

under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under section 438.730(e).

§ 438.730 Sanction by CMS: Special rules for MCOs

(a) *Basis for sanction.* (1) A State agency may recommend that CMS impose the denial of payment sanction specified in paragraph (e) of this section on an MCO with a contract under this part if the agency determines that the MCO acts or fails to act as specified in § 438.700(b)(1) through (b)(6).

(b) *Effect of an Agency Determination.* (1) The State agency's determination becomes CMS's determination for purposes of section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days.

(2) When the agency decides to recommend imposing the sanction described in paragraph (e) of this section, this recommendation becomes CMS's decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days.

(c) *Notice of sanction.* If the State agency's determination becomes CMS's determination under section (b)(2), the State agency takes the following actions:

(1) Gives the MCO written notice of the nature and basis of the proposed sanction;

(2) Allows the MCO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction;

(3) May extend the initial 15-day period for an additional 15 days if—

(i) the MCO submits a written request that includes a credible explanation of why it needs additional time;

(ii) the request is received by CMS before the end of the initial period; and

(iii) CMS has not determined that the MCO's conduct poses a threat to an enrollee's health or safety.

(d) *Informal reconsideration.* (1) If the MCO submits a timely response to the notice of sanction, the State agency—

(i) Conducts an informal reconsideration that includes review of the evidence by a State agency official who

did not participate in the original recommendation;

(ii) Gives the MCO a concise written decision setting forth the factual and legal basis for the decision; and

(iii) Forwards the decision to CMS.

(2) The agency decision under paragraph (d)(1)(ii) of this section becomes CMS's decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS.

(3) If CMS reverses or modifies the State agency decision, the agency sends the MCO a copy of CMS's decision.

(e) *Denial of payment.* (1) CMS, based upon the recommendation of the agency, may deny payment to the State for new enrollees of the HMO under section 1903(m)(5)(B)(ii) of the Act in the following situations:

(i) If a CMS determination that an MCO has acted or failed to act, as described in paragraphs (b)(1) through (b)(6) of § 438.700, is affirmed on review under paragraph (d) of this section.

(ii) If the CMS determination is not timely contested by the MCO under paragraph (c) of this section.

(2) Under § 438.726(b), CMS's denial of payment for new enrollees automatically results in a denial of agency payments to the HMO for the same enrollees. (A new enrollee is an enrollee that applies for enrollment after the effective date in paragraph (f)(1) of this section.)

(f) *Effective date of sanction.* (1) If the MCO does not seek reconsideration, a sanction is effective 15 days after the date the MCO is notified under paragraph (b) of this section of the decision to impose the sanction.

(2) If the MCO seeks reconsideration, the following rules apply:

(i) Except as specified in paragraph (d)(2)(ii) of this section, the sanction is effective on the date specified in CMS's reconsideration notice.

(ii) If CMS, in consultation with the State agency, determines that the MCO's conduct poses a serious threat to an enrollee's health or safety, the sanction may be made effective earlier than the date of the agency's reconsideration decision under paragraph (c)(1)(ii) of this section.

(g) *CMS's role.* (1) CMS retains the right to independently perform the

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functions assigned to the State agency under paragraphs (a) through (d) of this section.

(2) At the same time that the agency sends notice to the MCO under paragraph (c)(1)(i) of this section, CMS forwards a copy of the notice to the OIG.

(3) CMS conveys the determination described in paragraph (b) of this section to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and part 1003 of this title. In accordance with the provisions of part 1003, the OIG may impose civil money penalties on the MCO in addition to, or in place of, the sanctions that may be imposed under this section.

Subpart J—Conditions for Federal Financial Participation

§ 438.802 Basic requirements.

FFP is available in expenditures for payments under an MCO contract only for the periods during which the contract—

- (a) Meets the requirements of this part; and
- (b) Is in effect.

§ 438.806 Prior approval.

(a) *Comprehensive risk contracts.* FFP is available under a comprehensive risk contract only if—

(1) The Regional Office has confirmed that the contractor meets the definition of an MCO or is one of the entities described in paragraphs (b)(2) through (b)(5) of § 438.6; and

(2) The contract meets all the requirements of section 1903(m)(2)(A) of the Act, the applicable requirements of section 1932 of the Act, and the implementing regulations in this part.

(b) *MCO contracts.* Prior approval by CMS is a condition for FFP under any MCO contract that extends for less than one full year or that has a value equal to, or greater than, the following threshold amounts:

(1) For 1998, the threshold is \$1,000,000.

(2) For subsequent years, the amount is increased by the percentage increase in the consumer price index for all urban consumers.

(c) FFP is not available in an MCO contract that does not have prior ap-

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proval from CMS under paragraph (b) of this section.

§ 438.808 Exclusion of entities.

(a) *General rule.* FFP is available in payments under MCO contracts only if the State excludes from the contracts any entities described in paragraph (b) of this section.

(b) *Entities that must be excluded.* (1) An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

(2) An entity that has a substantial contractual relationship as defined in § 431.55(h)(3) of this chapter, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act.

(3) An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

(i) Any individual or entity excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

(ii) Any entity that would provide those services through an excluded individual or entity.

§ 438.810 Expenditures for enrollment broker services.

(a) *Terminology.* As used in this section—

Choice counseling means activities such as answering questions and providing information (in an unbiased manner) on available MCO, PIHP, PAHP, or PCCM delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider;

Enrollment activities means activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone or in person;

Enrollment broker means an individual or entity that performs choice counseling or enrollment activities, or both, and;

Enrollment services means choice counseling, or enrollment activities, or both.