



# Quality Improvement Cost Guidance

## Introduction

Per their contracts with the Health and Human Services Commission (HHSC), managed care plans are required to provide certain services, both medical and non-medical, and conduct certain activities for quality improvement (QI). For activities that are not covered medical or dental services, the Code of Federal Regulations ([42 CFR § 438.8\(e\)\(3\)](#)) allows certain expenses for activities that are designed to improve health care quality to be included in the numerator of the medical loss ratio for managed care plans in Medicaid.<sup>1</sup> For expenditures on activities that improve health care quality to be included in the numerator of the medical loss ratio, they must fall into one of the following categories:

- 1) An activity to improve quality that meets the requirements in [45 CFR § 158.150\(b\)](#) and is not excluded under 45 CFR 158.150(c);
- 2) An activity related to Medicaid managed care External Quality Review (EQR) activities described in [42 CFR § 438.358\(b\) and \(c\)](#); or
- 3) An expenditure related to Health Information Technology (HIT) and meaningful use, meeting the requirements in [45 CFR § 158.151](#), and not considered incurred claims under [42 CFR § 438.8\(e\)\(2\)](#).

Activities that improve health care quality must meet all the following criteria:<sup>2</sup>

- Be designed to improve health quality;
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
- Be directed toward either individuals or segments of enrollee populations, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and
- Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by accreditation bodies, recognized professional

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<sup>1</sup> See 42 CFR §457.1203 for application of §438.8 to CHIP.

<sup>2</sup> Per [45 CFR § 158.150](#)

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medical associations, government agencies, or other national health care quality organizations.

## HHSC Guidance

In Texas, Medicaid and the Children’s Health Insurance Program (CHIP), costs which managed care plans are allowed to report on their Financial Statistical Reports (FSRs) are addressed in the Uniform Managed Care Contract (UMCC), CHIP, STAR, STAR Kids, STAR+PLUS, STAR Health and Dental contracts, and the Uniform Managed Care Manual (UMCM), specifically the FSR Instructions and Chapter 6.1, Cost Principles for Expenses. QI costs are reported on the Combined Admin and QI FSR Template<sup>3</sup> using the instructions for the template (UMCM, Ch. 5.3.1.84). Managed care plans must be able to document specific and measurable activities that support their QI costs.

With some exclusions<sup>4</sup>, expenses to implement, promote, and increase wellness and health are allowable as QI expenses on the FSRs, per [45 CFR § 158.150-151](#). Additionally, covered Medicaid medical services should be claimed under medical spending, not QI. Expenses for Value-Added Services (VAS), case-by-case services, or other benefits managed care plans agree to provide in their contracts should also not be claimed as QI.

Managed care plans that report activities as QI costs must maintain documentation that supports:

- How the activity meets the criteria for QI;
- The member characteristics or population needs targeted;
- How the activity is designed to improve health outcomes; and
- How the activity conforms to specific evidence-based approaches or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

Suggestions for documentation of the evidence base supporting the activity include:

- The results of evidence-based literature reviews;

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<sup>3</sup> UMCM, Ch. 5.3.1.83 – Combined Admin and QI FSR Template for transactions occurring on or after 9/1/18, QI – Parts 1 through 4

<sup>4</sup> The exclusions are listed at [45 CFR § 158.150\(c\)](#).

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- Leveraging research repositories such as the [Evidence & Resource Library](#) at the Social Interventions Research & Evaluation Network at the University of California, San Francisco;
  - Evidence-based intervention criteria and research published by federal agencies such as the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality; and
  - Any future guidance or research issued by HHSC.

Managed care plans are responsible for meeting all relevant federal requirements and must be able to support or justify QI costs in response to any audit. Please refer to [45 CFR § 158.150-151](#) for the federal requirements, and the UMCC and the UMCM, CHIP, STAR, STAR Kids, STAR+PLUS, STAR Health and Dental contracts, and this document for clarification or answers to specific questions.

See Frequently Asked Questions, below, for additional guidance and examples of activities that may qualify as QI costs.

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# Frequently Asked Questions

## Frequently Asked Questions Index:

1. Can HHSC provide QI-specific “Cost Principles” similar to the current UMCM Chapter 6.1, Cost Principles for Expenses?
2. Are VAS such as member wellness events/health fairs, smoking cessation programs, obesity prevention, pest control, blood pressure kits, home exercise kits, incentives for preventative-related medical services such as flu shots, etc. allowable on the FSRs as QI expenses?
3. Are activities addressing social determinants of health (SDOH) allowable QI costs?
4. What considerations should be reviewed when determining if case management, care coordination, chronic disease management, and medication and care compliance initiatives should be included as medical or QI costs?
5. What general considerations should be reviewed to determine if payments related to HIT should count as a QI cost?
6. What general considerations should be reviewed to determine if payments/expenses for Health Information Exchange (HIE) should be reported as a QI cost?
7. Under what conditions would it be inappropriate to report HIT and HIE costs as a QI cost?
8. What considerations should be reviewed to determine if expenses for deploying technology, such as smartphones and other equipment or services, to Medicaid enrollees or providers to facilitate tele-healthcare can be reported as a QI cost?
9. Should expenses related to non-electronic reporting for a QI purpose, such as reducing medical errors and potentially preventable events be reported as a QI cost?
10. Should expenses related to value-based contracting be reported as a QI cost?

See the following pages for answers to these questions.

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## **1) Can HHSC provide QI-specific “Cost Principles” similar to the current UMCM Chapter 6.1, Cost Principles for Expenses?**

UMCM Chapter 6.1, Cost Principles for Expenses was revised November 1, 2016, to add Section VIII - Quality Improvement Costs. Please continue to use Chapter 6.1 for all cost principles. The managed care plans may include activities that improve health care quality as specified in federal code, the UMCC and the UMCM, CHIP, STAR, STAR Kids, STAR+PLUS, STAR Health and Dental contracts and this document and may also include in QI cost reporting expenditures related to HIT that are necessary to accomplish those QI activities. Please review [45 CFR §158.151 for the federal regulations relating to including HIT costs in QI reporting.](#)

To classify costs related to QI activities as QI costs, the managed care plan must ensure that they were not provided under one of the approved HHSC templates for VAS, Medicare-Medicaid Plan (MMP) Rewards & Incentives, or MMP Flexible Benefits. In addition to documenting internal approval of costs, managed care plans bear the responsibility to objectively measure and document the results of QI activities as support for QI expenses. This documentation may be expected upon audit. A managed care plan’s costs to administer VAS, MMP Rewards & Incentives, Case-by-Case Services, and MMP Flexible Benefits are allowed as QI expenses, but not the VAS, MMP Rewards, Case-by-Case Services, or MMP Flexible Benefits themselves. See **Appendix A** for a table that distinguishes these various expenditure types.

## **2) Are VAS such as member wellness events/health fairs, smoking cessation programs, obesity prevention, pest control, blood pressure kits, home exercise kits, incentives for preventative-related medical services such as flu shots, etc. allowable on the FSRs as QI expenses?**

If the managed care plan has an approved VAS template, expenses for those VAS may not be included as a QI Expense on the FSRs. However, if an approved VAS was designed primarily to improve health quality as supported by the appropriate evidence, the administration of the VAS could be claimed as a QI cost. Allowable administration of the VAS would be direct and indirect costs of QI programs maintained by the managed care plan.

For example, the cost of outreach, distribution, and monitoring the impact of pest control services or blood pressure kits that are provided under an approved VAS

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template may be claimed as a QI cost, while the cost of the VAS pest control service or blood pressure kit itself may not.

“Value-added Services” is a defined term under HHSC’s CHIP, UMCC, STAR, STAR Kids, STAR+PLUS, STAR Health, and Dental contracts. VAS may be additional health care benefits or positive incentives that HHSC agrees will promote healthy lifestyles and improve health outcomes among Members. UMCM Chapter 4.7, Value-added Services Template Instructions, Appendix A includes a non-exhaustive list of general categories and examples of VAS. “Flexible Benefits” is a defined term under the MMP contract<sup>5</sup>. Flexible Benefits may be additional services for coverage beyond covered services, which may be actual health care services or benefits that HHSC and CMS determine will promote healthy lifestyles and improve health outcomes among enrollees.

VAS and Flexible Benefits are not included in the rate-setting process nor the capitation rates. Managed care plans do not receive compensation for VAS or Flexible Benefits and may not report the costs as Allowable Medical, QI, or Administrative Expenses on the FSRs.

### **3) Are activities addressing social determinants of health allowable QI costs?**

Activities addressing social determinants of health (SDOH) (further referenced in this guidance as “SDOH activities”) that meet the requirements of 45 CFR 158.150(b) and are not excluded under 45 CFR § 158.150(c) may qualify as QI costs.

The SDOH activity must be allowed by the managed care plan contract and meet the federal criteria listed on page 1 of this document. In addition, the SDOH activities must be primarily designed to meet at least one of the following federal criteria<sup>6</sup>:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
- Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;
- Improve patient safety, reduce medical errors, and lower infection and mortality rates; or

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<sup>5</sup> [MMP Contract](#), Sec. 1.72, Flexible Benefits

<sup>6</sup> [45 CFR § 158.150-151](#)

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- Implement, promote and increase wellness and health activities.

### **Examples**

Examples of activities to address SDOH that could meet the above criteria and requirements include:

- Screening clients for needs related to SDOH
- Connecting patients with community resources (including obtaining authorization for coverage of services if applicable and helping to set up an appointment to receive the services); may include Service Coordination and Service Management costs if they are not allocated as medical spending
- Following up on the results of any additional services provided through referrals or by the managed care plan and communicating those results to a patient's medical provider
- Services to connect target populations to community services and provide patient education, including when those services are provided by a promotora or community health worker
- Supporting transitions to housing after homelessness or inpatient discharge

## **4) What considerations should be reviewed when determining if case management, care coordination, chronic disease management, and medication and care compliance initiatives should be included as medical or QI costs?**

If services and activities can be allocated to medical spending, they should be reported as such and not as QI costs. Per 45 CFR § 158.150(c)(4), those activities that are covered and can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services cannot be claimed as QI costs. Therefore, services such as mental health targeted case management that are Medicaid billable by eligible providers would be included in medical spending. In addition, services that otherwise meet criteria for inclusion on the medical spending portion of the managed care plan's associated FSR would be included in medical spending.

Case management, care coordination, chronic disease management, and medication and care compliance initiatives are provided<sup>7</sup> by the federal regulation as activities that can qualify as QI costs if they are primarily designed to improve health outcomes or reduce health disparities among specified populations and meet the additional requirements referenced in the introduction of this document. This

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<sup>7</sup> 45 CFR § 158.150(b)(2)(i)(A)(1)

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may include service coordination and service management costs if they are not allocated as medical spending. The QI regulation further makes explicit that these activities that qualify as QI costs could either be conducted directly by the managed care plan, or they could be delegated by contract as long as the managed care plan ultimately retains responsibility for the activity and incurs the expense.<sup>8</sup>

### **Examples**

Examples of case management, care coordination, chronic disease management, and medication and care compliance activities that could meet these criteria if delivered in a way that aligns with these requirements include:

- Care coordination activities provided by staff at a member's patient-centered medical home if the services conform to an evidence-based model of care.
- Providers performing the data monitoring, reporting, and process improvement work involved in initiatives such as the [Texas Alliance for Innovation on Maternal Health](#).
- Staff training for case management, care coordination, chronic disease management, and medication and care compliance or other QI programs.<sup>9</sup>
- Medication therapy management by a pharmacist.
- Diabetes outpatient self-management training services.
- Education and training for patient self-management for individuals and small groups.
- Chronic care management services.
- Medical team coordination with interdisciplinary teams of health care professionals.

Expenses for the examples above are reported on the Admin/QI FSR, QI – Part 2, including routine service coordination and service management activities required by the contract. Per the exclusion in 45 CFR §158.150(c)(1), if the services are designed primarily to control or contain costs, they may not be included as QI costs.

## **5) What should be reviewed to determine if payments related to HIT should count as a QI cost?**

Requirements for QI expenditures related to HIT and meaningful use are described by 45 CFR §158.151.

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<sup>8</sup> 45 CFR § 158.150(b)(2)(i)(A)

<sup>9</sup> Service Coordination costs that can be allocated as medical spending should not be counted as QI costs.



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According to the regulation, HIT-related activities that may be reported as expenses under QI costs improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible by doing one or more of the following:

1. Making incentive payments to health care providers for the adoption of certified electronic health record (EHR) technologies and their “meaningful use”, as defined by the United States Health and Human Services, to the extent such payments are not included in the reimbursement for clinical services;
2. Implementing systems to track and verify the adoption and meaningful use of certified EHR technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified EHR technologies;
4. Monitoring, measuring, or reporting clinical effectiveness, including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as the National Committee for Quality Assurance or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, Consumer Assessment of Healthcare Providers and Systems surveys or chart review of Healthcare Effectiveness Data and Information Set measures and costs for public reporting mandated or encouraged by law);
5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
6. Advancing HIE and interoperability, including the ability of enrollees, providers, issuers, or other systems to communicate patient-centered information to determine patient status, avoid harmful drug interactions, or direct appropriate care.
7. Reformatting, transmitting, or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or
8. Provisioning EHRs, patient portals, and tools to facilitate patient self-management.

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## 6) What general considerations should be reviewed to determine if payments/expenses for HIE should be reported as a QI cost?

HIE allows for the secure and timely exchange of protected health information between providers, caregivers, health insurers, and other organizations that have an interest in a patient's care. Managed care plans may engage in HIE activities with all these entities.

Available evidence indicates that the completeness of a patient's record and availability of up-to-date information at the point of care have a significant impact on patient outcomes. Thus, federal policy has been supportive of efforts by health plans to promote HIE for purposes of improving healthcare quality and outcomes through case management, care coordination, chronic disease management, medication and care compliance, and related activities. Specifically, [45 CFR §158.151](#) states that expenses for HIT, including HIE, needed to accomplish the purposes of [45 CFR §158.150](#), typically should be reported as a QI cost (see question above).

Most recently, the federal government is moving to require payer-to-payer data exchange, subject to the approval of a current or former plan enrollee, using a US Core Data for Interoperability defined data set. According to federal guidance, expenses for data exchanges, such as this, for purposes of care coordination and improved patient care, should qualify as a QI cost.

## 7) Under what conditions would it be inappropriate to report HIT and HIE costs as a QI cost?

Under federal regulations, HIT activities that do not have a primary purpose of improving care or health quality outcomes cannot be counted as a QI cost.

Examples of HIT and HIE that **should not** be reported as QI costs:

- Implementation of HIT designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims;
- Implementations of HIT or HIE with a primary goal of controlling costs or streamlining business processes;
- HIT/HIE activities, even when implemented for the purpose of improving quality, when the expenditures are paid for by a grant or other funding separate from managed care plan premium revenue or when the

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services/expenditures could be reimbursed as part of a clinical service or meet the definition for a value-added, case-by-case, or in-lieu-of service.

## **8) What considerations should be reviewed to determine if expenses for deploying technology, such as smartphones and other equipment or services, to Medicaid enrollees or providers to facilitate tele-healthcare can be reported as a QI cost?**

The COVID-19 public health emergency has highlighted the capabilities of telehealth and telemedicine to support many core healthcare functions and promote improved healthcare outcomes. However, in some cases, Medicaid enrollees and providers may lack the technical infrastructure needed to participate in teleservices.

Managed care plans may count as a QI cost the provision of “technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible...” (per [45 CFR §158.151\(a\)](#)). An example cited as a legitimate QI cost is an intervention involving direct interaction between health plans, providers, and enrollees through “face-to-face, telephonic, web-based interactions or other means of communication” when these activities are structured as part of a documented program to improve quality and outcomes or reduce disparities (per [45 CFR § 158.150\(b\)\(2\)\(A\)](#)).

Technology used for service coordination can be a QI cost when these activities are structured as part of a documented program to improve quality and outcomes or reduce disparities. Service coordination costs that can be allocated as medical spending should not be counted as QI costs.

## **9) Should expenses related to non-electronic reporting for a QI purpose, such as reducing medical errors and potentially preventable events be reported as a QI cost?**

Yes. Generally, [45 CFR §158.150](#) lays out requirements for QI activities that are independent of the reporting formats. The use of non-electronic formats is explicitly recognized for quality reporting and documentation related to activities that prevent hospital readmissions, reduce medical errors, improve patient safety, and support wellness and health promotion.

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## **10) Should expenses related to value-based contracting be reported as a QI cost?**

Costs for performance and outcome measurement, reporting, analytics, evaluation, and value-based payment program design qualify as QI activities if they are primarily intended to improve health care quality rather than control costs and meet the other criteria referenced in the introduction of this document.

Payments made to providers for covered medical services would be classified as medical expenses, not as QI costs, even when they are provided through a value-based contract or payment model.

## Appendix A: Reporting Activities that Improve Health Care Quality

	All Managed Care Programs	CHIP, STAR, STAR+PLUS, STAR Kids, STAR Health and Dental (Non-MMP)			Medicare-Medicaid Plan (MMP) Dual Demonstration	
Applicable Term	QI Costs	"In Lieu of" Services	Case-by-case Services	VAS	Rewards and Incentives	Flexible Benefits
Purpose	Report activities that improve health care quality and the likelihood of desired outcomes through evidence-based medicine, best clinical practice, or criteria issued by certain recognized entities, and associated health IT costs.	Report cost-effective services not covered in the Medicaid State Plan but offered in lieu of a covered service or setting. These must be approved by HHSC and included in the managed care plan contract.	Report benefits outside the scope of covered services that are provided and do not require HHSC approval. Managed care plans may choose to offer case-by-case services in appropriate situations to any of their members but are not required to do so.	Report services, benefits, or positive incentives that promote healthy lifestyles and improve health outcomes among Enrollees; attract or keep Enrollees; save other health-related expenses; or other purposes as may be determined by the managed care plan. These must be approved by HHSC and included in managed care plan contract.		
MAY include	Managed care plans may claim QI costs that meet federal requirements in the Code of Federal Regulations and this state guidance.	Inpatient mental health care provided at an institution for mental disease (IMD)) <sup>10</sup> in lieu of acute care hospitals, and certain services in chemical dependency treatment facilities for substance use disorder treatment <sup>11</sup> in lieu of acute care hospitals.	Services provided may be based on Medical Necessity, or for STAR+PLUS, STAR Kids, and STAR Health members, Functional Necessity; cost-effectiveness; wishes of Member or Legally Authorized Representative; or potential for improved health of Member.	Examples: 24-Hour Nurse Line; Alzheimer's Care; Behavioral Health Services; Disease Management; Over-the-counter Benefits; Emergency Response Services; Non-emergency transportation assistance; Extra Dental Services; Extra Foot Doctor (Podiatry) Services; Extra home health services; Extra Vision Services; Weight loss Programs; Smoking cessation; Healthy Play and Exercise Programs; Home Visits; Pest Control; Short-term Phone Help; Dental care kit; Gift Programs, Extra Help for Pregnant Women; Sports and School Physicals; other programs approved by HHSC and the Centers for Medicare and Medicaid Services (CMS).		

<sup>10</sup> For members enrolled in STAR Health

<sup>11</sup> For members enrolled in STAR or STAR+PLUS

## Appendix A: Reporting Activities that Improve Health Care Quality

	All Managed Care Programs	CHIP, STAR, STAR+PLUS, STAR Kids, STAR Health and Dental (Non-MMP)			Medicare-Medicaid Plan (MMP) Dual Demonstration	
		Services that are not specified under contract as "In-lieu-of" services	Covered Services, or VAS	Best practice approaches to delivering Covered Services	Covered Services, or Co-Pays	Covered Services, or Rewards & Incentives
<b>May NOT include</b>	Covered Services, VAS, MMP Rewards & Incentives; MMP Flexible Benefits; "In-lieu-of" Services; Case by Case Services					
<b>Counted in numerator of the MLR?</b>	Yes	Yes	Yes	Yes	Yes	Yes
<b>May be considered in capitation rate development?</b>	Yes	Yes <sup>12</sup>	No	No	No	No

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<sup>12</sup> By regulation, cost for managed care members ages 21 through 64 who have an IMD stay in excess of 15 days during a month may not be used in the rate development.

## Appendix A: Reporting Activities that Improve Health Care Quality

	All Managed Care Programs	CHIP, STAR, STAR+PLUS, STAR Kids, STAR Health and Dental (Non-MMP)			Medicare-Medicaid Plan (MMP) Dual Demonstration	
<b>CFR Reference</b>	Activities that Improve Health Care Quality within 45 C.F.R. §158.150; activity related to Medicaid managed care External Quality Review described in 42 CFR §438.358; expenditure related to Health IT and meaningful use within 45 CFR §158.151	42 C.F.R. §438.3(e)(2)	May fall under Activities that Improve Health Care Quality within 45 C.F.R. §158.150	Some VAS can fall under Activities that Improve Health Care Quality within 45 C.F.R. §158.150	Rewards and incentives defined at 42 C.F.R. §422.134	May fall under Activities that Improve Health Care Quality within 45 C.F.R. §158.150
<b>Other Contract References</b>	UMCM, Ch. 6.1 Cost Principles for Expenses	UMCC 8.1.15.7.1 Psychiatric Services, UMCC Attachments B-2, and B-2.2; STAR+PLUS Expansion, STAR+PLUS MRSA, and STAR Health Contracts, Attachment B-2, 8.1.15.7.1, "Psychiatric Services"; STAR Kids Contract, Attachment B-2; Section 1115 demonstration waiver, "Texas Healthcare Transformation and Quality Improvement Program"	UMCC, STAR+PLUS Expansion, STAR+PLUS MRSA, and STAR Health Contracts, Sec. 8.1.2.2 Case-by-Case Services; STAR Kids Contract, §8.1.2.4, "Case-by-Case Services"	UMCC version 2.30 Definitions; STAR+PLUS Expansion; STAR+PLUS MRSA, and STAR Health Contracts, Attachment A, §8.1.2.1, "Value-added Services"; STAR Kids Contract, Attachment A, §8.1.2.3, "Value-added Services"	MMP Contract, Sec. 1.142, Rewards, and Incentives	MMP Contract, Sec. 1.72, Flexible Benefits

## Appendix A: Reporting Activities that Improve Health Care Quality

	All Managed Care Programs	CHIP, STAR, STAR+PLUS, STAR Kids, STAR Health and Dental (Non-MMP)			Medicare-Medicaid Plan (MMP) Dual Demonstration	
<b>Reporting on the FSR</b>	<p>Expenses should be reported on the QI Parts of the Combined Admin and QI FSR Template (UMCM, 5.1.3.83)</p> <p>Per UMCM, Ch. 6.1 Cost Principles for Expenses, Quality Improvement Cost has the meaning as described in 45 C.F.R. §§158.150 and 151.</p>	<p>Expenses are reported on the STAR, STAR+PLUS, or STAR Health FSR Template, in Parts 4 and 5, Medical Expenses.</p> <p>“In-lieu-of” Services are Allowable Costs on the FSRs in the same way as Covered Services.</p>	<p>Expense should be reported in the designated informational line on Part 5 of the appropriate Program FSR.</p> <p>Case-by-case Services are non-allowable costs under HHSC’s contracts. Related expenses should not be included in the calculation of FSR net income.</p>	<p>VAS-related costs must be reported in the informational lines of Admin/QI FSR Part 1, or Part 5 of the Program FSR, as appropriate.</p> <p>Any services or benefits that are approved as Value-added Services (VAS) are deemed to be non-allowable costs under HHSC’s contracts.</p>	<p>Related costs must be reported in the MMP FSR Template, Part 5, Line 79 only.</p> <p>Any services or benefits approved as Rewards and Incentives are deemed non-allowable costs under the three-way contract with CMS.</p>	<p>Related costs should be reported on the MMP FSR Template, Part 5, in the lines provided for approved flexible benefits.</p> <p>Any services or benefits that are approved as Flexible Benefits are deemed to be Allowable Costs on the FSRs.</p>
<b>Documentation standard</b>	<p>Managed care plans must maintain appropriate audit-level support<sup>13</sup> for expenses submitted on UMCM, 5.3.1.83</p>	<p>Requires the same documentation as Covered Services</p>	<p>Managed care plans must maintain appropriate audit-level support for each approved expense for each Member.</p>	<p>Approved VAS Template, UMCM Chapter 4.4 or 4.5</p>	<p>Approved MMP Rewards and Incentives Template, UMCM Chapter 4.10</p>	<p>Approved MMP Flexible Benefits Template, UMCM Chapter 4.8</p>

<sup>13</sup> Please see UMCC Section 9.01, Record retention and audit. Also, UMCC, Attachment B-1, Section 8.1.18.3 System-wide Functions –“all managed care plans must ensure that financial transactions are auditable according to GAAP guidelines”