Requirement Numbers	Applicable Tips
	health specialist.
I.F.4.05	This requirement at 42 CFR 438.910(d)(3) applies to any MCO, PIHP, or PAHP providing access to out-of-network providers for medical/surgical benefits, in states covering medical/surgical and mental health or substance use disorder services under the state plan. This requirement at 42 CFR 438.910(d)(3) applies to MCOs or a PIHP or PAHP providing services to an MCO enrollee, in states covering medical/surgical and mental health or substance use disorder services under the state plan.
I.F.6.02, I.F.6.03	States have the option to provide Alternative Benefit Plans (ABP) specifically tailored to meet the needs of certain Medicaid population groups. For those populations, this requirement under 42 CFR 438.210(a)(2) is met if the contract requires the MCP to furnish services in an amount, duration and scope that is no less than the amount, duration and scope described in the approved ABP state plan.
I.F.6.10	Per 42 CFR 438.910(d), NQTLs include, but are not limited to: • Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; • Formulary design for prescription drugs; • For MCOs, PIHPs, or PAHPs with multiple network tiers (such as preferred providers and participating providers), network tier design; • Standards for provider admission to participate in a network, including reimbursement rates; • MCO, PIHP, or PAHP methods for determining usual, customary, and reasonable charges; • Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); • Exclusions based on failure to complete a course of treatment; • Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the MCO, PIHP, or PAHP; and • Standards for providing access to out-of-network providers. Pursuant to 42 CFR 438.210(a)(5), the contract should be clear as to whether the MCP is responsible for providing the full range of EPSDT services, including necessary health care, diagnostic services, treatment and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screening, whether or not such services are covered under the State Plan.
I.F.6.11 - I.F.6.14	Pursuant to 42 CFR 438.210(a)(5), the contract should be clear as to whether the MCP is responsible for providing the full range of EPSDT services, including necessary health care, diagnostic services, treatment and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered during

Requirement Numbers	Applicable Tips
	screening, whether or not such services are covered under the State Plan.
I.F.7.01	Pursuant to 42 CFR 447.26(c), no reduction in payment for a provider preventable condition is imposed when the condition defined as a provider preventable condition for a particular patient existed prior to the initiation of treatment for that patient by that provider. Reductions in provider payment may be limited to the extent that the identified provider-preventable conditions would otherwise result in an increase in payment; and the MCP can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
I.F.9.01	This prohibition under section 1903(i) of the Act (final sentence) and section 1903(i)(1) of the Act is only applicable when the contract requires the MCP to cover organ transplants.
I.F.12.01 - I.F.12.03	Applies to MCOs or a PIHP or PAHP providing services to an MCO enrollee, in states covering medical/surgical and mental health or substance use disorder services under the state plan. The contract would also meet this requirement if, instead of including the regulatory text, the contract specifies that the MCP must comply with parity requirements for aggregate lifetime and annual dollar limits in 42 CFR 438.905 or specifies that the MCP cannot impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits. 42 CFR part 438, subpart K neither sanctions nor prohibits aggregate lifetime and annual dollar limits; the rule merely provides the standards for applying parity requirements to such limits if the limits are otherwise authorized. Applies where the full scope of medical/surgical and mental health and substance use disorder services are provided through the MCO.
I.F.12.04	Applies to MCOs or a PIHP or PAHP providing services to an MCO enrollee, in states covering medical/surgical and mental health or substance use disorder services under the state plan. Applies where the full scope of medical/surgical and mental health and substance use disorder services are provided through the MCO.
I.F.12.05, I.F.12.06	Applies to MCOs or a PIHP or PAHP providing services to an MCO enrollee, in states covering medical/surgical and mental health or substance use disorder services under the state plan.
I.F.12.07	Applies to MCOs or a PIHP or PAHP providing services to an MCO enrollee, in states covering medical/surgical and mental health or substance use disorder services under the state plan. Per 42 CFR 438.910(d), NQTLs include, but are not limited to: • Medical management standards limiting or excluding benefits based on

Requirement Numbers	Applicable Tips
	medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; • Formulary design for prescription drugs; • For MCOs, PIHPs, or PAHPs with multiple network tiers (such as preferred providers and participating providers), network tier design; • Standards for provider admission to participate in a network, including reimbursement rates; • MCO, PIHP, or PAHP methods for determining usual, customary, and reasonable charges; • Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); • Exclusions based on failure to complete a course of treatment; • Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the MCO, PIHP, or PAHP; and • Standards for providing access to out-of-network providers.
I.F.12.08	Applies to MCOs or a PIHP or PAHP providing services to an MCO enrollee, in states covering medical/surgical and mental health or substance use disorder services under the state plan.
I.F.13.03	If the MCP is required to provide services that could be authorized through sections 1915(c), 1915(i), or 1915(k) of the Act, and the 42 CFR 441.301(c)(4) settings requirements do apply to the MCP contract period under review, the contract must specify that the LTSS are provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings. If the MCP contract provides for the delivery of services that could be authorized through 1915(c), 1915(i), or 1915(k) authority and were initially approved by CMS, under any federal authority, on or after 3/17/14, the MCP contract must comply with the settings requirements. If the MCP contract provides for the delivery of services that could be authorized through 1915(c), 1915(i), or 1915(k) authority and were initially approved by CMS, under any federal authority, prior to 3/17/14, the MCP contract must comply with settings requirements based on the timeframe described in the state's settings transition plan approved by CMS. The Home and Community-Based Services (HCBS) settings requirements apply to services that are authorized through a 1915(c) waiver, a 1915(i) SPA, or a 1915(k) SPA. The settings requirements also apply to services authorized under any federal authority that "could be" authorized through a 1915(c) waiver, a 1915(i) SPA, or a 1915(k) SPA. For instance, a service authorized under 1115 waiver or 1915(b)(3) authority must meet the settings requirements when the service is of a nature that "could be" authorized under 1915(c), 1915(i), or 1915(k).
I.F.14.01 - I.F.14.03	This requirement only applies to PAHP contracts if the PAHP's provider network includes provider types outlined at 42 CFR 489.102(a), including: home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious

Requirement Numbers	Applicable Tips
	nonmedical institutions.
I.G. Quality and Utilization Management	
I.G.1.01	This requirement per 42 CFR 438.310(c)(2) applies to PCCM entities whose contracts with the state provide for shared savings, incentive payments or other financial reward for the PCCM entity for improved quality outcomes.
I.G.2.05	Related to subpart K, Parity in Mental Health and Substance Use Disorder Benefits, the contract should specify (1) a mechanism for the MCP to work with other MCPs to ensure that any MCO enrollee is provided access to a set of benefits that meets the requirements of 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits, regardless of what mental health or substance use disorder benefits are provided by the MCO; and (2) specify that the MCP coordinate with other MCPs and with providers to deliver an integrated set of benefits to MCO enrollees.
I.G.2.13	States must have in effect a transition of care policy in accordance with 42 CFR 438.62 and must require the MCPs to implement the transition to care policy. How a state chooses to meet these federal requirements may vary. For example, a state may: (1) Include its transition to care policy within the MCP contract or as an attachment to the contract; (2) Outline in the contract the process by which the state will share the model enrollee handbook; or (3) Use another method.
I.G.3.06	This requirement under 42 CFR 438.910(d) applies to MCOs or a PIHP or PAHP providing services to an MCO enrollee, in states covering medical/surgical and mental health or substance use disorder services under the state plan.
I.G.5.01	This requirement per 42 CFR 438.310(c)(2) applies to PCCM entities whose contracts with the state provide for shared savings, incentive payments or other financial reward for the PCCM entity for improved quality outcomes.
I.G.5.03 - I.G.5.04, I.G.5.09, I.G.5.17	This requirement per 42 CFR 438.310(c)(2) applies to PCCM entities whose contracts with the state provide for shared savings, incentive payments or other financial reward for the PCCM entity for improved quality outcomes.
I.G.7.07	For the requirement at 42 CFR 438.208(c)(3)(ii), see the person-centered planning process and person-centered service plan requirements at 42 CFR 431.301(c)(1) and (2), as the treatment or service plan must meet these requirements.
I.G.7.14	Pursuant to 42 CFR 438.208(c)(4), the mechanism, for example, may function through a standing referral or an approved number of visits.
I.H. Grievance and Appeals	
I.H.1.02	For the rating periods for contracts starting on or after July 1, 2017, managed care plans may not maintain more than one level of appeal. 42 CFR 438.402(b) requires that MCOs, PIHPs, and PAHPs "may have only one level of appeal for

Requirement Numbers	Applicable Tips
	enrollees." States may modify managed care contracts to require managed care plans to provide one level of internal appeal in advance of the rating period for contracts starting on or after July 1, 2017, as subpart F in the 2002 final rule permitted states flexibility as to the number of internal appeals. Please see page 27509 of the Final Rule for additional explanatory information.
I.H.1.11	Pursuant to 438.56(d)(5)(iii), the contract provides that if, as a result of the grievance process, the MCP approves a disenrollment request, the state agency is not required to make a determination.
I.H.2.01 - I.H.2.06	If the contract clearly specifies that the enrollee will receive a notice of adverse benefit determination when payment for a service has been denied, then the contract also meets the requirement in 42 CFR 438.915(b) (in Subpart K, Parity in Mental Health and Substance Use Disorder Benefits), which requires the MCP to make available to the enrollee the reason for any denial by the MCP of reimbursement or payment for services for mental health or substance use disorder benefits to the enrollee. If the contract does not clearly provide this, then follow up is required to include this language.
I.H.3.03	In accordance with 42 CFR 438.6(e), states may make a monthly capitation payment to an MCO or PIHP for an enrollee aged 21-64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crises residential services, and the length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment. Given this change in policy, the determination of when a beneficiary is ineligible for further services under the MCP contract, given admittance to an IMD, may change from practice prior to the implementation of this provision on July 5, 2016.
I.H.3.08, I.H.3.09	Pursuant to 42 CFR 438.408(c),the MCP may extend the 14 calendar day service authorization notice timeframe by up to 14 additional calendar days if the enrollee or provider requests extension, or if the MCP justifies (to the state agency upon request) a need for additional information and how the extension is in the enrollee's interest.
I.H.3.12	Pursuant to 42 CFR 438.404(c)(5), untimely service authorizations constitute a denial, and are thus adverse benefit determinations.
I.H.6.04	Pursuant to 42 CFR 438.406(b)(3), oral inquiries seeking to appeal an adverse benefit determination are treated as appeals in order to establish the earliest possible filing date for the appeal.
I.H.6.10	Pursuant to 438.408(b)(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 MCP receives the appeal. Pursuant to 438.408(b)(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 MCP receives the appeal.

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I.H.8.01	Refer to the Beneficiary Notification section of this State Guide for further detail regarding the notification requirements at 42 CFR 438.408(d)(2)(i).
I.H.9.06	For service authorizations or denials under 42 CFR 438.210(c), please see the notice and timing requirements in 42 CFR 438.404.
I.H.10.09	Refer to the Beneficiary Notification section of this State Guide for further detail regarding the notification requirements at 42 CFR 438.408(d)(1).
I.I. Program Integrity	
I.I.1.01	Pursuant to 42 CFR 438.214(d)(1), CMS encourages states to require the MCP to check their employees and contractors every month against the OIG's list of Excluded Individuals/Entities (LEIE) and the GSA Excluded Parties List System (EPLS) to ensure that no employee or contractor has been excluded. Pursuant to 42 CFR 438.214(d)(1), CMS encourages the state to require MCPs to notify the state agency promptly of any action it takes to limit the ability of an individual or entity to participate in its network. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the network to avoid a formal sanction.
I.I.1.02	In accordance with section 1128(b)(8) of the Act, a sanctioned individual is a person who: 1. Has a direct or indirect ownership or control interest of 5 percent or more in the entity, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program 2. Has an ownership or control interest (as defined in section 1124(a)(3) of the Act) in the entity, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program 3. Is an officer, director, agent, or managing employee of the MCP, and: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or

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	b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or c. Has been excluded from participation under a program under title XVIII or under a state health care program 4. No longer has direct or indirect ownership or control interest of 5 percent or more in the MCP or no longer has an ownership or control interest defined under section 1124(a)(3) of the Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who: a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Act] This requirement only applies to PIHPs, PAHPs, PCCMs, and PCCM entities that operate under section 1915(b)(1) authority. This requirement applies to all MCOs and HIOs.
I.1.03	This requirement only applies to PIHPs, PAHPs, PCCMs, and PCCM entities that operate under section 1915(b)(1) authority. This requirement applies to all MCOs and HIOs. Crimes under section 1128(b)(8)(B) of Act include conviction relating to fraud, conviction relating to obstruction of an investigation or audit, misdemeanor conviction relating to a controlled substance, conviction of program-related crimes, conviction relating to patient abuse, felony conviction relating to health care fraud, and felony conviction relating to a controlled substance.
I.I.1.04 - I.I.1.07	This requirement only applies to PIHPs, PAHPs, PCCMs, and PCCM entities that operate under section 1915(b)(1) authority. This requirement applies to all MCOs and HIOs.
I.I.1.08, I.I.1.09	This requirement only applies to PIHPs, PAHPs, PCCMs, and PCCM entities that operate under section 1915(b)(1) authority. This requirement applies to all MCOs and HIOs. An individual or entity that would provide services through an individual or entity debarred, suspended, or excluded under 42 CFR 438.610(a) or (b) is an individual or entity that intends to meet its contractual obligations by subcontracting or employing an individual or entity debarred, suspended, or excluded under 42 CFR 438.610(a) or (b). For example, a MCO contracts with a Pharmacy Benefits Manager (PBM), which subcontracts to a pharmacy, which employs a debarred pharmacist. Because of the debarred pharmacist, the MCO cannot contract with the PBM (until the pharmacy or pharmacist is terminated).

Requirement Numbers	Applicable Tips
I.I.2.01	Under 42 CFR 438.818, enrollee encounter data reports must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, and reports must be submitted in the format required by the Medicaid Statistical Information System or format required by any successor system to the Medicaid Statistical Information System. Additionally, states must ensure that enrollee encounter data is validated for accuracy and completeness as required under 42 CFR 438.242 before submitting to CMS, and must validate that the data submitted to CMS is a complete and accurate representation of the information submitted to the state by the MCP.
I.I.2.14 - I.I.2.16	The data, documentation and information that must be certified under 42 CFR 438.604 and 42 CFR 438.606 is described in I.I.2.01 - I.I.2.13 and I.I.6.05.
I.I.2.38	Under 42 CFR 438.608(b), this provision does not require the network provider to render services to FFS beneficiaries. Pursuant to 42 CFR 438.608(b), the disclosure and screening functions can be delegated. The enrollment functions, however, cannot.
I.I.6.01 - I.I.6.03	This recovery provision under 42 CFR 438.608(d)(1) does not apply to any amount of a recovery to be retained under FCA cases or through other investigations.
I.J. General Terms and Conditions	
I.J.1.06	This provision only applies to risk-bearing entities. HIOs and MCOs are always risk bearing in accordance with 42 CFR 438.2, however PIHPs, PAHPs, and NEMT PAHPs may be risk-based or non-risk.
I.J.1.07	NEMT PAHPs are only subject to the data, information, and documentation provisions specified in 42 CFR 438.610 under this requirement at 42 CFR 438.3(u).
I.J.3.01 - I.J.3.08	This subcontractor requirement under 42 CFR 438.230 only applies to contracts where the MCP has a subcontractor(s).
I.J.5.01, I.J.5.02	This requirement applies to PCCMs and PCCM entities at the state's option. Therefore, this requirement is not applicable for PCCMs and PCCM entities if the State does not exercise this option under 42 CFR 438.700(a).
I.J.5.03	Pursuant to 42 CFR 438.700(b)(3), this includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services. This requirement applies to PCCMs and PCCM entities at the state's option. Therefore, this requirement is not applicable for PCCMs and PCCM entities if the state does not exercise this option under 42 CFR 438.700(a).

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J.5.04, J.5.05	This requirement applies to PCCMs and PCCM entities at the state's option. Therefore, this requirement is not applicable for PCCMs and PCCM entities if the state does not exercise this option under 42 CFR 438.700(a).
I.J.5.06	PIP requirements are described in the "Providers and Provider Networks" and "Beneficiary Notification" sections of the tool. This requirement applies to PCCMs and PCCM entities at the state's option. Therefore, this requirement is not applicable for PCCMs and PCCM entities if the state does not exercise this option under 42 CFR 438.700(a).
I.J.5.07, I.J.5.09	This requirement applies to PCCMs and PCCM entities at the state's option. Therefore, this requirement is not applicable for PCCMs and PCCM entities if the state does not exercise this option under 42 CFR 438.700(a).
I.J.5.13	Pursuant to 42 CFR 438.700(b)(3), discrimination among enrollees on the basis of their health status or need for health care services includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
I.J.7.06	An exception to the solvency requirement at 42 CFR 438.116(b) applies when the MCP 1) does not provide inpatient hospital and physician services, 2) is a public entity, 3) is, or is controlled by, an FQHC and meets the state's FQHC solvency requirements, or 4) has solvency guaranteed by the state.
I.L. State Obligations	
I.L.1.01	For additional information on contract language requirements at 42 CFR 438.10(d)(1), see related items in I.C.1 'Language and Format' in the "Beneficiary Notification" Section.
I.L.2.01	Pursuant to 42 CFR 438.704(c), the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater.
I.L.4.01	If the state or enrollment broker is responsible for this identification under 42 CFR 438.208(c)(1), the contract should indicate the mechanism through which the MCP is notified of persons identified as having special health care needs. It is necessary for the MCP to be notified of enrollees with special health care needs in order for the MCP to meet the requirement at 42 CFR 438.208(c)(2), described in the Quality and UM section of this tool, to assess those individuals. Related to the identification of persons as having special health care needs under 42 CFR 438.208(c)(1), see the related "Special Health Care Needs: Assessment and Treatment Plans" Subsection in the Quality and Utilization Management Section.
I.L.4.02	Related to the identification of persons as having LTSS needs under 42 CFR 438.208(c)(1), see the related "Special Health Care Needs: Assessment and Treatment Plans" Subsection in the Quality and Utilization Management

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	Section.
I.L.6.05	This requirement at 42 CFR 438.602(b)(1) 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.

Section IV: Glossary of Terms[10]

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [42 CFR 438.2; 42 CFR 455.2]

Access: As used in part 438 subpart E and pertaining to external quality review, the timely use of services to achieve optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR §438.68 (Network adequacy standards) and §438.206 (Availability of services). [42 CFR 438.320]

Actuary: An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In Part 438, Actuary refers to an individual who is acting on behalf of the state when used in reference to the development and certification of capitation rates. [42 CFR 438.2]

Adverse benefit determination: In the case of an MCO, PIHP, or PAHP, any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by the state.
(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in 42 CFR 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 42 CFR 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. [42 CFR 438.400(b)]

Aggregate lifetime dollar limit: A dollar limitation on the total amount of specified benefits that may be paid under a MCO, PIHP, or PAHP. [42 CFR 438.900]

Annual dollar limit: A dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a MCO, PIHP, or PAHP. [42 CFR 438.900]

Appeal: A review by an MCO, PIHP, or PAHP of an adverse benefit determination. [42 CFR

[10] Note that some definitions apply to 42 CFR 438 in its entirety, while other definitions apply to a subpart. Please see the regulatory citation following each definition for further details.

Limited English proficient (LEP): Potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient (LEP) and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. [42 CFR 438.10(a)]

Long-term services and supports (LTSS): Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. [42 CFR 438.2]

Managed care organization (MCO): An entity that has, or is seeking to qualify for, a comprehensive risk contract under Part 438, and that is— (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; (ii) Meets the solvency standards of 42 CFR 438.116. [42 CFR 438.2]

Managed care program (MCP): A managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act. [42 CFR 438.2]

Mandatory enrollment: Enrollment where one or more groups of beneficiaries as enumerated in section 1905(a) of the Act must enroll in an MCO, PIHP, PAHP, PCCM or PCCM entity to receive covered Medicaid benefits. [42 CFR 438.54(b)(2)]

Marketing: Any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan. [42 CFR 438.104(a)]

Marketing materials: Materials that—

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

(2) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM, or PCCM entity to potential enrollees. [42 CFR 438.104(a)]

MCO, PIHP, PAHP, PCCM, or PCCM entity: Any of the entity's employees, network providers, agents, or contractors. [42 CFR 438.104(a)]

Medical/surgical benefits: Benefits for items or services for medical conditions or surgical procedures, as defined by the state and in accordance with applicable Federal and state law, but do not include

	mental health or substance use disorder benefits. Any condition defined by the state as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines). Medical/surgical benefits include long term care services. [42 CFR 438.900]
Member months:	The number of months an enrollee or a group of enrollees is covered by an MCO, PIHP, or PAHP over a specified time period, such as a year. [42 CFR 438.8(b)]
Mental health benefits:	Benefits for items or services for mental health conditions, as defined by the state and in accordance with applicable Federal and state law. Any condition defined by the state as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines). Mental health benefits include long term care services. [42 CFR 438.900]
Medical Loss Ratio (MLR) reporting year:	A period of 12 months consistent with the rating period selected by the state. [42 CFR 438.8(b)]
Network provider:	Any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement. [42 CFR 438.2]
No credibility:	A standard for which the experience of an MCO, PIHP, or PAHP is determined to be insufficient for the calculation of a MLR. An MCO, PIHP, or PAHP that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements. [42 CFR 438.8(b)]
Non-claims costs:	Those expenses for administrative services that are not: (1) Incurred claims; (2) Expenditures on activities that improve health care quality; or (3) Licensing and regulatory fees, or (4) Federal and state taxes. [42 CFR 438.8(b)]
Non-Emergency Medical Transportation PAHP (NEMT PAHP):	An entity that provides only NEMT services to enrollees under contract with the state, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates. [42 CFR 438.9(a)]
Nonrisk contract:	A contract between the state and a PIHP or PAHP under which the contractor— (1) Is not at financial risk for changes in utilization or for costs incurred under the

contract that do not exceed the upper payment limits specified in 42 CFR 447.362; and

(2) May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. [42 CFR 438.2]

Outcomes: As used in part 438 subpart E, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services. [42 CFR 438.320]

Overpayment: Any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act. [42 CFR 438.2]

Partial credibility: A standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target MLRs is statistically significant. An MCO, PIHP, or PAHP that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR. [42 CFR 438.8(b)]

Passive enrollment: In its discussion of the final Medicaid managed care rule at 81 FR 27613, CMS defined a passive enrollment process as one in which the state selects an MCP for a potential enrollee but provides a period of time for the potential enrollee to decline the managed care plan selection before enrollment became effective. [81 FR 27613]

Pass-through payment: Any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 CFR 438.6 for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; graduate medical education payments; or FQHC or RHC wrap around payments. [42 CFR 438.6]

Person-centered planning process: A process led by the individual, where possible, and includes the individual's representative in a participatory role, as needed and as defined by the individual, unless state law confers decision-making authority to the legal representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(1) Includes people chosen by the individual;

(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

(3) Is timely and occurs at times and locations of convenience to the individual;

(4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible

to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);

(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

(6) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the state demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the state must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process;

(7) Offers informed choices to the individual regarding the services and supports they receive and from whom;

(8) Includes a method for the individual to request updates to the plan as needed;

(9) Records the alternative home and community-based settings that were considered by the individual. [42 CFR 441.301(c)(1)]

Person-centered service plan:

A person-centered plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the state's 1915(c) HCBS waiver, the written plan must:

(1) Reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;

(2) Reflect the individual's strengths and preferences;

(3) Reflect clinical and support needs as identified through an assessment of functional need;

(4) Include individually identified goals and desired outcomes;

(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports;

(6) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b) of this chapter;
(8) Identify the individual and/or entity responsible for monitoring the plan;
(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation;
(10) Be distributed to the individual and other people involved in the plan;
(11) Include those services, the purpose or control of which the individual elects to self-direct;
(12) Prevent the provision of unnecessary or inappropriate services and supports;
(13) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of 42 CFR 431.301, must be supported by a specific assessed need and justified in the person-centered service plan. [42 CFR 431.301(c)(2)]

Poststabilization care services: Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the enrollee's condition. [42 CFR 438.114(a)]

Potential enrollee: A Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity. [42 CFR 438.2]

Prepaid ambulatory health plan (PAHP): An entity that—
(1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates.
(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract. [42 CFR 438.2]

Prepaid inpatient health plan (PIHP): An entity that—
(1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates.
(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) (3) Does not have a comprehensive risk contract. [42 CFR 438.2]

Prevalent: A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient. [42 CFR 438.10(a)]

Primary care: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, OB/GYN, pediatrician, or other licensed practitioner as authorized by the state Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them. [42 CFR 438.2]

Primary care case management (PCCM): A system under which:

(1) A primary care case manager contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or
(2) A PCCM entity contracts with the state to provide a defined set of functions. [42 CFR 438.2]

Primary care case management entity (PCCM entity): An organization that provides any of the following functions, in addition to primary care case management services, for the state:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.
(2) Development of enrollee care plans.
(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.
(4) Provision of payments to FFS providers on behalf of the state.
(5) Provision of enrollee outreach and education activities.
(6) Operation of a customer service call center.
(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.
(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
(9) Coordination with behavioral health systems/providers.
(10) Coordination with LTSS systems/providers. [42 CFR 438.2]

Primary care case manager (PCCM): A physician, a physician group practice or, at state option, any of the following:

(1) A physician assistant.
(2) A nurse practitioner.
(3) A certified nurse-midwife [42 CFR 438.2]

Private insurance: Does not include a qualified health plan, as defined in 45 CFR 155.20. [42 CFR 438.104(a)]

Provider: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services. [42 CFR 438.2]

Other disclosing entity: Any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, RHC, or HMO that participates in Medicare (title XVIII);
(2) Any Medicare intermediary or carrier; and
(3) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act. [42 CFR 455.101]

Quality: As used in part 438 subpart E and pertaining to external quality review, the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2)) increases the likelihood of desired outcomes of its enrollees through:

(1) Its structural and operational characteristics.
(2) The provision of services that are consistent with current professional, evidenced-based-knowledge.
(3) Interventions for performance improvement. [42 CFR 438.320]

Rating period: A period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR 438.7(a). [42 CFR 438.2]

Readily accessible: Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. [42 CFR 438.10(a)]

Risk contract: A contract between the state an MCO, PIHP or PAHP under which the contractor—

(1) Assumes risk for the cost of the services covered under the contract; and
(2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract. [42 CFR 438.2]

Risk corridor: A risk sharing mechanism in which states and MCOs, PIHPs, or PAHPs may share in profits and losses under the contract outside of a predetermined threshold amount. [42 CFR 438.6]

Rural Area: Any county designated as “micro,” “rural,” or “County with Extreme Access Considerations (CEAC)” in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year. [42 CFR 438.52(b)(3)]

Sanctioned individual: In accordance with section 1128(b)(8) of the Act, a sanctioned individual is a person who:

5. Has a direct or indirect ownership or control interest of 5 percent or more in the entity, and:

a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or
c. Has been excluded from participation under a program under title XVIII or under a state health care program

6. Has an ownership or control interest (as defined in section 1124(a)(3) of the Act) in the entity, and:
    a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
    b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or
    c. Has been excluded from participation under a program under title XVIII or under a state health care program
7. Is an officer, director, agent, or managing employee of the MCP, and:
    a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
    b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or
    c. Has been excluded from participation under a program under title XVIII or under a state health care program
8. No longer has direct or indirect ownership or control interest of 5 percent or more in the MCP or no longer has an ownership or control interest defined under section 1124(a)(3) of the Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:
    a. Has had a conviction of relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony healthcare fraud; or
    b. Has been assessed a civil monetary penalty under section 1128A or 1129 of the Act; or
    c. Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Act]

Service Authorization: A managed care enrollee's request for the provision of a service. [42 CFR 431.201]

State: A Medicaid agency is the Single state agency as specified in §431.10 of this chapter. [42 CFR 438.2; 42 CFR 431.10]

State fair hearing:	The process set forth in subpart E of part 431 chapter IV, title 42. [42 CFR 438.400(b)]
Subcontractor:	An individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the state. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP. [42 CFR 438.2]
Substance use disorder benefits:	Benefits for items or services for substance use disorders, as defined by the state and in accordance with applicable Federal and state law. Any disorder defined by the state as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines). Substance use disorder benefits include long term care services. [42 CFR 438.900]
Timely files:	Files for continuation of benefits on or before the later of the following: (i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination. (ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination. [42 CFR 438.420(a)]
Treatment limitations:	Include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (*See* 42 CFR 438.910(d)(2) for an illustrative list of NQTLs.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. [42 CFR 438.900]
Validation:	As used in part 438 subpart E, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. [42 CFR 438.320]
Withhold arrangement:	Any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement. [42 CFR 438.6]
Voluntary enrollment:	Enrollment where one or more groups of beneficiaries as enumerated in section of section 1905(a) of the Act have the option to either enroll in a MCO, PIHP,

PAHP, PCCM or PCCM entity, or remain enrolled in FFS to receive Medicaid covered benefits. [42 CFR 438.54(b)(1)]