

Appendix B: Federal Requirements Deemed for Nonduplication in Apple Health (Medicaid)

Appendix B of the [Washington State Managed Care Quality Strategy](#).

Requirements Deemed for nonduplication in Apple Health

Below is a table reflecting managed care federal regulations HCA determined to be deemed eligible for and has implemented use of non-duplication regulations under 42 C.F.R. 438.360 for Apple Health MCOs and PIHPs (BHSO program), serving Medicaid and CHIP enrollees. States may elect to use nonduplication when Federal regulations allow, which may fall into three categories for deeming determination:

1. **Met:** HCA fully deemed and implemented use of non-duplication regulations under 42 C.F.R. 438.360.
2. **Partially Met:** HCA partially deemed the requirements. This may be due to Apple Health requirements being greater than NCQA Accreditation and/or NCQA Health Equity Accreditation requirements or the remaining element(s) being an Apple Health priority for HCA monitoring within scheduled EQR activities. Requirements that are partially met will either list the items that were deemed or list by exception.
3. **Not Met:** Federal requirements not appearing on the grid are not deemed. Elements which are not deemed may be in this category for various reasons: NCQA Accreditation(s) do not address the requirement, HCA determined not to deem due to the requirement being a priority for HCA monitoring within scheduled EQR activities, or further review is required to clarify how the NCQA Accreditation and/or NCQA Health Equity Accreditation standards address the federal regulation. For deeming to apply, the MCO/PIHP must follow the accreditation standard. Apple Health MCOs are required to provide all applicable accreditation materials to HCA, including reports, findings, and other results applicable to the EQR-related 93 activities. Elements not listed in the table below are required within the scheduled EQR TEAMonitor Compliance Review.

For deeming to apply, the MCO/PIHP must follow the accreditation standard. Apple Health contracts require Apple Health MCOs to provide all applicable accreditation materials to HCA for review. For additional information regarding NCQA Accreditation Standards as they relate to nonduplication, review [NCQA's managed care toolkit](#).

Table key

- **Federal Regulation (42 C.F.R. 438)** and applicable Apple Health Contract Section
- **Accreditation Standard:** Description and reference to accreditation standard addressed as part of the private accreditation review, i.e., NCQA Health Plan Accreditation process
- **Deeming Status:** Met or Partially Met
 - If Partially Met, description of what is deemed or not deemed is included

Information Systems Capabilities Assessment (ISCA)

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§ 438.242(a) IMC/IFC Contract Section: Performance Measures And NCQA Accreditation	<p>NCQA Review Standard:</p> <p>The State must ensure, through its contracts, that each MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.</p> <p>As allowed in 438.360, NCQA Accreditation requires plans to produce HEDIS and other reports that require a robust health information system consistent with the federal requirement.</p>	Met

Practice Guidelines

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§438.236(b) IMC/IFC Contract Section: Practice Guidelines	<p>NCQA Review Standard: MED 2, Element A</p> <p>Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:</p> <p>(1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.</p> <p>(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.</p> <p>(3) Are adopted in consultation with contracting health care professionals.</p> <p>(4) Are reviewed and updated periodically as appropriate.</p>	Met
§438.236(c) IMC/IFC Contract Section: Practice Guidelines	<p>NCQA Review Standard: MED 2, Element B</p> <p>Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.</p>	Partially Met; Met with exception of AH Requirement: MCO monitoring of 60-day timeliness.
§438.236(d) IMC/IFC Contract Section:	<p>NCQA Review Standard: UM 2 Element C, Med 2, Element A, Element C</p>	Partially Met; Met with exception of AH Requirement: MCO/PIHP

Practice Guidelines	Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	monitoring of subdelegated behavioral health functions.
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Credentialing

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§438.214(b) IMC/IFC Contract Section: Provider Credentialing	NCQA Review Standard: CR 1, Element A, B; CR 2, Element A Demonstrates that its network providers are credentialed as required by §438.214. Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of network providers.	Met

Availability of Services

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§438.206(b)(1) IMC/IFC Contract Section: Access to Care and Provider Network	NCQA Review Standard: NET 1, Element A, B, and C; MED 3, Element A and B; MED 12, Element A Maintains and monitors a network of appropriate providers this is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.	Partially Met; Met with exception of AH Requirement: MCO monitoring of provider turnover; compliance with RCW 74.09.492
§438.206(b)(2) IMC/IFC Contract Section: Enrollee Rights and Protections	NCQA Review Standard: NET 1, Element A; MED1, Element A Provides female enrollees with direct access to women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	Partially Met; Met with exception of AH Requirement: Monitoring compliance with WAC 284-170-350
§438.206(b)(3) IMC/IFC Contract Section(s): Access to Care and Provider Network; Benefits	NCQA Review Standard: MED 1, Element C Provides for a second opinion from a network provider or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Met

§438.206(b)(4)	NCQA Review Standard: NET 1, Element B and C	Partially Met; Met with exception of
IMC/IFC Contract Section(s): Access to Care and Provider Network; Special Provisions	If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP's provider network is unable to provide them.	AH Requirement: MCO monitoring referrals of out-of-network IHCP who refers an AI/AN enrollee to a network provider.

§438.206(b)(5)	NCQA Review Standard: MED 1, Element E	Met
IMC/IFC Contract Section(s): Access to Care and Provider Network; Subcontracts; Enrollee Rights and Protections	Requires out-of-network providers to coordinate with the MCO, PHIP, or PAHP for payment and ensures the cost to enrollee is no greater than it would be if the services were furnished within the network.	

§438.206(b)(7)	NCQA Review Standard: NET 1, Element B and C	Met for MCO (IMC), not applicable to PIHP (BHSO)
IMC/IFC Contract Section: Access to Care and Provider Network	Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.	

§438.206(c)(1)	NCQA Review Standard: NET 2, Element A, B, and C; MED 1, F and G; QI2, Element A; CR 5, Element A	Partially Met; Met with exception of
IMC/IFC Contract Section(s): Access to Care and Provider Network; Subcontracts	<i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details</i>	AH Requirement: Monitoring MCO capacity to provide medically necessary services and monitoring of transitional health care services.

§438.206(c)(2)	NCQA Review Standard: MED 12, Element A; NET 1, Element A; MED 2, Element B	Partially Met; Met with exception of
IMC/IFC Contract Section(s): Access to Care and Provider Network; Enrollee Rights and Protections	Access and cultural considerations. Each MCO, PIHP, and PAHP participates in the State's efforts to promote delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.	AH Requirement: AI/AN cultural training

Coordination and Continuity of Care

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.208</p> <p>IMC/IFC Contract Section: Care Coordination</p> <p>Subsections(s) Continuity of Care and Coordination Between the Contractor and External Entities</p>	<p>NCQA Review Standard: MED 5, Element A; NET 1, Element B; NET 2, Element A</p> <p>(1) Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity;</p>	<p>Partially Met; Deeming met for policies related to uninterrupted care, preservation of provider relationships, and MCO/BHSO care transitions</p>
<p>§438.208 (b)</p> <p>IMC/IFC Contract Section: Care Coordination</p> <p>Subsections(s) Bi- Directional Behavioral and physical Health Integration and Care</p> <p>Coordination Services (CCS) General Requirements</p>	<p>NCQA Review Standard: MED 6, Element A, Element B</p> <p>(ii) The State bases its determination on the needs of the population it requires the MCO to serve.</p> <p>3) Provide that the MCO, PIHP or PAHP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.</p> <p>(4) Share with the State or other MCOs, PIHPs, and PAHPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities;</p>	<p>Partially Met; Met with exception of AH requirement: Confirming of confidentiality, monitoring the integration of GFS funded services, and assessment of the role of Care Coordinators</p>

Coverage and Authorization of Services

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.210 (a) and (b)</p> <p>IMC/IFC Contract Section: Utilization Management Program and Authorization of Services</p>	<p>NCQA Review Standard: UM 1, Element A; UM 2 Element A, Element C; UM 4 Element B</p> <p>(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 an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.</p>	<p>Partially Met: Met with exception of AH requirement: Review of BH coordination, UM annual assessment, service update notices, adverse benefit determinations, MICP/EPST files, and experimental/investigational services</p>

§438.210 (c)

NCQA Review Standard: UM7

Partially Met: Met with exception of AH requirement: contractual requirements for notification of adverse authorization and approval decisions

IMC/IFC Contract
Section: Utilization Management Program and Authorization of Services

Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details

Subsection:
Notification of Coverage and Authorization Determinations

§438.210 (d)

NCQA Review Standard: UM 5, Element A; MED 9, Element A

Partially met: Deeming met for evidence of 10-day notice of service termination and review of policy and procedures for timelines for authorization decisions

IMC/IFC Contract
Section: Utilization Management Program and Authorization of Services

Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details

Subsection: Service Authorization Decisions and Timeframes

§438.210 (e)

NCQA Review Standard: MED 9, Element E

Met

IMC/IFC Contract
Section: Utilization Management Program and Authorization of Services

Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §438.3(i), and §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.

Subsection: Utilization Management General Requirements

Emergency and Post-Stabilization Services

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.114</p> <p>IMC/IFC Contract Section: General Description of Contracted Services</p> <p>Subsection: Contracted Services</p>	<p>NCQA Review Standard: MED 9, Element D</p> <p><i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details</i></p>	Met

Information Requirements

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.100 (b)(2)(i) – 438.10(c)</p> <p>IMC/IFC Contract Section: Enrollee Materials, Marketing, and Information Requirements</p>	<p>NCQA Review Standard: MED 12, MED, 13, MED 14, ME 2, Element A, MED 12, Element B, ME 1, Element B</p> <p><i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details</i></p>	Partially Met: Deeming met for process used to monitor written client and marketing materials and ensure information is easily understandable and accessible
<p>§438.100 (b)(2)(i) – 438.10(d)(3)</p> <p>IMC/IFC Contract Section: Enrollee Materials, Marketing, and Information Requirements</p> <p>Subsection: Value-Added Benefits</p>	<p>NCQA Review Standard: MED 12, Element C, Element D, Element E</p> <p><i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details</i></p>	Met
<p>§438.100 (b)(2)(i) – 438.10(d)(4) and (5)</p> <p>IMC/IFC Contract Section: Enrollee Materials, Marketing, and Information Requirements</p> <p>Subsection: Value-Added Benefits (VAB) Web Page</p>	<p>NCQA Review Standard: MED 12, Element H, MED 13, Element B, Element C, NET 1, MED 13, Element C, ME 2, Element A, Element B</p> <p><i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details</i></p>	Met

<p>§438.100 (b)(2)(i) – 438.10(d)(6)</p>	<p>NCQA Review Standard: MED 12, Element C, Element D, Element E, NET 5, Element J, ME 2, Element A, Element B</p>	<p>Met</p>
<p>IMC/IFC Contract Section: Enrollee Materials, Marketing, and Information Requirements</p>	<p><i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA’s Managed Care Toolkit for full details</i></p>	
<p>§438.100 (b)(2)(i) – 438.10(f)(2)</p>	<p>NCQA Review Standard: MED 1, Element H, NET 4, Element A</p>	<p>Met</p>
<p>IMC/IFC Contract Section: Enrollee Materials, Marketing, and Information Requirements</p>	<p>(1) The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.</p>	
<p>§438.100 (b)(2)(i) – 438.10(g)(1-4)</p>	<p>NCQA Review Standard: ME 2, Element A, Element B, MED 9, Element D, ME 3, MED 1, MED 8, MED 12, Element C, ME 1, UM 8, UM 9, Element I, NET 5, Element J, Element E, Element C, UM 3, MED 13</p>	<p>Met</p>
<p>IMC/IFC Contract Section: Enrollee Materials, Marketing, and Information Requirements</p>	<p><i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA’s Managed Care Toolkit for full details</i></p>	
<p>Subsection: Marketing</p>		
<p>§438.100 (b)(2)(i) – 438.10(i)</p>	<p>MED 1, Element K, UM 11, Element B</p>	<p>Met</p>
<p>IMC/IFC Contract Section: Enrollee Materials, Marketing, and Information Requirements</p>	<p><i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA’s Managed Care Toolkit for full details</i></p>	
<p>§438.100 (b)(2)(ii-iv) and (3)</p>	<p>NCQA Review Standard: MED 1, Element I</p>	<p>Partially Met: Met with exception of AH requirement: Review of employee and community education on advance directives and POLSTs</p>
<p>IMC/IFC Contract Section: Enrollee Rights and Protections</p>	<p><i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA’s Managed Care Toolkit for full details</i></p>	
<p>Subsection: General Requirements</p>		
<p>§438.100 (d)</p>	<p>NCQA Review Standard: MED 12, Element C, ME 1, Element A</p>	<p>Met</p>
<p>IMC/IFC Contract Section: General Terms and Conditions</p>	<p>(ix) Enrollee rights and responsibilities, including the elements specified in Sec. 438.100 and, if applicable, §438.3(e)(2)(ii).</p>	

Subsections: Assignment and Billing Limitations		
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Sub-contractual Relationships and Delegation

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§438.230 (b)	NCQA Review Standard: CR 8, ME 8, UM 13, QI 5, Element B	Met
IMC/IFC Contract Section: Subcontracts Subsections: Required provisions	(1) Notwithstanding any relationship(s) that the MCO, PIHP, PAHP, or PCCM entity may have with any subcontractor, the MCO, PIHP, PAHP, or PCCM entity maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and (2) All contracts or written arrangements between the MCO, PIHP, PAHP, or PCCM entity and any subcontractor must meet the requirements of paragraph (c) of this section.	

Grievance and Appeal Systems

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§438.402 (a) and (b) and §438.228 (b)	NCQA Review Standard: MED 10, Element A, Element B, ME 7, Element A, Element B, UM 8, Element A, ME 2, Element A, Element B	Met
IMC/IFC Contract Section: Grievance and Appeals System Subsections: Grievance Process and Appeals Process	Each MCO, PIHP, and PAHP must have a grievance and appeals system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in §438.9, are not subject to this subpart F. For grievances and appeals at the plan level, an applicable integrated plan as defined in §422.561 of this chapter is not subject to this subpart F and is instead subject to the requirements of §§422.629 through 422.634 of this chapter. For appeals of integrated reconsiderations, applicable integrated plans are subject to §438.408(f). Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.	
§438.228	NCQA Review Standard: UM 7, Element C, Element F, UM 8, Element A, UM 3, Element A, MED 10,	Partially Met: Met with exception of AH requirement:

IMC/IFC Contract Section: Grievance and Appeals System	Element A, UM 9, Element A, ME 2, Element A, Element B	Independence of the MCO/PIHP in hearings and reviews, timely acknowledgment of grievances and appeals, and handling of decisions for appeals involving medical necessity, service failures, or exhausted GFS funding.
Subsections: Grievance Process and Appeals Process	<i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details</i>	

Statutory Basis, Definitions, and Applicability

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§438.400 (b) IMC/IFC Contract Section: Definitions	NCQA Review Standard: Appendix 5, UA8, Element A, MED 10, Element A <i>Due to the length of the descriptions for some NCQA Accreditation Standards, please refer to NCQA's Managed Care Toolkit for full details</i>	Partially Met: Met with exception of AH requirement: grievance classifications

General Requirements

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§438.402 (c)(2) IMC/IFC Contract Section: Grievance and Appeals System Subsections: Appeals Process	NCQA Review Standard: MED 10, Element A, UM 8, Element A (2) Timing. (i) Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (ii) Appeal. Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.	Met

Timely and Adequate Notice of Adverse Benefit Determination

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
§438.404 (c)	NCQA Review Standard: MED 9, Element A	Met

<p>IMC/IFC Contract Section: Utilization Management Program and Authorization of Services</p> <p>Subsections: Notification of Coverage and Authorization Determinations</p>	<p>(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §431.211, 431.213, and 431.214 of this chapter.</p>	
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Handling of Grievances and Appeals

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.406 (a)</p>	<p>NCQA Review Standard: UM 3, Element A, MED 10, Element A</p> <p>In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.</p>	<p>Met</p>
<p>§438.406 (b)(2)</p> <p>IMC/IFC Contract Section: Grievance and Appeals System</p> <p>Subsections: Grievance Process and Appeals Process</p>	<p>NCQA Review Standard: UM 8, Element A, UM 9, Element A, MED 10, Element A</p> <p>(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—</p> <p>(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.</p> <p>(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.</p> <p>(A) An appeal of a denial that is based on lack of medical necessity.</p> <p>(B) A grievance regarding denial of expedited resolution of an appeal.</p> <p>(C) A grievance or appeal that involves clinical issues.</p> <p>(iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.</p>	<p>Met</p>
<p>§438.406 (b)(5)</p> <p>IMC/IFC Contract Section: Grievance and Appeals System</p>	<p>NCQA Review Standard: UM 8, Element A</p> <p>(5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or</p>	<p>Met</p>

Subsections: Appeals Process	PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c).	
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Resolution and Notification: Grievances and Appeals

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.408 (d) and (e)</p> <p>IMC/IFC Contract Section: Grievance and Appeals System</p> <p>Subsections: Grievance Process and Appeals Process</p>	<p>NCQA Review Standard: MED 10, Element A, MED 12, Element F, ME 7, Element B, UM 9, Element D</p> <p>(1) The results of the resolution process and the date it was completed. (2) Appeals.</p> <p>(i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10.</p> <p>(ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.</p>	Met

Expedited Resolution of Appeals

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.410 (a)</p> <p>IMC/IFC Contract Section: Grievance and Appeals System</p> <p>Subsections: Expedited Appeal Process</p>	<p>NCQA Review Standard: UM 8, Element A</p> <p>Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP 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, physical or mental health, or ability to attain, maintain, or regain maximum function.</p>	Met
<p>§438.410 (b)</p> <p>IMC/IFC Contract Section: Grievance and Appeals System</p>	<p>NCQA Review Standard: MED 10, Element A</p> <p>The MCO, PIHP, or PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.</p>	Met

Information About the Grievance and Appeal System to Providers and Subcontractors

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.414</p> <p>IMC/IFC Contract Section: Subcontracts</p> <p>Subsections: Required Provisions</p>	<p>NCQA Review Standard: MED 10, Element B</p> <p>The MCO, PIHP, or PAHP must provide the information specified in § 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.</p>	<p>Met</p>

Recordkeeping Requirements

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.416 (a) and (b)</p> <p>IMC/IFC Contract Section: Grievance and Appeals System</p> <p>Subsections: Expedited General Requirements</p>	<p>NCQA Review Standard: MED 10, Element C, UM 9, Element A</p> <p>The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.</p> <p>(b) The record of each grievance or appeal must contain, at a minimum, all of the following information:</p> <ol style="list-style-type: none"> (1) A general description of the reason for the appeal or grievance. (2) The date received. (3) The date of each review or, if applicable, review meeting. (4) Resolution at each level of the appeal or grievance, if applicable. (5) Date of resolution at each level, if applicable. (6) Name of the covered person for whom the appeal or grievance was filed. 	<p>Met</p>

Continuation of Benefits While the MCO, or PAHP Appeal and the State Fair Hearing are Pending

Federal Regulation (42 C.F.R. 438)	Accreditation Standard:	Deeming Status: Met or Partially Met
<p>§438.420 (a)</p> <p>IMC/IFC Contract Section: Grievance and Appeals System</p> <p>Subsections: Appeals Process, Administrative Hearing, and Continuation of Services</p>	<p>NCQA Review Standard: MED 11, Element B</p> <p>As used in this section-- Timely files means files for continuation of benefits on or before the later of the following:</p> <p>(i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination.</p> <p>(ii) The intended effective date of the MCO's, or PIHP's', or PAHP's proposed adverse benefit determination.</p>	<p>Met</p>
<p>§438.420 (d)</p> <p>IMC/IFC Contract Section: Grievance and Appeals System</p> <p>Subsections: Appeals Process, Administrative Hearing, and Continuation of Services</p>	<p>NCQA Review Standard: MED 11, Element B, Element C</p> <p>If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under §431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.</p>	<p>Met</p>