



# Looking at the New Medicaid/CHIP Managed Care Regulations Through a Children's Lens

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*Georgetown University Center for Children and Families (CCF) and the National Health Law Program (NHeLP) have teamed up to bring advocates for children and families critical information about the recently finalized Medicaid and CHIP managed care regulations. This paper is the first in the series, and it provides an overview of the new rules through a children's lens – identifying those provisions that are of utmost importance to children given that nearly nine of every 10 children enrolled in Medicaid and CHIP receive health care through a managed care arrangement.*

*Future briefs in the series will dive into issues important to low-income families in greater detail by focusing on improving consumer information, 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

In May 2016, the Centers for Medicare & Medicaid Services (CMS) finalized sweeping regulatory changes for managed care in Medicaid and the Children's Health Insurance Program (CHIP).<sup>1</sup> The application of the various provisions in the rule varies depending on the type of managed care entity: managed care organization (MCO), primary care case management (PCCM) and primary care case management entity (PCCM entity), prepaid inpatient health plan (PIHP) and prepaid ambulatory health plan (PAHP) (see text box).

### Managed Care Entities

- Managed Care Organization (MCO): an entity that agrees to provide a comprehensive set of services, assume the risk for the cost of those services and incur a loss if the cost is greater than the payments under the contract.
- Primary Care Case Management (PCCM): a system in which a primary care case manager provides case management to enrollees who receive their care on a fee-for-service basis.
- Primary Care Case Management entity (PCCM entity): an entity that provides not only 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.
- Prepaid Inpatient Health Plan (PIHP): an entity that receives capitation payments in exchange for providing inpatient or institutional services to enrollees.
- Prepaid Ambulatory Health Plan (PAHP): an entity that receives capitation payments in exchange for providing outpatient or ambulatory services to enrollees.

See § 438.2 for full definitions



Comprehensive, risk-based managed care is the predominant delivery system in Medicaid, with 39 states relying on MCOs to cover all or some of their Medicaid populations.<sup>2</sup> All but two states had some form of managed care in place in 2015, including MCOs, PCCMs, PCCM entities, PIHPs or PAHPs.<sup>3</sup> MCOs are also the predominant delivery system in CHIP, with 30 of 37 states with separate CHIP programs relying on MCOs, PCCMs or PCCM entities.<sup>4</sup>

Almost nine of every 10 children enrolled in Medicaid and CHIP receive health care through a managed care arrangement. Nationwide, 66 percent of children in Medicaid and CHIP were enrolled in MCOs with another 22 percent enrolled in PCCMs or PCCM entities in 2012.<sup>5</sup> Though more recent nationwide data is not yet available, the percentage of children enrolled in MCOs has likely increased as several states have moved toward this model in recent years.<sup>6</sup> Additionally, 56 percent of children nationwide were enrolled in limited-benefit PIHPs or PAHPs in 2012, most commonly for dental or behavioral health services.<sup>7</sup>

There is considerable variation across states in terms of both populations served and benefits covered by managed care. However, children and their families are the most likely groups to be covered by MCOs and a large proportion of children are covered by managed care in states using this model. In 2015, 32 of the 39 Medicaid MCO states covered 75 percent or more children through MCOs<sup>8</sup> and 80 percent of children in separate CHIP programs are covered through MCOs.<sup>9</sup>

## General Provisions

### Network Adequacy and Access to Services

Medicaid MCOs, PIHPs and PAHPs restrict enrollees to a network of providers. Therefore, federal law requires such plans to ensure that all covered Medicaid services are available and accessible to managed care enrollees.<sup>10</sup> Network adequacy and access to services requirements are key components of ensuring that children are able to access needed services in Medicaid and CHIP. As such, a future brief in this series will focus exclusively on network adequacy and access to services, but the highlights are described below.

Plans must have a network of providers sufficient to serve enrollees, including those with limited English proficiency and physical or mental disabilities.<sup>11</sup> Plans must also provide access to women's health specialists and family planning providers within the network.<sup>12,13</sup> They are required to cover services out-of-network for emergency care or if the existing network cannot provide the services in an adequate and timely manner.<sup>14</sup>

The new rules strengthen network adequacy by requiring states to establish quantitative time and distance standards for specified provider types and by recognizing the unique needs of children. At a minimum, they must establish such standards for:

- Pediatric and adult primary care;
- Pediatric and adult specialty care;
- Pediatric dental care;
- OB/GYN;
- Pediatric and adult behavioral health;
- Hospital;
- Pharmacy; and
- Long-term services and supports (LTSS), for enrollees that must travel to the LTSS provider.<sup>14</sup>



The final regulations also require states to monitor network adequacy and determine whether plans complied with the network adequacy and access to services requirements.<sup>15</sup> In addition, they contain a new requirement that MCOs, PHIPs and PAHPs must coordinate with community and social support providers, recognizing that many Medicaid and CHIP beneficiaries utilize these services too.<sup>16</sup> For example, this requirement could include linking children to legal aid services for assistance with accessing educational support.

These new requirements present important opportunities to improve network adequacy and access to services.<sup>17</sup> Some states already have time and distance standards, either imposed by law or specified in a managed care contract.<sup>18</sup> Many, however, do not. Existing standards may also need improvement. Moreover, while the final regulations do not require states to establish specific provider-to-enrollee ratios or impose limits on wait times, advocates can and should encourage their states to do so. Again, a number of states do require certain ratios and restrict excessive wait times, thus there are examples to support policy improvement efforts.<sup>19</sup> In addition, the requirement that plans coordinate with community providers could help children access services through schools and other non-traditional providers. Stakeholders should encourage their states to require plans to coordinate with schools.

The final regulations significantly expand the requirement that states provide for continued services for beneficiaries who are disenrolled or who were enrolled in plans whose contract was terminated.<sup>20</sup> States must now have a transition of care policy to ensure services during transition from fee-for-service to any type of managed care plan when lack of continued services would cause an enrollee “to suffer serious detriment to their health or be at risk of hospitalization or institutionalization.”<sup>21</sup>

## Quality<sup>22</sup>

States and managed care plans must participate in a number of activities related to measuring and improving quality of care in managed care. States must implement a comprehensive quality strategy for its MCOs, PIHPs, PAHPs and certain PCCM entities.<sup>23, 24</sup> It must include a quality rating system (QRS), similar to that for Medicare and qualified health plans in the health insurance marketplaces, that measures and reports on plan performance based on metrics that will be created by CMS.<sup>25</sup> They must require such plans to have ongoing Quality Assessment and Performance Improvement (QAPI) projects that assess the quality of services.<sup>26</sup> Plans are also required to conduct Performance Improvement Projects (PIPs) that focus on clinical and nonclinical areas. PIPs must include performance measures, interventions, and evaluation.<sup>27</sup> Finally, states must contract with External Quality Review Organizations (EQROs) to perform an annual external quality review of managed care, which has been broadened to require validation of network adequacy.<sup>28</sup>

States will have considerable flexibility in the topics on which their quality improvement programs focus. Child health stakeholders urged CMS to include specific requirements for quality projects to focus on delivery of services to children. For the most part, CMS declined to do so. Accordingly, this decision will be made on a state level.



**Encourage states to establish specific provider-to-enrollee ratios and impose limits on wait times.**



**Influence states to focus on pediatric quality improvement.**



**Timeline: CMS will issue guidance on the QRS and quality strategy in 2018.**

Other aspects of the quality strategy will be developed at the federal level. CMS will develop the QRS in consultation with states and other stakeholders and after providing public notice and opportunity to comment.<sup>29</sup> In addition, CMS has the option of establishing national performance measures and PIP topics. If it does, it must solicit input from states and other stakeholders through a public notice and comment process.<sup>30</sup> CMS stated that, if they did establish such measures and topics, it would consider ones that focus on children.<sup>31</sup>

The development of the required quality strategy provides many opportunities to focus plans, states and the federal government on child health. CMS encouraged stakeholders to work with their states and with plans to incorporate the needs of children.<sup>32</sup> Accordingly, stakeholders should press their states and plans to include projects that focus on child health. Child health stakeholders should also encourage CMS to include pediatric measures when it establishes national standards projects.

### **Children & Youth with Special Health Care Needs (CYSHCN)**

For many years, Medicaid managed care primarily served low-income women and children. Medicaid beneficiaries with special health care needs, particularly children, were generally not enrolled in Medicaid managed care. Recently, however, the trend has been to enroll more beneficiaries of all ages with disabilities and chronic conditions into managed care. Providing services to this higher needs population is more costly and complicated than serving traditional Medicaid beneficiaries. Thus, Medicaid managed care plans—and state Medicaid agencies—have had to adapt in order to appropriately serve this population.

The federal agency has had to adapt as well. CMS recognized that the previous version of the Medicaid managed care regulations needed to be modernized to reflect the fact that states now use managed care to deliver services to enrollees with more complex needs, including disabilities and chronic conditions. Therefore, the final regulations include many revisions designed to improve delivery of services to people with special health care needs and those who need LTSS.<sup>33</sup>

The Medicaid managed care regulations have long required that states ensure that care and services are coordinated for all MCO, PIHP and PAHP enrollees. Plans are required to implement mechanisms to identify persons with special health care needs, to ensure that they are assessed, they have treatment plans and their needs are met.<sup>34</sup> The final rule modified this requirement to include the needs of those who need LTSS.<sup>35</sup> Despite requests from stakeholders, CMS declined to define the term “special health care needs,” preferring to leave it to the states’ discretion.<sup>36</sup> There is therefore an opportunity for child health stakeholders to urge their states to include a specific definition of “children and youth with special health care needs” (CYSHCN) when they define the term generally.

Moreover, as noted above, CMS will require states to establish time and distance standards for LTSS.<sup>37</sup> In addition, states’ quality improvement strategies must describe how the state will comply with the continuity of care requirement to identify people with special health care needs.<sup>38</sup>



**Encourage CMS to establish pediatric measures when it establishes national standards projects.**



**Urge states to include a specific definition of “children and youth with special health care needs” and incorporate CYSHCN in the LTSS and continuity of care requirements.**



## Children's Provisions

### EPSDT and Medical Necessity

The Medicaid statute includes a specific medical necessity standard for services for children. Under Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, beneficiaries under age 21 are entitled to an array of screening and treatment services.<sup>39</sup> Children must receive medical (including mental health), dental, vision, and hearing screenings at pre-set intervals, regardless of whether there is a particular health problem, and when a health problem is suspected.<sup>40</sup> They are also entitled to any Medicaid service that can be covered under the federal Medicaid program, regardless of whether it is covered for adults, when necessary to "correct or ameliorate" a condition or illness.<sup>41</sup>

*Medicaid managed care plans generally may not have a stricter definition of medical necessity and must cover services to the same extent that they are covered under the state Medicaid plan.*<sup>42</sup> Over the years, there have been problems when states and managed care plans fail to comply with this requirement. This is particularly true with EPSDT, because its broad entitlement to treatment can be inconsistent with the way that managed care plans operate. MCOs, PIHPs and PAHPs receive a set payment for services they provide, which creates a strong incentive to limit coverage of services. Moreover, EPSDT's expansive medical necessity standard is much broader than medical necessity standards in managed care generally. Thus, managed care plans and state Medicaid agencies must make specific efforts to conform to EPSDT's requirements.

The proposed regulations added a requirement that MCO, PIHP and PAHP contracts define medical necessity in a manner that meets EPSDT's requirements, including the broad

medical necessity standard.<sup>43</sup> CMS stated that it "believed the change was necessary to ensure that state definitions of medical necessity complied with federal EPSDT laws."<sup>44</sup>

However, in the final regulation, CMS removed the reference to EPSDT and revised the regulation to provide:

"Each contract between a state and an MCO, PIHP, or PAHP must do the following: . . . Require that the services . . . be furnished in an amount, duration and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in § 440.230 of this chapter, and for enrollees under the age of 21, **as set forth in subpart B of part 440 of this chapter.**"<sup>45</sup>

Subpart B of part 440 describes the coverage standard for services for adults. This is likely a typographical error in the rule because the description of this issue in the preamble to the final rule refers to subpart B of part 441 of this chapter,<sup>46</sup> which addresses EPSDT for children under age 21. However, subpart B, part 441 regulations were promulgated prior to the 1989 Medicaid Act amendments clarifying EPSDT coverage. At that time, states were only required to include limited coverage beyond their state Medicaid plans and the rule in part 441 reflects that outdated standard.<sup>47</sup> By referencing the older rule, the requirement is inconsistent with the Medicaid Act's current EPSDT coverage standards on the precise point that the regulation is attempting to address, because it does not reflect the broad coverage requirements of the EPSDT statutory provisions.

The statutory requirement governs. States must cover all medically necessary services that can be covered under the Medicaid program even if they are not included in the



state plan. The regulation should be amended to align with the statute. In the meantime, CMS should clarify that managed care plans may not have a stricter definition of medical necessity and must cover all Medicaid services necessary to correct or ameliorate conditions or illnesses.

### Children's Health Insurance Program (CHIP)

States may design their CHIP programs as an expansion of Medicaid, a separate program, or a combination of the two, and the design choice dictates which federal rules apply.<sup>48</sup> Historically, CHIP has had few managed care regulations, despite managed care being the predominant delivery system since CHIP began. The CHIP provisions of the rule will have the greatest impact on those states with large separate CHIP programs who use managed care, like Colorado, Florida, Georgia, New York, Pennsylvania and Texas.<sup>49</sup>

Only six statutory provisions from Medicaid apply to CHIP.<sup>50</sup> These statutory changes were first implemented in two State Health Official letters,<sup>51</sup> but are now part of the CHIP regulations.<sup>52</sup> While these changes are significant given the relative lack of CHIP managed care regulations previously, the new CHIP rules are aligned with those of Medicaid and the Marketplace where possible, so they should be familiar to states and plans. Many of the new CHIP provisions are incorporated by cross reference to the related Medicaid provisions, and future briefs in this series will outline the details of the Medicaid provisions. Below are highlighted some of the key differences between Medicaid and CHIP because the scope of the CHIP regulations is narrower. For a crosswalk of all of the CHIP provisions to Medicaid, see Appendix A.

### Standard Contract Requirements<sup>53</sup>

The final rule adopts many of the managed care contracting requirements from Medicaid.<sup>54</sup> However, the CHIP rules differ from the Medicaid rules in two key ways:

1. While states must submit CHIP MCO, PIHP, PAHP, PCCM and PCCM entity contracts to CMS for review, prior CMS approval is not required as a condition of receipt of federal funding.
2. The CHIP contract submissions must include the rate that will be paid to the managed care entity, but CMS will not review the rates to ensure compliance with rate-setting standards, as CHIP is not adopting the Medicaid rate review provisions.

The final rule makes managed care contracts more transparent than ever before, giving advocates new opportunities to identify the managed care requirements and support compliance. A future brief in this series will explain the contracting requirements applicable to Medicaid and CHIP in greater detail in order to highlight those areas where state-level advocacy could result in improved care for children and families.

### Rate Development Standards and Medical Loss Ratio<sup>55</sup>

The final rule re-designates some existing CHIP rate setting requirements<sup>56</sup> and adds new provisions related to medical loss ratio (MLR) by cross-reference to Medicaid.<sup>57</sup> The rate development standards in CHIP are narrower than those in Medicaid, because the CHIP statute does not require as much federal oversight of rates. Like Medicaid, CHIP rates must be designed to reasonably achieve an MLR of 85 percent. The state also must submit to CMS an annual summary of the reports each MCO, PIHP or PAHP provides to the state about its expenditures. This will be a topic of a future brief in the series.



**Timeline: Most CHIP provisions are effective no later than the beginning of the state fiscal year beginning on or after July 1, 2018.**



### **Enrollment Process<sup>58</sup>**

In CHIP, unlike in Medicaid, states may require prospective, mandatory enrollment in managed care without offering beneficiaries a choice of plan. This additional statutory flexibility is reflected in the final rule, which describes the requirements for a default MCO, PIHP, PAHP, PCCM or PCCM entity enrollment process should the state choose to operate one. However, children in CHIP would benefit from having some of the same choices and enrollment protections as children have under the Medicaid rules and beyond. This will be a topic of a future brief in the series.

### **Quality Measurement and Improvement; External Quality Review<sup>59</sup>**

The rule applies the quality measurement and improvement provisions and the external quality review (EQR) provisions from Medicaid to CHIP MCOs, PIHPs, PAHPs and those PCCM entities whose contracts include shared savings, incentive payments or other financial rewards for quality improvement.<sup>60</sup> The Medicaid provisions will be a topic of a future brief in this series, but there are two key differences to note for CHIP:

1. EQR activities in CHIP are matched at the regular CHIP match rate (rather than the 75 percent match in Medicaid); and
2. EQR activities in CHIP are subject to the 10 percent administrative cap.

Please see appendix A for a complete list of the CHIP managed care provisions, the related Medicaid cross-references, applicability to different managed care entities, and notable differences between CHIP and Medicaid.

Future briefs in the series will highlight opportunities to strengthen the CHIP provisions as the related Medicaid provisions are discussed more fully.

## **Conclusion**

In the coming months and years, as states and plans grapple with implementing these new rules, child health stakeholders have a remarkable opportunity to influence the process to improve the delivery of services for children and low-income families in Medicaid and CHIP. It will be critical to engage early and often to encourage states to go beyond the federal minimum requirements to make these rules even better.



## Appendix A: CHIP Summary Table

Provision	CHIP Section	Medicaid Section	Applicable Entities	Notable Differences
Basis, Scope and Applicability	§ 457.1200	N/A	Varies by provision	Only certain provisions from Title XIX Section 1932 apply to Title XXI, so the scope of the CHIP rules is narrower than Medicaid.
Standard Contract Requirements	§ 457.1201	§ 438.3	MCO, PIHP, PAHP, PCCM, PCCM entity	All of § 438.3 is applicable to CHIP without modification, except: <ul style="list-style-type: none"> <li>• § 457.1201(a) requires only CMS review of contracts for CHIP rather than prior approval;</li> <li>• § 457.1201(b) excludes HIOS from CHIP;</li> <li>• § 457.1201(c) requires submission of rates only upon request from the Secretary;</li> <li>• § 457.1201(d) does not require voluntary enrollment in managed care;</li> <li>• § 438.3(g) regarding provider preventable conditions does not apply to CHIP;</li> <li>• § 438.3(j) regarding advance directives does not apply to CHIP;</li> <li>• § 457.1201(i) uses CHIP rules regarding sub-contractual relationships at § 457.1233(b) rather than Medicaid rules at § 438.3(k);</li> <li>• § 438.3(o) regarding LTSS does not apply to CHIP;</li> <li>• § 438.3(p) regarding HIOS does not apply to CHIP; § 457.1201(m) requires PCCM compliance with CHIP disenrollment standards at § 457.1212 rather than Medicaid standards at § 438.56(c);</li> <li>• § 457.1201(n) describes additional rules for PCCM entities in CHIP rather than following the Medicaid rules at § 438.3(r);</li> <li>• § 438.3(s) regarding outpatient drugs does not apply to CHIP;</li> <li>• § 438.3(t) regarding dual eligibles does not apply to CHIP;</li> <li>• § 457.1201(o) describes CHIP attestation requirements; and</li> <li>• § 457.1201(p) describes the CHIP requirement not to avoid costs.</li> </ul>
Rate Development Standards and Medical Loss Ratio	§ 457.1203	N/A	MCO, PIHP, PAHP	CHIP statute has fewer provisions related to payment rates so the rule follows CHIP standards (not Medicaid) except for application of an MLR in the rate setting process (§ 438.8) and related reporting requirements (§ 438.74).
Non-emergency Medical Transportation PAHPs	§ 457.1206	§ 438.9	NEMT PAHPs	Like Medicaid, CHIP imposes fewer regulations on PAHPs that provide NEMT services only. The CHIP rules mirror the Medicaid rules except CHIP does not include rules related to LTSS.
Information Requirements	§ 457.1207	§ 438.10	MCO, PIHP, PAHP, PCCM, PCCM entity	None
Provider Discrimination Prohibited	§ 457.1208	§ 438.12	MCO, PIHP, PAHP	None
Contracts Involving Indians, Indian Health Care Provider, and Indian Managed Care Entities	§ 457.1209	§ 438.14	MCO, PIHP, PAHP, PCCM, PCCM entity	None
Enrollment Process	§ 457.1210	N/A	MCO, PIHP, PAHP, PCCM, PCCM entity	Unlike Medicaid, CHIP allows mandatory, prospective enrollment in managed care without choice of plan. The CHIP enrollment rules simply set out the requirements for a default enrollment process, should the state choose to operate one.



## Appendix A: CHIP Summary Table (continued)

Provision	CHIP Section	Medicaid Section	Applicable Entities	Notable Differences
Disenrollment Process	§ 457.1212	§ 438.56	MCO, PIHP, PAHP, PCCM, PCCM entity	References to “fair hearings” in Medicaid should be read to refer to “reviews” in CHIP because Medicaid beneficiaries have different due process rights.
Conflict of Interest Safeguards	§ 457.1214	§ 438.58	MCO, PIHP, PAHP	None
Continued Services to Enrollees	§ 457.1216	§ 438.62	MCO, PIHP, PAHP, PCCM, PCCM entity	None
Network Adequacy Standards	§ 457.1218	§ 438.68	MCO, PIHP, PAHP	None
Enrollee Rights	§ 457.1220	§ 438.100	MCO, PIHP, PAHP, PCCM, PCCM entity	None
Provider-Enrollee Communication	§ 457.1222	§ 438.102	MCO, PIHP, PAHP	None
Marketing Activities	§ 457.1224	§ 438.104	MCO, PIHP, PAHP, PCCM, PCCM entity	CHIP state agencies are not required to consult with the Medical Care Advisory Committee when approving marketing materials.
Liability for Payment	§ 457.1226	§ 438.106	MCO, PIHP, PAHP	None
Emergency and Post-stabilization Services	§ 457.1228	§ 438.114	MCO, PIHP, PAHP, PCCM, PCCM entity	The CHIP provision relies on the CHIP definition of emergency services at § 457.10 rather than the Medicaid definition in § 438.114, though the two definitions are similar.
Access Standards	§ 457.1230	§§ 438.206, 207, 208, 210	MCO, PIHP, PAHP	§§ 438.206, 207 and 208 apply to CHIP without modification. All of § 438.210 applies to CHIP without modification except § 438.210(a)(5) related to medical necessity and § 438.210(b)(2)(iii) related to LTSS do not apply to CHIP.
Structure and Operation Standards	§ 457.1233	§§ 438.214, 230, 236, 242	MCO, PIHP, PAHP	None
Quality Measurement and Improvement	§ 457.1240	§§ 438.330, 332, 334	MCO, PIHP, PAHP, some PCCM entities*	§§ 438.332 and 334 apply to CHIP without modification. § 438.330 applies to CHIP without modification except § 438.330(d)(4) related to dual eligibles does not apply.
External Quality Review	§ 457.1250	§§ 438.350, 352, 354, 356, 358, 360, 364	MCO, PIHP, PAHP, some PCCM entities*	§§ 438.350, 352, 354, 356, 358 and 364 apply to CHIP without modification. § 438.360 only applies to CHIP with respect to private accreditation (Medicare accreditation may not substitute for EQR in CHIP). Note that unlike Medicaid, CHIP EQR activities are matched at the CHIP match and subject to the 10% administrative limit. States may amend an existing Medicaid EQRO contract to include CHIP.
Grievance System	§ 457.1260	§ 438 Subpart F	MCO, PIHP, PAHP	All of § 438 Subpart F applies to CHIP except § 438.420 with respect to continuation of benefits pending appeal. References to “fair hearings” in Medicaid should be read to refer to “reviews” in CHIP because Medicaid beneficiaries have different due process rights.
Sanctions	§ 457.1270	§ 438 Subpart I	MCO	None
Conditions Necessary to Contract as an MCO, PIHP or PAHP	§ 457.1280	N/A	MCO, PIHP, PAHP	The rule moves existing program integrity rules related to managed care from § 457.955 to § 457.1280 and adds requirements related to compliance enforcement.
Program Integrity Safeguards	§ 457.1285	§ 438 Subpart H	Varies by provision	All of § 438 Subpart H applies to CHIP without modification except § 438.604(a)(2) regarding dual eligibles does not apply.

\* Like Medicaid, the quality measurement and external quality review provisions in CHIP apply to MCO, PIHP, PAHP and those PCCM entities whose contracts provide for shared savings, incentive payments, or other financial reward for improved quality outcomes. In the preamble to the proposed rule (80 Fed. Reg. at 31,163) CMS identified seven states whose PCCM entities included such financial arrangements, though they later clarified that only six such states are known: North Carolina, Oklahoma, Indiana, Arkansas, Colorado and Louisiana.



## Endnotes

<sup>1</sup> 42 C.F.R. Part 438 and 42 C.F.R. Part 457 Subpart L, available at <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>.

<sup>2</sup> V. Smith, K. Gifford, E. Ellis, R. Rudowitz, L. Snyder, and E. Hinton, “Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016,” Health Management Associates and Kaiser Family Foundation, October 2015, available at <http://kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016/>. Totals include states and D.C.

<sup>3</sup> V. Smith et al 2015. Exceptions are Alaska and Connecticut. Note that the definitions of PCCM and PCCM entity at 42 C.F.R. § 438.2 are new and may not align perfectly with the definition used in the survey.

<sup>4</sup> Medicaid and CHIP Payment and Access Commission, “Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY 2013,” available at <https://www.macpac.gov/wp-content/uploads/2015/03/March-2014-MACStats.pdf>. California and Vermont excluded because children are no longer enrolled in separate CHIP programs in those states. Minnesota, Nebraska, Oklahoma and Rhode Island excluded because separate CHIP program limited to unborn populations.

<sup>5</sup> Medicaid and CHIP Payment and Access Commission, “Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2012,” available at <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-29.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2012.pdf>.

<sup>6</sup> See, for example, Florida, Illinois, Louisiana, Mississippi, New Hampshire, and Utah moving toward more MCO coverage while only Connecticut moved toward more fee-for-service coverage between 2012 and 2016.

<sup>7</sup> Medicaid and CHIP Payment and Access Commission, “Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2012,” available at <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-29.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2012.pdf> and Medicaid and CHIP Payment and Access Commission email to Georgetown University Center for Children and Families staff, May 6, 2016. Note that nationwide percentages total more than 100 percent because children may be covered by more than one entity, like an MCO and a dental PAHP.

<sup>8</sup> Kaiser Family Foundation, “Medicaid Managed Care Penetration Rates by Eligibility Group as of July 1, 2015,” available at <http://kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/>.

<sup>9</sup> Medicaid and CHIP Payment and Access Commission, “Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY 2013,” available at <https://www.macpac.gov/wp-content/uploads/2015/03/March-2014-MACStats.pdf>.

<sup>10</sup> Soc. Sec. Act § 1932(b)(5) (SSA), 42 C.F.R. § 438.206(a).

<sup>11</sup> 42 C.F.R. § 438.206(b)(1).

<sup>12</sup> *Ibid.* at § 438.206(b)(2), (7).

<sup>13</sup> Note that beneficiaries must also have access to family planning services outside of the network consistent with the freedom of choice provisions at SSA §§ 1902(a)(23)(B) and 1905(a)(4)(C).

<sup>14</sup> 42 C.F.R. § 438.206(b)(4).

<sup>15</sup> *Ibid.* at § 438.358(b)(1)(iii), (iv).

<sup>16</sup> *Ibid.* at § 438.208(b)(2)(iv).

<sup>17</sup> Indeed, CMS stated that states should work with “their stakeholder community” to set network adequacy standards. 81 Fed. Reg. at 27633.

<sup>18</sup> See, e.g., 28 Cal. Admin. Code § 1300.51.H (providing that all managed care enrollees have a residence or workplace within 30 minutes or 15 miles of a primary care provider).

<sup>19</sup> See, e.g., 28 Cal. Admin. Code § 1300.67.2.2.5 (placing limits on time that managed care enrollees must wait for appointments); *Ibid.* at § 1300.67.2 (requiring plans to maintain certain ratios of physicians to enrollees).

<sup>20</sup> 42 C.F.R. § 438.62.

<sup>21</sup> *Ibid.* at § 438.62(b).

<sup>22</sup> The fifth in this series of explainer briefs will focus on the quality provisions of the rule. For a broader discussion of this topic, see T. Brooks, “Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders. Washington, D.C.,” Georgetown University Health Policy Institute, Center for Children and Families. Accessed June 1, 2016, <http://ccf.georgetown.edu/wp-content/uploads/2016/03/Measuring-Health-Quality-Medicaid-CHIP-Primer.pdf>.

<sup>23</sup> 42 C.F.R. § 438.310(b)(4).

<sup>24</sup> Quality provisions at § 438.330(b)(2), (b)(3), (c), and (e), § 438.340, and § 438.350 apply to PCCM entities whose contracts with the state provide for shared savings, incentive payments or other financial reward for the PCCM entity.

<sup>25</sup> States may also seek approval to establish their own QRS standards.

<sup>26</sup> 42 C.F.R. § 438.330(a).

<sup>27</sup> *Ibid.* at § 438.330(b), (d).

<sup>28</sup> *Ibid.*, § 438.350.

<sup>29</sup> 42 C.F.R. § 438.334(a) and 81 Fed. Reg. at 27689.

<sup>30</sup> 42 C.F.R. § 438.330(a)(2).



<sup>31</sup> 81 Fed. Reg. at 27680; see also 42 C.F.R. § 438.330(a)(2) (providing that CMS may specify performance measures and PIPs).

<sup>32</sup> See, e.g., 80 Fed. Reg. at 27693 (encouraging stakeholders to use the state's public process to recommend additional, state-specific elements, such as pediatric quality improvement, for the required quality strategy).

<sup>33</sup> Long-term services and supports are “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. . .” 42 C.F.R. § 438.2.

<sup>34</sup> See 42 C.F.R. § 438.208 (2002).

<sup>35</sup> 42 C.F.R. § 438.208(c).

<sup>36</sup> 81 Fed. Reg. at 27645.

<sup>37</sup> 42 C.F.R. § 438.68(b)(2).

<sup>38</sup> 42 C.F.R. § 438.340(b)(9).

<sup>39</sup> SSA § § 1902(a)(43), 1905(a)(4)(B), 1905(r)(5).

<sup>40</sup> SSA § 1905(r)(5); see also U.S. Department of Health & Human Services, “EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. Centers for Medicare and Medicaid Services,” accessed June 7, 2016, [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT\\_Coverage\\_Guide.pdf](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf).

<sup>41</sup> S.S.A. § 1905(r)(5).

<sup>42</sup> 42 C.F.R. § 438.210(a)(2).

<sup>43</sup> 42 C.F.R. § 438.210(a)(5)(ii) (proposed at 80 Fed. Reg. 31098, 31276 (June 1, 2015)).

<sup>44</sup> 80 Fed. Reg. at 31138.

<sup>45</sup> 42 C.F.R. § 438.210(a)(2) (finalized at 81 Fed. Reg. 27498, 27879 (May 6, 2016)) (emphasis added).

<sup>46</sup> 81 Fed. Reg. at 27634.

<sup>47</sup> See 42 C.F.R. § 441.56(c) (requiring coverage of vision, hearing, dental and immunization services “[i]n addition to any diagnostic and treatment services included in the [state] plan”); *Ibid.* at § 441.57 (describing other services as discretionary).

<sup>48</sup> Nine states use Medicaid to cover children financed by CHIP and must follow Medicaid rules for all children covered (Alaska, District of Columbia, Hawaii, Maryland, New Hampshire, New Mexico, Ohio, South Carolina and Vermont). Five additional states rely primarily on Medicaid to cover children financed by CHIP and must follow Medicaid rules for the vast majority of children (California, Minnesota, Nebraska, Oklahoma and Rhode Island). Two states operate completely separate CHIP programs and must follow CHIP rules for all children covered and financed by CHIP (Connecticut and Washington). The remaining 35 states use a combination of Medicaid and CHIP to cover children financed by CHIP and must follow

Medicaid rules for those children enrolled in Medicaid and CHIP rules for those enrolled in CHIP (Alabama, Arkansas, Arizona, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Jersey, New York, North Carolina, North Dakota, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin and Wyoming).

<sup>49</sup> Medicaid and CHIP Payment and Access Commission, “Table 5: Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY2013,” available at [https://www.macpac.gov/wp-content/uploads/2015/01/2014-03-14\\_Macpac\\_Report.pdf](https://www.macpac.gov/wp-content/uploads/2015/01/2014-03-14_Macpac_Report.pdf). As of FY 2013, 23 states with separate CHIP programs enrolled 80 percent or more of their CHIP beneficiaries in managed care. California has since switched to a Medicaid expansion program. Minnesota and Rhode Island cover large proportions of their separate CHIP enrollees in managed care, but they are not children. This leaves 20 states with 80 percent or more of their separate CHIP children enrolled in managed care: Arizona, Colorado, Delaware, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Michigan, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, Utah, Virginia, Wisconsin and Wyoming.

<sup>50</sup> SSA § 2103(f)(3) applies the following Medicaid managed care provisions to CHIP: Process for enrollment and termination and change of enrollment (SSA § 1932(a)(4)); provision of information (SSA § 1932(a)(5)); beneficiary protections (SSA § 1932(b)); quality assurance standards (SSA § 1932(c)); protections against fraud and abuse (SSA § 1932(d)); and sanctions for noncompliance (SSA § 1932(e)).

<sup>51</sup> SHO 09-008 available at <https://downloads.cms.gov/cmssgov/archived-downloads/SMDL/downloads/SHO083109a.pdf> and SHO 09-013 available at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO102109.pdf>.

<sup>52</sup> 42 C.F.R. § 457 Subpart L.

<sup>53</sup> *Ibid.* at § 457.1201

<sup>54</sup> *Ibid.* at § 438.3.

<sup>55</sup> *Ibid.* at § 457.1203

<sup>56</sup> Re-designated from § 457.940(b)(2), (c), and (e).

<sup>57</sup> 42 C.F.R. §§ 438.8 and 438.74.

<sup>58</sup> *Ibid.* at § 457.1210

<sup>59</sup> *Ibid.* at §§ 457.1240 and 457.1250

<sup>60</sup> *Ibid.* at §§ 438.330, 438.332 and 438.334, 438.350, 438.352, 438.354, 438.356, 438.358, 438.360 and 438.364.



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