

least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCO, PIHP, PAHP or PCCM entity receives updated provider information.

(4) Provider directories must be made available on the MCO's, PIHP's, PAHP's, or, if applicable, PCCM entity's Web site in a machine readable file and format as specified by the Secretary.

(i) *Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Formulary.* Each MCO, PIHP, PAHP, and when appropriate, PCCM entity, must make available in electronic or paper form, the following information about its formulary:

(1) Which medications are covered (both generic and name brand).

(2) What tier each medication is on.

(3) Formulary drug lists must be made available on the MCO's, PIHP's, PAHP's, or, if applicable, PCCM entity's Web site in a machine readable file and format as specified by the Secretary.

(j) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with § 438.10 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

§ 438.12 Provider discrimination prohibited.

(a) *General rules.* (1) An MCO, PIHP, or PAHP may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If an MCO, PIHP, or PAHP declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with network providers, an MCO, PIHP, or PAHP must comply with the requirements specified in § 438.214.

(b) *Construction.* Paragraph (a) of this section may not be construed to—

(1) Require the MCO, PIHP, or PAHP to contract with providers beyond the number necessary to meet the needs of its enrollees;

(2) Preclude the MCO, PIHP, or PAHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(3) Preclude the MCO, PIHP, or PAHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

§ 438.14 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs).

(a) *Definitions.* As used in this section, the following terms have the indicated meanings:

Indian means any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

(i) Is a member of a Federally recognized Indian tribe;

(ii) Resides in an urban center and meets one or more of the four criteria:

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations issued by the Secretary;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian health care provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Indian managed care entity (IMCE) means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(b) *Network and coverage requirements.* All contracts between a State and a MCO, PIHP, PAHP, and PCCM entity, to the extent that the PCCM entity has a provider network, which enroll Indians must:

(1) Require the MCO, PIHP, PAHP, or PCCM entity to demonstrate that there are sufficient IHCPs participating in the provider network of the MCO, PIHP, PAHP, or PCCM entity to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.

(2) Require that IHCPs, whether participating or not, be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:

(i) At a rate negotiated between the MCO, PIHP, PAHP, or PCCM entity, and the IHCP, or

(ii) In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO, PIHP, PAHP, or PCCM entity would make for the services to a participating provider which is not an IHCP; and

(iii) Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.

(3) Permit any Indian who is enrolled in a MCO, PIHP, PAHP, PCCM or PCCM entity that is not an IMCE and

eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.

(4) Permit Indian enrollees to obtain services covered under the contract between the State and the MCO, PIHP, PAHP, or PCCM entity from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

(5) In a State where timely access to covered services cannot be ensured due to few or no IHCPs, an MCO, PIHP, PAHP and PCCM entity will be considered to have met the requirement in paragraph (b)(1) of this section if—

(i) Indian enrollees are permitted by the MCO, PIHP, PAHP, or PCCM entity to access out-of-State IHCPs; or

(ii) If this circumstance is deemed to be good cause for disenrollment from both the MCO, PIHP, PAHP, or PCCM entity and the State's managed care program in accordance with § 438.56(c).

(6) MCOs, PIHPs, PAHPs, and PCCM entities, to the extent the PCCM entity has a provider network, must permit an out-of-network IHCP to refer an Indian enrollee to a network provider.

(c) *Payment requirements.* (1) When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the MCO, PIHP, PAHP or PCCM entity, it must be paid an amount equal to the amount the MCO, PIHP, PAHP, or PCCM entity would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the State to make up the difference between the amount the MCO, PIHP, PAHP or PCCM entity pays and what the IHCP FQHC would have received under FFS.

(2) When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, PIHP, PAHP and PCCM entity or not, it has the right to receive its applicable encounter rate published annually in the FEDERAL REGISTER by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology.

(3) When the amount a IHCP receives from a MCO, PIHP, PAHP, or PCCM entity is less than the amount required by paragraph (c)(2) of this section, the State must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, or PCCM entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

(d) *Enrollment in IMCEs.* An IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs, as defined in 25 U.S.C. 1603(12), may restrict the delivery of services to Indians, without being in violation of the requirements in § 438.3(d).

Subpart B—State Responsibilities

SOURCE: 81 FR 27853, May 6, 2016, unless otherwise noted.

§ 438.50 State Plan requirements.

(a) *General rule.* A State plan that requires Medicaid beneficiaries to enroll in MCOs, PCCMs, or PCCM entities must comply with the provisions of this section, except when the State imposes the requirement—

(1) As part of a demonstration project under section 1115(a) of the Act; or

(2) Under a waiver granted under section 1915(b) of the Act.

(b) *State plan information.* The plan must specify—

(1) The types of entities with which the State contracts.

(2) The payment method it uses (for example, whether FFS or capitation).

(3) Whether it contracts on a comprehensive risk basis.

(4) The process the State uses to involve the public in both design and initial implementation of the managed care program and the methods it uses to ensure ongoing public involvement once the State plan has been implemented.

(c) *State plan assurances.* The plan must provide assurances that the State meets applicable requirements of the following statute and regulations:

(1) Section 1903(m) of the Act, for MCOs and MCO contracts.

(2) Section 1905(t) of the Act, for PCCMs and PCCM or PCCM entity contracts.

(3) Section 1932(a)(1)(A) of the Act, for the State's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities.

(4) This part, for MCOs, PCCMs, and PCCM entities.

(5) Part 434 of this chapter, for all contracts.

(6) Section 438.4, for payments under any risk contracts, and § 447.362 of this chapter for payments under any nonrisk contracts.

(d) *Limitations on enrollment.* The State must provide assurances that, in implementing the State plan managed care option, it will not require the following groups to enroll in an MCO, PCCM or PCCM entity:

(1) Beneficiaries who are also eligible for Medicare.

(2) Indians as defined in § 438.14(a), except as permitted under § 438.14(d).

(3) Children under 19 years of age who are:

(i) Eligible for SSI under Title XVI;

(ii) Eligible under section 1902(e)(3) of the Act;

(iii) In foster care or other out-of-home placement;

(iv) Receiving foster care or adoption assistance; or

(v) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.

§ 438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities.

(a) *General rule.* Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid beneficiaries to:

(1) Enroll in an MCO, PIHP, or PAHP, must give those beneficiaries a choice of at least two MCOs, PIHPs, or PAHPs.

(2) Enroll in a primary care case management system, must give those beneficiaries a choice from at least two primary care case managers employed or contracted with the State.