Issue Brief

# Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability – Final Regulation

## Background

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published a final regulation entitled "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability." This lengthy document provides the first update to CMS' Medicaid managed care rules since 2002.

Medicaid is the largest payer for births in the US, covering some 44% of all births.[1] The majority of adults covered by Medicaid (55%) are enrolled in a comprehensive managed care plan.[2] As a result, this rule is likely to impact many midwifery patients.

The rule itself is quite lengthy and deals with many different aspects of operating a managed care program, not all of which are of interest to midwives. If you wish to read the rule itself, it is available on-line.[3] ACNM staff have reviewed the rule and prepared a summary of key issues below.

### Timely and Adequate Notice of Adverse Benefit Determinations

When a plan decides not to cover a given item or service, it must notify the beneficiary. The adverse coverage determination includes the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. This additional documentation would include information regarding medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

This information will help beneficiaries and their providers understand why the plan may have denied coverage and can be used in an appeals process.

[1] CDC/NCHS, National Vital Statistics System. Available at: http://www.cdc.gov/nchs/data_access/vitalstats/vitalstats_births.htm

[2] MACSTATS. Available at: https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state/

[3] 81 Federal Register 27497. 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#h-33

**Grievances and Appeals**

CMS has shortened the timeframe for managed care plans to make a decision in response to a beneficiary's appeal for coverage. Previously the timeframe had been 45 days. The final rule moves that to 30 calendar days.

With regard to expedited review of requests for time sensitive services, the prior standard had been 3 working days. CMS has modified the requirement so that plans must make a decision within 72 hours of receiving a request for expedited review.

**Network Adequacy**

CMS established several important requirements in the final rule with regard to Medicaid managed care provider network adequacy. These include standards to ensure ongoing state assessment and certification of plan networks, threshold standards for the establishment of network adequacy measures for a specified set of providers, and transparency of network adequacy standards.

The previously existing network adequacy standards for Medicaid managed care did not include detailed and specific standards for how far away providers were from plan enrollees, or how long it would take to access them, nor did the standards include provider to enrollee ratios but deferred to each state to develop specific standards. The prior regulations relied heavily on attestations and certifications from states, with supporting documentation, about the adequacy of the network.

The final rule keeps this same general approach, as a way of providing states flexibility to address their specific conditions. However, CMS does now require that the states must establish, at a minimum, network adequacy standards for specified provider types. Notably, states must establish time and distance standards for OB/GYNs. Although ACNM and others commented that CMS should include other provider types in these specific standards, the agency declined to do so.

The final rule does permit states to vary those standards in different geographic areas to account for the number of providers practicing in a particular area and does not limit states to only the mandatory time and distance standards but also would have states consider additional elements when developing network adequacy standards.

In establishing their network adequacy standards, states must consider expected utilization and the characteristics and health needs of the covered population, geographic location and accessibility, as well as the ability of providers to ensure physical access, accommodations, and accessible equipment available for Medicaid enrollees with physical or mental disabilities, with proposed additional standards that the accommodations be reasonable and that the ability of providers to ensure culturally competent communication be considered. CMS also added a requirement that states consider the ability of network providers to communicate with limited English proficient (LEP) enrollees in their preferred language when the state is developing time and distance access standards.

CMS clarified in the final rule that states are not required to set the same network adequacy standards across all provider types and can vary such standards based on appropriate state benchmarks. States were also given flexibility to set varying network adequacy standards across rural and urban population centers. Further, states will have the authority to add

additional network adequacy standards if they choose in addition to the required time and distance standards.

To ensure transparency, states must publish their network adequacy standards on a public Web site. CMS also encourages states to include appropriate and meaningful stakeholder engagement and feedback when setting their network adequacy standards.

States must ensure that all services covered under the state plan are available and accessible to enrollees of managed care plans and plans must annually submit documentation, verified by the state, certifying the adequacy of the provider networks. Plans must also submit such documentation when significant changes have been made to their network.

**Quality**

CMS included a lengthy discussion of quality improvement in the final rule. In general, it focused on three different areas.

(1) *Transparency:* A key component in designing health care quality transparency initiatives is the use of meaningful and reliable data that is comparable across managed care plans, providers, and programs. The regulatory changes are intended to improve transparency with the goal of increasing both state and managed care plan accountability in the quality of care provided to Medicaid beneficiaries. Transparency will help stakeholders (including beneficiaries) to engage in informed advocacy, compare the performance of providers and managed care plans, and make informed managed care plan choices.

(2) *Alignment with other systems of care:* Integrating the approaches to quality measurement and improvement across different programs so that they result in a more streamlined system for states, managed care plans, stakeholders, and beneficiaries.

(3) *Consumer and Stakeholder Engagement:* Consumer and stakeholder engagement is particularly important when designing an approach to measuring quality for Medicaid managed care. Providing consumers with information about their managed care plan is one tool for engaging them in health care decision-making; another is soliciting consumer participation in the development of state strategies for improving care and quality of life. The regulatory changes seek to strengthen the role of consumers in health care decision-making through use of new tools to enhance active engagement.

**Provider Discrimination**

In the discussion of comments, CMS indicates that, managed care plans can contract for less than the full scope of services available from a provider and/or for less than the full scope of services covered in the managed care plan's contract with the state. Midwives should thus pay close attention to contracts offered by managed care plans to determine whether there are any such limitations.

**Conclusion**

The final rule is effective, for the most part, on July 5, 2016. If you have questions about this regulation, please reach out to Jesse Bushman, ACNM's Director of Advocacy and Government Affairs at jbushman@acnm.org