STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Tennessee

DEFINITION OF AN HMO THAT IS NOT FEDERALLY QUALIFIED

The State definition of HMO complies with Subpart C, 42 CFR 434.20(c) as follows:

The HMO must be organized primarily for the purpose of providing comprehensive health care services and insure that the services provided to its Medicaid enrollees are as accessible to them in terms of timeliness, amount, duration and scope as are provided to non enrolled Medicaid recipients within the area served by the HMO.

The HMO must make provision to the Medicaid agency to guarantee against risk insolvency, as defined in Tennessee Code Annotated Title 56, Chapter 32, which regulates HMO doing business in the State of Tennessee, and assures that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

The HMO must meet all requirements of Tennessee Code Annotated Title 56, Chapter 32, and the State Medicaid Rules and Regulations under Rules 1200-13-1-.05 and 1200-13-7.

The department will require organizational, operational, and financial data from the HMO.