.204(c) [included below] and §438.240(a)(2); **(2)** Submit to the State, data specified by the State, that enables the State to measure the MCO's or PIHP's performance; or **(3)** Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section. ********** **438.204(c)** Performance measures and levels identified and developed by CMS in consultation with States and other relevant stakeholders. **********			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
Documentation for 438.240(b)(2) and (c)*, and 438.204(c) Performance measurement:*			
438.240 Quality assessment and performance improvement program. **(b)** ***Basic elements of MCO and PIHP quality assessment and performance improvement programs***. At a minimum, the State must require that each MCO and PIHP comply with the following requirements-- **(3)** Have in effect mechanisms to detect both underutilization and overutilization of services;			
Documentation for 438.240(b)(3) ***Basic elements of MCO and PIHP quality assessment and performance improvement:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.240 Quality assessment and performance improvement program. **(b)** ***Basic elements of MCO and PIHP quality assessment and performance improvement programs***. At a minimum, the State must require that each MCO and PIHP comply with the following requirements-- **(4)** Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.			
Documentation for 438.240(b)(4) ***Basic elements of MCO and PIHP quality assessment and performance improvement:***			
438.240 Quality assessment and performance improvement program. **(e)** ***Program review by the State.*** **(1)** The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program. The review must include-- **(i)** The MCO's PIHP's performance on standard measures on which it is required to report; and **(ii)** The results of each MCO's and PIHP's perfroamnce improvement projects. **(2)** The State may require that an MCO or PIHP have in effect a process for its own evaluation of its quality assessment and performance improvement program.			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
Documentation for 438.240(e) ***Basic elements of MCO and PIHP quality assessment and performance improvement- Program review by the State:***			
438.242 Health information systems. **(a)** ***General rule.*** The State must ensure through its contracts, that each MCO and PIHP maintains a health information system that collects, analyzes, integrates, and reports sata and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances, and disenrollments for other than loss of Medicaid eligibility.			
Documentation for 438.242(a) ***Health information systems- General rule:***			

Subpart D Regulations: Quality Assessment and Performance Improvement	Met	Partially met	Not met
438.242 Health information systems. **(j)** ***Basic elements of a health information system.*** The State must require, at a minimum, that each MCO and PIHP comply with the following: **(1)** Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or such other methods as may be specified by the State. **(2)** Ensure that data received from providers is accurate and complete by-- **(i)** Verifying the accuracy and timeliness of reported data; **(ii)** Screening the data for completeness, logic, and consistency; and **(iii)** Collecting service information in standardized formats to the extent feasible and appropriate.			
Documentation for 438.242(b)(1) and (2) ***Basic elements of a health information system:***			
438.242 Health information systems. **(b)** ***Basic elements of a health information system.*** The State must require, at a minimum, that each MCO and PIHP comply with the following: **(3)** Make all collected data available to the State and upon request to CMS, as required in this subpart.			
Documentation for 438.242(b)(3) ***Basic elements of a health information system:***			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
438.402 General requirements. **(a)** ***The grievance system.*** Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.			
Documentation for 438.402(a) The grievance system:			
438.402 General requirements **(b)** ***Filing requirements.*** **(1)** ***Authority to file.*** **(i)** An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing. **(ii)** A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.			
Documentation for 438.402(b)(1) Filing requirements - Authority to file:			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
438.402 General requirements **(b)** ***Filing requirements.*** **(2)** ***Timing.*** The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe-- **(i)** The enrollee or the provider may file an appeal; and **(ii)** In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.			
Documentation for 438.402(b)(2) Filing requirements – Timing:			
438.402 General requirements **(b)** ***Filing requirements.*** **(3)** ***Procedures.*** **(i)** The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP. **(ii)** The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.			
Documentation for 438.402(b)(3). Filing requirements – Procedures:			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
438.404 Notice of action **(a)** ***Language and format requirements.*** The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding. [Sections §438.10(c) and (d) are restated below.] ********** **§438.10 Information requirements.** **(c)** ***Language.*** The State must: **(1)** Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State. **(2)** [This paragraph contains a requirement for the State; not the MCO or PIHP.] **(3)** Require each MCO, PIHP, . . . to make its written information available in the prevalent, non-English languages in its particular service area. (cont.) **(4)** … require each MCO, PIHP, . . . to make those services [i.e., oral interpretation services] available free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent. **(5)** … require each MCO, PIHP,… to notify its enrollees- **(i)** That oral interpretation is available for any language and written information is available in prevalent languages; and **(ii)** How to access those services. **(d)** ***Format.*** **(1)** Written material must-- **(i)** Use easily understood language and format; and **(ii)** Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. **(2)** All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
Documentation for 438.404(a) ***Notice of action - Language and format:***			
438.404 Notice of action ***(b) Content of notice.*** The notice must explain the following: **(1)** The action the MCO or PIHP or its contractor has taken or intends to take. **(2)** The reasons for the action. **(3)** The enrollee's or the provider's right to file an MCO or PIHP appeal. **(4)** If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing. **(5)** The procedures for exercising the rights specified in this paragraph. **(6)** The circumstances under which expedited resolution is available and how to request it. **(7)** The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued and, the circumstances under which the enrollee may be required to pay the costs of these services.			
Documentation for 438.404(b) ***Notice of action - Content of notice:***			

438.404 Notice of action ***(c) Timing of notice.*** The MCO or PIHP must mail the notice within the following timeframes: **(1)** For termination, suspension, or reduction of previously authorized Medicaid-covered service, within the time frames specified in §§431.211, 431.213, and 431.214 of this chapter. **[Note: Sections 431.211, 431.213, and 431.214 are restated, below.]** ********** **431.211 Advance notice.** The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214 of this subpart. **431.213 Exceptions from advance notice.** The agency may mail a notice no later than the date of action if-- **(a)** The agency has factual information confirming the death of a recipient; **(b)** The agency receives a clear written statement signed by the recipient that-- **(1)** He no longer wishes services; or **(2)** Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; **(c)** The recipient has been admitted to an institution where he is ineligible under the plan for further services; **(d)** The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231(d) of this subpart [**restated below]** for procedure if the recipient's whereabouts become known); **[Section 431.231 Reinstatement of services.** **(d)** If a recipient's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to him, any discontinued service must be reinstated if his whereabouts become known during the time he is eligible for services.**]**			

(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; **(f)** A change in the level of medical care is prescribed by the recipient's physician; **(g)** The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(r) of the Act; or; **(h)** The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i). **431.214 Notice in the case of probable fraud.** The agency may shorten the period of advance notice to 5 days before the date of action if-- **(a)** The agency has facts indicating that action should be taken because of probable fraud by the recipient; and **(b)** The facts have been verified, if possible, through secondary sources. ********** **(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 time frame specified in §438.210(d)(1) **[Section 438.210(d)(1) is restated, below.]** ********** **438.210(d)** ***Timeframe for decisions.*** Each MCO, PIHP,… contract must provide for the following decisions and notices: ***(1) Standard authorization decisions.*** For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— (i) The enrollee, or the provider, requests an extension; or (ii) The MCO, PIHP,… justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. **********			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
(4) If the MCO or PIHP extends the timeframe in accordance with §438.210(d)(1), it must-- **(i)** Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and **(ii)** Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. **(5)** For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire. **(6)** For expedited service authorization decisions, within the timeframes specified in §438.210(d). [Section 438.210(d)(2) provisions pertaining to expedited authorizations are restated below.] ********** **438.210(d)** ***Timeframe for decisions.*** Each MCO, PIHP,… contract must provide for the following decisions and notices: ***(2) Expedited authorization decisions.*** **(i)** For cases in which a provider indicates, or the MCO, PIHP,… 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,… must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. **(ii)** The MCO, PIHP,… may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO or PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
Documentation for §438.404(c): Notice of action - timing of notice:			
438.406 Handling of grievances and appeals. **(a)** ***General requirements.*** In handling grievances and appeals, each MCO and each PIHP must meet the following requirements; **(1)** Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. **(2)** Acknowledge receipt of each grievance and appeal. **(3)** Ensure that the individuals who make decisions on grievances and appeals are individuals-- **(i)** Who were not involved in any previous level of review or decision-making; and **(ii)** Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise 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.			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
Documentation for 438.406(a) Handling of grievances and appeals -General requirements:			
438.406 Handling of grievances and appeals. **(b)** ***Special requirements for appeals.*** The process for appeals must: **(1)** Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or provider requests expedited resolution. **(2)** Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.) **(3)** Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process. **(4)** Include, as parties to the appeal-- **(i)** The enrollee and his or her representative; or **(ii)** The legal representative of a deceased enrollee's estate.			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
Documentation for 438.406(b) Handling of grievances and appeals -Special requirements for appeals:			
438.408 Resolution and notification: Grievances and appeals. **(a)** ***Basic rule.*** The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.			
Documentation for 438.408(a) Resolution and notification: Grievances and appeals- Basic rule:			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
438.408 Resolution and notification: Grievances and appeals. **(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 days from the day the MCO or PIHP receives the grievance. **(2) Standard resolution of appeals.** For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section. **(3) Expedited resolution of appeals.** For expedited resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section. **(c)** ***Extension of timeframes.*** **(1)** The MCO or PIHP 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 or PIHP shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest. **(2)** ***Requirements following extension.*** If the MCO or PIHP extends the timeframes, it must--for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.			
Documentation for 438.408(b) and (c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
438.408 Resolution and notification: Grievances and appeals. **(d)** ***Format of notice.*** **(1)** ***Grievances.*** The State must establish the method the MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance. **(2)** ***Appeals.*** **(i)** For all appeals, the MCO or PIHP must provide written notice of disposition. **(ii)** For notice of expedited resolution, the MCO or PIHP 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 to receive benefits while the hearing is pending, and how to make the request; and **(iii)**That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.			
Documentation for 438.408 (d) and (e) Resolution and notification: Grievances and appeals- Format of notice and Content of notice of appeal resolution:			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
438.408 Resolution and notification: Grievances and appeals: **(f)** ***Requirements for State fair hearings.--*** **(1)** ***Availability.*** The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies-- **(i)** If the State requires exhaustion of the MCO or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or **(ii)** If the State does not require exhaustion of the MCO or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the MCO's or PIHP's notice of action. **(2)** ***Parties.*** The parties to the State fair hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.			
Documentation for 438.408(f) Resolution and notification: Grievances and appeals- Requirements for State fair hearings:			
438.410 Expedited resolution of appeals. **(a)** ***General rule.*** Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function.			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
(b) Punitive Action. The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal. **(c)** ***Action following denial of a request for expedited resolution.*** If the MCO or PIHP denies a request for expedited resolution of an appeal, it must-- **(1)** Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2); **(2)** Make reasonable effort to give the enrollee prompt oral notice of the denial, and follow up within 2 calendar days with a written notice.			
Documentation for 438.410 Expedited resolution of appeals:			
438.414 Information about the grievance system to providers and subcontractors. The MCO or PIHP must provide the information specified at §438.10(g)(1) **[restated below]** about the grievance system to all providers and subcontractors at the time they enter into a contract. ********** **§438.10(g)(1)** Grievance , appeal … procedures, and timeframes, as provided in §§438.400 through 438.424, in a State-developed or State-approved description, that must include: **(i)** . . . (Requirement applies only to the State.) **(ii)** The right to file grievances and appeals. **(iii)**The requirements and time frames for filing a grievance or appeal. **(iv)**The availability of assistance in the filing process. **(v)** The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
Documentation for 438.414 Information about the grievance system to providers and subcontractors:			
438.416 Recordkeeping and reporting requirements. The State must require MCOs and PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy.			
Documentation for 438.416 Recordkeeping and reporting requirements:			
438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending. **(a)** ***Terminology.*** As used in this section, "timely" filing means filing on or before the later of the following: **(1)** Within 10 days of the MCO or PIHP mailing the notice of action. **(2)** The intended effective date of the MCO's or PIHP's proposed action.			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
(b) ***Continuation of benefits.*** The MCO or PIHP must continue the enrollee's benefits if-- **(1)** The enrollee or the provider files the appeal timely; **(2)** The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; **(3)** The services were ordered by an authorized provider; **(4)** The original period covered by the original authorization has not expired; and **(5)** The enrollee requests extension of benefits. **(c)** ***Duration of continued or reinstated benefits.*** If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: **(1)** The enrollee withdraws the appeal. **(2)** Ten days pass after the MCO or PIHP 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. **(4)** The time period or service limits of a previously authorized service has been met. **(d)** ***Enrollee responsibility for services furnished while the appeal is pending.*** If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in §431.230(b) of this chapter. **[Section 431.230(b) is restated below.]** ********** **§431.230 Maintaining services.** **(b)** If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section. **********			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
Documentation for 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending:			
438.424 Effectuation of reversed appeal resolutions. **(a)** ***Services not furnished while the appeal is pending***. If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires. **(b)** ***Services furnished while the appeal is pending.*** If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.			

Subpart F Regulations --Grievance System	Met	Partially Met	Not met
Documentation for 438.424 Effectuation of reversed appeal resolutions:			

END OF APPENDIX C