



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

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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 low-income families critical information about the recently finalized Medicaid and CHIP managed care regulations. This paper is the fourth in the series, and it describes how the new rules assure network adequacy and access to services. Other briefs in this series include:*

- [Looking at the New Medicaid/CHIP Managed Care Regulations Through a Children's Lens](#), which gives an overview of the rules with an appendix detailing which Medicaid provisions also apply to the Children's Health Insurance Program (CHIP).
- [Medicaid/CHIP Managed Care Regulations: Improving Consumer Information](#), which covers new provisions for accurate, timely, accessible, and complete consumer information.
- [Medicaid/CHIP Managed Care Regulations: Enhancing the Beneficiary Experience](#), which describes how the new rule improves enrollment processes and establishes a new beneficiary support system.

*Future briefs in the series will dive into other issues important to low-income families in greater detail by focusing on topics such as 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 health 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. This issue brief series will identify those opportunities for action.*

## Background

As managed care and particularly mandatory managed care programs have become the predominant model for delivering care in Medicaid, there has been a growing recognition of the need to ensure that Medicaid plans contract with a sufficient number and range of providers to deliver all covered Medicaid benefits in a timely fashion. To this end, the modernization of federal Medicaid and Children's Health Insurance Program (CHIP) Managed Care regulations released in May 2016 seeks to ensure that enrollees have access to needed care by improving the standards and procedures related to network adequacy and access to services. The regulations continue to require states to adhere to a basic rule requiring that all services covered under the state plan are available and accessible to enrollees of managed care plans in a timely manner.<sup>1</sup> In order to make this basic rule easier to implement and monitor, the regulations include new requirements for states to develop quantitative network adequacy standards and carefully monitor access to care. In addition, the new rule enhances existing provisions that require plans to coordinate care for their enrollees, authorize services according to clinically appropriate criteria, and allow enrollees to appeal plan decisions to deny, terminate, or reduce services. Some provisions are applicable to all managed care entities, but some are narrower in scope (see the appendix for definitions of different managed care arrangements).

States that have implemented CHIP as a Medicaid expansion program, also known as M-CHIP, must follow the Medicaid rules. Separate CHIP programs are governed by different rules that may or may not mirror the Medicaid rules. Provisions that apply to separate CHIP programs are summarized at the end of this brief (see page 13).



## Network Adequacy and Availability of Services

Applies to MCOs,  
PIHPs, and PAHPs.

Timeline:  
For the rating period  
beginning on or after  
July 1, 2018.

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.

### Availability of Services (§ 438.206)

As noted, the final regulations continue to require states to ensure that all services covered under the state plan are available and accessible to enrollees of managed care plans in a timely manner. This basic rule is further defined by describing the requirements for each plan related to their delivery networks and the furnishing of services in a timely and accessible way.

The new rule does not require Medicaid plans to contract with particular provider types or to ensure that they cover a particular number of providers per enrollee. Instead, states must ensure that each plan maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract, and if the provider network is unable to provide the necessary services, the plan must cover those services out-of-network in an adequate and timely manner.<sup>2</sup> The rule builds on the longstanding Medicaid statutory requirement that states must ensure that plans provide access to emergency care out-of-network without requiring prior authorization.<sup>3</sup> States must also guarantee that plans provide or arrange for enrollees to seek second opinions, including by arranging for enrollees to see an out-of-network provider, if necessary. Finally, under “freedom of choice” rules, plans must allow enrollees to see the out-of-network family planning provider of their choice without first requiring a referral from the plan.<sup>4</sup> In all cases where enrollees are authorized to see an out-of-network provider, the plan must also coordinate payment with that out-of-network provider to ensure that the enrollee does not incur greater costs than if they had received care in-network.

Timely access standards require plans to

ensure that their networks are sufficient to provide enrollees with access to care within a specified number of days or hours. The new rule maintains the requirement that Medicaid plans provide enrollees with timely access to services. States must address timely access in their contracts with plans, but have flexibility to determine what those timely access standards will be. In developing their timely access standards, states must consider the urgency of care and must ensure that plans provide hours of operation no less than that offered to commercial enrollees or comparable to the state’s fee-for-service (FFS) program if the provider serves only Medicaid enrollees. In addition, states must require plans to make services available 24 hours a day, seven days a week when medically necessary (see text box on defining medical necessity on page 3). States must also establish mechanisms to monitor and ensure compliance by network providers and take corrective action when necessary.

Some states already employ specific timely access standards, typically differentiating between routine and urgent care. For example, Texas requires plans to provide appointments within 14 days for routine primary care and within 24 hours for urgent care. For specialty care, Texas requires plans to provide appointments within 30 days for routine care and within 24 hours for urgent care.<sup>5</sup>



Encourage your state, which will already be in the process of revising and developing network adequacy standards, to adopt new or improved quantitative timely access to care standards.



### What is “medically necessary”?

Federal law does not define the term “medically necessary” for adults in Medicaid. Instead, states define the term based on federal laws regarding the scope of coverage, such as mandatory versus optional benefits, and the requirement that services must be covered in sufficient amount, duration, and scope to reasonably achieve their purpose. Over time, states and plans have narrowed the definition of medically necessary services, often as a mechanism to constrain costs.

Federal law is more prescriptive in defining medical necessity for children because of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit. Under EPSDT, a determination of whether a service is medically necessary must be based on: 1) whether the service is necessary to correct or ameliorate a physical or mental health condition and 2) a particular child’s needs.



Review your state’s definition of medical necessity and work to ensure it complies with the criteria described by NHeLP in the [“Q&A: Defining Medical Necessity”](#) and CMS’ [EPSDT Coverage Guide](#).

Applies to  
MCOs, PIHPs,  
and PAHPs.

Timeline:  
For the rating period  
beginning on or after  
July 1, 2018.

### Network Adequacy Standards (§ 438.68)

The availability of services provisions at § 438.206 also require compliance with a new regulatory section requiring states to develop network adequacy standards, including specific time and distance standards for certain classes of providers. Time and distance standards require a plan to ensure that its network provides access to certain provider types within a specified number of miles or minutes from an enrollee. States must develop and implement standards in several different areas:

- Pediatric dental;
- Pediatric primary care;
- Pediatric behavioral health, including mental health and substance use disorder services;
- Pediatric specialist;
- OB/GYN;
- Adult primary care;

- Adult specialist;
- Adult behavioral health, including mental health and substance use disorder services;
- Hospital;
- Pharmacy; and
- LTSS services that require the enrollee to travel to the provider.

CMS may also identify additional provider types that states must subject to time and distance standards when doing so promotes the objectives of the Medicaid program.<sup>6</sup>

States must develop standards for all geographic areas of the state covered by the managed care program, but may allow plans to meet different standards in different parts of the state. State time and distance standards must be published on the state’s website and available in hard copy and accessible formats upon request.



Many states already use time and distance standards for their managed care plans. For example, Pennsylvania requires Medicaid plans to ensure that at least one or two specialists in designated specialty areas are available within 30 minutes of members' homes in urban areas, and within 60 minutes in rural areas; travel time is to be calculated accounting for use of public transit to the extent it is available.<sup>7</sup> Similarly, Michigan requires plans to make primary care and hospital services available within 30 minutes or 30 miles of enrollees' homes.<sup>8</sup> But many states do not have standards for the entire range of services and provider types required by the rule, thus close scrutiny will be needed to ensure that these states update their standards to be comprehensive. In 2013, nearly all states studied by the Department of Health and Human Services Office of Inspector General had some sort of time and distance standard for primary care, but only about half of the states studied had such standards for specialty care.<sup>9</sup>



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.

When setting the time and distance standards described in § 438.68(b), and with respect to all measurements of network adequacy, the rule requires states to consider certain factors. The factors include: the expected enrollment and utilization of services; characteristics and health needs of Medicaid enrollees; the number and types of providers, in terms of training, experience and specialization; number of providers who have closed panels; and the geographic location of providers and enrollees, considering distance, travel time, and the means of transportation used. States must also consider the ability of providers to communicate with enrollees with limited English proficiency (LEP) in their preferred language and to ensure physical access, reasonable accommodations, culturally competent communication, and accessible equipment for enrollees with physical or mental disabilities. Finally, states must consider the availability of triage lines, telemedicine and other innovative technological solutions.<sup>10</sup> For long term services and supports (LTSS), states must also consider elements that would support the enrollee's choice of provider and community integration.<sup>11</sup>



Applies to  
MCOs, PIHPs,  
and PAHPs.



Timeline:

For the rating period  
beginning on or after  
July 1, 2018.

## Assurances of Adequate Capacity and Services (§ 438.207)

The final rule maintains the requirement that MCOs, PIHPs, and PAHPs provide certain assurances to the state that the plans have the capacity to serve the expected enrollment in accordance with the state-set standards for access to care under §§ 438.206 and 438.68. In order to improve compliance with the network adequacy and access to services provisions, the new rule also requires plans to provide documentation of their network capacity to the state when they enter into a contract, and annually thereafter, or whenever there is a significant change that could affect network capacity.<sup>12</sup> The documentation must show that the plan offers an appropriate range of preventive care, primary care, specialty services, and LTSS and that the plan maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees. The state must review each plan's documentation and certify compliance with state standards to CMS; CMS may review the underlying documentation collected by the state. States must also post the documentation on which the state bases its certification on its website.<sup>13</sup>



Applies to states.



Timeline:

For the rating  
period that starts after  
release of related CMS  
guidance.

## State Monitoring Requirements (§ 438.66)

In addition to the assurances provided by the plans and certified by the state to CMS, the new rule considerably strengthens states' responsibilities to monitor and enforce network adequacy and availability of services standards. States must implement a monitoring program for their managed care entities that accounts both for plans' management of their provider networks and for plans' making services available and accessible.<sup>14</sup> States must conduct a readiness review for new MCOs, PIHPs, PAHPs, or PCCM entities and those that

expand (in terms of service area or population served) that evaluates the plan's capacity to manage its provider network.<sup>15</sup> Moreover, in their annual program assessment report to CMS, states must include an assessment of the availability and accessibility of services within capitated plans, including an evaluation of their plans' compliance with state network adequacy standards.<sup>16</sup> In addition, whenever a state grants an exception to state time and distance standards, it must monitor access to the provider type for which they have granted an exception, and report their findings in their annual program assessment report.

## State Monitoring System (§ 438.66(b))

States are required to develop a monitoring system for all managed care programs that addresses at least the following:

- Administration and management
- Appeal and grievance systems
- Claims management
- Enrollee materials and customer services, including the beneficiary support system
- Finance, including medical loss ratio
- Information systems, including encounter data reporting
- Marketing
- Medical management, utilization management, and case management
- Program integrity
- Provider network management, including provider directory standards
- Availability and accessibility of services, including network adequacy standards
- Quality improvement
- Areas related to LTSS
- All other contract provisions, as appropriate



The rule includes two additional oversight mechanisms, which will be covered in greater detail in upcoming briefs in this series. First, the state's managed care quality strategy must include the network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs. States must ensure that the network adequacy of each capitated plan is validated annually by the State, its agent, or an External Quality Review Organization (EQRO).<sup>17</sup> The fifth brief in this series will explore the quality-related provisions further.

Second, the capitation rates for managed care plans must be reviewed and approved by CMS as actuarially sound. To be approved, capitation rates must be adequate to meet the requirements on managed care plans regarding the availability of services (§ 438.206), adequate capacity and services (§ 438.207), and coordination and continuity of care (§ 438.208). More information on the rating requirements will be covered in the sixth brief in this series.



Encourage your state to ensure that an independent entity validates plan networks—either another state agency or an EQRO.

## Provider Inclusion Rules



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

### Process for Screening and Enrolling Providers in Plan Networks (§§ 438.602(b) and 438.608(b))

The new rule adds a requirement that each Medicaid Managed Care entity ensure that its contracted providers are screened by the state Medicaid program, even if they do not deliver services to Medicaid fee-for-service (FFS) beneficiaries. This program integrity provision is intended to provide greater consistency in Medicaid by ensuring that all providers who deliver services to Medicaid enrollees meet the same standards and to prevent providers barred from Medicaid FFS from serving in Medicaid managed care. A managed care entity may only enroll providers by entering provider contracts with them once they have successfully completed screening.



Timeline:

For the rating period beginning on or after July 1, 2018.

The state may perform provider screening itself, delegate this function to a third party, or allow the plans to conduct screening themselves. If a state permits plans to screen their own providers, it must monitor the plans' screening to ensure that the plans' processes are consistent and meet the state's quality standards. Plans may enter into short-term contracts of up to 120 days with providers while the outcome of a screen is pending, so long as the contract permits the plan to terminate the contract immediately if the provider does not pass the screen. The rule continues to permit plans to impose their own criteria for network inclusion that go beyond the state's minimum standards, so long as a plan's criteria do not discriminate against providers that serve high-risk populations or specialize in expensive treatments.<sup>18</sup>



Applies to MCOs,  
PIHPs, and PAHPs.



Timeline:

For the rating period  
beginning on or after  
July 1, 2018.

## Numbers and Types of Providers that Must be Included in Plan Networks (§§ 438.206(b) and 438.207(b))

The new rule does not require Medicaid plans to contract with particular provider types or to ensure that they cover a particular number of providers per enrollee. However, the Medicaid statute requires Medicaid programs to cover services provided by a few specific provider types including federally qualified health centers (FQHCs), nurse-midwives, and certified nurse practitioners.<sup>19</sup> States must also cover services provided by rural health clinics and free-standing birth centers to the extent permitted by state law.<sup>20</sup> CMS recently clarified in a guidance letter that, starting in 2017, it will require Medicaid plans to include at least one FQHC in their networks for the plan's contracted service area, as well as one rural health clinic and one free-standing birth center to the extent permitted by state law, when those services are covered in the plan's contract.<sup>21</sup>

Some other types of public health care programs require participating plans to meet more comprehensive numerical standards for provider inclusion. For example, Marketplace

plans must contract with a specified proportion of "essential community providers" (ECPs), which includes not only FQHCs and RHCs, but also Ryan White providers, family planning providers, and certain hospitals.<sup>22</sup> Another example is the federal Medicare rules, which require Medicare Advantage plans to meet specific provider-to-covered person ratios in several specified specialty areas.<sup>23</sup> In the new rule, CMS declined to require Medicaid plans to meet particular provider ratios, but noted that many states already employ ratios as a way of measuring the adequacy of their Medicaid plans' networks.<sup>24</sup>



Encourage your state to require plans to contract with any willing safety net provider, including Ryan White Providers and Children's hospitals.



TIP

Work with your state to incorporate provider-covered person ratios for specialty areas where there have been historic access problems, such as behavioral health and pediatric subspecialists.



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



Timeline:

For the rating period  
beginning on or after  
July 1, 2017.

## Special Rules for Indian Health Care Providers (§§ 438.14(b)(1))

The new rule also clarifies that state contracts with managed care entities serving Native American enrollees must require the managed care entity to ensure timely access to Indian Health Care Providers for all eligible Native American enrollees. The new rule also clarifies that managed care entities must pay out-of-network Indian Health Care Providers when

they deliver care to eligible Native American enrollees. Managed care entities must also permit eligible Native American enrollees to select an Indian Health Care Provider as a primary care provider.



## Care Coordination



Applies to MCOs,  
PIHPs, and PAHPs.



Timeline:

For the rating period  
beginning on or after  
July 1, 2017.

### Coordination and Continuity of Care (§ 438.208)

The rule expands the existing requirement on Medicaid MCOs, PIHPs, and PAHPs to coordinate care for enrollees. For new enrollees, the rule adds a requirement that plans conduct a screening within the first 90 days of enrollment in order to identify the enrollee's needs. The rule makes clear that plans not only have an obligation to ensure that each enrollee has an ongoing source of appropriate care, but also that the plan assigns a person or entity to be primarily responsible for coordinating the enrollee's services. This designee must coordinate: 1) the services that the plan provides to the enrollee, 2) care during transitions from one setting to another, 3) any services the enrollee receives from another managed care plan, 4) any carved-out services, and 5) community and social support services. The new rule clarifies that plans must ensure that their contracted providers maintain and share enrollee records, as appropriate, and in keeping with applicable privacy laws.

The new rule also clarifies special procedures that plans must follow to provide coordinated care to enrollees with special health care needs. The rule clarifies that these procedures should be applied for enrollees who use long-term services and supports (LTSS). The rule continues to require that plans have procedures in place to identify enrollees with special health care needs and individuals who need LTSS, assess their needs, and design a treatment plan based on those needs. In addition, the rule continues to require plans to allow these enrollees to see a specialist directly, for example, through a standing referral or an approved number of visits, where appropriate.



Urge your state to develop and include in contracts a specific definition of "children and youth with special health care needs (CYSHCN)" for whom the LTSS and continuity of care requirements should apply. Note, this may be a different definition than your state uses for other purposes related to CYSHCN.



Encourage your state to ensure that in requiring plans to coordinate community and social support services, that plans account for organizations such as Protection and Advocacy organizations, legal services organizations, Aging and Disability Resources Centers, Centers for Independent Living, Area Agencies on Aging, United Way 211 lines, and local and state government resources.



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



Timeline:

For the rating period  
beginning on or after  
July 1, 2018.

## Continued Services to Enrollees (§ 438.62)

The new rule adds protections that require states to ensure that enrollees can continue seeing their existing providers during certain times of transition. Specifically, the rule requires states to develop transition of care policies to permit enrollees to continue seeing existing providers who are out-of-network with their new plans when: 1) they move into a Medicaid Managed Care entity from FFS Medicaid, or they change plans; and 2) without

continuity of care, the enrollee is at risk of hospitalization or institutionalization. States have discretion to set the length of time that enrollees can continue to see their current providers who are out-of-network with their new plan.



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

## Service Authorization



Applies to MCOs,  
PIHPs, and PAHPs.



Timeline:

For the rating period  
beginning on or after  
July 1, 2017.

## Coverage and Authorization of Services (§ 438.210)

This rule continues several longstanding requirements on the scope of services that plans must authorize derived from the Medicaid statute.<sup>25</sup> Specifically, plans must provide all covered services in a sufficient amount, duration, and scope to achieve their purpose and such services must be identified and defined in the contract.<sup>26</sup> In addition, plans may not arbitrarily deny or reduce the amount, scope, or duration of covered services solely based on an enrollee's diagnosis, type of illness, or condition. Each plan must also ensure that covered services are provided in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries in FFS Medicaid or as required for children under the EPSDT benefit.<sup>27</sup> (For more on the EPSDT requirements in the new rule, see the first brief in this series.) But plans may place "appropriate limits" on covered services, as long as they are either based on criteria used by the state like medical necessity, or in order to control utilization.<sup>28</sup>

The new rule clarifies that plans must also define when a covered service will be considered medically necessary in a manner that is "no more restrictive" than the criteria used in the state's FFS program.<sup>29</sup> Where a plan limits services for utilization control reasons, it must nevertheless comply with the prior authorization and amount, duration, and scope rules set forth above. Thus the new rule makes clear that plans have a choice with respect to utilization review: they may either use the same criteria and process that the state uses in FFS Medicaid, or they may develop their own criteria and processes, as long as they are not more restrictive than those used in FFS Medicaid in terms of quantitative and non-quantitative limits. CMS has provided little guidance to states and plans, however, as to how they should determine whether a plan's particular criteria or process that is different from a criteria or process in the state's FFS Medicaid program is "more restrictive."



Urge your state to set uniform medical necessity criteria for services that apply to all plans, with special consideration for children and EPSDT. If your state allows plans to use their own criteria, make sure the state closely scrutinizes them to ensure that they are not more limiting.



The rule also continues to require that plans respond to service authorization requests within 14 calendar days.<sup>30</sup> In cases where waiting 14 days creates a risk of harm, the plan must expedite review and render a decision within 72 hours, or earlier if required by the enrollee's health condition. In all cases, the response time may be extended by an additional 14 calendar days at the request of the enrollee or provider, or when the plan determines that an extension is in the enrollee's best interest. Thus, for example, a child's pediatrician may determine that the child needs speech therapy services, and send a prior authorization request to the plan to cover those services. The plan has 14 days to notify the pediatrician and the child whether it will cover the requested speech therapy. If the plan needs additional information to make a decision, it may take up to 28 days to respond if it finds that taking more time is in the enrollee's best interest. Conversely, if the pediatrician tells the plan that the child needs to start services right away or risk her health, the plan must expedite its review and come to a decision within 72 hours.

The new rule adds two important protections in terms of service authorization. First, it requires that plans make sure that services for people with ongoing or chronic conditions are authorized in a manner that reflects their ongoing need.<sup>31</sup> Second, it emphasizes that plans must ensure that family planning services are available in- and out-of-network, consistent with freedom of choice.<sup>32</sup>



Applies to MCOs, PIHPs, and PAHPs.

### Special Rules for Prescription Drugs (§§ 438.3(s) and 438.210(d))

In addition to the rules described above, when a Medicaid plan uses utilization control techniques

to limit access to covered outpatient drugs, it must comply with the requirements set forth in the Medicaid statute.<sup>33</sup> Plans must abide by the statutory provisions that govern prior authorization of drugs. Thus, for drug authorization requests, plans must respond by telephone or other telecommunications method within 24 hours. In addition, plans are responsible for dispensing of a 72-hour supply of a covered outpatient drug in emergency situations.



Timeline:

For the rating period beginning on or after July 1, 2017.



Encourage your state to require that long-term services and supports or services aimed at treating chronic conditions are authorized for a twelve-month period unless there is a clinical reason for a shorter authorization period.



# Appeals



Applies to MCOs,  
PIHPs, and PAHPs.



Timeline:

For the rating period  
beginning on or after  
July 1, 2017.

## Right to Appeal Service Denials and Delays (§§ 438.400-424)

To fully access covered benefits, Medicaid beneficiaries must have an opportunity to contest limitations on services. Consistent with principles of due process, the rules have long required Medicaid plans to allow enrollees to appeal denials, delays, or modifications of all or part of a requested service, or reductions, suspensions or terminations of an existing service. The new rules make significant updates to these provisions.

First, the rule distinguishes between adverse benefit determinations and other matters. An adverse benefit determination includes the prior regulatory definition of an “action” (e.g., the denial, reduction, suspension, termination or delay of a service) and is expanded to include 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.”<sup>34</sup>

Second, for other matters, the rule continues to require each plan to have a grievance system in place for enrollees.<sup>35</sup> The grievance process allows enrollees to express dissatisfaction with matters that are not adverse benefit determinations, such as being treated rudely. Grievances also include disputes over an extension of time proposed by a plan to make an authorization decision. Grievances can be filed with the plan at any time.

Third, for adverse benefit determinations, the rule continues to require each plan to have an appeal system in place for enrollees. The rule clarifies that there can be only one level of appeal. In a major change, however, the rule will require enrollees to exhaust that

appeal before requesting a state fair hearing. The enrollee must file the appeal within 60 calendar days from the date of the adverse benefit determination notice from the plan. The appeal can be filed orally or in writing.

Usually, the rule will require enrollees to exhaust the plan-level appeal and only permit them to request a state fair hearing after receiving notice that the adverse benefit determination has been upheld. Notably, however, it does make an exception to this provision: If the plan fails to adhere to notice and timing requirements set forth in the rule, the enrollee is deemed to have exhausted the in-plan appeal process and can immediately request an impartial state fair hearing.<sup>36</sup>



TIP

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.

Plans must have an expedited review process for appeals. An expedited appeal occurs when the plan determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee’s behalf or in support of the enrollee’s request) that taking the time for standard resolution “could seriously jeopardize the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.”<sup>37</sup> Plans must ensure that punitive actions are not taken against providers who seek expedited resolutions. If the plan denies the enrollee’s request, it must process the appeal under the requirements for standard resolution and give the enrollee notice of the right to file a grievance disputing the decision to deny expedited resolution.



Applies to MCOs,  
PIHPs, and PAHPs.



Timeline:

For the rating period  
beginning on or after  
July 1, 2018.

### Continuation of Benefits while the Appeal and the State Fair Hearing are Pending (§ 438.420)

The regulations finalize a significant change that protects enrollees during the pendency of the appeal and state fair hearing. The plan must continue the enrollee's services if **all** of the following occur: 1) the enrollee files a timely appeal under § 438.404(c) (that is, an appeal is filed within 60 calendar days from the date on the adverse benefit determination notice); 2) the appeal involves 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; and 5) the enrollee timely files for continuation of benefits (that is, the enrollee requests continuation of benefits on or before 10 calendar days of the health plan sending the notice of adverse benefit determination). If these conditions are met, the benefit must continue until the enrollee withdraws the appeal or fair hearing request, the enrollee does not request a state fair hearing within 10 calendar days after the health plan sends notification of its adverse resolution, or the state fair hearing is decided against the enrollee.

When an appeal or state fair hearing is concluded adverse to the enrollee, the plan can recover the costs of the services furnished to the enrollee during the pendency of the review, to the extent benefits were furnished "solely because of the requirements of this section" and to the extent it is consistent with state policy.<sup>28</sup>

Prior to this regulation, a health plan would approve a set amount of a service, for example 60 days of home health, and at the end of the 60-day period say that the enrollee had received the entire service (60 days of home health) with no right to continued benefits. Any request for additional home health was treated as a new service request. This construct was particularly harmful to Medicaid enrollees with chronic and disabling conditions that are not going to go away. With this new regulation, so long as the preconditions noted above are met, services must continue.<sup>29</sup>



TIP

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

## Conclusion

As more and more Medicaid and CHIP enrollees receive benefits through managed care arrangements, the new requirements to ensure adequate networks and access to care provide important consumer protections. 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 timely and appropriate access to covered services.



## Separate CHIP Program Provisions

States that have implemented CHIP as a Medicaid expansion program, also known as M-CHIP, must follow the Medicaid rules outlined above. Separate CHIP programs are governed by different rules that may or may not mirror the Medicaid rules.

### ► Network Adequacy and Availability of Services

- **Availability of Services (§ 457.1230(a))**

The rule applies Medicaid's availability of services rules to CHIP for the first time by cross-referencing the Medicaid rules at § 438.206.

- **Network Adequacy Standards (§ 457.1218)**

The new time and distance standards are applied in their entirety to CHIP by cross-reference to the Medicaid standards at § 438.68.

- **Assurances of Adequate Capacity and Services (§ 457.1230(b))**

The rule applies Medicaid's adequate capacity rules to CHIP for the first time by cross-referencing the Medicaid rules at § 438.207.

- **State Monitoring Requirements (N/A)**

The state monitoring requirements described at § 438.66 were not adopted in CHIP. Existing CHIP regulations at § 457.495 require the state plan to include a description of the methods that a state uses for assuring the quality and appropriateness of care provided, including timely access. However, these rules are broader than the specific requirements of § 438.66 which require program monitoring, performance improvement activities, and annual reports to CMS.



Encourage your state to adopt the more specific review provisions of § 438.66 to CHIP in order to ensure compliance with the access standards.

### ► Provider Inclusion Rules

- **Process for screening and enrolling providers in plan networks (§ 457.1285)**

All of the program integrity provisions in § 438 Subpart H are applicable to CHIP, including the rules requiring provider screening.

- **Numbers and types of providers (§457.1230(a) and (b))**

Like Medicaid, CHIP rules require plans to contract with sufficient numbers and types of providers to demonstrate adequate availability and capacity by incorporating the Medicaid provisions from §§ 438.206 and 438.207. The Medicaid rules requiring plans to include at least one FQHC in their network as well as one rural health clinic and one free-standing birth center (see SHO # 16-006) do not apply to CHIP.

- **Special Rules for Indian Health Care Providers (§ 457.1209)**

The CHIP rules also require compliance with additional rules for plans serving Native Americans by cross-referencing the Medicaid rules at § 438.14.



## ► Care Coordination

- **Coordination and Continuity of Care (§ 457.1230(c))**

The rule applies the expanded version of an existing Medicaid requirement for plans to coordinate care to CHIP for the first time by cross-referencing the Medicaid provision at § 438.208.

- **Continued Services to Enrollees (§ 457.1216)**

The CHIP rules incorporate the Medicaid rules at § 438.62 that require plans to allow enrollees to continue to see existing providers during certain times of transition, even if those providers are out-of-network with the new plan.

## ► Service Authorization

- **Coverage and Authorization of Services (§ 457.1230(d))**

Most of the Medicaid rules related to coverage and authorization of services at § 438.210 apply to CHIP by cross-reference at § 457.1230(d). There are two exceptions: the rules related to specifying medical necessity standards at § 438.210(a)(5) and the rules related to LTSS at § 438.210(b)(2)(iii) do not apply to CHIP.

- **Special rules for prescription drugs (§ 457.1230(d))**

The contract provisions related to prescription drugs at § 438.3(s) do not apply to CHIP. However, the timeframes for prescription drug prior authorization decisions and short-term emergency supplies at § 438.210(d) are applicable to CHIP.

## ► Appeals

- **Right to appeal service denials and delays § 457.1260**

Most of the Medicaid rules related to grievances and appeals in § 438 Subpart F apply to CHIP by cross-reference at § 457.1260. There are two exceptions: there is no right to continuation of aid paid pending an appeal (Medicaid's rule at § 438.420 does not apply to CHIP) and references to "fair hearings" in the Medicaid rules should be read as "reviews" in CHIP because Medicaid beneficiaries have different due process rights.



## 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

<sup>1</sup> 42 C.F.R. § 438.206(a)

<sup>2</sup> Id. § 438.206(b)

<sup>3</sup> Social Security Act § 1936(b)(2); 42 C.F.R. §§ 438.114(b)-(c). Medicaid MCOs, PIHPs, and PAHPs must also cover post-stabilization care in certain circumstances. See Social Security Act § 1852(d)(2); 42 C.F.R. §§ 438.114(b), (e).

<sup>4</sup> Social Security Act §1902(a)(23); see also 42 C.F.R. 438.10(g)(2)(vi) (new requirement that plans explain freedom of choice in the enrollee handbook); id. § 438.206(b)(7) (new requirement that plans demonstrate adequate capacity to deliver timely access to family planning services from network providers, notwithstanding enrollees' right to seek such services out-of-network).

<sup>5</sup> Department of Health and Human Services, Office of Inspector General, "State Standards for Access to Care in Medicaid Managed Care," Sept. 2014, OEI-02-11-00320, available at <https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>.

<sup>6</sup> 42 C.F.R. § 438.68(b)

<sup>7</sup> Commonwealth of Pennsylvania, HealthChoices Physical Health Agreement, Apr. 1, 2015, Ex. AAA, AAA(1), available at [http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p\\_040150.pdf](http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf).

<sup>8</sup> Michigan Department of Management & Budget Purchasing Operations, Contract No. 071B02000, Comprehensive Health Care Program for the Michigan Department of Community Health, Jan. 1, 2016, Ex. A § V(a)(11), available at [http://www.michigan.gov/documents/contract\\_7696\\_7.pdf](http://www.michigan.gov/documents/contract_7696_7.pdf).

<sup>9</sup> Department of Health and Human Services, Office of Inspector General, "State Standards for Access to Care in Medicaid Managed Care," Sept. 2014, OEI-02-11-00320, available at <https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>.

<sup>10</sup> 42 C.F.R. § 438.68(c)(1)

<sup>11</sup> Id. § 438.68(c)(2)

<sup>12</sup> Id. C.F.R. § 438.207.

<sup>13</sup> Id. §§ 438.602(g)(2) and 438.604(a)(5)

<sup>14</sup> 42 C.F.R. § 438.66(b)(10)-(11).

<sup>15</sup> Id. § 438.66(d).

<sup>16</sup> Id. § 438.66(e)(2)(vi).

<sup>17</sup> Id. § 438.358(b)(1)(iv).

<sup>18</sup> See Id. § 438.214(c).

<sup>19</sup> Social Security Act §§ 1905(a)(2), (a)(17), (a)(21). The Medicaid Act also requires states to cover broad provider categories, including hospitals and physicians, but does not specify that states must cover particular physician specialists or specialty hospitals. See Id. §§ 1905(a)(1), (a)(17).

<sup>20</sup> Id. §§ 1905(a)(2), (a)(28); see also SHO # 16-006 at 4-5, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf>.

<sup>21</sup> SHO # 16-006 at 5.

<sup>22</sup> Marketplace ECP rules can be found at 45 CFR § 156.235. For more information about how a provider is designated as an ECP in the Federally Facilitated Marketplace, see Center for Consumer Information and Insurance Oversight, 2017 Letter to Issuers in the Federally-Facilitated Marketplaces 32 (2016), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>. While some advocates requested that CMS also require Medicaid plans to contract with ECPs, CMS explained in the preamble to the final rule: "The Medicaid program has a long history with ECPs, and . . . most Medicaid managed care plans contract with ECPs on a regular basis. . . . Therefore, we find the requirement to add specific access standards for ECPs in the Medicaid program to be duplicative and unnecessary." Medicaid and Children's Health

Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,498 at 27,660 (May 6, 2016), available at <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.

<sup>23</sup> CMS, Medicare Advantage Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance 7 (2012), available at [https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013\\_HSD\\_Provider\\_Facility\\_Specialties\\_Criteria\\_Guidance\\_111011.pdf](https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf).

<sup>24</sup> 81 Fed. Reg. 27,661. For examples of state standards, see, e.g., California Department of Health Care Services, Sample Contract Boilerplate for Geographic Managed Care, Ex. A, Att. 6 § 3 (2014), <http://www.dhcs.ca.gov/progovpart/Documents/GMCBoilerplate032014.pdf>; Wisconsin Medicaid Standards, Contract for BadgerCare Plus § V(G)(2), Jan. 1, 2016 – Dec.

<sup>25</sup> 31 – 2017, available at <https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Providers/2016-2017HMOContract.pdf>.

<sup>26</sup> See Social Security Act §1902(a)(10)(B).

<sup>27</sup> 42 C.F.R. §§ 438.210(a) and 438.210(a)(3)(i).

<sup>28</sup> Id. § 438.210(a)(2).

<sup>29</sup> See Id. § 438.210(a)(5).

<sup>30</sup> Id. § 438.210(d).

<sup>31</sup> Id. § 438.210(a)(4)(ii)(B).

<sup>32</sup> Id. § 438.210(a)(4)(ii)(C).

<sup>33</sup> Social Security Act § 1927; see 81 Fed. Reg. at 27,553 (preamble to final rule, stating that "states may allow managed care plans to use their own formularies, as well as their own utilization management tools to the extent they are consistent with the requirements of [42 U.S.C. § 1396r-8]"). The prior regulations did not specifically incorporate Social Security Act § 1927(d)(5) (A) against plans, but CMS has long interpreted plans to be subject to that provision. See 81 Fed. Reg. at 27544-45, 27552-54, 27635-36 (describing CMS's interpretative history).

<sup>34</sup> 42 C.F.R. §§ 438.400(b)(1), (7).

<sup>35</sup> The new rule excludes PAHPs that provide only non-emergency medical transportation and no other service from the requirement to maintain a grievance procedure, however. Id. § 438.402(a).

<sup>36</sup> Id. § 438.402(c)(1)(i)(A).

<sup>37</sup> Id. § 438.410(a).

<sup>38</sup> Id. § 438.424(d); see 81 Fed. Reg. at 27,516 ("[I]f the state does not exercise the authority for recoupment under §431.230(b) for FFS [fee for service], the same practice must be followed by the state's contracted MCOs, PIHPs, and PAHPs.").

<sup>39</sup> See 81 Fed. Reg. at 27,636 (noting that under the 2002 regulatory preamble, if the plan did not authorize additional days, ending treatment as provided by the original authorization would not constitute a termination triggering the right to continued benefits. "For purposes of the continuation of benefits under this regulation, however, the removal of paragraph (c)(4) means that an enrollee must continue to receive benefits without interruption, if elected by the enrollee, through the conclusion of the SFH [state fair hearing] process if the enrollee appeals an MCO's, PIHP's, or PAHP's adverse benefit determination.").



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