Compliance Standards (DRAFT)

Standards	Topic	QExA contract RFP section citations	QUEST contract RFP section citations	Description of Contract Language
42 CFR 438.206(b)(1)	Contracted Network of Appropriate Providers	40.210, 40.220, 40.230, 40.240, 40.250, 40.260	40.210, 40.220, 40.230	Delivery Network. The MCOs are required to maintain a network of appropriate providers that is supported by written agreements and maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract. The MCO contracts require a network of providers that is sufficient in number, mix, and geographic distribution. The contracts specifically specify that MCOs contract with hospitals, emergency transportation providers, primary care providers, specialists, pharmacies, labs, PT/OT/Speech therapists, behavioral health providers, state licensed special treatment facilities, home health agencies, hospices, physician assistants, providers of lodging and meals, sign language and foreign language interpreters, home and community based providers, and long-term care providers. The contracts also specify minimum numbers of specialists for the number of members and geographic area, geographic access standards for the provider network, and minimum wait times acceptable for provider access.
42 CFR 438.206(b)(2)	Direct Access to Women's Health Specialist	40.270	40.240	Direct Access to Women's Health Specialist. The MCOs are required to provide female members 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 member's designated source of primary care if that source is not a woman's health specialist. Routine and preventive women's health care services include, but are not limited to, breast cancer screening and cervical cancer screening.
42 CFR 438.206(b)(3)	Adequate and Timely Second Opinion	41.100	40.500	Second Opinion. The MCOs are required to provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the member to obtain one outside the network, at no cost to the member.
42 CFR 438.206(b)(4) & (b)(5)	Adequate and Timely Out-of-Network Providers	40.210	40.220, 40.260	Out-of-Network Providers. The contracts require that if the MCO networks are unable to provide necessary medical services covered under the contract to a particular member, the MCO must adequately and timely cover these services out of network for the member, for as long as the MCOs are unable to provide them. The MCOs are required to coordinate reimbursement with out-of-network providers, and neither the MCOs nor the out-of-network providers are allowed to 'balance bill' the member.
42 CFR 438.206(b)(6)	Provider Credentialing as Required in Regulation	40.400	40.210	Credentialing. The contracts include a requirement that the MCO demonstrate that its providers are credentialed per the State's credentialing policy.
42 CFR 438.206(c)(1)(i-vi)	Timely Access	40.230	40.220	Timely Access. The contracts require that the MCOs and its providers meet State standards for timely access to care and services and offers hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service and are available 24 hours a day, 7 days a week when medically necessary. The contracts specify specific acceptable wait times. There are also specific geographic access standards that MCO must meet.

				The contracts require established mechanisms to ensure that network providers comply with the timely access requirements. They require MCO monitoring to determine compliance and corrective actions taken as needed. The acceptable wait times specified in the contracts include: • Immediate care 24 hours a day, 7 days a week without prior authorization for emergency medical situations; • Appointments within 24 hours for urgent care and PCP pediatric sick visits; • Appointments within 72 hours for PCP adult sick visits; • Appointments within 21 days for PCP routine visits for adults and children.
42 CFR 438.206(c)(2)	Cultural Considerations	40.910	41.110	Cultural Considerations. The contracts require that the MCOs participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCOs shall have a comprehensive cultural competency plan that includes identification of members with cultural needs and designing programs, interventions, and services that address cultural and language barriers.
42 CFR 438.207(b)(c)	Documentation of Adequate Capacity and Services	40.220	40.210	Documentation of Adequate Capacity and Services. The contracts require that the MCOs submit documentation to the State to demonstrate, in a format specified by the State, that they offer an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of members for the service area as well as maintain 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. The contracts require that the MCOs submit the documentation assuring adequate capacity and services as specified by the State, and specifically, but no less frequently than at the time they enter into a contract with the State, at anytime there has been a significant change (as defined by the State) in the MCO operations that would affect adequate capacity and services, including changes in services, benefits, geographic service area or payments, or enrollment of a new population in the MCO.
42 CFR 438.208 (a) 42 CFR 438.208 (b)(1-4)	Primary Care and Coordination of Health Care Services for all MCOs	40.260, 40.810-40.830	40.230 40.400	Primary Care and Coordination of Health Care Services. The contracts require that the MCOs 1) implement procedures to ensure that each member 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 member; 2) implement procedures to coordinate the services the MCO furnishes to the member with the services the member receives from any other entity; 3) implement procedures to share with other entities serving the member the results of its identification and assessment of any member with special health care needs (as defined by the state) so that those activities need not be duplicated; 4) implement procedures to ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160-164.
42 CFR 438.208(c)(1)(2)	Identification and Assessment	40.810, 40.820	40.325	Members with Special Health Care Needs Assessment. The contracts require that the MCOs implement mechanisms to assess each Medicaid member identified as having special health care needs in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. All QExA members are considered individuals with special health care needs and are treated as such.
42 CFR 438.208	Enrollees with Special	40.830	40.325	Members with Special Health Care Needs Assessment. The State requires the MCOs to produce a treatment plan for members

(c)(3)	Health Care Needs - Treatment Plans			determined to need a course of treatment or regular care monitoring, the treatment plan must be developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member; approved by the MCO in a timely manner, if this approval is required; and in accordance with any applicable State quality assurance and utilization review standards.
42 CFR 438.208(c)(4)	Enrollees with Special Health Care Needs - Direct Access to Specialists	40.260	40.325	Members with Special Health Care Needs- Direct Access to Specialists. For members determined to need a course of treatment or regular care monitoring, MCOs are required to have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.
42 CFR 438.210(a)(1-4)	Amount, Scope and Duration of Service Coverage	40.710, 40.720, 40.730, 40.740, 40.750	40.300	(1) The contracts identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer. (2) Coverage. The contract states that the amount, duration, and scope should be no less than the amount, duration, and scope for the same services furnished to clients under fee-for-service Medicaid. (3) The MCOs (i) are required to provide for all medically necessary and appropriate Medicaid covered services, which are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished. (ii) may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. (iii) may place appropriate limits on a service on the basis of criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. (4) Medically Necessary Services. The contract specifies what constitutes "medically necessary services" in a manner that is no more restrictive than the State Medicaid program and addresses the extent to which the MCO is responsible for covering services relating to the following: prevention, diagnosis, and treatment impairments, ability to achieve age-appropriate growth and development, the ability to attain, maintain, or regain functional capacity.
42 CFR 438.210(b)(1-3)	Polices and Procedures for Authorization of Services	50.700	50.700	(b)(1) The contracts require the MCO and its subcontractors have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services. (2) The contracts require a consistent application of review criteria for authorization decisions and procedures to consult with any requesting provider when appropriate. (3) Service Authorization Process: Procedure. The contracts states 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, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
42 CFR 438.210(c)	Notice of Adverse Action	50.860	50.860	Provider Notice of Adverse Action. The contracts require the MCOs to notify both the member and the requesting provider, in writing, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
42 CFR 438.210(d)(1)	Timeframe for Decisions	50.860	50.860	Timeframe for Notice of Action. Standard Service Authorization Denial. The MCOs are required to give notice as expeditiously as the member'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 calendars days, if

				the member or the provider requests extension or the MCO justifies a need for additional information and how the extension is in the member's interest.
42 CFR 438.21(d)(2)	Timeframe for Decisions	50.860	50.860	Time frames for Notice of Action: Expedited Service Authorization Denial. The contracts state that for cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCOs provide notice to make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request for service.
42 CFR 438.210(e)	Compensation for UM activities	50.600	50.600	Compensation for Utilization Management Activities. The contract requires that 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 member.
42 CFR 438.114	Emergency & Post Stabilization Care Services	30.200, 40.750.1.e	30.200, 40.335, 40.340	(a) Emergency Medical Condition The MCO contracts specify that MCOs cannot limit the definition of emergency medical condition on the basis of diagnosis/symptom lists. The contracts define emergency medical conditions as a medical condition manifesting itself by acute symptoms of sufficient severity (including sever pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to results in the following: placing the physical or mental health of the individual (or with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or others due to an alcohol or drug abuse emergency, injury to self or bodily harm to others, or with respect to a pregnant woman having contractions- adequate time to effect a safe transfer before delivery or that transfer may pose a threat to the health and safety of the woman or her unborn child. (b) Emergency Services Emergency services include inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition, furnished by a provider that is qualified to furnish such services. The MCOs are required to provide payment for emergency services regardless of whether the provider is in the MCO's network, without prior authorization. The MCOs shall pay for all emergency services that are medically necessary until the member is stabilized and shall assure that a member who has had an emergency is not held liable for payment of subsequent screening, diagnosis, and treatment. The MCOs shall ensure that the attending emergency physician or treating physician is responsible for determining the member's stabilization for transfer or discharge. The MCOs are also required to cover emergency services if the member is instructed to seek emergency services by his/her PCP or health plan representative regardless to whether the condition meets the prudent layperson standard. (c) Post Stabilization Services The MCOs are responsible for post-stabilization care services 24 hours a day, 7 days a week, both inpatient and outpatient, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition as described in 42 CFR 438.114, to improve or resolve the member's condition. Services should be provided whether the provider is within or outside of the provider network. Services may be prior authorized; however, the MCO is required to cover post-stabilization services without prior authorization, whether within or outside the provider network, for any of the

				following conditions: the MCO does not respond to the provider's request for prior authorization within 1 hour; the MCO cannot be contacted; or the MCO representative and attending physician cannot reach an agreement concerning the member's care and the MCO physician is not available for consultation.
42 CFR 438.214(a)	Provider Selection and Retention	40.210	40.210	(a) Selection and Retention of Providers. The contracts require the MCOs to have written policies and procedures for selection and retention of providers. (b) Credentialing and Recredentialing Requirements. Each MCO must demonstrate that its providers are credentialed in accordance with the State credentialing policy.
42 CFR 438.214(b)(1,2)	Credentialing and Recredentialing Requirements	40.400	40.210	Credentialing. The contracts include a requirement that the MCO have written policies and demonstrate that its providers are credentialed per the State's credentialing policy.
42 CFR 438.214(c), 438.12(a)	Nondiscrimination	40.210	40.210	Nondiscrimination. The contracts require that the MCO provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
42 CFR 438.12 (b)(1-3)	Construction of Providers	40.210	40.210	The MCOS will not be required to contract with providers beyond the number necessary to meet the needs of the members, preclude the MCO from using different reimbursement amounts for different specialties or for different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to member.
42 CFR 438.214(d)	Excluded Providers	40.210	40.210	Excluded providers. The contracts ensure that the MCOs may not employ or contract with providers excluded from participation in Federal Health Care Programs under either section 1128 or section 1128A of the Social Security Act.
42 CFR 438.214(e)	State Requirement	40.610, 40.620, 40.630, 40.640, 40.650	40.290	Provider Services. The contracts require that the MCOs offer provider education semi-annually on the roles and responsibilities of the provider. Providers shall have access to the MCO provider manuals both electronically and in hard copy, if requested. The contracts describe all of the minimal requirements of the provider manual. In addition, the MCOs shall have a grievance, complaints, and appeals process as well as a provider call center and website. The MCOs are also required to have policies and procedures in place to monitor provider compliance.
42 CFR 438.224 45 CFR parts 160-164	Confidentiality Requirements Consistent with 45 CFR parts 160-164	71.200	71.200	Confidentiality. The contracts ensure that for medical records and any other health and enrollment information that identifies a particular member, each MCO establishes and implements procedures consistent with confidentiality requirements in 45 CFR parts 160-164.
42 CFR 438.226 42 CFR 438.56	Enrollment, Disenrollment, Transfer	30.520, 30.550, 30.560, 30.600, 40.295, 50.200,	30.500, 30.550, 30.560, 30.600, 40.260, 50.100,	The contracts require MCO compliance with the enrollment and transfer requirements and limitations set forth in 438.56. (a) Provisions apply to all managed care arrangements. (b)(1) MCOs must specify reasons for which they may request disenrollment of a member. (b)(2) MCOs may not request disenrollment because of a change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior. (b)(3) MCOs must specify methods by which they assure the State that they do not request disenrollment for reasons other than those permitted under the contract.

		50.210, 50.220, 50.230	50.200, 50.210, 50.220, 50.250, 50.230	(c) The contracts provide that a member may request disenrollment for cause at any time. (d) The member must submit an oral or written request to the State or to the MCO. (2) The following are causes for disenrollment: The member moves out of the service area; the MCO does not cover the service; the member needs related services; poor quality of care; lack of access to service and/or experienced providers. (e) The contracts provide for automatic reenrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less. The State is the sole determiner of disenrollment from an MCO. A client who becomes disabled as determined by the State is transferred from a QUEST MCO to a QExA MCO.
42 CFR 438.228	Grievance System	50.800	50.800	Grievance System. The contracts require a grievance system for members meeting all regulation requirements, including a grievance process, an appeal process, and access to the State's fair hearing system.
42 CFR 438.400	Statutory Basis and Definitions	41.200, 50.310, 50.340, 50.350, 50.380, 50.800, 50.815, 50.820, 50.825, 50.850	40.700, 50.300, 50.330, 50.340, 50.370, 50.800, 50.815, 50.820, 50.825, 50.850	Information to enrollees of MCO. The contracts state that MCOs must provide to all members the following information on grievance appeal and fair hearing procedures: procedures and timeframes, State fair hearing, right to file, timeframes for filing, toll free numbers, continuation of benefits, pay for services, failure of an organization to cover a service, advance directives, information on the structure and operation of the MCO, physician incentive plans.
42 CFR 438.402 42 CFR 438.402(a)	General Requirements. The Grievance System	50.800	50.800	Grievance System. The contracts require a grievance system for members meeting all regulation requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The contracts have requirements separately addressing each of these functions.
42 CFR 438.402(b)	Authority to File	50.830	50.830	Appeal Process: Authority to File. The contracts state an enrollee may file an MCO level appeal. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.
42 CFR 438.402(b)(2)	Timing	50.830	50.830	Appeal process: Timing. The contracts state that a member or provider may file an appeal and request a fair hearing within a reasonable timeframe that cannot be less than 20 days and not to exceed 90 days from the date on the notice of action.
42 CFR 438.402(b)(3)	Procedure	50.830	50.830	Appeal process: Procedures. The contract states an enrollee or provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed, appeal
42 CFR 438.228	Grievance System	50.800	50.800	Grievance System. The MCO shall have a grievance system process for meeting 42CFR 438 Subpart F. In addition, the State monitors the grievance process to include conducting random reviews of MCOs notice of actions.

42 CFR 438.200(b)	MCO Notification of State Procedures	50.825	50.825	MCO Notification of State Procedures. The contracts require that MCOs provide members with information on the State's grievance and review process.
42 CFR 438.404(a), 438.10(c)(d)	Language and Format	50.860, 50.330	50.860, 50.320	(a) Notice of Action. The contracts state that the MCOs must give the member written notice of any action within the timeframes for each type of action. (c)(d) Language and Format. The notice must be in writing and must meet the language and format requirements, including requirements for alternative formats taking into consideration special needs, other non-English language as specified in the contracts, grade 6 reading level, among others.
42 CFR 438.404(b)	Notice of Adverse Action	50.860	50.860	Notice of Adverse Action: Content. The contracts state that the notice must explain: The action the MCO or its contractor has taken or intends to take; the reasons for the action; the member's or the provider's right to file an appeal; the State does not require the member to exhaust the MCO level appeal the procedures; the member's right to request a State fair hearing; procedures for exercising member's right to appeal or grieve; circumstances under which expedited resolution is available and how to request it; the member's right to have benefits continue pending the resolution of the appeal; how to request that benefits be continued; and the circumstances under which the member may be required to pay the costs of these services.
42 CFR 431.206(b) 42 CFR 431.210	Notice of Adverse Action	50.860	50.860	CFR 431.206 Notice of Action: The contracts state that the MCO must give the member written notice of any action (not just service authorization actions) within the timeframes for each type of action.
42 CFR 438.404(c)(1)	Timeframes for Notice of Action	50.860	50.860	CFR 438.404 (c) Timeframes for Notice of Action: Termination, suspension, or reduction of services. The contracts state that the MCOs must give notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized medicaid covered services, except the period of advanced notice is shortened to 5 days if probable recipient fraud has been verified.
42 CFR 438.404(c)(2-6)	Untimely Notice of Action	50.860	50.860	(c) (2) Timeframes for Notice of Actions: Denial of payment. The contracts state that the MCOs give notice on the date of action when the action is a denial of payment. (3)(4) Standard Service. The contracts state that the MCOs provide notice as expeditiously as the member'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. (5) Untimely Service Authorization Decisions. The contracts state that the MCOs provide notice on the date that the timeframes expire. Untimely service authorizations constitute a denial and are thus adverse actions. (6) Expedited Service Authorization Denial. The contracts state that the MCOs provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request for service.
42 CFR 438.406 42 CFR 438.406(a)	Handling of Grievance and Appeals	50.805	50.805	Grievance System: General Requirements. The contracts state that the MCOs must give members any reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. The MCOs are required to acknowledge receipt of each grievance and appeal within 5 business days. MCOs shall also ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the member's condition or disease if any of the following apply: an appeal of a denial based on lack of medical necessity, a grievance regarding denial of expedited

				resolutions of an appeal, any grievance or appeal involving clinical issues.
42 CFR 438.406(b)	Special Procedures	50.830	50.830	Appeal Process: Procedures. The contracts state that the MCOs must: a) ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquires in writing, unless the member or the provider requests expedited resolution; b) send an acknowledgement of the receipt of the appeal within 5 business days of the receipt of written or oral appeal; c) provide the member a reasonable opportunity to present evidence and allegations of fact or laws in person as well as in writing; d) allow the member and representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents and records; e) consider the member, representative, or estate representative of a deceased member as parties to the appeal.
42 CFR 438.408(a-c)	Resolution and Notification	50.830	50.830	Appeal Process: Resolution and Notification. The contracts state that the MCOs must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within State established timeframes- no more than 30 calendar days from the day the MCOs receives the appeal. The MCOs may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and how the delay is in the member's interest. For any extension not requested by the enrollee, the MCO must give the member written notice of the reason for the delay.
42 CFR 438.408(d)(e)	Format and Content of Resolution Notice	50.830	50.830	Format and Content of Resolution Notice. The contracts state that the MCOs must provide written notice of disposition. The written resolution notice must include the results and date of the appeal resolution. For decisions not wholly in the member's favor, the written notice shall also include: The right to request a State fair hearing, how to request a State fair hearing, the right to continue to receive benefits pending a hearing, how to request the continuation of benefits, and as statement that if the MCO action is upheld in a hearing, the member may be liable for the cost of any continued benefits.
42 CFR 438.408(f)	Requirements for State Hearings	50.840	50.840	(f)(2) State Fair Hearing: The contracts state that the parties include the MCO as well as the member and his or her representative or the representative of a deceased member's estate. The contracts also state that the member has the right to file a fair hearing with the state if he/she is not satisfied with the MCO appeal disposition. The State will reach a decision within 90 days of the date the member filed for a fair hearing request.
42 CFR 438.410 42 CFR 438.410(a)	Expedited Appeals Process	50.835	50.835	Expedited Appeals Process – General. The contracts require the MCOs to establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
42 CFR 438.410(b)	Punitive Action	50.835	50.835	Punitive Action. The contracts require that the MCOs ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports a member's appeal.
42 CFR 438.410(c)	Action Following a Denial of a Request for Expedited Resolution	50.835	50.835	Action Following Denial of a Request for Expedited Resolution. The contracts state that if the MCO denies a request for expedited resolution of an appeal, it must: a) transfer the appeal to the standard timeframe of no longer than 45 days from the day the MCO receives the appeal with a possible 14-day extension (see 438.408(b)(2)); and b) make reasonable efforts to

				give the member prompt oral notice of the denial and follow-up with a written notice within two calendar days; c) inform the member that he/she may file a grievance for the denial of an expedited appeal.
42 CFR 438.414	Information about Grievance System	50.840, 50.845	50.840, 50.845	State Fair Hearing Process: MCO notification of State Procedures. The contracts state that if the MCO takes action and the member requests a State fair hearing, the State (not the MCO) must grant the member a State fair hearing.
42 CFR 438.10(g)	Information	41.200, 50.320, 50.330, 50.340, 50.395, 50.800, 50.805, 50.820, 50.830, 50.840, 50.845, 50.850, 50.860	40.700, 50.320, 50.330, 50.340, 50.390, 50.800, 50.805, 50.820, 50.830, 50.840, 50.850, 50.860	(1) The contract states that the MCOs must provide information on grievance appeal and fair hearing, including procedures and timeframes related to grievance, appeal, and fair hearings, the right to and method to obtain a State fair hearing, the fact that benefits will continue during the appeal/fair hearing process when requested by a member, and the fact that the member may be required to pay the cost of services furnished while an appeal is pending if the decision is adverse to the member. (2) Advance Directives. The contracts state that the MCOs must provide for compliance with the requirements of 422.128 for maintaining written policies and procedures for advance directives.
42 CFR 438.416	Record Keeping and Reporting Requirements	50.805, 50.810, 51.350.4	50.805, 50.810	Grievance System: Record Keeping and Reporting. The contracts state that the MCOs must maintain records of grievances and appeals.
42 CFR 438.420 42 CFR 483.420(a)(b)	Terminology, Timely Filing and Continuation of Benefits	50.850	50.850	Appeal and State Fair Hearing Process: Continuation of benefits. The contracts state that the MCOs must continue the member's benefits if the appeal is filed timely, meaning on or before the later of the following: within 10 days of the MCO mailing the notice of action or the intended effective date of the MCO's proposed action. The MCOs must also continue benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the authorization period has not expired; or the member requests extension of benefits.
42 CFR 483.420(c)	Duration of Continued or Reinstated Benefits	50.850	50.850	Appeal and State Fair Hearing process: Duration of Continued or Reinstated Benefits. The contract states that if the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: The member withdraws the appeal; the member does not request a fair hearing within 10 days from when the MCO mails an adverse decision; a State fair hearing decision adverse to the member is made; the authorization expires; or the authorization service limits are met.
42 CFR 438.420(d)	Enrollee Responsibility for Services Furnished	50.850	50.850	Appeal and State Fair Hearing Process: Member responsibility for services furnished while the appeal is pending. The contracts states that the MCOs may recover the cost of the continuation of services furnished to the member while the appeal

				was pending if the final resolution of the appeal upholds the MCO's action.
42 CFR 483.424(a)	Effectuation when Services were not Furnished	50.850	50.850	Appeal and State Fair Hearing Process: Effectuation when services were not furnished. The contracts state that the MCOs must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the appeal is pending and the MCO or the State fair hearing officer reverses a decision to deny, limit, or delay services.
42 CFR 483.424(b)	Effectuation when Services were Furnished	50.850	50.850	Appeal and State Fair Hearing Process: Effectuation when services were furnished. The contracts state that the MCOs or the State must pay for disputed services, in accordance with State policy and regulations, if the MCO or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending.
42 CFR 438.230(a)	Subcontractual Relationships and Delegation	70.500	70.500	Sub contractual relationship and delegation. The contracts ensure that the MCOs oversee and are held accountable for any functions and responsibilities that are delegated to any subcontractor.
42 CFR 438.230(b)	Periodic Performance Review	70.500	70.500	(1)(2)(3) Sub contractual Relationships and Delegation- Periodic Performance Review. The contracts state that the MCOs must evaluate the prospective subcontractor's ability to perform the activities to be delegated. The MCOs must maintain a written agreement between the entity and the subcontractor that specifies the activities and report responsibilities delegated, provides for revoking delegation, or imposing other sanctions if the subcontractor's performance is inadequate. The MCO periodic evaluation of subcontractor performance is subject to formal review according to a periodic schedule established by the State, consistent with industry standards, or State MCO laws and regulations.
42 CFR 438.230(b)	Corrective Action Plan	70.500	70.500	(4) Sub contractual Relationships and Delegation- Corrective Action Plan. The contracts state that the MCOs must identify deficiencies or areas for improvement, and that corrective action is taken.
42 CFR 438.236(c)	Dissemination	50.570	50.550	Dissemination of Guidelines. The contracts require that the MCOs disseminate the guidelines to all affected providers and, upon request, to enrollees and potential members.
42 CFR 438.236(d)	Application of Guidelines	50.570	50.550	Application of Guidelines. The contracts ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.
42 CFR 438.240 (b)	Quality Assessment and Performance Improvement Project/Program Requirements	50.520, 50.530, 50.540	30.810, 50.520, 50.540	The contracts require MCOs to have an ongoing Quality Assessment and Performance Improvement (QAPI) program consistent with Federal and State requirements and contractual obligations. The MCOs must comply with requirements set forth in 42 CFR 438.240 for conducting PIPs, submitting performance measurement data, mechanisms for detecting over and under utilization, and mechanisms for assessing quality and appropriateness of care furnished to SHCN members. QAPIs need to be approved annually, comply with standards set by the State, which are based on federal regulations and NCQA standards and guidelines for accreditation of managed care organizations. Performance Improvement Projects. The contracts ensure that the MCOs conduct performance improvement projects that are

				designed to achieve, through ongoing measurements and intervention significant improvement, sustained over time, in clinical care and nonclinical care areas that are suspected to have a favorable effect on health outcomes and member satisfaction.
42 CFR 438.240 (b)(3)	Under and Over Utilization	50.600	50.600	Quality Assessment and Performance Improvement Program. The contracts require that the MCOs have in effect mechanisms to detect both under-utilization and over-utilization of services. The MCOs shall have a written utilization management program (UMP) description, a corresponding work plan, UMP policies and procedures, and mechanisms to implement all UMP activities. The MCOs shall perform systematic monitoring of relevant data, analysis of data to identify causes of inappropriate utilization patterns, implement interventions to address potential or actual over- or under- utilization, and systematic measurement of effectiveness of intervention at achieving appropriate utilization.
42 CFR 438.240(b)(4)	Quality and Appropriateness of Care	50.530	50.520	Quality Assessment and Performance Improvement Program. The contracts ensure that the entity has mechanisms in effect to assess the quality and appropriateness of care furnished to members with special health care needs.
42 CFR 438.240 (b)(2),(c)	Performance Measurement	50.550, 51.360	51.360	Performance Measures. The contracts require MCOs address how clinical program initiatives will be addressed and to submit performance measures to the State for quality assurance and improvement activities. Performance measures are submitted at least on an annual basis, and ongoing reports are also reported monthly, quarterly, and semi-annually as specified in the MCO reporting calendar. The State and CMS may specify performance measures and topics for MCO required PIPs. The MCO must measure and report to the State its performance using standard measures specified by the State, including those developed in consultation with other stakeholders. The MCO must submit data to enable the State to measure its performance.
42 CFR 438.240 (b)(1) and 438.240(d)(1)	Requirements	50.540	50.540	Performance Improvement Projects. The contracts ensure that the MCOs conduct performance improvement projects that are 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 member satisfaction.
42 CFR 438.240(d)(2)	Reporting and Outcome	51.360.4, 51.360.5	50.540	Performance Improvement Projects. The contracts require that the MCOs report the status and results of each performance improvement project to the State as requested and annually for the EQR process.
42 CFR 438.240(e)(2)	State Review	50.530	30.800 51.520	Program Review by the State. The contracts require that MCOs have a process in effect for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. The MCOs will be subject to an annual review, including performance on required performance measures and on performance improvement projects.
42 CFR 438.10 (42 CFR 438.218)	Information Requirements	30.200, 40.300, 40.260, 41.200, 50.110, 50.320, 50.330, 50.340,	30.200, 40.230, 40.700, 50.300, 50.320, 50.330, 50.340, 50.350,	(b)(1) The State and MCOs adhere to the following definitions: Enrollee means a Medicaid recipient who is currently enrolled in an MCO in a given managed care program. Potential enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO. The term 'enrollee' is interchangeable with 'member', which is the convention used by the State and MCOs. (b)(3) Each MCO must have in place a mechanism to help members and potential members understand the requirements and benefits of the plan.

		50.350, 50.395, 50.805, 50.840, 50.845, 50.860 71.320, 72.140	50.390, 50.805, 50.830, 50,840, 50.845, 50.860 71.320, 72.140	(c) The contract states that the MCO must meet the language and format requirements. (c)(3) Language Requirements. The contracts state that each MCO must make its written information available in the prevalent non-English languages in its particular service area. (c)(4) Interpretation Services. MCOs must make oral interpretation services available free of charge to each potential and actual member. (c)(5)(i) Notification - Interpretation. MCOs must notify its members that oral interpretation is available for any language and written information is available in prevalent languages. MCOs must notify its members how to access those services. (d)(1)(i) Format Requirements. Written material must use easily understood language and format. (d)(1)(ii) Alternate Formats. Written material must 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. (d)(2) Notification - Alternate Formats. All members and potential members must be informed that information is available in alternate formats and how to access those formats. (f)(2) The contracts provide for all members, information on grievance appeal, and fair hearing procedures. (f)(3) Timeframe for Information. The contracts state that the MCOs must furnish to each of its members the information specified in paragraph 438.10(f)(6) of this section and, if applicable, paragraph 438.10(g) and 438.10(h) of this section, within a reasonable time after the MCO receives, from the State or its contracted representative, notice of the member's enrollment. (f)(4) Notice of Change of Information. MCOs must give each member written notice of any change (that the State defines as "significant") in the information specified in paragraph 438.10(f) of this section and, if applicable, paragraphs 438.10(g) and 438.10(h), at least 30 days before the intended effective date of the change. (f)(5) Notice of Provider Termination. MCOs must make in 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 member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. (f)(6)(i-xi)) MCOs shall provide to members information regarding: a) the names, locations, phone numbers, and non-English languages spoken by current contracted providers in the members service area, including providers not accepting new patients; b) restrictions on member freedom of choice among network providers; c) member rights consistent with 438.100; d) information on grievance and fair hearing; e) amount, duration, scope to help members understand benefit; f) procedures for obtaining benefits and authorizations; g) extent and how to obtain benefits from out of network providers; h) extent and how after-hours emergency services are provided; h) information to members according to 422.113; g) policy on referral to specialty care and other benefits not provided by the PCP; h) cost share information if any. (g)(1) The MCOs must provide grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract.

				(g)(2) The contract provides for compliance with the requirements of 422.128 for maintaining written policies and procedures for advance directives. Consistent with provisions of 42 CFR 438.10, if an MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service, because of an objection on moral or religious grounds; it must furnish information about the services it does not cover. Notice of Sanction and Pre-termination Hearing. The contracts state that the State must give the MCOs timely written notice that explains the basis and nature of the sanction and any other due process protections that the State elects to provide. The State must also provide the MCO with a pre-termination hearing.