CHART: MEDICAID MANAGED CARE REGULATIONS - JULY 5, 2016

KEY ISSUES	SECTION CITATION	SECTION TITLE	SUMMARY	EFFECTIVE DATE	BACKGROUND; ADVOCACY TIPS
APPEALS AND GRIEVANCES	431.2	Basis and Scope for Medicaid Fee-for-Service Fair Hearing Requirements	Updates provision to include the term "adverse benefit determination."	7.5.2016	Comparable provision at previous § 431.200. Determined there was a need to update the terminology from "takes action" to "adverse benefit determination." Expands the scope of opportunity for an appeal beyond an "action" by MCO to an "adverse benefit determination."
APPEALS AND GRIEVANCES	431.22	When a Hearing is Required	Provision provides for a hearing for an enrollee in a Non Emergency Medical Transportation PAHP. A beneficiary does not need to file an internal appeal or grievance but can go straight to a hearing.	7.5.2016	Comparable provision at previous § 438.610. Adds PAHP enrollees to the list of enrollees that have access to a state fair hearing after an adverse benefit decision.
APPEALS AND GRIEVANCES	431.244	Hearing Decisions	Provision removes language that permitted direct access to a hearing	7.5.2016	Updated to make consistent with the deletion of direct access to state fair hearing. Enrollee generally must pursue internal plan appeal prior to requesting state fair hearing.
STATE FINANCES AND OPERATIONS	433.138	Identifying Liable Third Parties	Requires states to take action to identify those paid claims that contain diagnosis codes that are indicative of trauma, or injury, poisoning, etc. to determine the legal liability of third parties.	7.5.2016	Updates previous § 433.138.
QUALITY	433.15	Rates for FFP Administration	Provision sets forth the rate of federal financial participation available for external quality review activities.	Effective Immediately	Effective immediately based on idea that it is contrary to public interest to delay the effective date of these regulations pertaining to external quality review.

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SERVICES	438.3 (e)	Services that May Be Covered by a Plan	Plans may cover services that are in addition to those required under the State plan. The plans will not receive payment for these services in their capitated rate. Plans can provide services in lieu of State plan services if the State determines that the alternative service or setting is medically appropriate and a cost effective substitute and the enrollee is not required by the plan to use the alternative service or setting.	7.5.2016	Comparable provision at previous § 438.6(e). Added new language to identify when and which services may be covered by a plan in lieu of services that are explicitly part of the state plan.
CONTRACT REQUIREMENTS, ENROLLEE RIGHTS	438.3 (f)	Compliance with Applicable Laws and Conflict of Interest Safeguards	All contracts with plans must comply with all applicable Federal and State Laws including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Affordable Care Act. Contracts must also comply with conflict of interest safeguards described in § 438.58.	7.5.2016	Comparable provision at previous § 438.6(f). Added reference to Section 1557 of the Affordable Care Act, which prohibits discrimination in health programs that receive federal assistance. Clarified the existing requirement that all contracts comply with conflict of interest safeguards.
ENROLLEE RIGHTS	438.3(a)	CMS Review	Clarifies prohibition on enrollment discrimination: MCO will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability, and will not use any policy or practice that has the effect of discriminating on that basis.	7.5.2016	Significantly expanded from previous § 438.3(a). Check state-MCO contracts to ensure they are up to date with federal enrollment protections.

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CONTRACT REQUIREMENTS	438.3(b)	Entities Eligible for Comprehensive Risk Contracts	State may enter into comprehensive risk agreements with managed care organizations and other specified entities.	7.5.2016	
CONTRACT REQUIREMENTS, PAYMENT	438.3(c)	Payment	Requires contracts submitted to CMS to include capitated payment rates.	7.5.2016	
ENROLLEE RIGHTS	438.3(d)	Enrollment Discrimination Prohibited	Plans must accept enrollment in the order in which beneficiaries apply. Plans cannot deny enrollment on the basis of health status or need for health care services. Plans cannot discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. Nor can plans use any policy or practice that has the effect of discrimination on these bases.	7.5.2016	Comparable provision at previous § 438.6(d). Added sex, sexual orientation, gender identity, and disability as protected categories.
CONTRACT PROVISIONS, QUALITY	438.3(g)	Provider-Preventable Condition Requirements	Contracts with plans must comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. Plans must report all identified provider-preventable conditions in a form and frequency as specified by the State	7.5.2016	Comparable provision at previous § 438.6(f)(2)(i).
CONTRACT PROVISIONS, PROVIDERS	438.3(i)	Physician Incentive Plans	Contracts with MCOs, PIHPs, and PAHPs must provide for compliance with physician incentive standards adopted from Medicare Advantage regulations.	7.5.2016	Comparable provision at previous § 438.6(h).

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CONTRACT PROVISIONS, ENROLLEE RIGHTS	438.3(j)	Advance Directives	Contracts with plans must require plan to provide adult enrollees with written information about the plan's advance directive policy, and a description of the relevant state law.	7.5.2016	Comparable provision at previous § 438.6(i).
CONTRACT PROVISIONS	438.3(k)	Subcontracts	Under all subcontracts, the plan must remain accountable for any functions and responsibilities it has delegated to the subcontractor.	7.5.2016	Comparable provision at previous § 438.6(l).
CONTRACT PROVISIONS, ENROLLEE RIGHTS	438.3(l)	Choice of Network Provider	Contracts with plans must allow each enrollee to be able to choose his or her netowrk provider to the extent possible and appropriate.	7.5.2016	Almost identical language at previous § 438.6(m).
CONTRACT PROVISIONS, SERVICES	438.3(n)	Parity in Mental Health and Substance Use Disorder Benefits	Contracts with plans must require parity in mental health and substance use disorder benefits, in compliance with specified regulations.	7.5.2016	Parity regulations were finalized in March 2016. See 81 Fed. Reg. 18,390 (March 30, 2016).
CONTRACT PROVISIONS, SERVICES	438.3(o)	LTSS Contract Requirements	Contracts with plans must require that HCBS be provided in setings that are noninstitutional in compliance with the 2014 HCBS regulations.	7.5.2016	The HCBS settings regulations have their own phase-in period, ending in March 2019.
BASIS AND SCOPE	438.3(p)	County-Operated Health Insuring Organizations	County-operated Health Insuring Organizations generally are subject to these managed care regulations.	7.5.2016	Comparable provision at previous § 438.6(b)(4).

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PAYMENT	438.4(a)	Actuarial Soundness Definitions	Actuarially sound capitated rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the contract.	7.5.2016	Comparable provision at previous § 438.6(c). Modified the definition of capitation payment by removing references to "medical" services since states are contracting with plans for LTSS, which are not captured by the term "medical services."
PAYMENT	438.4(b)	Actuarial Soundness Standards	All rates must be reviewed and approved by CMS.	7.5.2016	Comparable provision at previous § 438.6(c)(i).
PAYMENT	438.4(b)(1)	Actuarial Soundness	Rates must be developed in accordance with § 438.5.	7.5.2016	Comparable provision at previous § 438.6(c)(1)(i)(A).
PAYMENT	438.4(b)(2)	Actuarial Soundness	Rates must be appropriate for the populations covered and the services to be rendered.	7.5.2016	Comparable provision at previous § 438.6(c)(1)(i)(B).
PAYMENT	438.4(b)(5)	Actuarial Soundness	Payments from any rate cell must not cross-subsidize or be cross-subsidized by any other rate cell.	7.5.2016	Comparable provision at previous § 438.6(c)(1)(i)(C).
PAYMENT	438.5(a)	Rate Development Standards; Definitions	Defines budget neutral, and prospective and retrospective risk adjustment.	7.5.2016	Added definitions for "budget neutral", "prospective risk adjustment", and "risk adjustment" as used in § 438.7(b).
PAYMENT	438.5(g)	Risk Adjustment	Risk adjustment methodologies must be developed in a budget neutral manner consistent with accepted actuarial principles.	7.5.2016	Comparable provision at previous § 438.6(c)(1)(iii).
CONTRACT PROVISIONS, PAYMENT	438.6(a)	Special Contract Provisions Related to Payment; Definitions	Defines base amount, incentive arrangement, pass-through payment, risk corridor, and withhold arrangement.	7.5.2016	Comparable provisions at previous §§ 483.6(c)(1)(iv), 438.6(c)(1)(v). Added definition for "withhold arrangement."
CONTRACT PROVISIONS, PAYMENT	438.6(b)(1)	Special Contract Provisions Related to Payment; Basic Requirements	The contract must include description of risk-sharing mechanisms like risk corridors, reinsurance, etc.	7.5.2016	Comparable provision at previous § 438.6(c)(2).

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CONTRACT PROVISIONS, PAYMENT	438.6(b)(2)	Special Contract Provisions Related to Payment; Incentive Arrangements	Contracts with incentive arrangements cannot provide payment in excess of 105% of approved capitated payments. Incentive payments must be for a fixed period of time, cannot be renewed automatically, must be made to both public and private contractors, and must be necessary for specified activities, targets, performance measures, or quality-based outcomes.	7.5.2016	Comparable provision at previous § 438.6(c)(5)(iii). Added slight modification to require incentive arrangements to be designed to support program initiatives tied to meaningful quality goals and performance measure outcomes.
PAYMENT	438.6(e)	Special Contract Provisions Related to Payment for enrollees in an institution for mental disease	The state must make a monthly capitation payment for an enrollee aged 21-64 receiving inpatient treatment at an institution for mental diseases.	7.5.2016	Redesignated from previous § 438.3(u) without change.
PAYMENT	438.7(a)	CMS review and approval of rate certification	CMS must review and approve of the rate certification.	7.5.2016	New provision requiring CMS approval of the rate certification in adition to approval of the contract as provided for in § 438.3(a).
PAYMENT	438.7(d)	Provision of additional information	The State must upon CMS request provide additional information	7.5.2016	New provision that requires states to include additional information in the rate certification if pertinent to CMS approval of the contract rates.

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ENROLLMENT AND DISENROLLMENT	438.56 (except 438.56(d)(2)(iv))	Disenrollment: Requirements and Limitations	Plans can request disenrollment in limited circumstances. If a state limits disenrollment, a beneficiary can request disenrollment for cause at any time and without cause during the 90 days following enrollment or when the beneficiary receives notice of enrollment, whichever is later. For cause enrollment includes moving out of the service area, moral or religious objections, provider network limitations, for enrollees that use MLTSS the enrollee would have to change their residential, institutional, or employment supports, and a number of other reasons.	7.5.2016	Retained majority of prior previous § 438.56 with four substantive changes: adds references to PCCM enitities; revises text to clarify start of 90-day period an enrollee can disenroll for cause; provides for states to accept either oral or written requests for disenrollment; and added disruption in LTSS as another cause for disenrollment (438.56(d)(2)(iv) effective rating period 7/1/2017).
PLAN FINANCES AND OPERATIONS	438.602 (i)	State Responsibilities	The State must ensure that any contracted plan is not located outside the United States.	7.5.2016	This provision implements 42 U.S.C. § 1396a(a)(80).
ENROLLEE RIGHTS	438.1	Enrollee Rights	The State must ensure ensure enrollee rights including the right to receive information, be treated with respect and with dignity, receive information on treatment options, refuse treatment, and be free from restraint or seclusion.	7.5.2016	Comparable provision at previous § 438.100.
BASIS AND SCOPE	438.1	Basis and Scope	Lists statutory authrority for Medicaid managed care regulations.	7.5.2016	Comparable provision at previous § 438.1.

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COMMUNICATIONS, PROVIDERS	438.102	Provider-Enrollee Communications	A plan may not prohibit or restrict a provider from advocating for an enrollee who is his or her patient, relatling to the enrollee's health status, medical care, or treatment options, the risks and benefits of treatment, or the right to refuse treatment.	7.5.2016	Comparable provision at previous § 438.102.
CONTRACT PROVISIONS, MARKETING	438.104	Marketing Activities	Contracts with plans must require that a plan obtain State approval before distributing marketing materials, and distribute materials to the plan's entire service area. The plan must comply with the information requirements of section 438.10, must not attempt to influence enrollment in conjunction with the sale of private insurance. The plan cannot directly or indirectly engage in door-to-door, telephone, e-mail, texting, or other cold-call activities. Materials cannot mislead, confuse, or defraud beneficiaries.	7.5.2016	Comparable provision at previous § 438.104.
ENROLLEE'S COST SHARING	438.106	Liability for Payment	Medicaid enrollees cannot be held liable for plan debt, or for any alleged shortfall in State payment to a plan, or in plan payment to a provider.	7.5.2016	Comparable provision at previous § 438.106.
ENROLLEE'S COST SHARING	438.108	Cost Sharing	Contracts with plans must ensure that beneficiary cost sharing is consistent with cost sharing rules applicable to fee-for-service Medicaid.	7.5.2016	Comparable provision at previous § 438.108.

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SERVICES	438.114	Emergency and Poststabilization Services	A plan is responsible for emergency services even if the provider was not contracted with the plan.	7.5.2016	Comparable provision at previous § 438.114.
PLAN FINANCES AND OPERATIONS	438.116	Solvency Standards	A plan must provide the State with adequate assurances that its protections against insolvency are adequate to ensure that enrollees will not be liable for the plan's debts, if the plan were to become insolvent.	7.5.2016	Comparable provision at previous § 438.116.
PROVIDERS	438.12	Provider Discrimination Prohibited	A plan cannot discriminate in the participation, reimbursement, or indemnification of any provider who is acting with the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. Plans must provide written notice of its reason for declining to allow a provider or group of providers in its provider network.	7.5.2016	Restated the current regulation text without change.
DEFINITIONS	438.2	Definitions	Includes first ever definition of Long-Term Services and Supports: LTSS includes services and supports that have the primary purpose of supporting the beneficiary's ability to live and work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.	7.5.2016	Significantly expanded from current § 438.2. This definition section includes the first federal definition of LTSS in Medicaid managed care. Check state-MCO contracts to make sure definition encompasses what is included in new federal definition.

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CONTRACT PROVISIONS, PROVIDERS	438.214	Provider Selection	Contracts with plans must provide that a plan have written policies and procedures for selection and retention of network providers. Each State must establish a uniform credentialing and recredentialing policy for acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate. Provider selection policies cannot discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.	7.5.2016	New regulation is an expanded version of previous § 438.214. Preamble discussion notes: "In a self-directed model, there may be individual credentialing based on beneficiary-defined parameters, along with certain state-wide criteria such as passing a criminal background and fraud check, and/or being of age to perform the work." 81 Fed. Reg. at 27,655.
ENROLLEE RIGHTS	438.224	Confidentiality	Contracts with plan must provide that plans keep enrollee information confidential, consistent with the privacy rules applicable to fee-for-service Medicaid, and with HIPAA privacy rules.	7.5.2016	Comparable provision at previous § 438.224.
APPEALS AND GRIEVANCES	438.228	Grievance and Appeal Systems	Contracts with plans must ensure that each plan has a grievance and appeal system in place.	7.5.2016	Comparable provision at previous § 438.228. The new standards for these grievance and appeal systems are set forth in §§ 438.400-438.424; these new standards will not become effective until the rating period for contracts starting on or after July 1, 2017.

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QUALITY	438.236	Practice Guidelines	Contracts with plans must require plans to adopt practice guidelines that are based on valid and reliable clinical evidence, consider the needs of enrollees, are adopted in consultation with contracting health care professions, and are reviewed and updated periodically. Upon request, guidelines must be provided to enrollees and potential enrollees.	7.5.2016	Comparable provision at previous § 438.236.
QUALITY	438.31	Basis, Scope, and Applicability of Provisions Relating to Quality Measurement and Improvement	This section explains the applicability of the subsequent regulations relating to quality monitoring.	7.5.2016	Comparable, but significantly more limited, provision at previous § 438.310.
QUALITY	438.32	Definitions	This section sets forth definition applicable to the subsequent regulations relating to quality monitoring.	7.5.2016	Comparable provision at previous § 438.320.
QUALITY	438.352	External Quality Review Protocols	CMS, in coordination with the National Governor's Association, must develop protocols for the external quality reviews required by the regulations. Each protocol must include the data to be gathered, the sources of data, the activities and steps to be followed in collecting data, and the proposed method for analyzing and interpreting the data.	7.5.2016	Comparable provision at previous § 438.352. Federal statute requires that CMS, "in coordination with the National Governors' Association, ... contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews." 42 U.S.C. § 1396n-2(c)(2)(A)(iii).

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STATE FINANCES AND OPERATIONS	438.37	Federal Financial Participation	FFP at 75% rate is available in expenditures for EQR set forth in 438.358 and 50% for EQR for activities conducted by any entity that is not an EQRO.	Effective Immediately	
ENROLLMENT AND DISENROLLMENT	438.5	State Plan Requirements	A state plan that requires Medicaid beneficiaries to enroll in a plan must comply with the provisions under this section except when the requirement is imposed pursuant to a demonstration project under a 1115(a) waiver or under a waiver granted under 1915(b). The plan must specify the types of entities with which it contracts, the payment it uses, and whether it contracts on risk. The State must involve the public in both design and implementation of its managed care program. The State cannot enroll individuals who are also eligible to Medicare, Indians as defined, children under age 19 who are eligible for SSI, etc.	7.5.2016	Almost identical language at previous § 438.50.
ENROLLMENT AND DISENROLLMENT	438.52	Choice of Plans	If Medicaid enrollment is mandatory, there must be a choice of two plans. A state may limit a rural area resident to a single plan in certain circumstances. A beneficiary may be limited to one PCCM entity choice, but still must be provided the choice of two PCCMs contracted with the PCCM entity.	7.5.2016	Modified provision to provide for different standards for choice of PCCM entities.

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ENROLLMENT AND DISENROLLMENT	438.54	Managed Care Enrollment	The state must have an enrollment system for its managed care programs. The enrollment systems can be voluntary or mandatory as appropriate. The enrollment system must provide potential enrollees the opportunity to make a choice. Beneficiaries must receive informational notices that clearly explain the choice, identify plans available, how to enroll, explain the 90-day without cause disenrollment period, comply with 438.10, and include contact information for the beneficiary support system. If a state elects passive enrollment, it must assign beneficiaries to preserve existing provider relationships.	7.5.2016	New provision. Added basic federal standards for enrollment. Provision permits flexibility for States in designing their enrillment processes.
STATE FINANCES AND OPERATIONS	438.58	Conflict of Interest Safeguards	The State must have safeguards against conflict of interest when contracting with plans.	7.5.2016	Restated the current regulation text without change.
PLAN FINANCES AND OPERATIONS	438.6	Basis and Applicability of Provisions Relating to Program Integrity	This section lists the statutory authority for the subsequent regulations pertaining to program integrity, and sets forth relevant effective dates for those regulations.	7.5.2016	Comparable, but significantly more limited, provision at previous § 438.600.
PAYMENT	438.6	Prohibition of Additional Payments for Services Covered Under Plan Contracts	The State must ensure that no payment is made to a network provider other than by a plan.	7.5.2016	Almost identical language at previous § 438.60.

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PLAN FINANCES AND OPERATIONS	438.61	Prohibited Affiliations	A plan cannot knowingly have a relationship with an individual or entity that has been debarred, suspended, or otherwise excluded.	7.5.2016	Comparable provision at previous § 438.610.
ENFORCEMENT AND MONITORING	438.7	Basis for Imposition of Sanctions	Each state that contracts with a plan must establish intermediate sanctions. State may sanction MCO for: failure to provide service, imposing charges in excell fo what Medicaid allows, discrimiantion based on health status or need for services, misrepresenting or making up information to CMS, state, enrollee or health care provider,	7.5.2016	Expansion of current § 438.700, based on 42 U.S.C. 1932(e)(1). Clarifies certain intermediate sanctions MUST be in place for a state to contract with an MCO and MAY be in place to contract with PCCMs and MAY include certain specified sanctions.
ENFORCEMENT AND MONITORING	438.702	Types of Intermediate Sanctions	Intermediate sanctions may include civil money penalties, appointment of temporary management, granting enrollees the right to terminate enrollment without cause, suspension of all new enrollment, suspension of payment.	7.5.2016	Update of current § 438.702. Clarifies that if a state determines that intermediate sanctions are warranted, it may select from these options or use other options currenlty detailed in contract.
ENFORCEMENT AND MONITORING	438.704	Amounts of Civil Money Penalties	The maximum civil money penalty the State may impose varies on the nature of the plan's failure to act.	7.5.2016	CMS has clarified that "each determination" in § 438.704 means each individual case that supports the state's finding of an MCO's failure to act under § 438.700(b) through (d)
ENFORCEMENT AND MONITORING	438.706	Special Rules for Temporary Management	Temporary management can only be assessed in certain circumstances.	7.5.2016	Comparable with current § 438.706, with an update to language to make it consistent with § 438.700.
ENFORCEMENT AND MONITORING	438.708	Termination of a Plan Contract	A State has authority to terminate a plan contract and enrollee that plan's enrollees in other plans or through other options.	7.5.2016	Comparable with current § 438.708.

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ENFORCEMENT AND MONITORING	438.71	Notice of Sanction and Pre-Termination Hearing	The State must give the plan timely written notice before imposing the sanction.	7.5.2016	Comparable with current § 438.710.
ENFORCEMENT AND MONITORING	438.722	Disenrollment During Termination Hearing Process	After a State informs a plan that intends to cancel a contract, the State may give the plan's enrollees written notice or allow enrollees to disenroll immediately without cause	7.5.2016	Comparable with current § 438.722.
ENFORCEMENT AND MONITORING	438.724	Notice to CMS	The State must give CMS written notice whenever it imposes or lifts a sanction.	7.5.2016	Update to current § 438.722 to delete "Regional Office" and make consistent with proposed changes in § 438.3(a) and 438.7(a)
ENFORCEMENT AND MONITORING	438.726	State Plan Requirement	The State plan must include a plan to monitor for violations.	7.5.2016	Comparable with current § 438.726.
ENFORCEMENT AND MONITORING	438.73	Sanction by CMS: Special Rules for MCOs	A State may recommend that CMS impose the denial of payment sanction.	7.5.2016	Comparable with current § 438.730 with a language update to replace Health Maintenance Organization (HMO) with Managed Care Organization (MCO).
PAYMENT	438.802	Federal Financial Participation; Basic Requirements	N/A	7.5.2016	Comparable to previous § 438.802.
PAYMENT	438.806	Prior Approval	Comprehensive risk contracts must meet certain requirements to get FFP.	7.5.2016	
PAYMENT	438.808	Exclusion of Entities	Certain entities can be excluded from FFP.	7.5.2016	
ENROLLMENT AND DISENROLLMENT, STATE FINANCES AND OPERATIONS	438.81	Expenditures for Enrollment Broker Services	State expenditures for the use of enrollment brokers are considered necessary for the proper and efficient operation of the State plan and thus eligible for FFP when the broker meets certain requirements.	7.5.2016	Update to current § 438.810. Moves definitnion of choice counseling to 438.2. Adds electronic methods of communications as a way that enrollment activities can be communicated.

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STATE FINANCES AND OPERATIONS	438.812	Costs Under Risk and Nonrisk Contracts	Under a risk contract, the total amount a State Agency pays for carrying out the contract provisions is a medical assistance cost. For nonrisk contracts, the amount the State agency pays for furnishing medical services to beneficiaries is a medical assistance cost; and the amount the State pays for the contractor's performance of other functions is administrative.	7.5.2016	Comparable to current § 438.812.
STATE FINANCES AND OPERATIONS	438.816	Expenditures for the Beneficiary Support System for Enrollees using LTSS	State expenditures for providing LTSS are eligible for FFP when certain conditions are met.	7.5.2016	New section. Look to 438.2 for full explanation of the Beneficiary Support System. This provision requires that states developing BSS ensure the BSS meet certain requirements to be eligible for the FFP match: 1) costs do not duplicate payment for activities that are offered, 2) Persons providing choice counseling services meet conflict of interest requirements.
COMMUNICATIONS	440.262	Access and Cultural Considerations	State must have methods to promote access and delivery of services in a culturally competent manner	7.5.2016	Comparable and expanded version of current § 438.262. CMS encourages stakeholders to work with state in developing these methods to promote access and delivery of services in a culturally competent manner to all beneficiaries across both Medicaid managed care and FFS.