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42 CFR Managed Care Quality Framework — Regulatory Summary

Summarize the federal managed care quality requ...

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Organization: Vantage Policy Group

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Analysis

Mar 01, 2026 11:02 PM

Federal Medicaid Managed Care Quality Requirements: A Comprehensive Analysis

Executive Summary

The federal managed care quality requirements under **42 CFR Parts 438, 437, and 431** establish a comprehensive regulatory framework for ensuring quality healthcare delivery through Medicaid managed care organizations (MCOs). While the retrieved context provides extensive state-level implementation examples and some federal regulatory foundation from **42 CFR Part 438**, the specific detailed provisions of Parts 437 and 431 are not fully represented in the available materials.

Based on the federal framework established in **42 CFR Part 438** and state implementation patterns observed across all jurisdictions, the regulatory scheme creates four primary areas of obligations: **state oversight responsibilities**, **MCO operational requirements**, **network adequacy standards**, and **Quality Assessment and Performance Improvement (QAPI) requirements**. These regulations represent the federal government's effort to ensure that managed care delivery systems maintain quality standards while providing cost-effective care to Medicaid beneficiaries.

The regulatory structure reflects Congress's recognition in **Section 1932 of the Social Security Act** (codified at **42 USC 1396u-2**) that states need flexibility to implement managed care programs while maintaining federal oversight to protect beneficiary interests and ensure program integrity.

Federal Regulatory Framework Analysis

Core Federal Requirements Under 42 CFR Part 438

42 CFR Part 438 serves as the primary federal regulatory framework governing Medicaid managed care quality requirements. The regulation establishes that states contracting with MCOs must ensure compliance with comprehensive quality standards that protect beneficiary access, safety, and outcomes.

Statutory Foundation and Scope

The federal requirements derive from multiple statutory authorities within the Social Security Act. **42 CFR 438.1** establishes that the regulatory framework is based on:

- **Section 1902(a)(4)** requiring states to provide methods of administration necessary for proper and efficient operation
- **Section 1903(m)** containing comprehensive risk contract requirements
- **Section 1932** establishing rules for MCO contracts, enrollee protections, and mandatory quality assessment strategies
- **Section 1905(t)** governing Primary Care Case Management requirements

The scope of **42 CFR Part 438** encompasses all managed care entities including MCOs, Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), Primary Care Case Managers (PCCMs), and PCCM entities. Requirements vary based on entity type and contractual authority, with enhanced requirements for comprehensive risk contracts under Section 1932(a)(1)(A).

Federal Quality Strategy Mandates

Under **42 CFR Part 438**, states must develop and implement written quality strategies that assess and improve healthcare quality. These strategies must be submitted to CMS for review and updated at least every three years. The federal requirements mandate that state quality strategies include specific measurable components addressing network adequacy, quality metrics, performance improvement

projects, and external quality reviews.

State Implementation Patterns

Examining state implementations reveals consistent patterns in how jurisdictions interpret and operationalize federal requirements:

Quality Strategy Development: States like **Minnesota** have implemented comprehensive quality strategies under **Minnesota Statutes Section 256B.69** that exceed federal minimums. Minnesota's approach includes defined network adequacy requirements, measurable continuous quality improvement goals, quality metrics with performance targets, annual external reviews, transition of care policies, health disparities reduction plans, intermediate sanctions frameworks, and mechanisms for identifying special needs populations.

Network Adequacy Standards: States have developed specific distance, time, and provider-to-enrollee ratio standards. **Oklahoma** established network adequacy standards under **Oklahoma Statutes Section 56-4002.4** that meet minimum federal requirements in **42 CFR 438.68**, including specific provisions for health professional shortage areas and requirements for essential community providers.

Quality Oversight Mechanisms: States have implemented various oversight structures. **Louisiana's** managed care program includes medical loss ratio requirements of at least 85% using definitions from **45 CFR Part 158**, quarterly financial reporting, and risk-adjusted capitation rates updated periodically to reflect enrollee health status changes.

State Obligations Under Federal Framework

Quality Strategy Development and Implementation

States must develop comprehensive written quality strategies that demonstrate how they will assess and improve quality of care provided by contracted managed care entities. The federal framework requires these strategies to be data-driven, outcome-focused, and regularly updated based on performance results and stakeholder input.

Strategic Planning Requirements: States must establish measurable goals and objectives for continuous quality improvement that consider the health status of all covered populations. This includes developing quality metrics with specific performance targets, designing performance improvement projects with documented interventions, and creating mechanisms for annual external quality reviews.

Stakeholder Engagement: Federal requirements mandate meaningful stakeholder engagement in quality strategy development. States must obtain input from beneficiaries, providers, advocacy organizations, and other interested parties. **Minnesota's** implementation demonstrates best practices by requiring consultation with Medicaid Citizens' Advisory Committees, tribal consultation processes, and public comment periods.

CMS Oversight: States must submit quality strategies to CMS for review and feedback. Significant changes based on federal input must be published with public access to revised strategies. This creates a feedback loop ensuring federal-state alignment on quality priorities.

Monitoring and Enforcement Responsibilities

States bear primary responsibility for monitoring MCO performance and enforcing contractual compliance with quality requirements. This includes establishing intermediate sanctions for non-compliance and implementing corrective action procedures.

Performance Monitoring Systems: States must develop comprehensive monitoring systems that track MCO performance across multiple domains including access, quality, member satisfaction, and financial

stability. **Texas** demonstrates robust monitoring through **Texas Health and Safety Code Section 32.049**, requiring implementation plans, status reports, compliance reviews, and readiness assessments before MCO operations begin.

Sanctions and Corrective Actions: Federal regulations require states to establish intermediate sanctions that can be imposed on MCOs failing to meet quality requirements. These may include corrective action plans, civil monetary penalties, suspension of new enrollment, appointment of temporary management, or contract termination in severe cases.

External Quality Review: States must arrange for annual external quality reviews by qualified independent organizations. These reviews must evaluate access, quality, and timeliness of services, validate performance improvement projects, and assess compliance with state and federal requirements.

Provider Network Management

States must establish and enforce network adequacy standards that ensure beneficiary access to covered services within reasonable time and distance parameters. This includes both initial network adequacy certification and ongoing monitoring of network changes.

Essential Provider Requirements: States must ensure MCO contracts include essential community providers, federally qualified health centers, and other safety net providers critical to serving Medicaid populations. **Florida** exemplifies comprehensive essential provider requirements under **Florida Statutes Section 409.975**, mandating inclusion of specific provider categories and establishing good faith negotiation requirements.

Geographic Access Standards: Federal requirements mandate that states establish specific time and distance standards appropriate to different geographic areas, with special considerations for rural and underserved regions. States must also address provider availability during evenings, weekends, and emergency situations.

Specialty Care Access: States must ensure adequate access to specialty services, including behavioral health, long-term care, and other specialized services needed by Medicaid populations. This includes establishing referral procedures, coordination requirements, and timely access standards.

MCO Quality Obligations

Operational Quality Requirements

MCOs must establish comprehensive quality management systems that demonstrate systematic approaches to measuring, analyzing, and improving care quality. These systems must be integrated into all organizational functions and supported by adequate resources and executive leadership.

Quality Management Infrastructure: MCOs must designate qualified quality management staff with appropriate clinical expertise and administrative authority. Quality management activities must be integrated across all organizational functions including medical management, provider relations, member services, and information systems.

Clinical Practice Guidelines: MCOs must adopt evidence-based clinical practice guidelines for major clinical areas and high-volume services. These guidelines must be developed or endorsed by recognized medical professional organizations and updated regularly to reflect current medical knowledge.

Utilization Management: MCOs must implement utilization management programs that promote appropriate utilization while avoiding underutilization of needed services. **Connecticut** regulations under **17b-262-501** define utilization review as evaluation of necessity, appropriateness, and quality of medical services conducted on concurrent, prospective, or retrospective bases.

Member Services and Grievance Systems

Federal requirements mandate comprehensive member services infrastructure including grievance and appeals systems that protect beneficiary rights and ensure due process in coverage determination disputes.

Grievance and Appeals Systems: MCOs must establish formal grievance and appeals procedures that meet federal due process requirements including timely processing, independent review of clinical decisions, and continuation of benefits during appeals. **Tennessee** demonstrates comprehensive appeals protections under **Tennessee Code Section 71-5-139** for hospital care, home health services, and psychiatric services.

Member Education and Communication: MCOs must provide comprehensive member education about benefits, provider networks, grievance procedures, and member rights. Materials must be culturally appropriate and available in multiple languages as required by federal accessibility standards.

Access and Availability Standards: MCOs must maintain provider networks that ensure reasonable access to all covered services. This includes establishing appointment availability standards, after-hours coverage requirements, and geographic accessibility standards appropriate to the service area.

Performance Measurement and Reporting

MCOs must participate in comprehensive performance measurement systems that enable state and federal oversight of quality outcomes and support continuous improvement initiatives.

HEDIS and Core Set Reporting: MCOs must collect and report standardized quality measures including Healthcare Effectiveness Data and Information Set (HEDIS) measures and CMS Core Set measures. **Puerto Rico** participates in mandatory Core Set reporting as required under **42 CFR Parts 433, 437, and 457**.

Clinical Quality Improvement: MCOs must conduct ongoing clinical quality improvement activities including analysis of clinical outcomes, identification of improvement opportunities, implementation of interventions, and measurement of results. These activities must be documented and reported to state oversight agencies.

Member Satisfaction Monitoring: MCOs must regularly assess member satisfaction through standardized surveys and other feedback mechanisms. Results must be analyzed to identify improvement opportunities and incorporated into quality improvement planning.

Network Adequacy Standards

Federal Requirements Framework

Federal network adequacy standards under **42 CFR Part 438** require states to develop specific criteria ensuring that MCO provider networks can reasonably serve the expected enrollment in each service area. These standards must address both initial network certification and ongoing network monitoring.

Time and Distance Standards: States must establish maximum travel time and distance requirements for different types of providers, with more stringent requirements in urban areas and appropriate adjustments for rural regions. Standards must consider public transportation availability and geographic barriers.

Provider-to-Enrollee Ratios: For certain provider types, particularly primary care providers and specialists treating high-need populations, states must establish minimum provider-to-enrollee ratios ensuring adequate capacity to serve projected enrollment.

Appointment Availability Standards: MCOs must demonstrate that network providers can offer appointment availability that meets urgent and routine care needs within timeframes specified by state standards. This includes provisions for after-hours care, emergency services, and specialty referrals.

State Implementation Approaches

States have developed varying approaches to network adequacy standards that reflect local market conditions, geographic characteristics, and population needs:

Urban vs. Rural Standards: **Oklahoma** demonstrates differentiated standards under **Oklahoma Statutes Section 56-4002.4** with specific provisions for members in health professional shortage areas, ensuring access to both in-person healthcare and telehealth services with appropriate provider availability.

Essential Provider Requirements: **Florida** requires MCOs to contract with essential Medicaid providers including federally qualified health centers, statutory teaching hospitals, trauma centers, and geographically isolated hospitals. Non-contracting essential providers receive negotiated payment rates with good faith negotiation requirements.

Specialty Network Requirements: States establish specific network adequacy requirements for behavioral health, long-term care, and other specialty services. **Maryland** regulations under **Maryland Code Section 19-705.1** require 24-hour physician access, timely appointment availability, and continuity of care coordination.

Monitoring and Enforcement

Network adequacy standards require ongoing monitoring and enforcement mechanisms to ensure MCOs maintain compliant networks throughout contract periods:

Network Monitoring Systems: States must implement systems for ongoing monitoring of network changes including provider terminations, new provider additions, and capacity changes that might affect member access to covered services.

Member Access Monitoring: States must monitor actual member access through appointment availability studies, member complaints analysis, and utilization data review to identify potential access problems not apparent from network directory reviews.

Corrective Action Requirements: When network adequacy deficiencies are identified, states must require MCOs to implement corrective action plans with specific timelines for resolution and ongoing monitoring of improvement efforts.

QAPI (Quality Assessment and Performance Improvement) Requirements

Federal QAPI Framework

Quality Assessment and Performance Improvement requirements under **42 CFR Part 438** mandate that both states and MCOs implement systematic, comprehensive, and ongoing quality improvement programs that demonstrate measurable improvements in healthcare quality and member outcomes.

State QAPI Responsibilities: States must develop quality strategies that include QAPI components addressing how they will assess MCO performance, identify improvement opportunities, implement interventions, and measure results. These strategies must be evidence-based and incorporate stakeholder input.

MCO QAPI Programs: MCOs must implement internal QAPI programs that systematically evaluate care quality, identify improvement opportunities, design and implement interventions, and measure effectiveness. These programs must be integrated into organizational governance and supported by adequate resources.

Performance Improvement Projects: Both states and MCOs must conduct performance improvement projects (PIPs) that address clinical and non-clinical areas significant to member health outcomes. PIPs

must follow scientifically sound methodologies and demonstrate sustained improvement over time.

Clinical Quality Improvement

QAPI requirements emphasize clinical quality improvement activities that directly impact member health outcomes and care experiences:

Clinical Data Analysis: MCOs must systematically analyze clinical data to identify patterns, trends, and opportunities for improvement. This includes analysis of utilization patterns, outcomes data, member complaints, and provider performance metrics.

Evidence-Based Practice Implementation: QAPI programs must promote implementation of evidence-based clinical practices through provider education, clinical decision support systems, and performance incentive programs.

Care Coordination Improvement: MCOs must demonstrate systematic efforts to improve care coordination for members with complex conditions, chronic diseases, or multiple service needs. **New Mexico** demonstrates comprehensive care coordination protocols under its Centennial Care program for high-risk, high-utilization populations.

Performance Measurement and Improvement

QAPI requirements mandate comprehensive performance measurement systems that support continuous quality improvement:

Outcome Measurement: MCOs must measure clinical outcomes, functional status improvements, member satisfaction, and other indicators of care quality and effectiveness. These measurements must be compared to established benchmarks and improvement targets.

Benchmark Comparison: Performance must be compared to national, regional, or other appropriate benchmarks to identify areas where performance falls below acceptable standards and opportunities for improvement exist.

Improvement Target Setting: MCOs must establish specific, measurable improvement targets based on baseline performance and benchmark comparisons. Progress toward targets must be regularly monitored and reported.

External Quality Review Requirements

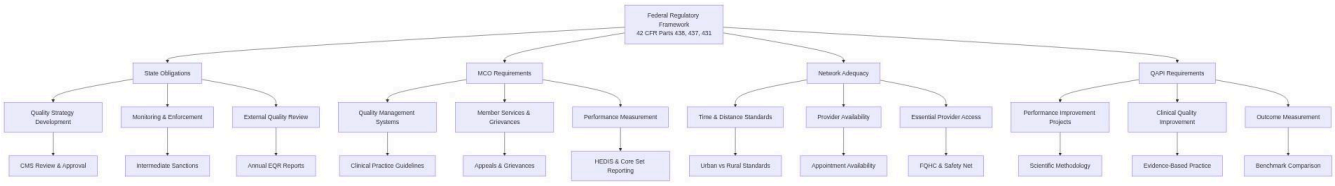
Federal regulations mandate annual external quality review (EQR) of MCO performance by qualified independent organizations:

EQR Scope and Methods: External quality reviews must evaluate access, structure and operations, quality, timeliness, and outcomes of care provided by MCOs. Reviews must use standardized methodologies and produce comparable results across MCOs.

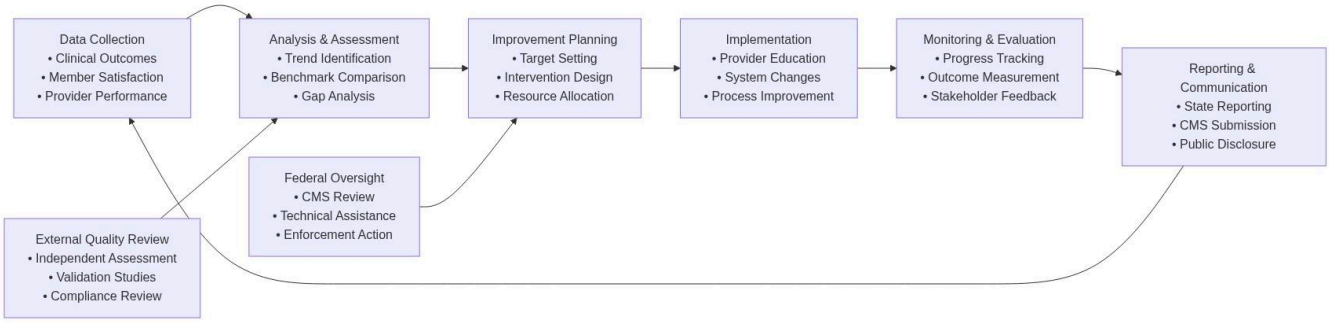
EQR Reporting: External quality review organizations must produce annual reports that describe MCO performance, identify deficiencies, recommend improvements, and assess progress on previous recommendations.

State Use of EQR Results: States must use external quality review results in oversight activities, contract compliance monitoring, quality strategy updates, and public reporting of MCO performance.

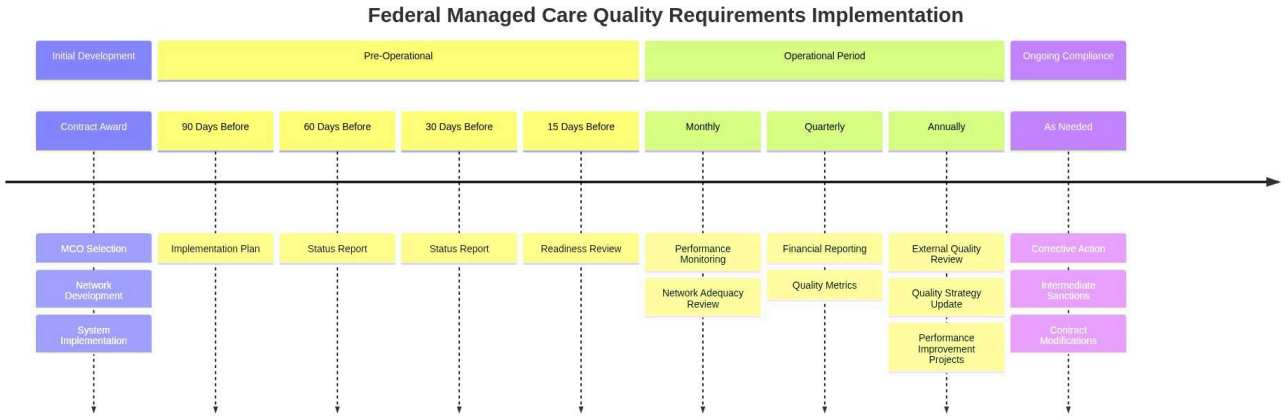
Visual Framework Analysis



Quality Improvement Process Flow



Regulatory Compliance Timeline



State-by-State Quality Implementation Analysis

California - Comprehensive Integration

Status: **Fully Implemented**

California's Medi-Cal managed care program demonstrates comprehensive integration of federal quality requirements through Health Net's quality management framework. The state requires **NCQA accreditation** for all MCOs, ensuring adherence to national quality standards. Health Net's provider agreements include specific language requiring cooperation with quality improvement activities and allowing use of performance data for quality initiatives.

Key Requirements:

- NCQA accreditation mandatory for all MCOs
- Provider performance data utilization for quality improvement
- Comprehensive delegated medical management oversight

- Annual audits and ongoing monitoring of delegated activities
- Federal and state regulatory compliance standards integration

Notable Features: California's approach emphasizes **accreditation-based quality assurance** with NCQA standards serving as the foundation for quality oversight. The state's delegation oversight model allows MCOs to delegate utilization management while maintaining accountability through regular auditing.

Texas - Robust Readiness Review

Status: **Comprehensive Framework**

Texas implements one of the most comprehensive **managed care contract compliance** systems under **Texas Health and Safety Code Section 32.049**. The state requires detailed implementation plans, multiple status reports, and thorough readiness reviews before MCO operations begin.

Key Requirements:

- Implementation plans required 90 days before service initiation
- Multiple status reports at 60-day, 30-day intervals
- Comprehensive readiness reviews 15 days before enrollment begins
- On-site inspections of service authorization and claims systems
- Authority to delay enrollment if MCOs unprepared

Notable Features: Texas demonstrates **proactive quality assurance** through extensive pre-operational review processes. The state's compliance framework includes specific testing of operational systems and authority to prevent MCO implementation if readiness standards aren't met.

Oregon - Provider-Focused Quality

Status: **Behavioral Health Integration**

Oregon's quality requirements under **ORS 414.592** emphasize **behavioral health quality metrics** and provider contract alignment. The state requires 90-day notice periods for contract changes and focuses on ensuring services lead to meaningful improvement in individuals' lives.

Key Requirements:

- Contracts must align with Behavioral Health Committee quality metrics
- 90-day notice requirement for contract modifications
- Focus on meaningful individual life improvement outcomes
- Responsive service delivery to community needs
- Easy access to needed care provisions

Notable Features: Oregon's approach demonstrates **outcome-focused quality measurement** with emphasis on behavioral health integration and meaningful life improvements rather than purely clinical metrics.

Georgia - Structured Service Delivery

Status: **Comprehensive State Plan**

Georgia's Department of Community Health administers quality requirements through **Georgia Code Section 49-4-142** with authority to establish comprehensive terms and conditions for medical assistance delivery.

Key Requirements:

- State plan administration within legislative appropriations
- Establishment of amount, duration, scope, and eligibility terms
- Rules and regulations for maximum federal financial participation
- Reasonable procedures for stakeholder notice and hearing opportunities

- Reciprocal arrangements with other states and institutions

Notable Features: Georgia emphasizes **legislative alignment** and **stakeholder engagement** in quality requirement development, ensuring comprehensive public input in quality standard establishment.

Florida - Essential Provider Integration

Status: **Robust Network Requirements**

Florida implements comprehensive **managed care plan accountability** under **Florida Statutes Section 409.975** with specific focus on essential provider network requirements and quality performance measurement.

Key Requirements:

- Essential provider network inclusion requirements
- Good faith negotiation requirements with essential providers
- Provider network standards for number, type, and regional distribution
- Performance measurement for all participating providers
- Specific payment methodology requirements

Notable Features: Florida's approach emphasizes **essential provider protection** and comprehensive network adequacy standards ensuring access to critical safety net providers throughout the state.

New York - Facility-Based Standards

Status: **Comprehensive Facility Requirements**

New York implements quality requirements through comprehensive **facility qualification standards** under **N.Y. Comp. Codes R. & Regs. Tit. 18 § 505.9** focusing on nursing facility and institutional care quality.

Key Requirements:

- Current operating certificates required for all facilities
- Medicare program qualification requirements
- Federal nursing facility requirement compliance
- Current provider agreements with Department of Social Services
- Out-of-state facility licensing and certification requirements

Notable Features: New York demonstrates **facility-focused quality assurance** with comprehensive certification requirements and dual federal-state compliance standards for institutional providers.

Louisiana - Financial Accountability

Status: **MLR and Financial Requirements**

Louisiana's Healthy Louisiana program emphasizes **medical loss ratio requirements** and comprehensive financial reporting as core quality assurance mechanisms.

Key Requirements:

- 85% minimum medical loss ratio requirement
- Annual MLR reporting aligned with capitation periods
- Quarterly financial reporting requirements
- Risk-adjusted capitation rate methodologies
- Comprehensive encounter data reliance for rate setting

Notable Features: Louisiana's approach demonstrates **financial accountability integration** with quality oversight, using medical loss ratios as a primary tool for ensuring appropriate resource allocation to member care.

Maryland - Access and Availability Focus

Status: **Comprehensive Access Standards**

Maryland implements detailed **quality of care standards** under **Maryland Code Section 19-705.1** emphasizing member access, availability, and care coordination.

Key Requirements:

- Regular service hours with timely access based on need immediacy
- 24-hour physician access system for immediate medical needs
- Toll-free telephone access for emergency departments
- Continuing medical management requirements for all members
- Nonparticipating provider documentation requirements

Notable Features: Maryland emphasizes **access-focused quality standards** with specific requirements for 24-hour availability and comprehensive care coordination across all service settings.

Colorado - Transparency and Accountability

Status: **Conflict of Interest Management**

Colorado implements comprehensive **managed care system standards** with specific focus on transparency, accountability, and conflict of interest management for provider-owned MCOs.

Key Requirements:

- Conflict of interest policies for provider-owned MCOs
- Quarterly reporting of provider application denials
- Rate range comparisons for ownership vs. non-ownership providers
- Community representation requirements on MCO boards
- Public process requirements for governing requirements

Notable Features: Colorado demonstrates **transparency-focused quality oversight** with specific attention to managing conflicts of interest when providers have ownership stakes in MCOs.

Utah - Federal Compliance Integration

Status: **Federal Requirement Alignment**

Utah emphasizes **federal Medicaid managed care requirement compliance** as the foundation for quality assurance under its managed care contracts.

Key Requirements:

- Full compliance with federal Medicaid managed care requirements
- Timely and accurate authorization and claims processing
- Adequate provider reimbursement for access maintenance
- Sufficient care management services for enrolled populations
- Timely dispute resolution between providers and enrollees

Notable Features: Utah's approach demonstrates **federal compliance integration** as the primary framework for quality assurance, ensuring alignment with all applicable federal requirements.

Detailed Compliance Analysis

Quality Strategy Requirements

States must develop comprehensive quality strategies that meet federal standards while addressing local population needs and market characteristics. The analysis reveals several common approaches:

Stakeholder Engagement Models: **Minnesota** demonstrates comprehensive stakeholder engagement through Medicaid Citizens' Advisory Committees, tribal consultation processes, and public comment

periods. This approach ensures quality strategies reflect diverse community perspectives and needs.

Performance Measurement Integration: States consistently integrate **HEDIS measures**, **CMS Core Set indicators**, and state-specific quality metrics into comprehensive performance measurement systems. **Puerto Rico** participates in mandatory Core Set reporting demonstrating territorial compliance with federal quality measurement requirements.

Continuous Improvement Frameworks: Quality strategies must demonstrate systematic approaches to identifying improvement opportunities, implementing interventions, and measuring results. **Michigan** emphasizes performance bonus incentive plans tied to quality measures for managed care providers.

Network Adequacy Implementation

Network adequacy standards represent one of the most complex areas of federal-state-MCO coordination, with significant variation in implementation approaches:

Geographic Considerations: **Oklahoma** addresses health professional shortage areas with specific network adequacy requirements ensuring both in-person and telehealth service availability. This demonstrates how states must adapt federal requirements to local geographic and workforce realities.

Essential Provider Protection: **Florida** implements comprehensive essential provider requirements including federally qualified health centers, teaching hospitals, trauma centers, and geographically isolated facilities. The state's good faith negotiation requirements ensure MCOs cannot simply exclude critical safety net providers.

Specialty Network Requirements: States establish specific adequacy standards for behavioral health, long-term care, and other specialty services. **Tennessee** demonstrates comprehensive willing provider requirements for nursing facilities with specific transition protections for members when providers are excluded.

QAPI Implementation Patterns

Quality Assessment and Performance Improvement requirements show significant state innovation in implementation approaches:

Performance Improvement Projects: States require MCOs to conduct systematic performance improvement projects addressing both clinical and operational areas. **New Mexico** demonstrates comprehensive care coordination protocols for high-risk, high-utilization populations as part of QAPI requirements.

Clinical Quality Integration: **Connecticut** defines comprehensive utilization review requirements including concurrent, prospective, and retrospective review methodologies as part of broader quality assurance frameworks.

External Quality Review: States contract with independent organizations for annual external quality reviews providing objective assessment of MCO performance and compliance with quality requirements.

Conclusions and Policy Implications

The federal managed care quality requirements under **42 CFR Parts 438, 437, and 431** create a comprehensive regulatory framework that balances federal oversight with state flexibility in implementation. The analysis reveals several key themes:

Regulatory Complexity: The intersection of federal requirements, state implementation, and MCO operations creates significant regulatory complexity requiring sophisticated compliance systems and ongoing coordination among multiple stakeholders.

State Innovation: States demonstrate considerable innovation in implementing federal requirements, with

approaches ranging from **California's accreditation-focused model** to **Texas's comprehensive readiness review system** to **Louisiana's financial accountability integration**.

Provider Network Challenges: Network adequacy requirements represent ongoing challenges, particularly in rural and underserved areas. States must balance access requirements with provider availability and MCO financial sustainability.

Quality Measurement Evolution: The transition to mandatory Core Set reporting and emphasis on outcome-based quality measures reflects broader healthcare quality improvement trends emphasizing accountability and transparency.

Stakeholder Coordination: Successful implementation requires extensive coordination among state agencies, MCOs, providers, and beneficiaries. States with comprehensive stakeholder engagement processes demonstrate better quality outcomes and compliance rates.

The regulatory framework continues to evolve as CMS updates requirements based on implementation experience, research findings, and changing healthcare delivery models. States and MCOs must maintain adaptive capacity to meet evolving federal expectations while serving diverse Medicaid populations effectively.

Future policy development should focus on **streamlining compliance processes**, **enhancing outcome measurement capabilities**, **addressing rural access challenges**, and **promoting integration between physical and behavioral health quality requirements**. The comprehensive nature of current federal requirements provides a strong foundation for continued quality improvement in Medicaid managed care delivery systems.

Appendix A: Source References

[1] 49-4-142.
Department of Community Health established; adoption, administration, and modification of state plan; drug application fees; personal needs allowance.

Statute

Jurisdiction: GA
https://www.legis.ga.gov/

The Department of Community Health established under Chapter 2 of Title 31 is authorized to adopt and administer a state plan for medical assistance in accordance with Title XIX of the federal Social Security Act, as amended (Act of July 30, 1965, P.L.89-97, 79 Stat.343, as amended), provided su...

[2] Sec. 32.049.

Statute

Jurisdiction: TX
https://statutes.capitol.texas.gov/?tab=1&code=HR&chapter=HR.32&artSec=

MANAGED CARE CONTRACT COMPLIANCE.(a) The commission shall review each managed care organization that has contracted with the commission to provide medical assistance to medical assistance recipients through a managed care plan issued by the organization to determine whether the organization is prepa...

[3] Page 370

Transplant Reimbursement

Jurisdiction: CA
https://providerlibrary.healthnetcalifornia.com/content/dam/centene/healthnet/en/dita/providerlibrary/medi-cal/manuals/2025/Medi-Cal%20Provider%20Manual%20-%20January%202025.pdf

January 09,2025 14:05

Health Net is subject to various statutory, regulatory and accreditation requirements, and must ensure that all agreements comply with any such mandates. Accreditation from the National Committee for Quality Assurance (NCQA) is critical to both the health plan and network prov...

[4] Page 47

Donor Coverage

Jurisdiction: NV
https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C600/MSM_600_26_01_01.pdf

MTL 09/21
Section:
NEVADA MEDICAID 603
Subject:
MEDICAID SERVICES MANUAL POLICY

federal requirements for licensed facilities.Reference MSM Chapter 500, Nursing Facilities, for coverage and limitations.B.When the recipient is admitted to the NF in the course of an encounter...

[5] Page 23

Cell & Gene Therapy

Jurisdiction: KS
https://www.kdhe.ks.gov/DocumentCenter/View/420/Preferred-Drug-List-PDF

This PDL applies to drugs billed on the medical benefit and the pharmacy benefit.Generic drugs and interchangeable

biologic products are required when available on the market, for both preferred or non-preferred agents, unless a Brand Medical Necessity prior authorization request is approved...

[6] Section 115

Statute

Jurisdiction: HI
https://www.capitol.hawaii.gov/hrscurrent/vol07_ch0346-0398/HRS0346/HRS_0346-.htm

(a) of Public Law 104-193 shall not apply in Hawaii to persons who are complying with treatment or who have not refused or...346-53.4 Reimbursement to Expanded Adult Residential Care Home Operators.Qualified expanded adult residential care home operators under section 321-15.62 who accept residents ...

[7] SECTION 44

Statute

Jurisdiction: SC
https://www.scstatehouse.gov/code/t44c006.php

-6-50.

Contracts with other agencies; program monitoring.

In carrying out the duties provided for in Section 44-6-30 the department shall:

(1) Contract for health and human services eligibility determination with performance standards regarding quality control as required by law or regulation.
...

[8] Section 9

Statute

Jurisdiction: IL
https://www.ilga.gov/legislation/ILCS/details?MajorTopic=HUMAN+NEEDS&Chapter=PUBLIC+AID&ActName=Illinois+Public+Aid+Code.&ActID=1413&ChapterID=28&SeqStart=&ChapAct=FullText

of the State Finance Act notwithstanding, such contracts with State agencies, other health care and rehabilitation organizations, or fiscal intermediaries may provide for advance payments.(Source: P.A.95-331, eff.8-21-07.)
(305 ILCS 5/5-11a)
Sec.5-11a.Health Benefit Information Systems.(a) It is the...

[9] N.Y. Comp. Codes R. & Regs. Tit. 18 § 505.9 - Residential health care

Regulation

Jurisdiction: NY
https://www.health.ny.gov/regulations/nycrr/title_18/

N.Y.Comp.Codes R.& Regs.Tit.18 § 505.9 - Residential health care

State Regulations

Compare

(a)
Qualifications for participation.(1) In-state nursing facility care.Nursing care must be provided only in a nursing facility, as

defined in the regulations of the Department of Health, which:

(i) holds...

[10] Chapter 4

Statute

Jurisdiction: AZ
https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/36/02901.htm

HEALTH CARE INSTITUTIONSArticle 1 General Provisions § 36-401 Definitions;

Adult Foster Care A.In this chapter, unless the context otherwise requires: 1." Accredited health care institution" means a health care institution, other than a hospital,...§ 36-402 Exemptions A.This chapter and the rules ...

[11] Section 82

Statute

Jurisdiction: MA
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter118E

Requirement that division meets parity requirements described under federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and related guidance or regulations

[12] Page 323

Donor Coverage

Jurisdiction: WY
https://wyomingmedicaid.com/portal/sites/default/files/inline-files/Manuals_and_Bulletins/April_2024_Institutional_Provider_Manual.pdf

In state PRTFs must be certified as a PRTF by the Division of Healthcare Financing, in conjunction with the Office of Healthcare Licensing and Surveys and CMS, should they meet all the PRTF criteria.20.3 Letter of Attestation Each PRTF that provides inpatient psychiatric services to individuals unde...

[13] Subchapter 37.82.3 - Modified Adjusted Gross Income (MAGI)

Regulation

Jurisdiction: MT
https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74

Subchapter 37.82.3 - Modified Adjusted Gross Income (MAGI) State Regulations Compare Rule 37.82.301 - MAGI AS THE MEASURE OF INCOME State regulations are updated quarterly; we currently have two versions available. Below is a comparison between our most recent version and the prior quarterly release...

[14] NECESSITY, FUNCTION, AND CONFORMITY:

Regulation

Jurisdiction: KY
https://apps.legislature.ky.gov/law/kar/titles/907/001/

The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qual...

[15] § 4–205.47. Nursing care standard.

Statute

Jurisdiction: DC
https://code.dccouncil.gov/us/dc/council/code/titles/4/chapters/2/

(a) When a recipient is receiving nursing care in the home of a relative, the Mayor will apply the standard for room, board, and care in an intermediate care facility, based on the kind and extent of care required.

(b) The rate for care in a foster home or for residential placement shall be the sam...

[16] Page 2

Cell & Gene Therapy

Jurisdiction: KY
https://www.chfs.ky.gov/agencies/dms/dpo/ppb/Documents/PADDrugCriteria51624.pdf

Table of Contents
Aduhelm
Elevidys
Hemgenix
Leqembi
Roctavian
Vyjuvek

Special Notes:
The criteria for Aduhelm applies to all members covered by Managed Care or FFS.
All other criteria applies to FFS members only.
Criteria may differ for members covered by a managed care organization. ...

[17] 40-8.13-7. Willing provider.

Statute

Jurisdiction: RI
https://webserver.rilegislature.gov/Statutes/TITLE40/index.htm

A managed care organization must contract with and cover services furnished by any nursing facility licensed under chapter 17 of title 23 and certified by CMS that provides Medicaid-covered nursing facility services pursuant to a provider agreement with the state, provided that the nursing facility ...

[18] 20-9-212. Minimum standards for hospitals and other institutions.

Statute

Jurisdiction: AR
https://law.justia.com/codes/arkansas/2023/title-20/

The State Board of Health shall require hospitals and other institutions which receive federal aid for construction under the state plan to comply with such minimum standards prescribed by the Department of Health as may be promulgated in accordance with the federal act and federal rules and regulat...

[19] 414.592 Requirements for contracts between authority and providers; alignment with behavioral quality health metrics and incentives.

Statute

Jurisdiction: OR
https://www.oregonlegislature.gov/bills_laws/ors/ors414.html

(1) Contracts between the Oregon Health Authority and coordinated care organizations or individual providers for the provision of behavioral health services must align with the quality metrics and incentives developed by the Behavioral Health Committee under ORS 413.017 and contain provisions that e...

[20] Page 7

Transplant Reimbursement

Jurisdiction: PR
https://www.macpac.gov/wp-content/uploads/2020/08/Medicaid-and-CHIP-in-Puerto-Rico.pdf

7
Though Puerto Rico has historically delegated primary responsibility to plans for program integrity activities related to provider fraud, it has taken a number of steps to enhance its program integrity capabilities (AAFAF 2018).These include setting up a Medicaid fraud control unit (MFCU) and a pr...

[21] Section 60

Regulation

Jurisdiction: OH
https://codes.ohio.gov/ohio-administrative-code/chapter-5160-1

(A) Out-of-state providers:

(1) Should be licensed,
accredited, or certified by their respective states to be considered eligible to receive reimbursement for services provided to Ohio medicaid covered individuals.(2) Should meet any
standards applicable to the provision of the service in the state...

[22] HIPAA Manuals

Provider Manual

Jurisdiction: SD
https://dss.sd.gov/medicaid/providers/billingmanuals/

The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) requires the United States Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for pr...

[23] Acute Inpatient Hospital Manual for MassHealth Providers

Transplant Reimbursement

Jurisdiction: MA
https://www.mass.gov/lists/acute-inpatient-hospital-manual-for-masshealth-providers

This page, Acute Inpatient Hospital Manual for MassHealth Providers , is offered by

MassHealth

show more

Acute Inpatient Hospital Manual for MassHealth Providers

The Acute Inpatient Hospital Manual guides providers to the regulations and the administrative and billing instructions they need.

Ad...

[24] § 10

Regulation

Jurisdiction: NJ
https://www.nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_74%20Managed%20Health%20Care%20Services%20for%20Medicaid%20and%20NJ%20FamilyCare%20Beneficiaries.pdf

:74-1.1 Purpose
The rules in this chapter set forth the manner in which the New Jersey Medicaid/NJ FamilyCare programs shall provide covered health services to eligible persons through the Managed Care

program, by means of managed care organizations (MCOs).
History

HISTORY:
New Rule, R.2000 d.287, ...

[25] §9-1-2. Definitions.

Statute

Jurisdiction: WV
https://code.wvlegislature.gov/email/9/

(a) Notwithstanding any other provision to the contrary, the Bureau for Medical Services is exempt from all requirements of the Purchasing Division, authorized under §5A-3-1 et seq. of this code, with respect to managed care contracts: Provided, That for purposes of continuity of care, the Bureau fo...

[26] Medicaid program integrity—Managed care organizations—Contracts—Best practices.

Statute

Jurisdiction: WA
https://app.leg.wa.gov/rcw/default.aspx?cite=74.09&full=true

(1) Beginning January 1, 2024, the authority's contracts with managed care organizations must clearly detail each party's requirements for maintaining program integrity and the consequences the managed care organizations face if they do not meet the requirements.

The contract must ensure the penal...

[27] 208.918. Vendor requirements, philosophy and services. —

Statute

Jurisdiction: MO
https://revisor.mo.gov/main/ViewChapter.aspx?chapter=208

208.918.Vendor requirements, philosophy and services.— 1.In order to qualify for an agreement with the department, the vendor shall have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical ...

[28] Page 101

Statute

Jurisdiction: MI
https://www.legislature.mi.gov/documents/mcl/pdf/mcl-chap400.pdf

information is protected in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191.(d) Establish cost sharing requirements for enrollees described in subsection (1)(a) as approved by the United States Department of Health and Human Services.(e) Implem...

[29] Page 95

Regulation

Jurisdiction: ID
https://adminrules.idaho.gov/rules/2022%20Archive/16/160310.pdf

IDAHO ADMINISTRATIVE CODE IDAPA 16.03.10
Department of Health and Welfare Medicaid Enhanced Plan Benefits
Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, o r any applicable state or federal regulation.(3-17-22)
...

[30] Section 449.

Statute

Jurisdiction: PA
https://www.legis.state.pa.us/WU01/LI/LI/US/HTM/1967/0/0021..HTM

Medical Assistance Pharmacy Services.--(a) Any managed care organization under contract to the department, or an entity with
which the managed care organization contracts, must contract on an equal basis with
any pharmacy qualified to participate in the Medical Assistance Program that is willing
to ...

[31] Page 69

Statute

Jurisdiction: WI
https://docs.legis.wisconsin.gov/statutes/statutes/49.pdf

Updated 2023-24 Wis.Stats.Published and certified under s.35.18.January 30, 2026.69 Updated 23-24 Wis.Stats.PUBLIC ASSISTANCE AND CHILDREN AND FAMILY 49.45

or institution for mental diseases is denied under par.(b) or for fied under par.(am) 1.bm., 4., 5m., and 6.for the most recently
whom a det...

[32] Managed care plan accountability.—

Statute

Jurisdiction: FL
https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0409/0409.html

409.975 Managed care plan accountability.—In addition to the requirements of s.409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks...

[33] 42 CFR Part 438 - Managed Care

CFR

Jurisdiction: Federal
https://www.ecfr.gov/api/versioner/v1/full/title-42.xml?part=438

§ 438.1 Basis and scope.(a) Statutory basis.This part is based on the following statutory sections:
(1) Section 1902(a)(4) of the Act requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operation of the State plan.The application ...

[34] Section 167

Statute

Jurisdiction: NH
https://gc.nh.gov/rsa/html/XII/167/167-mrg.htm

:7 167:7 Amount of Assistance. I.The commissioner of health and human services may establish consolidated standards of need for the adult programs he administers, subject to appropriated funds and federal regulations.I-a.(a) The commissioner of health and human services may establish different stan...

[35] Section 22

Statute

Jurisdiction: AL
https://law.onecle.com/alabama/title-22/title-1/index.html

-6-223 Solvency and financial requirements

(a) An integrated care network shall meet minimum solvency and financial requirements as provided by the Medicaid Agency.

The Medicaid Agency shall require the integrated...

[36] §56

Statute

Jurisdiction: OK
https://www.oklegislature.gov/OK_Statutes/CompleteTitles/os56.pdf

-4002.4. Network adequacy standards for contracted entities.
A. The Oklahoma Health Care Authority shall develop network adequacy standards for all contracted entities that, at a minimum, meet the requirements of 42 C.F.R., Sections 438.3 and 438.68. Network adequacy standards established und...

[37] Core Set Data

Additional Resource

Jurisdiction: PR
https://www.medicaid.gov/state-overviews/puerto-rico.html

CMS developed the Medicaid and Children's Health Insurance Program (CHIP) Core Set Data Dashboard to improve accessibility of data about the quality of care provided to Medicaid and CHIP beneficiaries. CMS encourages users to explore Core Set Data to examine performance across states and to inspire ...

[38] Page 751

Statute

Jurisdiction: MD
https://mgaleg.maryland.gov/2022RS/Statute_Web/ghg/ghg.pdf

5. Comply with quality assurance, enrollee input, data collection, and other requirements specified by the Department in regulation.
(v) The Department may contract with a managed care organization for delivery of specialty mental health services if the managed care organization meets the ...

[39] 71-5-1412. Transition period following implementation of managed long-term care service delivery system.

Statute

Jurisdiction: TN
https://www.law.cornell.edu/regulations/tennessee/Tenn-Comp-R-Regs-1240-03-03-.02

A managed care organization

(MCO) shall contract with any nursing facility licensed under title 68, chapter 11, part 2, and certified by the centers for medicare and medicaid services, that provides medicaid nursing facility services pursuant to an approved preadmission evaluation

(PAE) and is wil...

[40] Page 116

Transplant Coverage

Jurisdiction: DE
https://dhss.delaware.gov/wp-content/uploads/sites/9/dmma/pdf/sp_attachment_3_1_a_to_3_1_i.pdf

Revision: HCFA-PM-87-4 (BERC) Supplement 2 to Attachment 3.l-A
March 1987 Page 3

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: DELAWARE
Regular Post Eligibility Continued
(C) Family (check one):
1. AFDC need standard
2. Medically needy inc...

[41] Page 6

Transplant Reimbursement

Jurisdiction: MS
https://medicaid.ms.gov/wp-content/uploads/2022/05/Title-23-Part-202-Hospital-Services-05.01.22.pdf

G. Copy of hospital license
1. Out-of-state facility: Copy of license/certification in effect during the claims period for which they are billing.
2. In-state facility: A copy of letter from the Mississippi State Department of Health is acceptable.
3. Hospital undergoing a Change...

[42] Page 22

Preferred Drug List

Jurisdiction: MT
https://medicaidprovider.mt.gov/docs/pharmacy/2026/January2026508CompliantBlackPDL.pdf

Montana Healthcare Programs Preferred Drug List (PDL)
Revised January 15, 2026
**Indicates a generic is available without prior authorization*
Clinical criteria can be found here: Pharmacy Services - Mountain Pacific Grandfathering of medications does not apply if samples, patient assistan...

[43] Page 23

Provider Manual

Jurisdiction: IA
https://hhs.iowa.gov/medicaid/about-medicaid/policies-rules-regulations/medicaid-provider-manuals-policies

Page
Provider and Chapter
19
All Providers
Date
Chapter I. General Program Policies
July 5, 2024
29. Local Education Agencies
Legal reference: 441 IAC 78.50(249A)
Medicaid covers services provided by local education agencies in connection with audiological services, physical ...

[44] Page 28

Transplant Reimbursement

Jurisdiction: SD
https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Institutional/Inpatient_Hospital_Services.pdf

SOUTH DAKOTA MEDICAID UPDATED
BILLING AND POLICY MANUAL January 26
Inpatient Hospital Services

2. "Diagnosis-related group (DRG)," a classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures...

[45] Chapter 18

Provider Manual

Jurisdiction: OK
https://oklahoma.gov/content/dam/ok/en/okhca/docs/providers/claim-tools/Provider%20Billing%20and%20Procedures%20Manual.pdf

: Quality Assurance and

Improvement

Introduction
The Quality Improvement Unit of the Oklahoma Health Care Authority (OHCA) coordinates the quality assurance evaluation and improvement processes for all OHCA medical programs. These functions are accomplished through ongoing monitori...

[46] Page 3

Donor Coverage

Jurisdiction: VA
https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-01/Hospital%20Chapter%205%20(updated%201.31.23)_Final.pdf

MANUAL TITLE: HOSPITAL MANUAL PAGE 3
CHAPTER 5, BILLING INSTRUCTIONS REVISION DATE: 1/31/2023

Program (Medicaid) for covered services provided to Medicaid-eligible individuals. The Department of Medical Assistance S...

[47] Page 9

Regulation

Jurisdiction: ND
https://ndlegis.gov/information/acdata/pdf/75-02-02.1.pdf

General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01
75-02-02.1-04.1.Certification of need for children in an institution for mental disease.1.Children under age twenty-one who seek services in an institution for mental disease must obtain certification of need in or...

[48] Page 84

Statute

Jurisdiction: IN
https://iga.in.gov/ic/2023/Title_12/Article_15.pdf

As added by P.L.2-1992, SEC.9.IC 12-15-12-4.5 Managed care prescription drug program requirements Sec.4.5.A managed care provider's contract or provider agreement with the office may include a prescription drug program, subject to IC 12-15-5-5, IC 12-15-35, and IC 12-15-35.5.As added by P.L.101...

[49] §17

Regulation

Jurisdiction: CT

https://eregulations.ct.gov/eRegsPortal/Browse/getDocument?guid={20766695-0000-C2C4-8051-5C7CE30ECE7F}

b-262-501 Department of Social Services
professionally recognized standard of acceptable medical care for the condition and the client under treatment.(32) "Retrospective Review" means the review conducted after services are provided to a client, to determine the medical necessity, appropriatenes...

[50] Page 25

Statute

Jurisdiction: ME
https://legislature.maine.gov/statutes/22/title22ch855.pdf

MRS Title 22, Chapter 855.AID TO NEEDY PERSONS

with consumers, providers and interested parties, shall develop the requirements for training and adopt rules containing those requirements.By July 1, 1997, the department, in consultation with consumers, providers and interested parties, s...

[51] Page 24

Transplant Reimbursement

Jurisdiction: IA
https://www.legis.iowa.gov/docs/ACO/chapter/441.79.pdf

Ch 79, p.24 Human Services[441] IAC 2/5/25

(4) Certification criteria for psychiatric units.A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)"i" if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of...

[52] Page 22

Transplant Reimbursement

Jurisdiction: VA
https://www.dmas.virginia.gov/media/pabfgrc3/419a-payment-rates-inpatient-care-general.pdf

Attachment 4.19-A
Page 11.1
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

5.Effective July 1, 2010, DSH payments shall be rebsed for all hospitals with the final calculation reduced by...

[53] Kan. Admin. Regs. § 30-5-81 - Scope of hospital services

Transplant Coverage

Jurisdiction: KS
https://sos.ks.gov/publications/pubs_kar_Regs.aspx?KAR=30-5

Kan.Admin.Regs.§ 30-5-81 - Scope of hospital services State Regulations Compare

(a) Each hospital shall be medicare-certified and shall annually update medicaid enrollment information.(b) Outpatient services shall be covered with the following limitations.(1) Services shall be ordered by an attendi...

[54] Page 73

Regulation

Jurisdiction: LA

https://www.doa.la.gov/media/vs3btetk/50.pdf

PUBLIC HEALTH—MEDICAL ASSISTANCE

2.As the Bayou Health managed care program matures and fee-for-service, shared savings and LBHP data are no available, there will be increasing reliance...

E.The MCO shall meet all financial reporting requirements specified in the terms of the contract.longer

[55] Sec. 47.07.030. Medical services to be provided.

Statute

Jurisdiction: AK
https://www.akleg.gov/basis/statutes.asp?media=print&secStart=47.07&secEnd=47.07.900

(a) The department shall offer all mandatory services required under 42 U.S.C.1396 □ 1396p (Title XIX of the Social Security Act).(b) In addition to the mandatory services specified in

(a) of this section and the services provided under

(d) of this section, the department may offer only the follow...

[56] Page 210

Transplant Coverage

Jurisdiction: SC
https://www.scdhhs.gov/providers

PHYSICIANS SERVICES PROVIDER MANUAL SOUTH CAROLINA DEPARTM ENT OF HEALTH AND HUM AN SERVICES

– All other service and coverage requirements listed in this section.
The incorrect use of modifiers or coding results in an over-payment or improper payment to the provider will result in rec...

[57] Page 75

Provider Manual

Jurisdiction: NM
https://www.hca.nm.gov/wp-content/uploads/2024-Policy-Manual-Full-FINAL.pdf

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019; October 1, 2020; July 1, 2024
Section 4: Care Coordination
Effective dates: July 1, 2024

4.9.Engagement of Members
HCA recognizes there may be a select few managed care Members who present challenges to the service deliver...

[58] Page 4

Transplant Coverage

Jurisdiction: NC
https://medicaid.ncdhhs.gov/11b-4-kidney-renal-transplantation/download?attachment

NC Medicaid Medicaid
Kidney (Renal) Transplantation Clinical Coverage Policy No: 11B-4
Amended Date: August 15, 2023

b.Provider(s) shall verify each Medicaid beneficiary's eligibility each time a

service is rendered.c.The Medicaid beneficiary may have service restrictions due to t...

[59] Subd. 2.Quality measurement tools for nursing facilities.

Statute

Jurisdiction: MN
https://www.revisor.mn.gov/statutes/cite/256B/full

(a) The commissioner shall implement a written quality strategy for assessing and improving the quality of health care and other services provided by managed care organizations.At a minimum, the quality strategy must include:

(1) defined network adequacy requirements and availability of services st...

[60] Page 234

Statute

Jurisdiction: UT
https://le.utah.gov/xcode/Title26B/C26B_2022050420220701.pdf

Utah Code

(a) individuals who qualify for the targeted adult Medicaid program who reside in the county;
(b) the county's executive officer, legislative body, and other county officials who are involved in the delivery of behavioral health services;
(c) the local mental health author...

[61] Page 55

Provider Manual

Jurisdiction: VT
https://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

7.A licensed provider qualified for scope of services must be immediately available in person or by phone within 15 minutes.2.Non-Licensed Providers
Supervisors may bill Medicaid for clinical services provided by the following non-licensed providers:
- *Master-level mental health practitio...*

[62] Page 10

Donor Coverage

Jurisdiction: NE
https://dhhs.ne.gov/Documents/471-10%20--%20Hospital%20Services.pdf

outlined in this chapter 471 NAC 10, the individual provider participation requirements in this chapter 471 NAC 10 will govern.003.02 SPECIFIC PROVIDER REQUIREMENTS.To participate in Nebraska Medicaid, a hospital that provides hospital inpatient or outpatient or emergency room services must:
(i)...

[63] Page 291

Statute

Jurisdiction: CO
https://content.leg.colorado.gov/sites/default/files/images/olls/crs2024-title-25.5.pdf

(IV) Meet statewide managed care system standards and operate as part of the overall managed care system.(8) Waivers.The implementation of this part 4 is conditioned, to the extent applicable, on the issuance of necessary waivers by the federal government.The provisions of this part 4 must be implem...

[64] Page 2

Transplant Reimbursement

Jurisdiction: WV

https://bms.wv.gov/media/21951/download?inline=

510.3 HOSPITAL INPATIENT SERVICES

BACKGROUND
This chapter sets forth requirements of the West Virginia Bureau for Medical Services (BMS) regarding coverage, payment, and processing for inpatient hospital services provided to eligible West Virginia Medicaid members by acute care, critical access, ps...