Appendix C

Federal Medicaid Managed Care Regulations (42 CFR 438.200 et seq.) Crosswalk to URAC Health Plan Standards (Version 7)

THE URAC GUIDE TO MEDICAID MANAGED CARE EXTERNAL QUALITY REVIEW illustrates how URAC Accreditation can serve to demonstrate compliance with federally mandated external quality review (EQR) activities in Medicaid Managed Care Oversight. The Guide incorporates references to relevant CMS protocols and highlights where URAC standards are comparable to federal Medicaid managed care requirements:

- For Access to Care (42 CFR §§ 438.206, 438.207, 438.208 and 438.210)
- For Structure and Operations (42 CFR §§ 438.214, 438. 218, 438.224, 438.226, 438.228 and 438.230); and
- For Quality Measurement and Improvement (42 CFR §§ 438.236, 438.240 and 438.242)

For questions concerning this Guide and additional URAC resources, including workshops, webinars and teleconferences for regulators, please contact URAC Government Relations and Public Policy staff at urac.gr@urac.org.

Crosswalk Key:

- Deemable Regulation
- Specific Duplication Potential
- Deeming authority for Mandatory EQR Activities

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
Title 42: Public Health **Chapter IV: Centers for Medicare and Medicaid Services, Department of Health and Human Services** **Part 438: Managed Care**			
Subpart A: General Provisions **42 CFR 438.10** **Information requirements.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 76-89)	
438.10 (b) Basic rules. (1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood. (2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program. (3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.	**Core 10 – Review of Marketing and Sales Materials -- See Core 10 (a)** **Core 37 –Consumer Rights and Responsibilities** **Core 40 – Health Literacy** **P-MR 1 – Marketing Safeguards** **P-MR 2 – Consumer and Employer Information Disclosure** **P-MR 5 – Online Access** **P-MR 6 – Health Literacy Support for Consumers** **P-MR 7 – Consumer Communications Plan** **P-MR 10 – Targeted Consumer Outreach** **P-OPS 1 – General Telephone Access to Customer Service** **P-OPS 2 – Urgent Telephone Access to Customer Service** **P-OPS 3 – One-on-One Customer Service** ***HP-13*** **P-OPS 4 – Scope of Customer Service** Note: 42 CFR 438.10(b)(2) applies to the State.	See Appendix D	Core 10(a), Core 37, Core 40 and P-MR 6 meet 438.10(b)(1) P-MR 1, P-MR 2, P-MR 5, P-MR 7, P-MR 10, P-OPS 1, P-OPS 2, P-OPS 3, and P-OPS 4 meet 438.10(b)(3)
438.10 (d) Format.	**Core 10 – Review of Marketing and Sales Materials -- See**	See Appendix D	

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(1) Written material must-- (i) Use easily understood language and format; and (ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. (2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.	**Core 10 (a)** **Core 37 – Consumer Rights and Responsibilities** **Core 40 – Health Literacy** **P-MR 2 – Consumer and Employer Purchaser Information Disclosures** **P-MR 6 – Health Literacy Support for Consumers**		Core 10(a), Core 37, Core 40 and P-MR 6 meet 438.10(d)(1)(i) P-MR 2 meets 438.10(d)(1)(ii) and 438.10(d)(2)
438.10 (e) Information for potential enrollees. (1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows: (i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program. (ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHPs, PAHPs, or PCCMs. (2) The information for potential enrollees must include the following: (i) General information about-- (A) The basic features of managed care; (B) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program;	**P-MR 2 – Consumer and Employer Information Disclosure** **P-MR 7 – Consumer Communications Plan** **P-OPS 5 – Provider Directory Updates** Note: 42 CFR 438.10(e) applies to the State. For 438. 10(e)(2)(ii)(D), see the following: P-MR 2 and P-OPS 5	See Appendix D	P-MR 7(b) meets 438.10(e)(2)(ii)(A) P-MR 7(e)(i) meets 438.10(e)(2)(ii)(B) P-MR 7(d)(ii) & (iv) meet 438. 10(e)(2)(ii)(C)P-MR 2(a) and (b) and P-OPS 5 partially meet 438.10(e)(2)(ii)(D) Note: The URAC Standards do not specifically address non-English languages spoken by current contracted providers, though P-MR 2(a)(i)

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and (C) MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care; (ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request: (A) Benefits covered. (B) Cost sharing, if any. (C) Service area. (D) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals. (E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.			provides for information and support for consumers for whom English is not their primary language. The URAC standards do not specifically address the identification of providers that are not accepting new patients.
438.10 (f) General information for all enrollees of MCOs, PIHPs, PAHPs, and	**P-MR 2 – Consumer and Employer Information Disclosure**	See Appendix D	P-MR 7 partially meets

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PCCMs. Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows:(1) The State must notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period. (2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year. (3) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the recipient's enrollment. (4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as ``significant'') in the information specified in paragraphs (f)(6) of	**P-MR 7 – Consumer Communications Plan** **Core 4 – Regulatory Compliance** **P-MR 8 – Covered Benefit Disclosure** **P-OPS 6 – Consumer Notification Regarding PCP Status** Note: 438.10(f)(1) applies to the State. For 438.10(f)(2), see URAC standards mapped to 438.10(f)(6), (g) and (h). Note: 438.10(f)(4) provides a 30 day prior notice, while P-MR 8 does not specify a timeframe.		438.10(f)(3) Note: The URAC Standards do not specifically address non-English languages spoken by current contracted providers, though P-MR 2(a)(i) addresses consumers for whom English is not their primary language, or identification of providers that are not accepting new patients. P-MR 8 partially meets 438.10(f)(4) Note: The URAC Standard P-MR 8 requires consumers to be informed prior to changes in covered benefits,but does not specify that this notice must be 30 days prior to the effective date of the change. In evaluating

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this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change. (5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.			Medicaid plans, URAC Reviewers would apply the 30 day requirement pursuant to URAC CORE Standard 4: Regulatory Compliance. P-OPS 6 partially meets 438.10f(5) Note: The URAC Standard requires that consumers receive written notification once a PCP is no longer participating in a network, but specifies that the notification must be received within 45 days, not 15 days. In evaluating Medicaid plans, URAC Reviewers would apply the 15 day requirement

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			pursuant to URAC Standard 4: Regulatory Compliance.
438.10(f)(6) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees: (i) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes, at a minimum, information on primary care physicians, specialists, and hospitals. (ii) Any restrictions on the enrollee's freedom of choice among network providers. (iii) Enrollee rights and protections, as specified in Sec. 438.100. (iv) Information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in Sec. 438.10(g)(1), and for PAHP enrollees, the information specified in Sec. 438.10(h)(1). (v) The amount, duration, and scope of benefits available under the contract in	**Core 37 –Consumer Rights and Responsibilities** **Core 35 – Consumer Complaint Process** ***HP-16*** **P-MR 2 – Consumer and Employer Information Disclosure** **P-MR 7 – Consumer Communications Plan** **P-OPS 2 – Urgent Telephone Access to Customer Service** For 438.10(f)(6)(iii-iv), see the following: Core 37; P-MR 7(i); and Core 35. Note: For 438.10(f)(6)(viii)(A), see also URAC standards mapped to §438.114 Note: **42 CFR 438.100** establishes enrollee rights and protections: 438.100 (a) General rule. The State must ensure that-- (1) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and (2) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees. (b) Specific rights-- (1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section. (2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to --	See Appendix D	Core 37 meets 438.10(f)(6)(iii) P-MR 7(k) and Core 35 meet 438.10(f)(6)(iv) P-MR 7(b), (d), (f), and (j) meet 438.10(f)(6)(v) P-MR 7(d) meets 438.10(f)(6)(vi) P-MR 7(d)(ii) meets 438.10(f)(6)(vii) P-MR 7(b) and (d)(ii) and P-OPS 2 meet 438.10(f)(6)(viii) P-MR 7(d) meets 438.10(f)(6)(x) P-MR 2(i) and P-MR 7(e) meet

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sufficient detail to ensure that enrollees understand the benefits to which they are entitled. (vi) Procedures for obtaining benefits, including authorization requirements. (vii) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers. (viii) The extent to which, and how, after-hours and emergency coverage are provided, including: (A) What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in Sec. 438.114(a) (B) The fact that prior authorization is not required for emergency services. (C) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent. (D) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract. (E) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency	(i) Receive information in accordance with Sec. 438.10. (ii) Be treated with respect and with due consideration for his or her dignity and privacy. (iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in Sec. 438.10(f)(6)(xiii).) (iv) Participate in decisions regarding his or her health care, including the right to refuse treatment. (v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. (vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR Sec. 164.524 and 164.526. (3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with Secs. 438.206 through 438.210. (c) Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee. (d) Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights		438.10(f)(6)(xi)

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care. (ix) The poststabilization care services rules set forth at Sec. 422.113(c) of this chapter. (x) Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider. (xi) Cost sharing, if any. (xii) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.	Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).		
438.10 (g) Specific information requirements for enrollees of MCOs and PIHPs. In addition to the requirements in Sec. 438.10(f), the State, its contracted representative, or the MCO and PIHP must provide the following information to their enrollees: (1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in Sec. 438.400 through 438.424, in a State-	**Core 4 – Regulatory Compliance** **Core 37 –Consumer Rights and Responsibilities** **Core 35 – Consumer Complaint Process** ***HP-16*** **P-MR 2 – Consumer and Employer Information Disclosure** **P-MR 7 – Consumer Communications Plan -- See P-MR 7(i)** **P-OPS 1 – General Telephone Access to Customer Service** **P-OPS 4 – Scope of Customer Service -- See P-OPS 4(d)**	See Appendix D	Core 37, Core 35 and P-MR 3(k) meet 438.10(g)(1)(ii) Core 37, Core 35, P-MR 7(k) and HUM 31(b) meet

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developed or State-approved description, that must include the following: (i) For State fair hearing-- (A) The right to hearing; (B) The method for obtaining a hearing; and (C) The rules that govern representation at the hearing. (ii) The right to file grievances and appeals. (iii) The requirements and timeframes for filing a grievance or appeal. (iv) The availability of assistance in the filing process. (v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone. (vi) The fact that, when requested by the enrollee-- (A)Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and (B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee. (vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service. (2) Advance directives, as set forth in Sec. 438.6(i)(2). (3) Additional information that is available	**P-HUM 31 – Non-Certification Appeals Process -- See P-HUM 31(b)** For 438.10(g)(3)(i), see the following: Core 37 and P-MR 2 Note: Pursuant to URAC Core Standard 4: Regulatory Compliance, the specific federal requirements in this section would have to be met. For example, the elements of a State fair hearing and availability of assistance in filing processes set forth in 42 CFR 438.10(g)(1)(i) and (iv).		438.10(g)(1)(iii) P-OPS 4(d) meets 438.10(g)(1)(iv) P-OPS 1 meets 438.10(g)(1)(v) P-MR 2(c) meets 438.10(g)(3)(ii)

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upon request, including the following: (i) Information on the structure and operation of the MCO or PIHP. (ii) Physician incentive plans as set forth in Sec. 438.6(h) of this chapter.			
Subpart C: Enrollee Rights and Protections **42 CFR 438.114** **Emergency and poststabilization services.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 89-90)	
438.114(c) Coverage and payment: Emergency services. (1) The entities identified in paragraph (b) of this section-- (i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, or PCCM; and (ii) May not deny payment for treatment obtained under either of the following circumstances: (A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section. (B) A representative of the MCO, PIHP, PAHP, or PCCM instructs the enrollee to seek emergency services. (2) A PCCM must-- (i) Allow enrollees to obtain emergency	**Core 4 – Regulatory Compliance** **P-NM 4 – Out of Network and Emergency Services**	See Appendix D	P-NM 4(b) meets 438.114(c)(1) P-NM 4(b) meets 438.114(c)(2)

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services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services; and (ii) Pay for the services if the manager's contract is a risk contract that covers those services.			
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.204** **Elements of State quality strategies.**	**STATE QUALITY STRATEGY**		
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.206** **Availability of services.**	**ACCESS TO CARE STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 112-122)	
438.206(b) Delivery network. The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements: (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP, and PAHP	**Core 4 – Regulatory Compliance** **Core 34 - Access to Services** **P-NM 1 – Scope of Services** **P-NM 2 – Provider Network Access and Availability** ***HP-2, HP-11*** **P-NM 3 – Provider Selection Criteria -- See P-NM 3(c)** **P-NM 7 – Participating Provider Written Agreements** **P-CR 14 – Participating Provider Credentialing Monitoring** **P-MR 2 – Consumer and Employer Information Disclosure** **P-OPS 5 – Provider Directory Updates**	**RESOURCE:** **CMS Protocol 7B** (pages 115-118) **Core 34** **Documents:** • Organizational access standards • Policies addressing consumer and client access to program services • Sample meeting minutes where data related to access to program services is shared with the relevant QM or departmental committee.	Core 34, P-NM 1, P-NM 2, P-NM 3, P-NM 7, P-CR 14, P-MR 2, and P-OPS 5 meet 438.206(b)(1)

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must consider the following: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP. (iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. (iv) The numbers of network providers who are not accepting new Medicaid patients. (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.		**Interview Questions** 1. Management interviews to discuss consumer and client access to program services with management. 2. Interview staff on how the organization monitors access to service. **P-NM 1** **Documents:** • Business Plan • Marketing Plan • Strategic Plan • Service area maps • Geographic Access Analyses • Applicable State Regulations • Regulatory documents specifying services offered, service area, etc. **Interview Questions** 1. Interview network management leadership to assess familiarity with organization's services, service area, and consumer demographics. **P-NM 7** **Documents:** • List of providers (e.g. provider directory) **Interview Questions** Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting.	
438.206(b)(4) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely	**Core 4 – Regulatory Compliance** **P-NM 4 – Out of Network and Emergency Services**	**P-NM 4** **Documents:** • Policies and procedures • Consumer documents explaining the	P-NM 4(a) meets 438.206(b)(4)

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cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP is unable to provide them.		organizations policy • Sample letters to consumers describing the policies • Sample scripts for customer service representatives describing the policies **Interview Questions** 1. Interview with medical director and member services to assess organizational ability to respond to members' needs for emergency and out of area services. 2. Interview management staff of network management department to examine examples of policy implementation.	
438.206(b)(6) Demonstrates that its providers are credentialed as required by Sec. 438.214.	**Core 4 – Regulatory Compliance** **P-CR 1 – Practitioner and Facility Credentialing** **P-CR 11 – Credentialing Application Review** See also: URAC standards mapped to 42 CFR § 438.214	**P-CR 1** **Documents:** • Formally approved credentialing plan, program description, charter or credentialing policies and procedures, herein collectively called the "credentialing plan" or "plan." • Sample (1) credentialing committee meeting minutes showing that providers applying for participation in the network have completed the credentialing process. **Interview Questions** 1. Interview medical director and credentialing management staff regarding scope and processes of the credentialing program. 2. Interview medical director and credentialing management and line staff for process of credentialing prior to listing a provider in the provider directory. 3. Interview medical director and credentialing management and line staff for frequency of	P-CR 1 and P-CR 11 meet 438.206(b)(6)

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		credentialing. **P-CR 11** **Documents:** • Organizational chart depicting key positions and committees. • Credentialing plan defining the process for submitting applications to the credentialing committee for approval. **Interview Questions** 1. Interviews with clinical leadership and credentialing staff, including management regarding the committee process.	
438.206(c) (1) Timely access. Each MCO, PIHP, and PAHP must do the following: (i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	**Core 4 – Regulatory Compliance** **Core 34 - Access to Services** **P-NM 2 – Provider Network Access and Availability** ***HP-2, HP-11*** **P-NM 4 – Out of Network and Emergency Services**	**Core 4** **Documents:** • Regulatory compliance program description or compliance P&Ps • Report listing relevant laws and analysis against organization's program • Copies of the organization's state licenses or sample correspondence with regulators or sample of regulatory filing as applicable for the organization's program **Interview Questions** 1. Interview person responsible for compliance. Describe compliance officer's role in the following activities: maintaining the organization state licensure(s), tracking state and federal regulations for compliance, tracking requirements for medical director licensure in a state or states, interface between compliance and quality management, mechanisms for compliance with HIPAA Privacy and HIPAA	Core 4, Core 34, P-NM 2 and P-NM 4 meet 438.206(c)(1)(i)

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		Security, Health Plan's mechanism for reporting state reportable events to the medical board (decredentialed providers), oversight mechanism for monitoring bonuses for staff, medical directors and network providers to comply with state laws, Organizational Code of Conduct, Sarbanes-Oxley compliance, state market conduct surveys, review of benefits plan documents for compliance with applicable laws and regulations.	
438.206(c)(1)(iv) Establish mechanisms to ensure compliance by providers. (v) Monitor providers regularly to determine compliance. (vi) Take corrective action if there is a failure to comply.	**P-NM 9 – Written Agreement Inclusions -- See P-NM 9(b), (c), (f), and (l)** **P-NM 13 – Participating Provider Violation Mechanism** **P-NM 17 – Participating Provider Suspension Mechanism for Consumer Safety** **P-CR 14 – Participating Provider Credentials Monitoring**	**P-NM 13** **Documents:** • Policies and procedures regarding provider disputes and appeals • "Blinded" examples of documentation generated through the dispute resolution process, including correspondence with providers • Samples of a practitioner's request for a dispute resolution that include examples of both Type A and Type B level of reviews. • Minutes of committees with responsibility for provider disputes and appeals **Interview Questions** 1. Interview medical director and senior management staff to assess understanding and implementation of the policies and procedures governing provider dispute resolution; also method for collecting, recording and tracking provider complaints/disputes. **P-NM 17** **Documents:**	P-NM 9 (b), (c), (f) and (l); P-NM 13; P-NM 17 and P-CR 14 meet 438.206(c)(1)(iv) P-NM 13 meets 438.206(c)(1)(vi)

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		• Policies and procedures regarding provider disputes and appeals. **Interview Questions** 1. Interview medical director, senior management staff, compliance office, provider relations, and credentialing staff to verify the provider events that would trigger an immediate suspension.	
438.206(c)(2) *Cultural considerations.* Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	**CORE 40 – Health Literacy** **P-MR 2 – Consumer and Employer Information Disclosure** **P-MR 7 – Consumer Communications Plans** **P-MR 10 – Targeted Consumer Outreach**		CORE 40, P-MR2, P-MR 7, and P-MR 10 meet 438.206(c)(2)
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.207** **Assurances of adequate capacity and services.**	**ACCESS TO CARE STANDARDS: DEEMABLE REGULATIONS**		
438.207 (a) Basic rule. The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this subpart.	**Core 2 – Organization Documents** **Core 4 – Regulatory Compliance** **P-NM 1 – Scope of Services** **P-NM 2 – Provider Network Access and Availability** ***HP-2, HP-11*** Note: 438.207 primarily applies to the State.	**Core 2** **Documents:** • Top-level organization charts • Departmental/program organization chart • Program description **Interview Questions** 1. Interview staff on accreditation activities included within the scope of the review, including organizational framework and types of patients managed.	Core 2(c) and (d), Core 4, P-NM 1(b) and P-NM 2 meet 438.207(a)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
438.207 (b) Nature of supporting documentation. Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the following requirements: (1) Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area. (2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	**Core 2 – Organization Documents** **Core 4 – Regulatory Compliance** **P-NM 1 – Scope of Services** **P-NM 2 – Provider Network Access and Availability** ***HP-2, HP-11*** **P-NM 3 – Provider Selection Criteria**	**P-NM 2** **Documents:** • Business Plan • Marketing Plan • Strategic Plan • Geographic Access Analyses • Availability Analyses • Member surveys addressing provider availability • "Secret shopper" calls testing provider availability during "off-hours" times and testing ability of member to get timely appointment • Reports of onsite examination of appointment records • Applicable State Regulations **Interview Questions** 1. Interview network management leadership to assess 1) understanding of the requirement for both access and availability goals, and 2) implementation of action plans to address performance deficiencies in achieving these goals.	Core 2(c) and (d), P-NM 1 and P-NM 3(c) meet 438.207(b)(1) Core 2(c) and (d), P-NM 2 and P-NM 3 meet 438.207(b)(2)
438.207 (c) Timing of documentation. Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following: (1) At the time it enters into a contract with the State.	**CORE 4 – Regulatory Compliance** **P-RPT 1 – Reporting to URAC on Mandatory Measures** **P-RPT 2 – Reporting to URAC on Exploratory (Leading) Measures**		Core 4: Regulatory Compliance implicitly covers state reporting requirements. P-RPT 1 and P-RPT 2 do not meet 438.207

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
(2) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect adequate capacity and services, including— (i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area or payments; or (ii) Enrollment of a new population in the MCO, PIHP, or PAHP.			(c), but require reporting of measures to URAC.
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.208** **Coordination and continuity of care.**	**ACCESS TO CARE STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 123-131)	
438.208(b)(4) Primary care and coordination of health care services for all MCO, PIHP, and PAHP enrollees. Each MCO, PIHP, and PAHP must implement procedures to deliver primary care to and coordinate health care service for all MCO, PIHP, and PAHP enrollees. These procedures must meet State requirements and must do the following: Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	**Core 4 – Regulatory Compliance** **Core 16 – Confidentiality of Individually-Identifiable Health Information** **Core 36 – Coordination with External Entities** ***HP-15*** **P-NM 9 – Written Agreement Inclusions -- See P-NM 9 (e) and (k)** Note: 45 CFR parts 160 and 164 refer to the HIPAA Privacy and Security regulations. In 2003, URAC established the nation's first independent accreditation programs for HIPAA Privacy and Security.	**Core 23** **Documents:** • Policies and procedures related to privacy, security, and information management of all documentation containing IIHI • Training agenda related to HIPAA Privacy rules **Interview Questions:** 1. Interview compliance officer, managers, and staff for compliance with privacy and security policies **P-NM 9** **Documents:**	Core 16, Core 36 and P-NM 9(e) and (k) meet 438.208(b)(4)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		• List of providers (e.g. provider directory) **Interview Questions** 1. Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting.	
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.210** **Coverage and authorization of services.**	**ACCESS TO CARE STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 131-138)	
438.210 (a) Coverage. Each contract with an MCO, PIHP, or PAHP must do the following: (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer. (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230. (3) Provide that the MCO, PIHP, or PAHP— (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose	**Core 4 – Regulatory Compliance** **Core 34 - Access to Services** **P-NM 1 – Scope of Services** **P-NM 9 – Written Agreement Inclusions -- See P-NM 9(c), (f) and (l)** **P-HUM 1 – Review Criteria Requirements** For 438.210(a)(3)(ii), see the following: P-NM 9(l) For 438.210(a)(3)(iii), see the following: P-HUM 1 Note: 42 CFR 438.210(a) applies to the State.	**P-HUM 1** **Documents:** • P&P covering development, approval and evaluation of criteria and scripts • Samples of scripts, clinical criteria or other pre-review documents. **Interview Questions** 1. Interview medical director to assess understanding of criteria selection (commercial or proprietary or both), criteria review and approval process, and medical director involvement and oversight of periodic review of criteria. 2. Interview UM management and staff to assess currency of UM criteria in use	P-NM 1 partially meets 438.210(a)(1) Core 34 and P-NM 9(l) partially meet 438.210(a)(3) Note: URAC Standards do not directly address the amount, duration and scope requirements. CMS interprets the Medicaid terminology "amount, duration, and scope" to mean

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
for which the services are furnished. (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary; (iii) May place appropriate limits on a service— (A) On the basis of criteria applied under the State plan, such as medical necessity; or (B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and (4) Specify what constitutes "medically necessary services" in a manner that— (i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and (ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following: (A) The prevention, diagnosis, and treatment			that MCOs, in their coverage limitations on Medicaid mandatory services, must offer benefits that would be sufficient to meet the needs of 90% of the Medicaid population. HUM 1(b) meets 438.210(a)(3)(iii)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
of health impairments. (B) The ability to achieve age-appropriate growth and development. (C) The ability to attain, maintain, or regain functional capacity.			
438.210 (b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require- (1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.	**Core 3 – Policy and Procedure Maintenance, Review, and Approval** **Core 8 – Delegation Contracts** **Core 4 – Regulatory Compliance**	**Core 3** **Documents:** • P&P governing document management. • Proof of P&P approval **Interview Questions** 1. Staff demonstration 2. Management interview for policy/procedure development, revision, and approval.	Core 3 and Core 8(b) meet 438.210(b)(1)
438.210(b) (2) That the MCO, PIHP, or PAHP-- (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and	**Core 28 – Staff Operational Tools and Support** **Core 29 – Staff Assessment Program** **Core 32 – Senior Clinical Staff Responsibilities** **Core 5 – Inter-departmental Coordination** **Core 4 – Regulatory Compliance** **P-HUM 10 – Initial Clinical Reviewer Qualifications** **P-HUM 13 – Peer Clinical Review Cases**	**Core 28** **Documents:** • Master list of P&Ps • Program Description indicating clinical decision support tools used **Interview Questions** 1. Staff interview/demonstration of operational and clinical decision support tools **Core 29** **Documents:** • Sample template used for annual evaluation of staff • P&P indicating at least an annual review requirement **Interview Questions** 1. Staff interview of organizational assessment program	Core 28, Core29, Core 32, Core 5, P-HUM 10 and P-HUM 13 meet 438.210(b)(2)(i)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		Core 32 **Documents:** • Job description for senior clinical staff person responsibilities, or if a contractor, the contract template describing responsibilities for the organization's program • Program description or P&Ps describing the senior clinical staff person's role and accountabilities **Interview Questions** 1. Senior clinical staff person interview for responsibilities and accountabilities for the organization's program **Core 5** **Documents:** • Documents including quality meeting minutes, departmental/team meetings, organizational newsletters • Job descriptions for staff functioning as a liaison to other departments **Interview Questions** 1. Interview staff and management for descriptions of interdepartmental coordination **P-HUM 10** **Documents:** • P&P prohibiting the issuance of non-certifications based on initial clinical review • P&P covering the initial clinical review process and the peer review process • Job description for initial clinical reviewers	

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		• Job description of the licensed doctor of medicine, or doctor of osteopathic medicine who is responsible for providing consultation to initial clinical review staff. **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with different levels of review. **P-HUM 13** **Documents:** • P&P covering the initial clinical review process and the peer review process • Job description/contracts for individuals who conduct peer clinical review **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with different levels of review.	
438.210(b)(2)(ii) Consult with the requesting provider when appropriate.	**Core 4 – Regulatory Compliance** **P-HUM 15 – Peer-to-Peer Conversation Availability**	**P-HUM 15** **Documents:** • P&P describing the peer-to- peer review process, including the mechanism used to make providers aware that they have this option • Job description/contracts for individuals who conduct peer clinical review • Sample template of written notification of non-certification informing providers of their option for a peer-to-peer conversation if not conducted prior to the non-	P-HUM 15 meets 438.210(b)(2)(ii)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		certification. **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with policy on peer-to peer conversation.	
438.210(b) (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	**Core 4 – Regulatory Compliance** **P-HUM 14 – Peer Clinical Reviewer Qualifications**	**P-HUM 14** **Documents:** • P&P covering the initial clinical review process and the peer review process • Job description/contracts for individuals who conduct peer clinical review **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with different levels of review.	P-HUM 14 meets 438.210(b)(3)
438.210(c) Notice of adverse action. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of Sec. 438.404, except that the notice to the provider need not be in writing.	**Core 4 – Regulatory Compliance** **P-HUM 22 – Written Notice of Non-Certification Decisions & Rationale** Note: URAC P-HUM Standard 22: Written Notice of Non-Certification Decisions and Rational, requires written notification on non-certification decisions and rationale. See also: URAC standards mapped to § 438.404 requirements.	**P-HUM 22** **Documents:** • P&P covering non-certifications • Sample template of written notification of non-certification **Interview Questions** 1. Interview initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with process for noncertification, including timeframes and notification requirements.	P-HUM 22 meets 438.210(c)
438.210(d) Timeframe for decisions. Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:	**Core 4 – Regulatory Compliance** **P-HUM 17 – Prospective Review Timeframes**	**P-HUM 17** **Documents:** • P&P covering prospective, concurrent, and	P-HUM 17 (b) and (c) partially meet

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
(1) Standard authorization decisions. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— (i) The enrollee, or the provider, requests extension; or (ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. (2) Expedited authorization decisions. (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. (ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a	For 438.201(d)(1), see the following: P-HUM 17 For 438.201(d)(2)(i), see the following: P-HUM 17(a) Note: URAC timeframes vary slightly. Pursuant to URAC Core Standard 4: Regulatory Compliance, where the federal requirement is more stringent than the URAC standard, the federal and State requirements would have to be met.	retrospective review • Sample template of written notice of extension to patient. **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with the prospective review processes, including review timeframes.	438.210(d)(1). Note: The URAC Standards allow 15 calendar days, while federal regulations allow 14 calendar days. In evaluating Medicaid plans, URAC Reviewers would apply the 14 day requirement pursuant to URAC CORE Standard 4: Regulatory Compliance. P-HUM 17(a) meets 438.210(d)(2)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
need for additional information and how the extension is in the enrollee's interest.			
438.210 (e) Compensation for utilization management activities. Each contract must provide that, consistent with Sec. 438.6(h), and Sec. 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	**Core 4 – Regulatory Compliance** **Core 33 – Financial Incentive Policy**	**Core 33** **Documents:** • Policy describing financial incentives for program staff and network providers that identifies those that are based upon consumer utilization of health care and mechanisms to protect consumers. **Interview Questions** 1. Interview compliance personnel and chief clinical staff person to clarify the metrics for bonuses and/or financial incentives; any reviews done for compliance with state laws and whether the bonus required state approval; indicators for receiving a bonus; oversight mechanism to monitor for potential harm to consumers for under-utilization or over-utilization 2. Interview supervisory staff and line staff regarding bonus/incentive program	Core 33 meets 438.210(e)
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.214** **Provider selection.**	**STRUCTURE AND OPERATIONS STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 138-143)	
438.214 (a) General rules. The State must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of providers and that those policies and	**Core 4 – Regulatory Compliance** **P-NM 3 – Provider Selection Criteria**	**P-NM 3** **Documents:** • Business plan • Marketing plan • Strategic plan	P-NM 3 meets 438.214(a)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
procedures include, at a minimum, the requirements of this section.		• Credentialing policies and procedures that describe provider selection criteria • Summary of minimum criteria for participating providers • Geographic mapping of provider locations • Provider service agreements • Reports of provider profiling • Provider manual • Related policies and procedures **Interview Questions** 1. Interview with network management leadership regarding current issues in network development to assess implementation of selection criteria.	
438.214 (b) Credentialing and recredentialing requirements. (1) Each State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow. (2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO, PIHP, or PAHP.	**Core 4 – Regulatory Compliance** **P-CR 1 – Practitioner and Facility Credentialing** **P-CR 4 – Credentialing Program Plan** **P-CR 15 - Recredentialing**	**P-CR 15** **Documents:** • Credentialing plan delineating the recredentialing process. • Credentialing committee meeting minutes demonstrating the recredentialing process. **Interview Questions** 1. Interview with the credentialing management and staff personnel regarding the recredentialing process.	P-CR 1 and P-CR 15 meet 438.214(b)(1) P-CR 4 meets 438.214(b)(2)
438.214 (c) Nondiscrimination. MCO, PIHP, and PAHP provider selection policies and procedures, consistent with Sec. 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	**Core 4 – Regulatory Compliance** **P-CR 4 – Credentialing Program Plan -- see P-CR 4(h)**	**P-CR 4** **Documents:** • Job description/contract for senior clinical staff person for the credentialing program (Medical Director). • Credentialing plan. **Interview Questions** 1. Interview Credentialing Manager and medical director to assess understanding of the	P-CR 4(h) meets 438.214(c)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		credentialing program and URAC requirements.	
438.214 (d) Excluded providers. MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	**Core 4 – Regulatory Compliance**	See Appendix D	Core 4 meets 438.214(d)
438. 214 (e) State requirements. Each MCO, PIHP, and PAHP must comply with any additional requirements established by the State.	**Core 4 – Regulatory Compliance**	See Appendix D	Core 4 meets 438.214(e)
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.218** **Enrollee information.**	**STRUCTURE AND OPERATIONS STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (page 143)	
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.224** **Confidentiality.**	**STRUCTURE AND OPERATIONS STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (page 143)	
438. 224 The State must ensure, through its contracts, that (consistent with subpart F of part 431 of this chapter), for medical records and any other health and enrollment information that identifies a particular enrollee, each MCO, PIHP, and PAHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these	**Core 4 – Regulatory Compliance** **Core 16 – Confidentiality of Individually-Identifiable Health Information**	See Appendix D	Core 16 meets 438.224

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
requirements are applicable.			
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.226** **Enrollment and disenrollment.**	**STRUCTURE AND OPERATIONS STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol** (pages 143-147)	
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.228** **Grievance systems.**	**STRUCTURE AND OPERATIONS STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 147-148)	
438.228 (a) The State must ensure, through its contracts, that each MCO and PIHP has in effect a grievance system that meets the requirements of subpart F of this part. (b) If the State delegates to the MCO or PIHP responsibility for notice of action under subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCO or PIHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.	**Core 4 – Regulatory Compliance** **Core 35 – Consumer Complaint Process** ***HP-16*** Note: For a map of URAC Standards to Subpart F, see Sections 438.408 – 438.424 in this crosswalk. Note: 438.228 applies to the State.	**Core 35** **Documents:** • QM program description or P&Ps addressing consumer and client access to program services, including standards for access • Reports summarizing data related to consumer and client complaints about program services and appeals of program decisions • Sample of correspondence that includes appeal rights. • Sample meeting minutes where data related to access to program services is shared with the QM committee **Interview Questions** 1. Interview management and line staff on process for handling, tracking and resolving	Core 35 meets 438.228(a)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		complaints. 2. Interview management staff on process for reporting complaints to the QMC.	
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.230** **Subcontractual relationships and delegation.**	**STRUCTURE AND OPERATIONS STANDARDS:** **DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 149-151)	
438.230(a) General rule. The State must ensure, through its contracts, that each MCO, PIHP, and PAHP-- (1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and (2) Meets the conditions of paragraph (b) of this section.	**Core 9 – Delegation Oversight** **Core 4 – Regulatory Compliance**	**Core 9** **Documents:** • P&P for oversight mechanism covering contractor responsibilities for delegated program functions • Samples or templates of documentation of annual compliance review audits of contractual requirements and policies and procedures for delegated functions. **Interview Questions** 1. Interview management staff responsible for delegation oversight about their role in overseeing the required services of contracted delegees.	Core 9 meets 438.230(a)
438.230 (b) Specific conditions. (1) Before any delegation, each MCO, PIHP, and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.	**Core 7 – Delegation Review**	**Core 7** **Documents:** • P&P outlining the process and criteria used for approving delegated contractors. **Interview Questions** 1. Interview management staff responsible for delegation oversight. Review audit tool used by applicant to evaluate ability of delegee to perform delegated functions	Core 7 meets 438.230(b)(1)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
438.230(b)(2) There is a written agreement that-- (i) Specifies the activities and report responsibilities delegated to the subcontractor; and (ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	**Core 8 – Delegation Contracts**	**Core 8** **Documents:** • Sample templates of written agreements with contractors **Interview Questions** 1. Interview management staff responsible for delegation oversight.	Core 8(a), (c) and (e) meet 438.230(b)(2)(i) Core 8(f) meets 438.230(b)(2)(ii)
438.230(b)(3) The MCO, PIHP, or PAHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.	**Core 9 – Delegation Oversight** **Core 4 – Regulatory Compliance**	See Appendix D	Core 9(a) and (b) meet 438.230(b)(3)
438.230(b)(4) If any MCO, PIHP, or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP, or PAHP and the subcontractor take corrective action.	**Core 8 – Delegation Contracts -- See Core 8(f)**	See Appendix D	Core 8(f) meets 438.230(b)(4)
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.236** **Practice guidelines.**	**MEASUREMENT AND IMPROVEMENT STANDARDS: DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 152-156)	
438.236 (b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements: (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. (2) Consider the needs of the MCO's,	**Core 4 – Regulatory Compliance** **P-HUM 1 – Review Criteria Requirements**	**RESOURCE:** **CMS Protocol 7B** (pages 152-153)	P-HUM 1 (b) meets 438.236(b)(1) P-HUM 1(a) and (d) meet 438.236(b)(3)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
PIHP's, or PAHP's enrollees. (3) Are adopted in consultation with contracting health care professionals. (4) Are reviewed and updated periodically as appropriate.			P-HUM 1(c) meets 438.236(b)(4)
438.236 (c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	**Core 4 – Regulatory Compliance** **P-HUM 23 – Clinical Rationale for Non-Certification Requirements** Note: P-MR 2(g) requires MCOs to make information regarding medical management requirements available to consumers. URAC's definition of medical management encompasses the clinical practice guidelines referenced in 438.236. (See Appendix E, Glossary, page 34.)	**RESOURCE:** **CMS Protocol 7B** (page 154) **P-HUM 23** **Documents:** • P&P covering non-certifications • Sample template of written notification of non-certification **Interview Questions** 1. Interview initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with process for providing clinical rationale upon request.	P-HUM 23 meets 438.236(c)
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.240** **Quality assessment and performance improvement program. (QAPI)**	**MEASUREMENT AND IMPROVEMENT STANDARDS: DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 156-162)	
438.240(a) General rules. (1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.	**P-QM 1 – Quality Management Program** Note: 438.240(a) applies to the State.	**RESOURCE:** **CMS Protocol 7B** (pages 156-157) **P-QM 1** **Documents:** • QM Program description or P&Ps addressing QM oversight of the program **Interview Questions** 1. Interview with program management to	P-QM 1 meets 438.240(a)(1)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		discuss the structure of the QM program as it effects the organization's program. 2. Interview with staff to discuss their role in the QM program.	
438.240 (b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements: (1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. (2) Submit performance measurement data as described in paragraph (c) of this section. (3) Have in effect mechanisms to detect both underutilization and overutilization of services. (4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	**Core 4 – Regulatory Compliance** **P-QM 5 - Quality Improvement Process** ***HP-5, HP-6, HP-7, HP-8*** **P-QM 7 – Three (3) Clinical Quality Improvement Projects for Health Plans** **P-QM 9 – Quality Improvement Project Requirements** For 438.240(b)(1), see the following: P QM 7. For 438.240(b)(2) and (4), see the following: P-QM 5 and P-QM 9. For 438.240(b)(3), see the following: P-QM 9. Note: Core 4 would address regulatory compliance with 438.240(b)(2) in that the measures required by the State must be addressed in the MCP performance data.	**RESOURCE:** **CMS Protocol 7B** (pages 156-157) **See CMS Protocol(s):** For §438.240(b)(2), see CMS Protocol 7B (pages 158-159) For §438.240(b)(3), see CMS Protocol 7B (page 159) For §438.240(b)(4), see CMS Protocol 7B (pages 160-161) • . **<u>P-QM 7</u>** **Documents:** • QI project descriptions for three (3) different projects for the program coming under accreditation. At least one project must focus on consumer safety, and if a clinical quality project, must involve a senior clinical staff person. Analyze QIPS for consumer focus/consumer safety issues. **Interview Questions** 1. Interview QM program management personnel on choosing QIPs and how the submitted QIPs focus on consumers and	P-QM 7 meets 438.240(b)(1) Core 4 and P-QM 5 meet 438.240(b)(2) P-QM 9 meets 438.240(b)(3). P-QM 9 meets 438.240(b)(4).

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		consumer safety.	
438.240 (c) Performance measurement. Annually each MCO and PIHP must— (1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of §§438.204(c) and 438.240(a)(2); (2) Submit to the State, data specified by the State, that enables the State to measure the MCO's or PIHP's performance; or (3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section	**CORE 4 – Regulatory Compliance** **P-RPT 1 – Reporting to URAC on Mandatory Measures** **P-RPT 2 – Reporting to URAC on Exploratory (Leading) Measures**		Core 4: Regulatory Compliance implicitly covers state reporting requirements. P-RPT 1 and P-RPT 2 meet 438.240 (c), but require reporting of measures to URAC.
438.240 (d) Performance improvement projects. (1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following: (i) Measurement of performance using objective quality indicators. (ii) Implementation of system interventions to achieve improvement in quality. (iii) Evaluation of the effectiveness of the interventions. (iv) Planning and initiation of activities for increasing or sustaining improvement.	**Core 4 – Regulatory Compliance** **P-QM 5 - Quality Improvement Process** ***HP-5, HP-6, HP-7, HP-8*** **P-QM 7 – Three (3) Clinical Quality Improvement Projects for Health Plans** **P-QM 8 – Data Management** **P-QM 9 – Quality Improvement Project Requirements**	**RESOURCE:** **CMS Protocol 7B** (pages 156-157) **P-QM 7 Documents:** • QI project descriptions for three (3) different projects for the program coming under accreditation. Two of the QIP's must be based on clinical quality, and one QIP must be related to consumer protection/safety. Analyze QIPS for: Quantifiable measures, baseline and remeasure of performance; measurable goals for improvement **Interview Questions** 1. Interview QM program management personnel on QIP methodologies, results and identified barriers (if any).	P-QM 7 meets 438.240(d) P-QM 5(a), P-QM 8(b), and P-QM 9 (a) meet 438.240(d)(1)(i) P-QM 5(c) and P-QM 9(b) meet 438.240(d)(1)(ii) P-QM 5(b) and P-QM 9(d) and (e) meet 438.240(d)(1)(iii

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
			) P-QM 9(h) meets 438.240(d)(1)(iv)
438.240(e) (2) The State may require that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.	**Core 4 – Regulatory Compliance** **P-QM 4 – Quality Management Committee**	**P-QM 4** **Documents:** • Program description and plan or P&Ps addressing QM oversight of the program. • QM program evaluation or sample meeting minutes reflecting evaluation of program effectiveness. **Interview Questions** 1. Interview QM program management personnel on CM committee activities, committee composition, communication with the organization's governing body, and QM program evaluation.	P-QM 4 meets 438.240(e)(2)
Subpart D: Quality Assessment and Performance Improvement **42 CFR 438.242** **Health information systems.**	**MEASUREMENT AND IMPROVEMENT STANDARDS: DEEMABLE REGULATIONS**	**RESOURCE:** **CMS Protocol 7B** (pages 162-165)	
438.242 (a) General rule. The State must ensure, through its contracts that each MCO and PIHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	**Core 13 - Information Management** **Core 4 – Regulatory Compliance** **Core 39 – Consumer Satisfaction** **Core 35 – Consumer Complaint Process** ***HP-16*** **P-QM 1 – Quality Improvement Program** Note:	**Core 13** **Documents:** • Data integrity audit results. • Disaster plan recovery testing documentation to include areas for improvement. • Information management P&Ps addressing data integrity, confidentiality, security, disaster recovery, storage, maintenance, and destruction. **Interview Questions**	Core 13, Core 4, Core 39, Core 35 and P-QM 1 address 438.242(a)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
	For data, see Core 13. For utilization, see P-QM 1. For grievances and appeals, see Core 35. For disenrollment, see Core 39 for support.	1. IT Staff interview Tour of data center (if onsite) to observe secured entry, fire retardation system, separate climate control (recommended), and servers on racks or raised floors. **<u>Core 39</u>** **Documents:** • QM or program description or P&Ps addressing consumer and client satisfaction • Sample of survey results, focus group outcomes, complaint/grievance reports, etc. **Interview Questions** 1. Management interviews related to collection of consumer satisfaction. **<u>Core 35</u>** **Documents:** • QM or program description or P&Ps addressing consumer and client access to program services, including standards for access • Reports summarizing data related to consumer and client complaints about program services and appeals of program decisions • Sample of correspondence that includes appeal rights • Sample meeting minutes where data related to access to program services is shared with the QM committee **Interview Questions** 1. Interview management staff on process for	

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
		reporting complaints to the QMC. **<u>P-QM 1</u>** **Documents:** • QM program description that addresses monitoring of key indicators relevant to the organization's services to consumers and clients; compliance with URAC standards; implementation of action plans to improve or correct identified problems. • Sample of survey results, focus group outcomes, complaint/grievance reports, etc. **Interview Questions** 1. Interview QM program management personnel to discuss structure and processes of the QM program.	
Subpart E: External Quality Review **42 CFR 438.358** **Activities related to external quality review.**			
CMS Protocal 2Subpart E: **External Quality Review** **42 CFR 438.360** **Nonduplication of mandatory activities.**			
Subpart F: Grievance System **42 CFR 438.400** **Statutory basis and definitions.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 166-169)	
438.400 (a) Statutory basis. This subpart is	**Core 4 – Regulatory Compliance**	See Appendix D	P-HUM 31

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act. (1) Section 1902(a)(3) requires that a State plan provides an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. (2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan. (3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.	**P-HUM 31 - Non-Certification Appeals Process**		meets 438.400(a)(3)
Subpart F: Grievance System **42 CFR 438.402** **General requirements.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 168-169)	
438.402 (a) The grievance system. Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.(b) Filing requirements--(1) Authority to file. (i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing. (ii) A provider, acting on behalf of the	**Core 4 – Regulatory Compliance** **Core 35 – Consumer Complaint Process** ***HP-16*** **P-HUM 31 – Non-Certification Appeals Process** **P-HUM 32 – Appeals Process**	See Appendix D	Core 35 meets 438.402(a) Core 35 and P-HUM 31 meets 438.402(b) P-HUM 32 meets

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so. (2) Timing. The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe-- (i) The enrollee or the provider may file an appeal; and (ii) In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing. (3) Procedures. (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP. (ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.			438.402(b)(3)
Subpart F: Grievance System **42 CFR 438.404** **Notice of action.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 170-177)	
438.404 (a) Language and format requirements. The notice must be in writing	**Core 4 – Regulatory Compliance** **P-HUM 22 – Written Notice of Non-Certification Decisions**	See Appendix D	P-HUM 22 meets 438.404(a)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding.	**and Rationale** Note: Pursuant to URAC Core Standard 4: Regulatory Compliance, the specific language and format requirements in this section would have to be met. Note: See URAC standards mapped to §438.10(c) and (d).		
438.404 (b) Content of notice. The notice must explain the following: (1) The action the MCO or PIHP or its contractor has taken or intends to take. (2) The reasons for the action. (3) The enrollee's or the provider's right to file an MCO or PIHP appeal. (4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing. (5) The procedures for exercising the rights specified in this paragraph. (6) The circumstances under which expedited resolution is available and how to request it. (7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.	**Core 4 – Regulatory Compliance** **P-HUM 22 – Written Notice of Non-Certification Decisions and Rationale**	See Appendix D	P-HUM 22 meets 438.404(b)(1), (2), (3) and (5)
438.404 (c) Timing of notice. The MCO or PIHP must mail the notice within the following timeframes:	**Core 4 – Regulatory Compliance** **P-HUM 17 – Prospective Review Time Frames** **P-HUM 18 – Retrospective Review Time Frames**	See Appendix D	P-HUM 17(c)(ii) and P-HUM 18(b)(ii) partially

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in Sec. Sec. 431.211, 431.213, and 431.214 of this chapter. (2) For denial of payment, at the time of any action affecting the claim. (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in Sec. 438.210(d)(1). (4) If the MCO or PIHP extends the timeframe in accordance with Sec. 438.210(d)(1), it must-- (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (5) For service authorization decisions not reached within the timeframes specified in Sec. 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire. (6) For expedited service authorization decisions, within the timeframes specified in Sec. 438.210(d).	See also 42 CFR §§431.211, 431.213, and 431.214. See also 42 CFR §438.210(d).		meet 438.404(c)(4) Note: The URAC Standards allow 15 calendar days, while federal regulations allow 14 calendar days. In evaluating Medicaid plans, URAC Reviewers would apply the 14 day requirement pursuant to URAC CORE Standard 4: Regulatory Compliance.

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
Subpart F: Grievance System **42 CFR 438.406** **Handling of grievances and appeals.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 177-180)	
438.406 (a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements: (1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (2) Acknowledge receipt of each grievance and appeal. (3) Ensure that the individuals who make decisions on grievances and appeals are individuals-- (i) Who were not involved in any previous level of review or decision-making; and (ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity. (B) A grievance regarding denial of expedited resolution of an appeal. (C) A grievance or appeal that involves	**Core 4 – Regulatory Compliance** **P-OPS 1 – General Telephone Access to Customer Service** **P-HUM 2 – Access to Review Staff** **P-HUM 3 – Review Service Communication and Time Frames** **P-HUM 33 – Appeal Peer Reviewer Qualifications**	See Appendix D	P-OPS 1 and P-HUM 2 meets 438.406(a)(1) P-HUM 3(b) meets 438.406(a)(2) P-HUM 33 meets 438.406(a)(3)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
clinical issues.			
438.406 (b) Special requirements for appeals. The process for appeals must: (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. (2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.) (3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process. (4) Include, as parties to the appeal-- (i) The enrollee and his or her representative; or (ii) The legal representative of a deceased enrollee's estate.	**Core 4 – Regulatory Compliance** **P-HUM 32 – Appeals Process** **P-HUM 35 – Expedited Appeals Process Time Frame** **P-HUM 37 – Written Notice of Upheld Non-Certifications**	See Appendix D See also Appendix D: Definitions **Consumer:** An individual person who is the direct or indirect recipient of the services of the organization. Depending on the on text, consumers may be identified by different names, such as "member," enrollee," "beneficiary," "patient," "injured worker," "claimant," etc… Note: In the case of a consumer who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the consumer behalf may be a consumer for the purposes of these standards.	P-HUM 32 and P-HUM 35 meet 438.406(b)(1) P-HUM 32(a) meets 438.406(b)(2) P-HUM 37 meets 438.406(b)(4) Note: The URAC definition for "consumer" relates to the required notice to the legal representative of a decedent.
Subpart F: Grievance System **42 CFR 438.408** **Resolution and notification: Grievances**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 180-184)	

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
and appeals.			
438.408 (a) Basic rule. The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.	**Core 4 – Regulatory Compliance** **Core 35 – Consumer Complaint Process** ***HP-16*** **P-HUM 35 – Expedited Appeals Process Time Frame** **P-HUM 36 – Standard Appeals Process Time Frame** **P-HUM 37 – Written Notification of Upheld Non-Certifications**	See Appendix D	Core ~~27~~ 35, P-HUM 35, P-HUM 36, and P-HUM 37 meet 438.408(a)
438.408 (b) Specific timeframes--(1) Standard disposition of grievances. For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the MCO or PIHP receives the grievance. (2) Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section. (3) Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.	**Core 4 – Regulatory Compliance** **Core 35 – Consumer Complaint Process** ***HP-16*** **See Core 35(d)** **P-HUM 35 – Expedited Appeals Process Time Frame** **P-HUM 36 – Standard Appeals Process Time Frame** Note: Core 35 partially meets 438.408(b)(1). The URAC standards require a "timely" response. Note: The URAC timeframe is tighter than the 438.408(b)(2) timeframe for standard appeals. HUM 34 requires standard appeals to be completed, and written notification of the appeal decision issued, within 30 calendar days of the receipt of the request for appeal. Note: The URAC timeframe is tighter than the 438.408(b)(3) timeframe for expedited appeals. P-HUM 35 requires expedited appeals to be completed, with verbal notification of determination within 72 hours of the request, followed by written confirmation of the notification within three calendar days.	See Appendix D	Core 35 partially meets 438.408(b)(1) Note: The URAC Standards require that responses to grievances are "timely," as compared to the 90 day regulatory requirement, In evaluating Medicaid plans, URAC Reviewers would apply the 90 day requirement pursuant to URAC CORE

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
			Standard 4: Regulatory Compliance. P-HUM 36 meets 438.408(b)(2) P-HUM 35 meets 438.408(b)(3)
438.408 (d) Format of notice-- (1) Grievances. The State must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance. (2) Appeals. (i) For all appeals, the MCO or PIHP must provide written notice of disposition. (ii) For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.	**Core 35 – Consumer Complaint Process** ***HP-16*** **See Core 35(b)** **P-HUM 35 – Expedited Appeals Process Time Frame** **P-HUM 36 – Standard Appeals Process Time Frame** **P-HUM 37 – Written Notification of Upheld Non-Certifications** Note: 438.408(d)(1) applies to the State. For 438.408(d)(1), see the following: Core 35 For 438.408(d)(2)(i), see the following: P-HUM 35, P-HUM 36 and P-HUM 37 For 438.408(d)(2)(ii), see the following: P-HUM 35	See Appendix D	Core 35(b) addresses 438.408(d)(1) P-HUM 35, P-HUM 36 and P-HUM 37 meet 438.408(d)(2)(i) P-HUM 35 meets 438.408(d)(2)(ii)
438.408 (e) Content of notice of appeal resolution. The written notice of the resolution	**Core 4 – Regulatory Compliance** **Core 35 – Consumer Complaint Process**	See Appendix D	Core 27(a) and HUM 35(a)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
must include the following: (1) The results of the resolution process and the date it was completed. (2) For appeals not resolved wholly in favor of the enrollees-- (i) The right to request a State fair hearing, and how to do so; (ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and (iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.	***HP-16*** **P-HUM 37 – Written Notification of Upheld Non-Certifications** Note: Core~~)~~ 35(c) and P-HUM 37(a) require that the written notification of an appeal resolution include the rationale for the determination, and this notification must be given within the timeframes established in the URAC standards or as required by the prevailing federal or state law (Core 4). The URAC standards do not specifically require that the written notification include the date the resolution process was completed, as stated in 438.408(e)(1).		partially meet 438.408(e)(1) Core 35, Core 35(c) and P-HUM 37(c) meet 438.408(e)(2)(i)
Subpart F: Grievance System **42 CFR 438.410** **Expedited resolution of appeals.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 184-186)	
438.410 (a) General rule. Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.	**Core 4 – Regulatory Compliance** **P-HUM 31 – Non-Certification Appeals Process -- See P-HUM 31(a)** **P-HUM 35 – Expedited Appeals Process Time Frame** Note: URAC Standards define "Case Involving Urgent Care" as any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the *consumer* or the ability of the *consumer* to regain maximum function, or (b) in the opinion of a physician with knowledge of the *consumer's* medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the	See Appendix D	P-HUM 31(a) and P-HUM 35 meet 438.410(a)

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
	case. (This definition is derived from the Department of Labor's definition of "claim involving urgent care.") Note: While the URAC standards are silent on the methods by which a claim is determined to be a "case involving urgent care," the Department of Labor claims regulation (29 C.F.R. § 2560.503-1(m)(1)) specifies that whether a claim is a "claim involving urgent care" is to be determined by an individual acting on behalf of the health benefits plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" shall be treated as a "claim involving urgent care."		
438.410 (b) Punitive action. The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	**Core 4 – Regulatory Compliance** **P-HUM 31 – Non-Certification Appeals Process --** **See P-HUM 31(b)(i)**	See Appendix D	P-HUM 31(b)(i) partially meets 438.410(b) Note: The related URAC Standards do not "ensure that punitive action" is not taken against a provider. The related URAC Standards disallow "gag clauses," or prohibitions on provider communications relevant to

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
			consumers' health care, and provide avenues for dispute resolution if an organization attempts to take punitive action against a provider.
Subpart F: Grievance System **42 CFR 438.414** **Information about the grievance system to providers and subcontractors.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 186-188)	
438.414 The MCO or PIHP must provide the information specified at Sec. 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.	**P-NM 9 – Written Agreement Inclusions -- See P-NM 9(c) and (i)** **P-NM 10 – Written Agreement Subcontracting** Note: See also URAC standards mapped to §438.10(g)(1).	See Appendix D	P-NM 10 and P-NM 9(c) meet 438.414
Subpart F: Grievance System **42 CFR 438.416** **Recordkeeping and reporting requirements.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 188-189)	
Subpart F: Grievance System **42 CFR 438.420** **Continuation of benefits while the MCO or**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 189-191)	

Federal Medicaid Managed Care Regulations	Related URAC Health Plan v. 7 Standards (bold) and Measures (bold italics) and URAC Comments	Sample Documentation and Onsite Survey Questions	Duplication Potential
PIHP appeal and the State fair hearing are pending.			
Subpart F: Grievance System **42 CFR 438.424** **Effectuation of reversed appeal resolutions.**	**USE AS COMPARISON TO STATE REQUIREMENTS**	**RESOURCE:** **CMS Protocol 7B** (pages 191-192)	

SAMPLE EVIDENCE OF COMPLIANCE: URAC HEALTH PLAN STANDARDS, VERSION 7

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
Core 2 Organization Documents	**Required Documentation** • Top-level organization charts • Departmental/program organization chart • Program description **Interview Questions** 1. Interview staff on accreditation activities included within the scope of the review, including organizational framework and types of patients managed
Core 3 Policy and Procedure Maintenance, Review and Approval	**Required Documentation** • Policies and procedures (P&Ps) governing document management • Proof of P&P approval **Interview Questions** 3. Staff demonstration 4. Management interview for policy/procedure development, revision, and approval
Core 4 Regulatory Compliance	**Required Documentation** • Regulatory compliance program description or compliance P&Ps • Report listing relevant laws and analysis against organization's program • Copies of the organization's state licenses, or sample correspondence with regulators, or sample of regulatory filing as applicable for the organization's program **Interview Questions** 1. Interview person responsible for compliance. Describe compliance officer's role in the following activities: maintaining the organization state licensure(s), tracking state and federal regulations for compliance, tracking requirements for medical director licensure in a state or states, interface between compliance and quality management, mechanisms for compliance with HIPAA Privacy and HIPAA Security, Health Plan's mechanism for reporting state reportable events to the medical board (decredentialed providers), oversight mechanism for monitoring bonuses for staff, medical directors and network providers to comply with state laws, Organizational Code of Conduct, Sarbanes-Oxley compliance, state market conduct surveys, review of benefits plan documents for compliance with applicable laws and regulations.
Core 5	**Required Documentation** • Documents including quality meeting minutes, departmental/team meetings, organizational newsletters

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
Inter-departmental Coordination	• Job descriptions for staff functioning as a liaison to other departments **Interview Questions** 1. Interview staff and management for descriptions of interdepartmental coordination
Core 7 Delegation Review	**Required Documentation** • P&P outlining the process and criteria used for approving delegated contractors **Interview Questions** 1. Interview management staff responsible for delegation oversight 2. Review audit tool used by applicant to evaluate ability of delegee to perform delegated functions
Core 8 Delegation Contracts	**Required Documentation** • Sample templates of written agreements with contractors **Interview Questions** 1. Interview management staff responsible for delegation oversight
Core 9 Delegation Oversight	**Required Documentation** • P&P for oversight mechanism covering contractor responsibilities for delegated program functions • Samples or templates of documentation of annual compliance review audits of contractual requirements and policies and procedures for delegated functions **Interview Questions** 1. Interview management staff responsible for delegation oversight about their role in overseeing the required services of contracted delegees
Core 10 Review of Marketing and Sales Materials	**Required Documentation** • P&P or marketing/communications program description covering mechanisms to ensure that accurate information is imparted to prospective and current consumers and clients • Samples of newsletters, Web site postings, brochures, or individual mailings • Samples of documentation of ongoing monitoring activities of existing marketing materials for accuracy **Interview Questions** 1. Proof of approval of communication materials. An example includes the interdepartmental review and approval of a new piece of marketing/communication piece. Another example includes the review and approval of an existing marketing/communication piece 2. Interview program staff regarding the types of information shared with clients and/or consumers 3. Interview marketing personnel for adherence to the standard
Core 13 Information Management	**Required Documentation** • Data integrity audit results • Disaster plan recovery testing documentation to include areas for improvement • Information management P&Ps addressing data integrity, confidentiality, security, disaster recovery, storage,

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
	maintenance, and destruction **Interview Questions** 1. IT Staff interview 2. Tour of data center (if onsite) to observe secured entry, fire retardation system, separate climate control (recommended), and servers on racks or raised floors
Core 16 Confidentiality of Individually-Identifiable Health Information	**Required Documentation** • Policies and procedures related to privacy, security, and information management of all documentation containing IIHI • Training agenda related to HIPAA Privacy rules **Interview Questions:** 1. Interview compliance officer, managers, and staff for compliance with privacy and security policies
Core 28 Staff Operational Tools and Support	**Required Documentation** • Master list of P&Ps • Program description indicating clinical decision support tools used **Interview Questions** 1. Staff interview/demonstration of operational and clinical decision support tools
Core 29 Staff Assessment Program	**Required Documentation** • Sample template used for annual evaluation of staff • P&P indicating at least an annual review requirement **Interview Questions** 1. Staff interview of organizational assessment program
Core 32 Senior Clinical Staff Responsibilities	**Required Documentation** • Job description for senior clinical staff person responsibilities, or if a contractor, the contract template describing responsibilities for the organization's program • Program description or P&Ps describing the senior clinical staff person's role and accountabilities **Interview Questions** 1. Senior clinical staff person interview for responsibilities and accountabilities for the organization's program
Core 33 Financial Incentive Policy	**Required Documentation** • Policy describing financial incentives for program staff and network providers that identifies those that are based upon consumer utilization of health care and mechanisms to protect consumers. **Interview Questions** 1. Interview compliance personnel and chief clinical staff person to clarify the metrics for bonuses and/or financial incentives; any reviews done for compliance with state laws and whether the bonus required state approval; indicators for receiving a bonus; oversight mechanism to monitor for potential harm to consumers for under-

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
	utilization or over-utilization 2. Interview supervisory staff and line staff regarding bonus/incentive program
Core 34 Access to Services	**Required Documentation** • Organizational access standards • Policies addressing consumer and client access to program services • Sample meeting minutes where data related to access to program services is shared with the relevant Quality Management (QM) or departmental committee **Interview Questions** 1. Management interviews to discuss consumer and client access to program services with management 2. Interview staff on how the organization monitors access to service
Core 35 Consumer Complaint Process	**Required Documentation** • QM or program description or P&Ps addressing consumer and client access to program services, including standards for access • Reports summarizing data related to consumer and client complaints about program services and appeals of program decisions • Sample of correspondence that includes appeal rights • Sample meeting minutes where data related to access to program services is shared with the QM committee **Interview Questions** 1. Interview management staff on process for reporting complaints to the QM committee
Core 37 Consumer Rights and Responsibilities	**Required Documentation** • Policies and procedures regarding responses to consumer safety address suicide, domestic violence, accessing emergency services for members, addressing significant reportable events, and quality of care concerns • QM program description that outlines the organizations plan for responding to urgent or immediate threats to consumers. **Interview Questions** 1. Staff and management interviews for handling safety issues, including emergency calls from clients that are voicing an intent to harm themselves or others. 2. Assess documentation for safety issues and the handling of the issue.
Core 39 Consumer Satisfaction	**Required Documentation** • QM or program description or P&Ps addressing consumer and client satisfaction • Sample of survey results, focus group outcomes, complaint/grievance reports, etc. **Interview Questions** 1. Management interviews related to collection of consumer satisfaction

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
P-NM 1 Scope of Services	**Required Documentation** • Business Plan • Marketing Plan • Strategic Plan • Service area maps • Geographic Access Analyses • Applicable State Regulations • Regulatory documents specifying services offered, service area, etc. **Interview Questions** 1. Interview network management leadership to assess familiarity with organization's services, service area, and consumer demographics.
P-NM 2 Provider Network Access and Availability	**Required Documentation** • Business Plan • Marketing Plan • Strategic Plan • Geographic Access Analyses • Availability Analyses • Member surveys addressing provider availability • "Secret shopper" calls testing provider availability during "off-hours" times and testing ability of member to get timely appointment • Reports of onsite examination of appointment records • Applicable State Regulations **Interview Questions** 2. Interview network management leadership to assess 1) understanding of the requirement for both access and availability goals, and 2) implementation of action plans to address performance deficiencies in achieving these goals
P-NM 3 Provider Selection Criteria	**Required Documentation** • Business plan • Marketing plan • Strategic plan • Credentialing policies and procedures that describe provider selection criteria • Summary of minimum criteria for participating providers • Geographic mapping of provider locations • Provider service agreements

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
	• Reports of provider profiling • Provider manual • Related policies and procedures **Interview Questions** 2. Interview with network management leadership regarding current issues in network development to assess implementation of selection criteria
P-NM 4 Out of Network and Emergency Services	**Required Documentation** • Policies and procedures • Consumer documents explaining the organizations policy • Sample letters to consumers describing the policies • Sample scripts for customer service representatives describing the policies **Interview Questions** 3. Interview with medical director and member services to assess organizational ability to respond to members' needs for emergency and out of area services 4. Interview management staff of network management department to examine examples of policy implementation
P-NM 7 Participating Provider Written Agreements	**Required Documentation** • List of providers (e.g. provider directory) **Interview Questions** 1. Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting
P-NM 9 Written Agreement Inclusions	**Required Documentation** • List of providers (e.g. provider directory) **Interview Questions** 1. Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting
P-NM 10 Written Agreement Subcontracting	**Required Documentation** • **Sample provider service agreement and any amendments relevant to P-NM 11 for each category of participating provider (if different templates used for different provider types).** • **Provider manual or other organizational documents that describe the relationship between the organization and its participating providers, for each category of participating provider.** • **A list of all significant revisions of provider service agreements within the last two years, along with**

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
	the date and a brief description of the nature of each such revision. **Interview Questions** 1. **Current copies of the organization's provider directory. A random sample of provider names will be selected for review of executed contracts.** 2. **Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting.**
P-NM 13 Participating Provider Violation Mechanism	**Required Documentation** • Policies and procedures regarding provider disputes and appeals • "Blinded" examples of documentation generated through the dispute resolution process, including correspondence with providers • Samples of a practitioner's request for a dispute resolution that include examples of both Type A and Type B level of reviews • Minutes of committees with responsibility for provider disputes and appeals **Interview Questions** 1. Interview medical director and senior management staff to assess understanding and implementation of the P&Ps governing provider dispute resolution; also method for collecting, recording and tracking provider complaints/disputes
P-NM 17 Participating Provider Suspension Mechanism For Consumer Safety	**Required Documentation** • Policies and procedures regarding provider disputes and appeals. **Interview Questions** 1. Interview medical director, senior management staff, compliance office, provider relations, and credentialing staff to verify the provider events that would trigger an immediate suspension.
P-CR 1 Practitioner and Facility Credentialing	**Required Documentation** • Formally approved credentialing plan, program description, charter or credentialing policies and procedures, herein collectively called the "credentialing plan" or "plan." • Sample (1) credentialing committee meeting minutes showing that providers applying for participation in the network have completed the credentialing process **Interview Questions** 4. Interview medical director and credentialing management staff regarding scope and processes of the credentialing program. 5. Interview medical director and credentialing management and line staff for process of credentialing prior to listing a provider in the provider directory. 6. Interview medical director and credentialing management and line staff for frequency of credentialing.

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
P-CR 4 Credentialing Program Plan	**Required Documentation** • Job description/contract for senior clinical staff person for the credentialing program (Medical Director). • Credentialing plan. **Interview Questions** 1. Interview Credentialing Manager and medical director to assess understanding of the credentialing program and URAC requirements.
P-CR 11 Credentialing Application Review	**Required Documentation** • Organizational chart depicting key positions and committees • Credentialing plan defining the process for submitting applications to the credentialing committee for approval **Interview Questions** 1. Interviews with clinical leadership and credentialing staff, including management regarding the committee process.
P-CR 15 Recredentialing	**Required Documentation** • Credentialing plan delineating the recredentialing process. • Credentialing committee meeting minutes demonstrating the recredentialing process. **Interview Questions** 1. Interview with the credentialing management and staff personnel regarding the recredentialing process.
P-MR 1 Marketing Safeguards	
P-MR 2 Consumer and Employer Purchaser Information Disclosure	
P-MR 5 Online Access	

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
P-MR 7 Consumer Communications Plans	
P-MR 8 Covered Benefit Disclosure	
P-MR 10 Targeted Consumer Outreach	
P-QM 1 Quality Management Program	**Required Documentation** • QM Program description or P&Ps addressing QM oversight of the program **Interview Questions** 1. Interview with program management to discuss the structure of the QM program as it effects the organization's program 2. Interview with staff to discuss their role in the QM program
P-QM 2 Quality Management Resources	
P-QM 3 Quality Management Program Requirements	**Required Documentation** • Complete QM committee minutes for the past two years, or since the inception of the QM program if less than that timeframe **Interview Questions** 1. Interview with program management to discuss the structure of the QM program as it effects the organization's program 2. Interview with staff to discuss their role in the QM program

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
P-QM 4 Quality Management Committee	**Required Documentation** • Program description and plan or P&Ps addressing QM oversight of the program. • QM program evaluation or sample meeting minutes reflecting evaluation of program effectiveness **Interview Questions** 1. Interview QM program management personnel on CM committee activities, committee composition, communication with the organization's governing body, and QM program evaluation
P-QM 5 Quality Management Improvement Process	**Required Documentation** • QM program description that addresses monitoring of key indicators relevant to the organization's services to consumers and clients; compliance with URAC standards; implementation of action plans to improve or correct identified problems • Sample of survey results, focus group outcomes, complaint/grievance reports, etc. **Interview Questions** 1. Interview QM program management personnel to discuss structure and processes of the QM program
P-QM 6 Selection and Prioritization of Quality Improvement Projects	
P-QM 7 Three (3) Clinical Quality Improvement Projects for Health Plans	**Required Documentation** • QI project descriptions for three (3) different projects for the program coming under accreditation. Two of the QIP's must be based on clinical quality, and one QIP must be related to consumer protection/safety. Analyze QIPS for: quantifiable measures, baseline and remeasure of performance; measurable goals for improvement **Interview Questions** 1. Interview QM program management personnel on QIP methodologies, results and identified barriers (if any)
P-QM 8 Data Management	
P-QM 9 Quality Improvement Project Requirements	**Required Documentation** • Three QIP descriptions summarizing the QIPs and addressing the elements in the standards. • QM meeting minutes illustrating committee selection of the QIPs and discussion of progress made towards attaining project goals. **Interview Questions** Interview QM program management personnel on QIP methodologies, results and identified barriers (if any).
P-OPS 1	

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
General Telephone Access to Customer Service	
P-OPS 2 Urgent Telephone Access to Customer Service	
P-OPS 3 One-on-One Customer Service	
P-OPS 4 Scope of Customer Service	
P-OPS 5 Provider Directory Updates	
P-OPS 6 Consumer Notification Regarding PCP Status	
P-HUM 1 Review Criteria Requirements	**Required Documentation** • P&P covering development, approval and evaluation of criteria and scripts • Samples of scripts, clinical criteria or other pre-review documents. **Interview Questions** 1. Interview medical director to assess understanding of criteria selection (commercial or proprietary or both), criteria review and approval process, and medical director involvement and oversight of periodic review of criteria. 2. Interview UM management and staff to assess currency of UM criteria in use
P-HUM 2 Access to Review Staff	
P-HUM 3 Review Service Communication and Time Frames	

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
P-HUM 10 Initial Clinical Reviewer Qualifications	**Required Documentation** • P&P prohibiting the issuance of non-certifications based on initial clinical review • P&P covering the initial clinical review process and the peer review process • Job description for initial clinical reviewers • Job description of the licensed doctor of medicine, or doctor of osteopathic medicine who is responsible for providing consultation to initial clinical review staff. **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with different levels of review.
P-HUM 13 Peer Clinical Review Cases	**Required Documentation** • P&P covering the initial clinical review process and the peer review process • Job description/contracts for individuals who conduct peer clinical review **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with different levels of review.
P-HUM 14 Peer Clinical Reviewer Qualifications	**Required Documentation** • P&P covering the initial clinical review process and the peer review process • Job description/contracts for individuals who conduct peer clinical review **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with different levels of review.
P-HUM 15 Peer-to-Peer Conversation Availability	**Required Documentation** • P&P describing the peer-to- peer review process, including the mechanism used to make providers aware that they have this option • Job description/contracts for individuals who conduct peer clinical review • Sample template of written notification of non-certification informing providers of their option for a peer-to-peer conversation if not conducted prior to the non-certification **Interview Questions** 1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with policy on peer-to peer conversation.
P-HUM 17 Prospective Review Time Frames	**Required Documentation** • P&P covering prospective, concurrent, and retrospective review • Sample template of written notice of extension to patient **Interview Questions**

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
	1. Interview administrative staff, initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with the prospective review processes, including review timeframes.
P-HUM 22 Written Notice of Non-Certification Decisions and Rationale	**Required Documentation** • P&P covering non-certifications • Sample template of written notification of non-certification **Interview Questions** 1. Interview initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with process for noncertification, including timeframes and notification requirements.
P-HUM 23 Clinical Rationale for Non-Certification Requirements	**Required Documentation** • P&P covering non-certifications • Sample template of written notification of non-certification **Interview Questions** 1. Interview initial clinical review staff and medical director/peer reviewers to assess staff understanding of and compliance with process for providing clinical rationale upon request.
P-HUM 31 Non-Certification Appeals Process	
P-HUM 32 Appeals Process	
P-HUM 33 Appeal Peer Reviewer Qualifications	
P-HUM 35 Expedited Appeals Process Time Frame	
P-HUM 36 Standard Appeals process Time Frame	
P-HUM 37 Written Notice of Upheld	

Standard	Required Documentation for Desktop Review & Onsite Survey Questions
Non-Certifications	
P-HUM 39 Independent Review Process	**Required Documentation** • Policies and procedures or UM program description addressing the independent review process • Sample template letter for adverse appeal determinations that includes the steps for initiating an independent review **Interview Questions** 1. Interview UM management staff and medical director to assess staff understanding of and compliance with external review process.