



Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

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NATIONAL HEALTH LAW PROGRAM

Medicaid/CHIP Managed Care Regulations: Network Adequacy and Access to Care

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August 5, 2016*

Children in Managed Care

- CMS finalized sweeping changes to Medicaid and CHIP managed care regulations in May 2016
- Regulations set minimum standards; states have flexibility to do more
- Many opportunities for legal and health advocates to take action



Flag potential actions for legal and health advocates

Why are these rules so important?

11% of
children in
Medicaid/
CHIP are
enrolled in
FFS

22% of
children in
Medicaid/
CHIP are
enrolled in
PCCMs

66% of children in
Medicaid/CHIP are
enrolled in MCOs



Managed Care Project

- Series of six explainer briefs and webinars
 - ① Looking at the Rule through a Children's Lens (6/17)
 - ② Improving Consumer Information (6/23)
 - ③ Enhancing the Beneficiary Experience (7/19)
 - ④ *Assuring Network Adequacy and Access to Services (8/5)*
 - ⑤ Advancing Quality (9/8)
 - ⑥ Ensuring Accountability and Transparency (9/29)
- Fall meeting in D.C. with child health and legal advocates to strategize over implementation
- Thanks to Robert Wood Johnson Foundation

Our Topic Today: Assuring Network Adequacy and Access to Services

- Network Adequacy and Availability of Services
- Provider Inclusion Rules
- Care Coordination
- Service Authorization
- Appeals
- CHIP



Flag potential actions for legal and health advocates



NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Kelly Whitener

Network Adequacy & Availability of Services

Section	Topic
438.206	Availability of Services
438.207	Assurances of Adequate Capacity and Services
438.68	Network Adequacy Standards
438.14(b)	Requirements Involving Indians & Indian Health Care Providers (IHCPs)
438.602(g)(2)	Transparency & Documentation
438.10(h)	Provider Directories
438.4(b)(3)	Assurances of Adequate Capacity & Actuarial Soundness
438.340(b)(1)	Managed Care Quality Strategy
438.358(b)(1)(iv)	EQR Activities

Availability of Services §438.206

- Basic Rule: Each state must ensure that *all services* covered under the state plan are *available* and *accessible* to enrollees of managed care plans in a *timely* manner.



Managed Care Organizations (MCO)
Prepaid Inpatient Health Plans (PIHP)
Prepaid Ambulatory Health Plans (PAHP)



No later than 12-month rating period starting on or after
July 1, 2018

Delivery Networks

- Managed care plans must maintain and monitor a network of appropriate providers sufficient to provide adequate access to all services covered under the contract
- If the provider network is unable to provide necessary services, the plan must adequately and timely cover these services out-of-network and no additional cost to the enrollee

Delivery Networks

- Female enrollees must have direct access to a women's health specialist in network
- The network must include sufficient family planning providers to ensure timely access



While freedom of choice permits enrollees to receive family planning services from out-of-network providers, encourage states to require plans to contract with any willing family planning provider so that enrollees have a choice of in-network and out-of-network providers.

Timely Access

- Managed care plans must require network providers to meet state standards for timely access to care, taking into account the urgency of the needed service
- Hours of operation must be no less than the hours of operation offered to commercial enrollees
- Services must be available 24/7 when medically necessary



Encourage your state to adopt new or improved quantitative timely access to care standards.

Side Note on Medical Necessity

Adults

- State definitions based on federal laws like:
 - Mandatory versus optional benefits
 - The requirement that services must be covered in sufficient amount, duration, and scope to reasonably achieve their purpose
- Definitions have narrowed over time

Children

- State definitions based on EPSDT which requires a determination of whether:
 - The service is necessary to *correct or ameliorate* a physical or mental health condition
 - For a particular child (i.e., must be made on case-by-case basis)

Network Adequacy Standards §438.68

- States must develop, enforce, and validate time and distance standards



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Time and Distance Standards

- Primary care, adult and **pediatric**
- OB/GYN
- Behavioral health (mental health and substance use disorder), adult and **pediatric**
- Specialty care, adult and **pediatric**
- Hospital
- Pharmacy
- **Pediatric** dental
- Additional provider types determined by CMS



However, the Rule does not....



- Specify what the time and distance standards must be
- Impose a national standard for provider to enrollee ratios, appointment wait times, or other types of standards
- Prevent states from adopting additional standards

CMS indicates state flexibility is important due the differing scope of state programs, populations served, and unique demographics and characteristics of each state.

Scope of Time & Distance Standards

- Must include all geographic areas covered in contracts
- Permits varying standards for same provider type based on geographic areas (i.e., rural)
- Requires separate standards for LTSS provider types
 - Enrollee must travel to provider
 - Provider must travel to enrollee

Factors in Developing Network Adequacy Standards

- Anticipated enrollment
- Expected utilization of services
- Characteristics and health care needs of specific populations covered
- Geographic location
- Ability to communicate with LEP enrollees
- Physical access and accommodations
- Numbers and types (in terms of training, experience and specialization) of network providers needed to furnish contracted services
- Availability of alternative access: screening, telemedicine, e-visits, evolving technology
- Number of providers not accepting new patients

State Flexibility to Allow Exceptions

- If allowed, the state must:
 - Stipulate the extent to which exceptions are allowed
 - Specify the standard by which an exception will be evaluated and approved
 - Monitor enrollee access to that provider type on an ongoing basis
 - Report to CMS as part of state monitoring requirements (§438.66)
- Exception(s) policy
 - Must be specified in contracts
 - Based, at a minimum, on the number of providers in that specialty practicing in the applicable service area

Public Input

- No explicit requirement for stakeholder input
- But, in the preamble, CMS encourages states to include appropriate and meaningful stakeholder engagement and feedback when setting their network adequacy standards



Review any existing state time and distance standards to ensure that they apply to all of the listed provider and service types. Encourage your state to involve stakeholders in the establishment and update of time and distance standards to ensure they are reasonable.

Assurances of Adequate Capacity & Services §438.207

- Plans must provide assurances to the state that they meet the standards and supporting documentation
- States must review the documentation and certify the plans if they are in compliance
- The documentation must be posted on the state's website



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State Monitoring Requirements

§438.66

- Readiness Reviews
 - States must assess plan readiness prior to implementation of a new managed care program, when the plan has not previously contracted with the state, or when the plan is covering new populations
 - Must be completed with sufficient time to ensure smooth implementation
- Annual Program Report
 - Beginning with the rating period that follows the release of CMS guidance, states must submit an annual report to CMS and post it on the state's website

Additional Oversight Mechanisms

Stay
tuned!

External Quality Review

- Validating network adequacy is a new, mandatory activity for the external quality review process



Encourage your state to use an independent entity to validate plan networks

Actuarial Soundness

- In order for capitation rates to be approved by CMS, they must be adequate to meet the requirements of
 - Availability of Services (§438.206)
 - Adequate Capacity and Services (§438.207)
 - Coordination and Continuity of Care (§438.208)



PROVIDER INCLUSION RULES

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Screening & Enrolling Providers

§§438.602(b) & 438.608(b)

- Plans must ensure that all network providers are screened by the state
- Plans may only enter into contracts with providers that have successfully completed screening
 - There is an exception for short-term contracts up to 120 days while the outcome of the screen is pending



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Primary Care Case Management (PCCM)
Primary Care Case Management Entities
(PCCM entities)



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Numbers & Types of Providers

Medicaid

- The rule does not require plans to contract with particular provider types or number of providers per enrollee
- Medicaid statute requires coverage of:
 - FQHCs & RHCs
 - Free-standing birth centers
 - Nurse-midwives & certified nurse practitioners

Marketplace and Medicare

- Marketplace plans require contracts with a specified proportion of essential community providers
- Medicare Advantage requires specific provider-to-covered person ratios



Encourage your state to require plans to contract with any willing safety net provider.

Work with your state to incorporate provider-covered person ratios, especially when there are known access problems.

Special Rules for Indian Health Care Providers §438.14

- Plans must:
 - Ensure timely access to Indian Health Care Providers
 - Pay out-of-network Indian Health Care Providers when they deliver care to eligible Native American enrollees
 - Permit eligible Native American enrollees to select an Indian Health Care Provider as a primary care provider



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CARE COORDINATION

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Coordination & Continuity of Care

§438.208

- The rule expands the existing requirement that plans must implement procedures to deliver care to and coordinate services for all enrollees



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General Coordination Requirements

- Screening within the first 90 days for new enrollees
- Designee to coordinate:
 - Services the plan provides to the enrollee
 - Care during transitions from one setting to another
 - Services the enrollee receives from another managed care plan
 - Carved-out services
 - Community and social support services



Encourage your state to include Protection and Advocacy organizations, legal services organizations, Aging and Disability Resource Centers, Centers for Independent Living, Area Agencies on Aging, United Way 211 Lines, and local and state government agencies.

Coordination for Enrollees with Special Health Care Needs

- Applicable to enrollees who use LTSS
- Plans must:
 - Identify enrollees with special health care needs and those who need LTSS
 - Assess their needs
 - Design a treatment plan based on those needs
 - Allow enrollees to see a specialist directly



Urge your state to develop and include a specific definition of “children and youth with special health care needs” for whom the LTSS and continuity of care provisions should apply.

Continued Services to Enrollees

§438.62

- During certain times of transition, plans must permit enrollees to continue to see their existing providers, even if they are out-of-network



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Continued Services to Enrollees

- Specifically, states must develop transition of care policies to permit enrollees to continue seeing their providers when:
 - Enrollees move into managed care from FFS **OR**
 - Enrollees change plans **AND**
 - Without continuity of care, the enrollee is at risk of hospitalization or institutionalization



Encourage your state to engage stakeholders in the development of these transition requirements.



SERVICE AUTHORIZATION

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Coverage & Authorization of Services

§438.210

- The contract between the state and the plan must:
 - Identify, define, and specify the amount, duration, and scope of each service the plan is required to offer
 - The amount, duration, and scope must be no less than that under FFS or as required by EPSDT



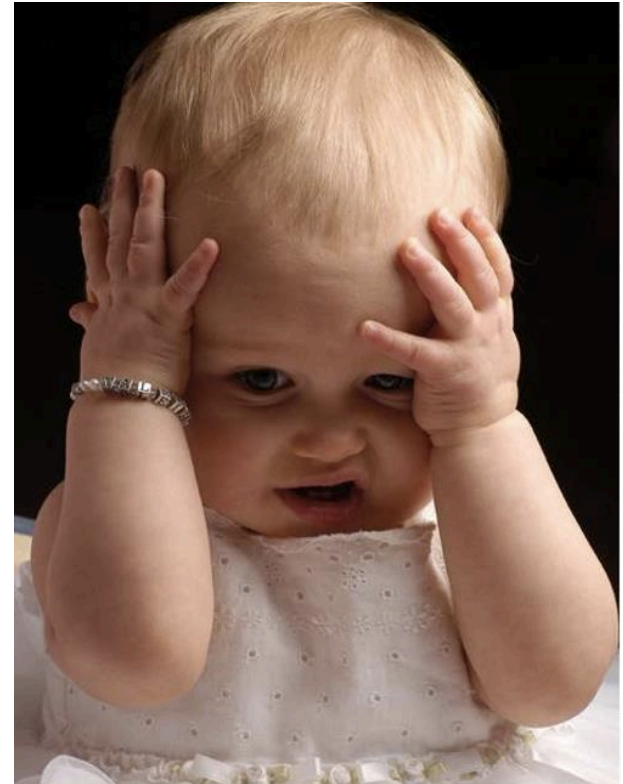
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Allowable Service Limitations

- Plans may place “appropriate limits” on covered services, as long as the limits are based on either criteria used by the state (like medical necessity) or in order to control utilization
- Plans must define when a covered service will be medically necessary in a manner that is “no more restrictive” than the criteria used in under FFS



Service Authorization Timelines

- Plans must respond to service authorization requests within 14 calendar days
- If waiting 14 days creates a risk of harm, plans must expedite review and decide within 72 hours
- The response time may be extended by an additional 14 days at the request of the enrollee or provider, or when the plan determines it is in the enrollee's best interest

New Service Authorization Protections

- Plans must make sure that services for people with ongoing or chronic conditions are authorized in a manner that reflects their ongoing need
- Plans must ensure that family planning providers are available in- and out-of-network, consistent with freedom of choice



Encourage your state to require that LTSS aimed at treating chronic conditions are authorized for a 12-month period unless there is a clinical reason for a shorter authorization period.

Special Rules for Prescription Drugs

§§438.3(s) & 438.210(d)

- Utilization controls for prescription drugs must also follow statutory requirements that govern prior authorization
- For drug authorization requests, plans must:
 - Respond within 24 hours
 - Dispense a 72-hour supply of a covered outpatient drug in emergencies



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APPEALS

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Adverse Benefit Determinations

- An adverse benefit determination includes
 - The prior definition of an action (e.g., denial, reduction, suspension, termination or delay of a service)
 - PLUS denial or limited authorization determinations based on:
 - Requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit, and
 - Disputes involving cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities
- For adverse benefit determinations, plans must have an appeal system

Other Matters

- The rule distinguishes adverse benefit determinations from “other matters”
- For other matters, plans must have a grievance system
- The grievance system allows enrollees to express dissatisfaction over things like being treated rudely and a plan’s authorization decision timing
- Grievances can be filed at any time

Appeal System

- Adverse benefit determinations are handled through an appeal system
 - There can only be one level of appeal
 - But enrollees must exhaust the appeal before requesting a state fair hearing
- An appeal must be filed within 60 days from the date of the adverse benefit determination
- Plans must have an expedited review process for appeals when the standard resolution time could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function

Deemed Exhaustion

- Typically, an enrollee will have to exhaust the in-plan appeal system before seeking a state fair hearing
- However, if the plan fails to adhere to notice and timing requirements, the enrollee is deemed to have exhausted the in-plan appeal system and can immediately request a state fair hearing



Work with your state to implement robust procedures for determining when an enrollee will be deemed to have exhausted the plan appeal process and monitor its implementation.

Continuation of Benefits Pending Appeal §438.420

- The new rule requires plans to continue the enrollee's services during an appeal and state fair hearing, if certain pre-conditions are met



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Conditions for Benefits Paid Pending

- The plan must continue the enrollee's services if ALL of the following occur:
 1. The enrollee files a timely appeal (e.g., within 60 days of the date on the adverse benefit determination notice)
 2. The appeal involves the termination, suspension, or reduction of a previously authorized service
 3. The service was ordered by an authorized provider
 4. The period covered by the original authorization has not expired
 5. The enrollee timely files for continuation of benefits (e.g., on or before 10 days of the plan sending the notice)

Benefits Paid Pending

- If these conditions are met, benefits must continue
- However, when an appeal or state fair hearing is concluded adverse to the enrollee, the plan can recover the costs of the services furnished during the pendency of the review
 - But only to the extent that the benefits were furnished solely because of this requirement and to the extent that the state recoups these fees under FFS



Encourage your state to implement robust protections to ensure that enrollees are apprised of their right to request aid paid pending appeal.



CHIP

Kelly Whitener

CHIP – Network Adequacy and Availability of Services

Applicable to CHIP:

- Availability of Services (§457.1230(a))
- Network Adequacy Standards (§457.1218)
- Assurances of Adequate Capacity and Services (§457.1230(b))

Not Applicable to CHIP:

- State Monitoring Requirements (but see related requirement at §457.495)



Encourage your state to adopt the more specific review provisions of § 438.66 to CHIP

CHIP – Provider Inclusion Rules

Applicable to CHIP:

- Screening and enrolling requirements (§457.1285)
- Special provisions for Indian Health Care Providers (§457.1209)
- Sufficient numbers and types of providers (§457.1230(a) and (b))

Not Applicable to CHIP:

- New Medicaid rules (described in SHO # 16-006) requiring plans to include at least one FQHC in their network as well as one rural health clinic and one free-standing birth center

CHIP – Care Coordination & Service Authorization

Care Coordination

Applicable to CHIP:

- Coordination and continuity of care (§457.1230(c))
- Continued services to enrollees (§457.1216)

Service Authorization

Applicable to CHIP:

- Coverage and authorization of services (§457.1230(d)) except provisions related to medical necessity & LTSS
- Special rules for prescription drugs (§457.1230(d)) except the contract provisions

CHIP – Appeals

Applicable to CHIP:

- Most Medicaid provisions related to grievances and appeals (§457.1260)

Not Applicable to CHIP:

- No right to aid paid pending an appeal
- References to “fair hearings” should be read to refer to “reviews”

Stay Tuned (September 8)



For More Information

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