Medicaid Managed Care Final Rule

Implementation / Timeline	Category	Reference	Requirement	Draft into Policy and Procedure	Update beneficiary informing materials (printed & electronic)	Update Posters / Posted Informing Materials	Update Provider Directory	Website		Update Provider Manual	Train Staff & Document Training
								Inter	Intra		
7/1/2017	**Beneficiary Informing - Website**	508 Guidelines, 504 and W3C's	1. Web format is readily accessible by modern accessibility standards - Assign to technology officer regarding website design for separate task list.					X			
7/1/2017	**Beneficiary Informing - Materials**	438.10	2. Member informing materials must be printable and given to beneficiaries within 5 business days [of enrollment].	X							
7/1/2017	**Beneficiary Informing - Materials**	438.10	**3. Plan must have mechanisms to help enrollees and potential enrollees understand the benefits of the plan.**								

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7/1/2017	**Beneficiary Informing - Translation**	438.10	4. Oral interpretation/translation services in all languages (not just threshold).					X			
7/1/2017	**Beneficiary Informing - Materials**	438.10	5. All written materials must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation	X	X	X	X	X	X		

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7/1/2017	Beneficiary Informing - Materials	438.10	6. Large print means printed in a font size no smaller than 18 point		X	X	X	X	X		
7/1/2017	Beneficiary Informing - Materials	438.10	7. Provider Directory - available in the prevalent non-English languages [in the county]				X				
7/1/2017	Beneficiary Informing - Materials	438.10	8. Handbook - available in the prevalent non-English languages [in the county]		X						
7/1/2017	Beneficiary Informing - Materials	438.10	9. Appeal and Grievance notices - available in the prevalent non-English languages [in the county]		X						
7/1/2017	Beneficiary Informing - Materials	438.10	**10. Denial and Termination notices - available in the prevalent non-English languages [in the county]**								

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7/1/2017	**Beneficiary Informing - Materials**	438.10	11. Alternate formats (i.e. Braille or Audio) and Auxiliary Aids (i.e. TTY/TDY and American Sign Language) must be made available upon request at no cost		**X**	**X**					
7/1/2017	**Beneficiary Informing - Handbook**	438.10	**12. Plan must provide the following information to enrollees (Handbook may be the best option): Features of managed care, covered benefits, provider directory and formulary information, cost sharing imposed by MHP, Adequate access to covered services, responsibility for coordination of enrollee care, quality and performance indicators for MHP, including enrollee satisfaction.**								

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7/1/2017	**Beneficiary Informing - Handbook**	438.10	13. Required Handbook topics: Benefits provided; how and where to access benefits (including cost sharing); amount, duration and scope of benefits in sufficient detail so beneficiaries understand what they are entitled; procedures for obtaining benefits (requirements for auths or referrals); how after hour emergency care is provided; how enrollees obtain benefits from out-of-network providers, enrollee rights and responsibilities; process to change a provider; grievance, appeal and fair hearing procedures and timeframes; how to exercise an advance directive; how to access auxiliary aids and services; translation and alternative format for materials; toll-free number for member services; how to report suspected fraud or abuse.		**X**						

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7/1/2017	**Beneficiary Informing - Provider Directory**	438.10	14. Information about network providers must be available on paper and electronic form: Providers name & group affiliation, street address, phone number; website/URL (if appropriate); specialty, as appropriate; if the provider is accepting new enrollees; provider's cultural and linguistic capabilities; provider's office/facility can accommodate people with disabilities.	X			X				X
7/1/2017	**Beneficiary Informing - Provider Directory**	438.10 (h)	15. Information in a paper provider directory must be updated at least monthly and the electronic provider directories must be updated no later than 30 calendar days after the Plan receives updated provider information. Must be made available on the Plan's website in a machine readable file and format (for printing).	X							

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7/1/2017	**Beneficiary Informing - Provider Directory**	438.10	16. MHP's must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt of the termination notice, to each enrollee who received his or her care from, or was seen on a regular basis by, the terminated provider.	X							
7/1/2017	**Beneficiary Informing - Provider Directory**	438.10	17. Create a provider role and responsibility agreement to include providing a written profile based on the template and required notification to the MHP upon termination and willingness to provide patient list with contract information for notification of a provider change.								
7/1/2017	**Beneficiary Protections - Transitions of Care**	438.620	18. The State agency must arrange for Medicaid services to be provided without delay to any Medicaid enrollee(b) The State must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to Plan or transition from one Plan to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.								

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7/1/2017	**Beneficiary Protections - Adverse Benefit Determination**	438.210	19. Each contract must provide for the Plan to notify the requesting provider, and give the enrollee written notice of any decision by the Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.								
7/1/2017	**Beneficiary Protections - Standard Authorizations**	438.210	20. Standard Authorization - For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if (i) The enrollee, or the provider, requests extension; or (ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.								

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7/1/2017	**Beneficiary Protections - Expedited Authorizations**	438.210	21. Expedited Authorizations: If following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.	X	X						

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7/1/2017	**Grievances and Appeals - Levels**	438.228, 438.402	22. The MHP must have a grievance and appeal system that meets the requirements of subpart F (overall). General requirements are: Each Plan must have a grievance and appeal system in place for enrollees **1)** Each Plan may have only one level of appeal for enrollees **2)** An enrollee may file a grievance and request an appeal **3)** An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld **4)** In the case of a Plan that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the Plan's appeals process and the enrollee may initiate a State fair hearing. **5)** The State may offer and arrange for an external medical review **6)** With the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee.	**X**	**X**	**X**		**X**	**X**		

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7/1/2017	**Adverse Benefit Determination - Definition**	438.400	23. Definition of adverse benefit determination - Adverse benefit determination means any of the following: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (2) The reduction, suspension, or termination of a previously authorized service. (3) The denial, in whole or in part, of payment for a service. (4) The failure to provide services in a timely manner, as defined by the State.	**X**	**X-AVATAR**					**X**	
7/1/2017	**Adverse Benefit Determination - Definition**	438.400	23. **(Continued)** (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network. (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.	**X**	**X-AVATAR**					**X**	

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7/1/2017	**Grievances and Appeals - Definitions**	438.400	24. Appeal and grievance definitions - Appeal means a review by a Plan of an adverse benefit determination 1) Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to: other quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee failure to respect the enrollee's rights regardless of whether remedial action is requested, an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. 2) Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them. 3) State fair hearing means the process set forth in subpart E of part 431 of this chapter.	**X**							

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7/1/2017	**Grievances and Appeals - Timing**	438.400	25. An enrollee may file a grievance with the Plan at any time. 1) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the Plan. 2) Following receipt of a notification of an adverse benefit determination by a Plan, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan. 3) The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.	X	X	X		X	X		

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7/1/2017	**NOA**	438.404	26. The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make. 1) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. 2) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at §438.402(b) and the right to request a State fair hearing consistent with §438.402(c). 3) The procedures for exercising the rights specified in this paragraph (b). 4) The circumstances under which an appeal process can be expedited and how to request it. **5) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services**.	**X**	**X**			**X**	**X**		

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7/1/2017	**Grievances and Appeals - Required Assistance**	438.406	27. Handling of Grievances and Appeals - In handling grievances and appeals, each Plan must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.	X							

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7/1/2017	**Grievances and Appeals - Handling**	438.406	28. A Plan's process for handling enrollee grievances and appeals of adverse benefit determinations must: 1) Acknowledge receipt of each grievance and appeal 2) Ensure that the individuals who make decisions on grievances and appeals are individuals—(i) Who were neither involved in any previous level of review or decision making nor a subordinate of any such individual. (ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating other enrollee's condition or disease. (iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.	X						X	

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7/1/2017	**Grievances and Appeals - Handling**	438.406	28. **(Continued)** - The Plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the appeal of the adverse benefit determination. 1) This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c). 2) Include, as parties to the appeal.	X						X	

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7/1/2017	**Grievances and Appeals - Timing Resolution & Notification**	438.408	29. Each Plan must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within timeframes: 1) For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the Plan receives the grievance. 2) For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the Plan receives the appeal. 3) For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the Plan receives the appeal.	X	X	X		X	X		

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7/1/2017	**Grievances and Appeals - Record Keeping**	438.416	30. a) The State must require Plans to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. b) The record of each grievance or appeal must contain, at a minimum, all of the following information: A general description of the reason for the appeal or grievance; The date received; The date of each review or, if applicable, review meeting; Resolution at each level of the appeal or grievance, if applicable; Date of resolution at each level, if applicable; Name of the covered person for whom the appeal or grievance was filed. (c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.								

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7/1/2017	**Adverse Benefit Determination - Effectuation of Reversals**	438.424	31. If the Plan 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 Plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. If the Plan 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 Plan must pay for those services, in accordance with State policy and regulations.	X							
60 days	**Program Integrity - Credentialing**	438.214	32. Each MHP must follow a documented process for credentialing and re-credentialing of network providers.	X							

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7/1/2017	**Program Integrity - Requirements under the Contract** ***(Section was added to spreadsheet as it was missing)***	438.608 (a,c,d)	33. Each MHP must have a compliance program, a Compliance officer, Compliance Committee, written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.								X
7/1/2017	**Program Integrity - Credentialing**	438.602 (a,c,d,e, f,g)	34. The State must screen and enroll, and periodically revalidate, all network providers of MHPs in accordance with the requirements of part 455, subparts B and E of this chapter. This requirement extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the State to provide services to FFS beneficiaries. This provision does not require the network provider to render services to FFS beneficiaries.								

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7/1/2018	**Program Integrity - Provider Screening and Enrollment Requirements**	438.608 (b)	35. Provider screening and enrollment requirements: The State, through its contracts with a MHP must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter. This provision does not require the network provider to render services to FFS beneficiaries.								
7/1/2017	**Data, Information & Documentation**	438.604	36. The State must require any MHP to submit to the State the following data: Data on the basis of which the State determines that the MHP has made adequate provision against the risk of insolvency as required under §438.116. Documentation described in §438.207(b) on which the State bases its certification that the MHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in §438.206. Information on ownership and control described in §455.104 of this chapter from MHP, and subcontractors as governed by §438.230. The annual report of overpayment recoveries as required in §438.608(d)(3).								

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7/1/2017	**Program Integrity - Compliance Program**	438.608 (a)	37. Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse: The State, through its contract with the MHP must require that the MHP or subcontractor to the extent that the subcontractor is delegated responsibility by the MHP for coverage of services and payment of claims under the contract between the State and the MHP implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.								
7/1/2017	**Program Integrity - Compliance Program**	438.608	38. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.								

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7/1/2017	**Program Integrity - Compliance Program**	438.608	39. A compliance program that includes, at a minimum, all of the following elements: Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors.								
7/1/2017	**Program Integrity - Compliance Program**	438.608	40. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.								
7/1/2017	**Program Integrity - Compliance Program**	438.608	41. Effective lines of communication between the compliance officer and the organization's employees.								

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7/1/2017	**Program Integrity - Compliance Program**	438.608	42. Enforcement of standards through well-publicized disciplinary guidelines.								
7/1/2017	**Program Integrity - Overpayment**	438.608	43. Each MHP requires and has a mechanism for a network provider to report to the MHP when it has received an overpayment, to return the overpayment to the MHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MHP in writing of the reason for the overpayment. Each MHP must report annually to the State on their recoveries of overpayments. The State must use the results of the information and documentation collected in paragraph (d)(1) of this section and the report in paragraph (d)(3) of this section for setting actuarially sound capitation rates for each MHP consistent with the requirements in §438.4.	**X**							

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7/1/2017	**Program Integrity - Overpayment**	438.608	44. Provision for prompt reporting to the State: All overpayments identified or recovered, specifying the overpayments due to potential fraud. The retention policies for the treatment of recoveries of all overpayments from the MHP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. The process, timeframes, and documentation required for reporting the recovery of all overpayments. The process, timeframes, and documentation required for payment of recoveries of overpayments to the State in situations where the MHP is not permitted to retain some or all of the recoveries of overpayments								
7/1/2017	**Program Integrity - Enrollee Status**	438.608	45. When the MHP receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following: Changes in the enrollee's residence; and, the death of an enrollee.								

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7/1/2017	**Program Integrity - Provider Status**	438.608	46. Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MHP.								
7/1/2017	**Program Integrity - Provider Status**	438.608	47. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.								
7/1/2017	**Program Integrity - Fraud Reporting**	438.608	48. Provision for the prompt referral of any potential fraud, waste, or abuse that the MHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.								

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								Inter	Intra		
7/1/2017	**Program Integrity - Fraud Reporting**	438.608	49. Provision for the MHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with §455.23 of this chapter.								
7/1/2017	**Program Integrity - Disclosures**	438.608	50. Disclosures: The State must ensure, through its contracts, that each MHP and any subcontractors: 1) Provides written disclosure of any prohibited affiliation under §438.610. 2) Provides written disclosures of information on ownership and control required under §455.104 of this chapter. 3) Reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.								

Marks in any column indicate that the associated item (PPG, Brochures, Provider Manual) requires updating.

Implementation / Timeline	Category	Reference	Requirement	Draft into Policy and Procedure	Update beneficiary informing materials (printed & electronic)	Update Posters / Posted Informing Materials	Update Provider Directory	Website		Update Provider Manual	Train Staff & Document Training
								Inter	Intra		
7/1/2017	**Program Integrity - Prohibited Affiliations**	438.610	51. A MHP may not knowingly have a relationship with: An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101. Individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.								

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Implementation / Timeline	Category	Reference	Requirement	Draft into Policy and Procedure	Update beneficiary informing materials (printed & electronic)	Update Posters / Posted Informing Materials	Update Provider Directory	Website		Update Provider Manual	Train Staff & Document Training
								Inter	Intra		
7/1/2017	**Program Integrity - Provider Credentialing**	438.10	52. The State, through its contracts with an MHP must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter. The provision does not require the network provider to render services to FFS beneficiaries. MHPs may execute network provider agreements pending the outcome of the [screening] process for up to 120 days, but must terminate a network provider immediately upon notification that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees.								

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Implementation / Timeline	Category	Reference	Requirement	Draft into Policy and Procedure	Update beneficiary informing materials (printed & electronic)	Update Posters / Posted Informing Materials	Update Provider Directory	Website		Update Provider Manual	Train Staff & Document Training
								Inter	Intra		
7/1/2017	**Quality Improvement - QAPI Program**	438.10	53. Each MHP must implement an ongoing and comprehensive QAPI program including key provisions: Performance Improvement Projects specified by the state and, if applicable, CMS; Collection and submission of performance measure data to the state; Mechanisms to detect under- and overutilization of services Assessment of the quality and appropriateness of care furnished to enrollees with special health care needs								
7/1/2017	**Quality Improvement - Accreditation**	438.332	54. Each MHP that has received accreditation by a private independent accrediting entity must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including: Accreditation status, survey type, and level (as applicable); Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and Expiration date of the accreditation.								

Marks in any column indicate that the associated item (PPG, Brochures, Provider Manual) requires updating.

Implementation / Timeline	Category	Reference	Requirement	Draft into Policy and Procedure	Update beneficiary informing materials (printed & electronic)	Update Posters / Posted Informing Materials	Update Provider Directory	Website Inter	Website Intra	Update Provider Manual	Train Staff & Document Training
	Quality Improvement - EQRO		55. New mandatory activity -validation of MCO, PIHP, and PAHP network adequacy during the preceding 12 months New optional EQR-related activity to assist with the quality rating of MCOs, PIHPs and PAHPs consistent with the Quality Rating System. CMS expects to issue protocols for the pre-existing mandatory and optional EQR activities in the Fall of 2017. CMS expects to issue the protocol for the new validation of network adequacy activity in a second round after the Fall of 2017.								
3 yrs. after publication from Federal Register	**Quality Improvement - Quality Rating System**	438.334	56. No later than 3 Years from Date of Final Notice Published in Federal Register. A public engagement process to develop a proposed QRS framework and methodology Similar to process used for Marketplace QRS including multiple state and stakeholder listening sessions and technical expert panel Publication of a proposed QRS in the Federal Register, with opportunity to comment, followed by notice of the final Medicaid and CHIP QRS expected in 2018								

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