



Medicaid/CHIP Managed Care Regulations: Improving Consumer Information

by *Tricia Brooks and Sarah Somers*

Georgetown University Center for Children and Families (CCF) and the National Health Law Program (NHeLP) have teamed up to bring advocates for children and low-income families critical information about the recently finalized Medicaid and CHIP managed care regulations. This paper is the second in the series, and it describes how the new rules improve consumer information. The first brief, [Looking at the New Medicaid/CHIP Managed Care Regulations Through a Children's Lens](#), provides an overview of the rules.

Future briefs in the series will dive into other issues important to low-income families in greater detail by focusing on enhancing the beneficiary experience, assuring network adequacy and access to services, advancing quality, and ensuring accountability and transparency. It is important to note at the outset that these new managed care rules lay out the minimum standards states must meet in Medicaid and CHIP, but they also provide health and legal advocates a tremendous opportunity to improve care delivery for low-income families through strategic engagement with states and plans as the rules are implemented over the next few years. States can and should do more than adopt the minimum standards for children and families, and this issue brief series will identify those opportunities for action.

Background

Over the past decade or so as managed care has become the predominant delivery system in Medicaid and CHIP, there has been a growing recognition of the need for current, accurate, and thorough consumer information to aid potential managed care enrollees in making an informed plan selection and in understanding how to maximize their benefits and rights. To this end, the modernization of federal managed care regulations released in May 2016 seeks to improve consumer information. The rules specify content, timeliness standards, and delivery methods for notices, enrollee handbooks, provider directories, and drug formularies to assure that consumers have current and complete information. Information for enrollees and potential enrollees must be provided in a manner and format that may be easily understood and is readily accessible. Importantly, the rule specifies language requirements and access to alternative formats and auxiliary aids.

The rule embraces current technology that enables states and managed care plans to provide access to information quickly, accurately, and less expensively. The rule pushes managed care consumer information into the digital age by allowing information to be made available electronically. If states or managed care plans meet specific standards for electronic sharing, the rule eliminates the redundant requirement for consumer information to be mailed in paper form to enrollees, although it must always be available at no cost upon request.



Introduction

The consumer information requirements apply to all managed care programs whether authorized through a state plan amendment, waiver or demonstration project¹—in both Medicaid and CHIP. Basic rules apply to enrollment brokers² and all types of managed care entities, including Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), Primary Care Case Management systems (PCCM), and Primary Care Case Management entities (PCCM entity). More specific provisions apply to the state or its contracted representative, and most but not all types of managed entities as noted throughout this brief. (For definitions of the different types of entities, see the Appendix.)

The effective date of the consumer information provisions depends on the 12-month rating period selected by the state, starting with rating periods beginning on or after July 1, 2017. While states may contract with plans for multiple years, rates must be determined and submitted to CMS for approval for 12-month periods.³



Timeline: Consumer information requirements detailed in § 438.10 apply to the rating period beginning on or after July 1, 2017.



Applies to states, enrollment brokers, MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities.

Basic Rules (§ 438.10(c))

The state, enrollment broker, and all types of managed care entities must ensure that all required consumer information to enrollees and potential enrollees is provided in a manner and format that is easily understood and is readily accessible.



States have flexibility to define what constitutes “easily understood.” Encourage your state to have a process for stakeholder review of materials and adopt best practices in testing consumer information such as conducting focus groups.

Differences in Consumer Information Requirements for PCCMs and PCCM Entities

States may use a Primary Care Case Management (PCCM) system in which a primary care case manager⁴ provides case management to enrollees who receive their care on a fee-for-service basis. Alternatively, states may contract with an PCCM entity that not only provides case management but also performs other administrative functions for the state, such as development of care plans, provision of payment to providers on behalf of the state, review of claims, or quality improvement activities. Both PCCMs and PCCM entities must ensure that all required consumer information to enrollees and potential enrollees is provided in a manner and format that is easily understood and that electronic information is readily accessible. Other consumer information requirements may apply to PCCM entities, as noted throughout this brief, depending on the services the entity is contracted to provide.



State Requirements

In providing consumer information, the state must utilize its beneficiary support system (§ 438.71), which will be covered in the third brief of this series. The state must also operate a website that provides access to enrollee handbooks, provider directories, and formularies either directly or by linking to individual MCO, PIHP, PAHP, and PCCM entity websites. Moreover, the state must ensure through its contracts that each MCO, PIHP, PAHP, and PCCM entity provides the required information to each enrollee. Thus, the state retains primary responsibility for ensuring that these rules are implemented and sustained.



Encourage your state to provide opportunities for website testing and feedback, and to explore the advantages of having all related consumer materials posted on the state's website as a single source of consumer information.

Consistency in Information

For consistency in information provided to enrollees, the state must develop and require all managed care entities to use consistent definitions for key managed care terms, and lists specific terms that must be included (see Table 1). The state must develop and require all managed care plans to use model enrollee handbooks and enrollee notices, which are described in detail later in this brief.



Encourage your state to provide opportunities for stakeholders to engage in the development of model enrollee handbooks and enrollee notices.

Table 1. Standardized Managed Care Terminology (§ 438.10(c)(4)(1))

- Appeal
- Copayment
- Durable medical equipment
- Emergency medical condition
- Emergency medical transportation
- Emergency room care
- Emergency services
- Excluded services
- Grievance
- Habilitation services and devices
- Health insurance
- Home health care
- Hospice services
- Hospitalization
- Hospital outpatient care
- Medically necessary
- Network
- Non-participating provider
- Physician services
- Plan
- Preauthorization
- Participating provider
- Premium
- Prescription drug coverage
- Prescription drugs
- Primary care physician
- Primary care provider
- Provider
- Rehabilitation services and devices
- Skilled nursing care
- Specialist
- Urgent care



States have flexibility to expand the list of standardized managed care terms. Encourage your state to seek stakeholder input on terms and standard definitions.



Applies to states, enrollment brokers, MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities.

Electronic Information Requirements (§ 438.10(c)(6))

While the rule allows for electronic posting of information, it also specifies the standards that *must be met before* information can be posted electronically:

- The format must be readily accessible,⁵ which means it must comply with modern accessibility standards such as section 508 guidelines and other federal standards⁶ regarding electronic content.
- The information must be posted in a prominent and readily accessible place on the state’s, MCO’s, PIHP’s, PAHP’s, PCCM’s,⁷ or PCCM entity’s website.
- The information can be electronically retained and printed.
- The information is consistent with content and language requirements.

- The enrollee is notified that the information is available at no cost upon request in paper form, which must be provided within 5 business days.

Plan Requirements (§ 438.10(c)(7))

Each managed care plan must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan.



Work with your state to define what “mechanisms” each plan must have in place to help enrollees understand plan requirements. For example, should plans have extended customer service hours or should they be required to make contact with new enrollees soon after enrollment?

Language and Format (§ 438.10(d))

Of note, the rules generally place primary responsibility for written translation, oral interpretation and notification for *potential enrollees* on the state, while managed care plans are primarily responsible for providing these services to *enrollees*.⁸ Also, while written translations are limited to prevalent languages *in the state* and may apply to the entire state or specific service areas, oral interpretations are required for all non-English languages.

Prevalent Language Requirements

The state must establish a methodology for identifying the prevalent non-English languages spoken throughout the state and in each MCO, PIHP, PAHP, or PCCM entity service area. In this context as defined by the rule, prevalent means “a non-English language determined to be spoken by a significant number or percentage of potential

enrollees and enrollees that are limited English proficient.”⁹ The rule further defines limited English proficient (LEP) as “potential limited English proficient (LEP) as “potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.”¹⁰ Individuals who meet this definition may receive language assistance for a particular type of service, benefit, or encounter.¹¹



The rule gives states flexibility to define what is a “significant number or percentage consumers who are LEP.” Encourage your state to consult with stakeholders in establishing parameters to identify prevalent non-English languages.



Applies to states and enrollment brokers.

State Requirements

States must make oral interpretation, including auxiliary aids such as TTY/TDY and American Sign Language, available *in all languages* to each potential enrollee at no cost. Written translations must be available in each prevalent non-English language. All written materials for potential enrollees must be available in alternative formats, such as braille, and include large print (no smaller than 18 point font size) taglines in the prevalent non-English languages in the state explaining the availability of language services along with the toll-free and TTY/TDY telephone number of the entity providing choice counseling services.¹²



TIP Encourage your state to provide stakeholders with an opportunity to provide input/feedback on the development of tagline language.

In addition to providing language services, states must require each MCO, PIHP, PAHP, and PCCM entity to meet language requirements and other rules described below.



Applies to MCOs, PIHPs, PAHPs, and PCCM entities.

Plan Requirements

Managed care entities must provide interpretation services and auxiliary aids such as TTY/TDY and American Sign Language to each enrollee free of charge, and notify enrollees about the availability of these services and how to access them. Oral interpretation applies to all non-English languages, not just those identified as prevalent. Each plan must provide written materials critical to obtaining services in *prevalent non-English languages in its particular service area*. At a minimum, this requirement applies to provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices. Written materials must be available in alternative formats and,

along with auxiliary aids and services, provided at no cost upon request. Written materials must include large print (no smaller than 18 point font size) taglines in *prevalent languages in the state* that explain the availability of written translation or oral interpretation and include the toll-free and TTY/TDY telephone numbers to reach the plan's member/customer service unit.



TIP States have flexibility to identify other critical written materials that plans must provide in prevalent non-English languages (such as all notices, not just denial and terminations). Encourage your state to engage stakeholders in determining additional materials that should be subject to language requirements.

General Written Material Requirements for States and Plans

Written materials must use easily understood language and format, with a font size no smaller than 12 point. Information must be available in alternative formats, including auxiliary aids and services in a manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or LEP.



TIP States have the flexibility to determine which alternative formats must be available to enrollees. Encourage your state to define minimum requirements for alternative formats and not leave these decisions to plan discretion.



Applies to the state or its contracted representative.

Information for Potential Enrollees (§ 438.10(e))

At the time a potential enrollee first becomes eligible to enroll in a voluntary managed care plan, or is required to enroll in a mandatory managed care plan,¹³ the state or its contracted representative (e.g., enrollment broker or choice counseling entity) must provide the following information in paper or electronic form within a timeframe that enables the potential enrollee to use the information in choosing among the available plans.

- Information about the enrollee's right to disenroll that clearly explains the process for doing so. (Enrollment and disenrollment requirements will be covered in the third brief in this series.)
- The basic features of managed care.
- Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily.
- The service area covered by each plan.
- Which benefits are covered by the plan or provided directly by the state.
- Where and how enrollees can obtain counseling or referral services not provided by the plan for moral or religious objections.

- Provider directory and prescription drug formulary information.
- Any cost-sharing requirements.
- Requirements of each plan to provide adequate access to covered services, including the state's network adequacy standards. (Network adequacy standards will be covered in the fourth brief in this series.)
- The plan's responsibilities for coordination of enrollee care.
- Quality and performance indicator data for each plan, including enrollee satisfaction. (Quality provisions will be covered in the fifth brief in this series.)



States have flexibility to determine a timeframe for providing materials that gives enrollees sufficient time to make an informed plan selection. Encourage your state to engage stakeholders in assuring that potential enrollees have adequate time to choose a plan before being automatically assigned.



Applies to MCOs, PIHPs, PAHPs, and PCCM entities (when appropriate).

Information for Enrollees (§ 438.10(f))

Plans must provide additional information once a beneficiary enrolls. In addition to enrollee handbooks, provider directories, and drug formularies, which are described later in this brief, each plan must provide any physician incentive plan upon request.¹⁴ Each plan must also make a good faith effort to give written notice of termination of a contracted provider, within 15 days, to each enrollee who received his or her primary care from or was seen by the terminated provider on a regular basis.



States have the flexibility to define what is "regular basis." Encourage your state to seek input from stakeholders in defining regular use of a provider. Of note, a regular provider such as an OB/GYN might only be seen once a year.



Applies to MCOs, PIHPs, PAHPs, and PCCM entities (when appropriate).

Enrollee Handbook (§ 438.10(g))

Each plan must provide each enrollee with an enrollee handbook within a reasonable time following enrollment. This handbook serves a similar function as the summary of benefits and coverage as required for private insurance in and outside the health insurance marketplaces.

Content of the enrollee handbook must include information that enables the enrollee to understand how to effectively use the managed care program. At a minimum, it must include:

- Benefits provided by the plan, including sufficient detail of the amount, duration, and scope of benefits to promote understandability.
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care or other benefits not furnished by the primary care provider.
- Cost sharing.
- How transportation is provided.
- The extent to which, and how, after-hours and emergency services are provided; what constitutes an emergency medical condition and emergency service; that prior authorization is not required for emergency services; and that the enrollee has a right to use any hospital or other setting for emergency care.
- Any restrictions on enrollee's freedom of choice among network providers.
- The extent to which, and how, enrollees can obtain benefits, including family planning services and supplies, from out-of-network providers. This includes the fact that the plan cannot require an enrollee to obtain a referral before choosing a family planning provider.
- How and where to access counseling or referral services that the plan does not cover based on moral or religious objections.
- How and where to access benefits provided by the state.
- Enrollee rights and responsibilities. (These provisions, as specified in § 438.100, will be covered in the third brief in this series.)
- The process of selecting or changing the enrollee's primary care provider.
- Grievance, appeal, and fair hearing procedures and timeframes, including the:
 - Right to file an appeal;
 - Requirements and timeframes for filing a grievance or appeal;
 - Availability of assistance in the filing process;
 - Right to request a state fair hearing in the case of adverse determinations of grievances or appeals;
 - Fact that benefits that are denied or terminated will continue if the enrollee files an appeal for a state fair hearing within state timeframes, and whether enrollees may be required to pay for the cost of services received while the fair hearing is pending in the case of an adverse determination.
- How to exercise an advance directive.
- How to access auxiliary aids and services, including additional information in alternative formats and languages.
- The toll-free telephone number for member services, medical management, and any other unit providing services.
- Information on how to report suspected fraud or abuse.
- Other content required by the state.



Plans have flexibility in how they provide the information to enrollees. They may mail a printed copy or provide the information by email after the enrollee agrees to receive information electronically. They may also inform enrollees by mail or email that the information is posted on its website, and provide the applicable Internet address. However, they must also provide enrollees with disabilities who cannot access online content with auxiliary aids and services upon request at no cost. And as noted previously, they must provide critical materials in writing to enrollees upon request at no cost. When there is a change that the state defines as significant, the plan must give each enrollee notice at least 30 days before the intended effective date of the change.



States have the flexibility to define “other content” that must be included in the enrollee handbook. Encourage your state to engage stakeholders in the development of the model enrollee handbook to ensure that it is useful, through, and easy to understand.



The rule gives states flexibility to define what is a “significant change.” Encourage your state to work with stakeholders in defining what constitutes a “significant change.”



Applies to MCOs, PIHPs, PAHPs, and PCCM entities (when appropriate).

Provider Directory (§ 438.10(h))

Each plan must make its provider directory available in electronic form and in paper form upon request. Information in paper directories must be updated at least monthly, and electronic directories must be updated no later than 30 days after the plan receives updated provider information. Provider directories must be posted on the plan’s website in machine-readable format. The following information must be provided for physicians, including specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers¹⁴ (as appropriate) covered under the plan’s contract:

- Provider’s name, as well as any group affiliation.
- Street address(es).
- Telephone number(s).
- Web site URL, as appropriate.
- Specialty, as appropriate.
- Whether the provider is accepting new enrollees.



The rule gives states flexibility to identify additional content and standardize the format of provider directories. Encourage your state to work with stakeholders in providing input/feedback on provider directory requirements.



Applies to MCOs, PIHPs, PAHPs, and PCCM entities (when appropriate).

Drug Formulary (§ 438.10(i))

Each plan must provide information in electronic or paper form to enrollees listing the medications (both generic and name brand) that are covered and each drug's tier (which may determine cost-sharing requirements). The formulary must also be posted on the plan's website in a machine-readable file and format as determined by the Secretary.



TIP The rule gives states flexibility to identify additional content, standardize the format, and set timeliness standards for updates of drug formularies. Encourage your state to work with stakeholders in providing input/feedback on drug formulary requirements.

Conclusion

As more and more Medicaid and CHIP enrollees receive benefits through managed care arrangements, the new requirements for consumer information provide critical details to potential enrollees in making an informed plan selection and to enrollees in using their benefits and exercising their rights. Importantly, the regulations set minimum standards, leaving a great deal of flexibility for states to boost requirements. Given that these requirements go into effect as early as July 2017, advocates should quickly reach out to their state Medicaid and CHIP agencies to discuss opportunities to work together to ensure that potential enrollees and enrollees have access to adequate, timely, and accessible information.



Appendix: Definitions Applicable to Managed Care Entities

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is –

- A federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
- Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
 - Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
 - Meets the solvency standards of § 438.116.

Prepaid ambulatory health plan (PAHP) means an entity that –

- Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates;
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and,
- Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

- Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
- Does not have a comprehensive risk contract.

Primary care case management (PCCM) is a system whereby the state contracts with a primary care case manager to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries. Primary care case manager means a physician, a physician group practice or, at state option, any of the following: a physician assistant; a nurse practitioner; a certified nurse-midwife.



Appendix (cont'd): Definitions Applicable to Managed Care Entities

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the state –

- Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.
- Development of enrollee care plans.
- Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.
- Provision of payments to FFS providers on behalf of the state.
- Provision of enrollee outreach and education activities.
- Operation of a customer service call center.
- Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.
- Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- Coordination with behavioral health systems/providers.
- Coordination with long-term services and supports systems/providers.

Risk contract means a contract under which the contractor –

- Assumes risk for the cost of the services covered under the contract; and
- Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Nonrisk contract means a contract under which the contractor –

- Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in §447.362 of this chapter; and
- May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits.



Endnotes

¹ Mandatory managed care programs can operate pursuant to a variety of statutory authorities: § 1915(b) waivers, § 1115 demonstrations, or state plan options authorized by § 1932. Mandatory enrollment of exempt groups, which include children with special health care needs or disabilities, children receiving foster care or adoption assistance, American Indians, Native Americans, and dual-eligibles, requires approval through a § 1915(b) waiver or § 1115 demonstration authority. Non-exempt groups, including children, parents and non-disabled, can be mandated to enroll in managed care through any type of authority, including a state plan amendment authorized by § 1932.

² An enrollment broker, defined at § 438.810(a), means an individual or entity that performs choice counseling or enrollment activities, or both.

³ § 438.2 defines rating period as “a period of 12 months selected by the state for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by § 438.7(a).” See also § 438.7(a) (requiring CMS review and approval of rate certification).

⁴ Primary care case managers are often physicians or other health professionals that may be required to provide language services and auxiliary aids as Medicaid providers. Those requirements are not covered under § 438.10, which is the focus of this brief.

⁵ The definition of ‘readily accessible’ can be found at § 438.10(a).

⁶ Other standards include section 504 of the Rehabilitation Act and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

⁷ There is a discrepancy between the preamble to the rule and the regulatory language regarding applicability of § 438.10(c)(6) to PCCMs. The preamble indicates that only the basic rules at § 438.10(c)(1) apply to PCCMs, while the regulation indicates that electronic information requirements at § 438.10(c)(6) also apply to PCCMs.

⁸ It is important to note that the regulations require states to ensure that plans comply with applicable provisions. Thus, the state ultimately remains responsible for ensuring that both potential enrollees and enrollees have access to appropriate information.

⁹ The definition of ‘prevalent’ can be found at § 438.10(a).

¹⁰ The definition for limited English proficient can be found at § 438.10(a)

¹¹ The preamble to the regulations indicates that CMS has adopted guidance relating to LEP developed by the Office of Civil Rights and the Department of Justice. Additional information can be found at <https://www.lep.gov/faqs/faqs.html>.

¹² The third brief in this series will provide additional information about choice counseling (§ 438.71(a)).

¹³ Op. cit. (1)

¹⁴ Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee (42 CFR 422.208).

¹⁵ Long-term services and supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual’s home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.



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Center for Children and Families
Health Policy Institute, Georgetown University
Box 571444, 3300 Whitehaven Street, NW, Suite 5000
Washington, D.C. 20057-1485
Phone (202) 687-0880
Email childhealth@georgetown.edu

 ccf.georgetown.edu/blog/

 facebook.com/georgetownccf

 twitter.com/georgetownccf



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