
42 C.F.R. § 438.3

Standard contract requirements.

(a) *CMS review.* The CMS must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in § 438.806. Proposed final contracts must be submitted in the form and manner established by CMS. For States seeking approval of contracts prior to a specific effective date, proposed final contracts must be submitted to CMS for review no later than 90 days prior to the effective date of the contract.

(b) *Entities eligible for comprehensive risk contracts.* A State may enter into a comprehensive risk contract only with the following:

(1) An MCO.

(2) The entities identified in section 1903(m)(2)(B)(i), (ii), and (iii) of the Act.

(3) Community, Migrant, and Appalachian Health Centers identified in section 1903(m)(2)(G) of the Act. Unless they qualify for a total exemption under section 1903(m)(2)(B) of the Act, these entities are subject to the regulations governing MCOs under this part.

(4) An HIO that arranges for services and became operational before January 1986.

(5) An HIO described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990).

(c) *Payment.* The following requirements apply to the final capitation rate and the receipt of capitation payments under the contract:

(1) The final capitation rate for each MCO, PIHP or PAHP must be:

(i) Specifically identified in the applicable contract submitted for CMS review and approval.

(ii) The final capitation rates must be based only upon services covered under the State plan and additional services deemed by the State to be necessary to comply with the requirements of subpart K of this part (applying parity standards from the Mental Health Parity and Addiction Equity Act), and represent a payment amount that is adequate to allow the MCO, PIHP or PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

(2) Capitation payments may only be made by the State and retained by the MCO, PIHP or PAHP for Medicaid-eligible enrollees.

(d) *Enrollment discrimination prohibited.* Contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities must provide as follows:

- (1) The MCO, PIHP, PAHP, PCCM or PCCM entity accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract.
- (2) Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in § 438.50(a).
- (3) The MCO, PIHP, PAHP, PCCM or PCCM entity will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.
- (4) The MCO, PIHP, PAHP, PCCM or PCCM entity will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, or disability.

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