
REGULATORY REQUIREMENTS THROUGH POLICIES, STANDARDS & MANUALS

(These provisions must be included in provider procedures, standards or manuals, etc.)

Provide Title of Manual:				
CMS REGULATION - 42 CFR 422	**Section/Page#**	**Section/Page#**	**Section/Page#**	**SectionPage#**
Permanent "out of area members to receive benefits in continuation area 422.54(b)				
Prohibition against discrimination based on health status 422.110(a)				
Pay for emergency and urgently needed care consistent with provisions 422.112(a)(9); 422.100(b)				
Pay for renal dialysis for those temporarily out of service area 422.100(b)(1)(iv)				
Direct access to mammography screening and influenza vaccinations 422.100(g)(1)				
No copay for influenza and pneumoccocal vaccines 422.100(g)(2)				
Agreements with providers to demonstrate "adequate" access. Network must be sufficient to provide access to covered services 422.112(a)(1)				
Direct access to in-network women's health specialist for routine and preventive services 422.112(a)(3)				
Services available 24 hrs/day, 7 days/week 422.112(a)(7)				
Suspension or termination of plan-contracted providers 422.204				
Safeguard privacy and maintain records accurately and timely 422.118				
Adhere to CMS marketing provisions 422.80(a), (b), (c)				
Ensure services are provided in culturally competent manner				

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422.112(a)(8)				
Conduct a health assessment of all new enrollees within 90 days of the effective date of enrollment 422.112(b)(4)				
Document in a prominent place in medial record if individual has executed Advance directive 422.128(b)(1)(ii)(E)				
Provide covered benefits in a manner consistent with professionally-recognized standards of health care 422.504(a)(3)(iii)				
Payment and incentive arrangements specified between MAO, providers, first tier, & downstream entities be specified in all contract(s) 422.504				
Subject to laws applicable to federal funds 422.504(h)				
Disclose to CMS all information necessary to (1) administer & evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services 422.64: 422.504(a)(4): 422.504(f)(2)				
Must make good faith effort to notify all affected members of the termination of a provider contract within 30 days of notice of termination by plan or provider 422.111(e)				
Submission medical records and certify completeness and truthfulness 422.504(a)(8); 422.504(d)-(e); 422.504(i)(3)-(4);422.504 (l)(3)				
Comply with medical policy, QM and MM. MAO must develop such standards in consultation with contracting providers 422.202(b); 422.504(a)(5)				
Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for benes enrolled in the plan for the previous two years 422.504(f)(2)(iv)(A)				
Disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction 422.504(f)(2)(iv)(B)				

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Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes 422.504(f)(2)(iv)(C)				
Notify provider in writing of reason for denial, suspension & termination 422.204(c)(1)				
Provide 60 days notice (terminating contract without cause) 422.204(c)(4)				
Comply with Civil Rights Act, ADA, Age Discrimination Act, federal funds laws 422.504(h)(1)				
Prohibits MAO, first tier & downstream entities from employing or contracting with individuals excluded from participation in Medicare under section 1128 or 1128A of the SSA 422.752(a)(8)				
Adhere to appeals/grievance procedures 422.562(a)				