Center for Medicare & Medicaid Services (CMS)
Medicaid and CHIP Managed Care Final Rule (CMS 2390-F)

Fact Sheet: Subpart B–State Responsibilities

NCSL

Definition of Terms

The final rule provides for a definition of terms for *Managed Care Organizations (MCOs), Pre-paid Inpatient Health Plans (PIHP), Pre-paid Ambulatory Health Plans (PAHP)* as follows:

- **An MCO** is defined as being an entity that has or is seeking to qualify for a comprehensive risk contract that is a federally qualified health maintenance organization (HMO), or meets the qualifications set forth by the secretary to make health services it provides to Medicaid enrollees.
- **A PAHP** is an entity that is responsible for **primarily ambulatory services** for enrollees under a contract with the state, and on the basis of a capitation payment, or other payment arrangements that do not use state plan payment rates.
- **A PIHP** is an entity that is responsible for the provision of **inpatient hospital or other types of institutional services** under contract with the state, and on the basis of a capitation payment, or other payment arrangements that do not use state plan payment rates.
- PAHPs and PIHPs do not enter into comprehensive risk contracts.

Subpart B—State Responsibilities

§438.50–State Plan requirements.

(b) State plan information. When a state plan requires a Medicaid beneficiaries to enroll in *Managed Care Organizations (MCOs), Primary Care Case Manager (PCCM), or PCCM* entity they must specify:

- The types of entities with which the states contracts,
- The payment method it uses (for example, whether fee-for-service (FFS) or capitation).
- Whether it contracts on a comprehensive risk basis.
- The process the state uses to involve the public in both design and initial implementation of the managed care program and the methods it used to ensure ongoing public involvement once the state plan is implemented.

(c) State plan assurances. The plan must provide assurance that the state meets applicable statutory and regulatory requirements regarding managed care contracts and freedom of choice, and that required groups will be exempt from mandatory enrollment in MCOs, PCCMs and PCCM entities.

(d) Limitation on enrollment. The state must provide assurance that in implementing the state plan managed care option, it will not require the following groups to mandatorily enroll in an MCO, PCCM, or PCCM entity:

- Beneficiaries who are also eligible for Medicare.
- Indians–This means the individual:
  - Is a member of a Federally recognized Indian tribe;
  - Resides in an urban center and meets one or more of the four criteria:
    i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
    ii. Is an Eskimo or Aleut or other Alaska Native;
    iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
    iv. Is determined to be an Indian under regulations issued by the Secretary;
  - Is considered by the Secretary of the Interior to be an Indian for any purpose; or
  - Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
- Children under 19 years of age who are:
  - Eligible for SSI under Title XVI:

- Eligible disabled children receiving home and community-based services under 1902(e)(3) of the Social Security Act;
- In foster care or other out-of-home placement;
- Receiving foster care or adoption assistance; or
- Receiving services through a program for children with special health care needs (CSHCN).

§438.52–Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities.

(a) General rule. Any state that requires Medicaid beneficiaries to enroll in a managed care entity or a primary care case management system must give beneficiaries a choice of at least two options in each entity. States may limit a beneficiary to a single PCCM entity, but the beneficiary must be permitted to choose from at least two primary care case managers employed by or contracted with the PCCM entity.

(b) Exception for rural area residents. A state may limit a rural area resident to a single MCO, PIHP, or PAHP through a state plan amendment, section 1115(a) waiver[i], or section 1915(b) waiver[ii]. To comply with this requirement a state must permit a beneficiary to choose from at least two primary care providers, and to obtain service from any other provider under any of the following circumstances:

- The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, or PAHP network.
- The provider is not part of the network, but is the main source of a service to the beneficiary, provided that:
  - The provider is given the opportunity to participate in the network,
  - If the provider chooses not to join the network, or does not meet the necessary requirements to join, the enrollee will be transitioned to a participating provider within 60 calendar days (after being given an opportunity to select a participating provider).
- The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks.
- The beneficiary's primary care provider determines that the beneficiary needs related services that would subject the beneficiary to unnecessary risk if received separately and not all of the related services are available within the network (for example a cesarean section and a tubal ligation).
- The state determines that other circumstances warrant out-of-network treatment.

"Rural area" is any county designated as "*micro*," "*rural*," or "*County with Extreme Access Considerations (CEAC)"* in the Medicare Advantage Health Service Delivery (HSD) Reference[iii] file for the applicable calendar year.

(c) Exception for certain health insuring organizations (HIOs). The state may limit beneficiaries to a single HIO if:

- The health insuring organization is county-operated as in section 1932(a)(3)(C) of the Social Security Act; and
- The beneficiary who enrolls in the HIO has a choice of at least two primary care providers within the entity.

(d) Limitations on changes between primary care providers. Any limitation the state imposes on an individual enrollees' freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment the state has chosen to include in their managed entity contracts under §438.56(c).

§438.54–Managed care enrollment.

(b) General rule. This section addresses a gap in current rule, there have been no federal regulations governing enrollment of beneficiaries into Medicaid managed care programs. CMS has set the minimum base standards and the state may use either an enrollment system that provides the beneficiary time to make an affirmative election to receive services through a managed care or FFS delivery system or a passive enrollment process.

- Voluntary managed care programs are those where one or more groups of beneficiaries have the option to either enroll in an MCO, PIHP, PAHP, PCCM or PCCM entity, or remain enrolled in FFS to received Medicaid covered benefits.
- Mandatory managed care programs are those where one or more groups of beneficiaries must enroll in an MCO, PIHP, PAHP, PCCM or PCCM entity to receive Medicaid benefits.

Period of election–A specific enrollment standards applicable to both voluntary and mandatory managed care programs

that all states must provide a period of time of at least 14 calendar days of FFS coverage for potential enrollees to make an active choice of their managed care plan. If an enrollee does not make a choice, then the potential enrollee will be enrolled in a managed care plan selected by the state's default process when the choice period ends. To minimize delays, CMS allow states to operationalize the 14-day active choice period by advising beneficiaries of the plan they would be enrolled into through the default process if they do not make an active choice.

(c) Voluntary managed care programs. States that have a voluntary managed care program must have an enrollment system that:

- Provides an enrollment choice period before enrollment is effectuated, or
- Employs a passive enrollment process in which the state enrolls the potential enrollee into an MCO, PIHP, PAHP, PCCM or PCCM entity and simultaneously provides a period of time for the enrollee to make an active choice of delivery system and, if needed, to maintain enrollment in the entity passively assigned or to select a different managed care entity.

A state must provide potential enrollees the opportunity to actively elect to receive covered services through the managed care or FFS delivery system. If the enrollee elects to receive covered services through the managed care delivery system they must then select an MCO, PIHP, PAHP, PCCMP, or PCCMP entity.

- If a state does not use a passive enrollment process and the potential enrollee does not make an active choice during the period allowed by the state, then the enrollee will continue to receive covered services through the FFS delivery system.
- If the state uses a passive enrollment process, the potential enrollee must select either to accept the managed care entity selected for them by the state's process, select a different entity, or elect to receive covered services through the FFS delivery system. If the enrollee does not make an active choice during the time allowed by the state, the enrollee will remain enrolled with the managed care entity selected by the passive enrollment process.

Informational notices–States must provide informational notices to each potential enrollee at the time the enrollee first becomes eligible to enroll in a managed care program. The notice shall:

- Clearly explain the implications to the enrollee of not making an active choice between managed care and FFS, selecting a different MCO, PIHP, PAHP, PCCM or PCCM entity, and accepting the managed care entity selected by the state,
- Identify the managed care entities available to the enrollee should they elect the managed care delivery system,
- Provide clear instructions for how to make known to the state the enrollee's selection of the FFS delivery system or a managed care entity,
- Provide a comprehensive explanation of the length of the enrollment period, the 90 day without cause disenrollment period, and all other disenrollment options, and
- Include the contact information for the beneficiary support system.

State enrollment systems must provide that beneficiaries already enrolled in a managed care entity are given priority to continue that enrollment if the entity does not have the capacity to accept all those seeking enrollment under the program.

Passive Enrollment Systems–If a state elects to use a passive enrollment process, the process must:

- Assign beneficiaries to a qualified MCO, PIHP, PAHP, PCCM or PCCM entity,
- Preserve existing provider beneficiary relationships and relationships with providers that have served Medicaid beneficiaries, or
- If the other options are not possible the state must distribute the beneficiaries equitably among the MCOs, PIHPs, PAHPs, PCCMs and PCCM entities.
- The state may not arbitrarily exclude any MCO, PIHP, PAHP, PCCM, or PCCM entity from being considered.
- The state may consider additional criteria to conduct the passive enrollment process, including:
  - the enrollment process, including the enrollment preference of family members, previous plan assignment of the beneficiary,
  - quality assurance and improvement performance,
  - procurement evaluation elements,
  - accessibility of provider offices for people with disabilities, and
  - other reasonable criteria that support the objectives of the managed care program.

If the enrollee does not elect to be enrolled into the FFS delivery system, the state must send a notice to the enrollee:

- Confirming that the enrollee's time to elect to enroll in the FFS delivery system has ended and that the enrollee will remain enrolled in the managed care delivery system for the remainder of the enrollment period unless one of the disenrollment reasons specified applies.
- Explaining the enrollee's right, and process to follow, to disenroll from the passively assigned managed care entity and select a different managed care entity within 90 days from the effective date of the enrollment or for any specified within disenrollment procedures.
- Within five calendar days of the end of the time allowed for making the delivery system selection.

(d) Mandatory managed care programs. States must have an enrollment system for a mandatory managed care program that includes the following elements:

- A state default enrollment system when enrollees fail to make an active choice,
- Informational notices provided by the state when an enrollee first becomes eligible to enroll in a managed care program.

§438.56–Disenrollment: Requirements and limitations.

(b) Disenrollment requested by the MCO, PIHP, PAHP, PCCM, or PCCM entity. All managed care entity contracts must:

- Specify the reasons for which the managed care entity may request disenrollment of an enrollee.
- Provide that the managed care entity may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.
- Specify the methods by which the managed care entity assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(c) Disenrollment requested by the enrollee. If the state chooses to limit disenrollment, its managed care entity contracts must provide that a beneficiary may request disenrollment as follows:

- For cause, at any time,
- Without cause, at the following times:
  - 90 days following the date of initial enrollment into the managed care entity, or during the 90 days following the date the state sends notice, whichever is later.
  - At least once every 12 months thereafter.
  - Upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.
  - When the state imposes an intermediate sanction.

(d) Procedures for disenrollment. A *request for disenrollment* by the beneficiary (or by their representative) must be submitted orally or in writing to the state (or its agent), or to the managed care entity.

Cause for disenrollment–The following are cause for disenrollment:

- The enrollee moves out of the service area,
- The plan does not, because of moral or religious objections, cover the service the enrollee seeks,
- The enrollee needs related services to be performed at the same time, not all related services are available within the provider network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
- For enrollees that use MLTSS, the enrollee would have to change their supports provider based on that provider's change in status from an in-network to an out-of-network provider with the managed care entity and as a result, would experience a disruption in their residence or employment.
- Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs.

MCO, PIHP, PAHP, PCCM, or PCCM entity action on request–When a state contract permits a managed care entity to process disenrollment requests, the managed care entity may either approve a request for disenrollment by or on behalf of an enrollee or refer the request to the state.

If the managed care entity or the state agency fails to make a disenrollment determination so that the beneficiary can be disenrolled within the timeframes, the disenrollment is considered approved.

State agency action on request–For a request for disenrollment received directly from the beneficiary, or referred from the managed care entity, the state agency must take action to approve or disapprove the request based on the reasons cited in the request, and the information provided by the managed care entity.

Use of the MCO's, PIHP's, PAHP's, PCCM's, or PCCMs entity's grievance procedures–The state agency may require that the enrollee seek redress through the managed care entity's grievance system before making a determination on the request. The grievance process must be approved and completed no later than the first day of the second month in which the enrollee requested the disenrollment.

If the managed care entity approved the disenrollment, the state agency is not required to make a determination.

(e) Timeframes for disenrollment determinations. Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the managed care entity refers the request to the state.

If the determination is not made within the required timeframe, the disenrollment is considered approved for the effective date that would have been established had compliance with the timeframe been met.

(f) Notice and appeals. A state that restricts disenrollment must provide enrollees and their representatives written notice of their disenrollment rights at least 60 days before the start of each enrollment period.

The state must also ensure the enrollee timely access to a State fair hearing (SFH) if they are dissatisfied with a state agency determination that there is not good cause for disenrollment.

(g) Automatic reenrollment: Contract requirement. This occurs if the state plan specifies, the contract must provide for automatic reenrollment of the beneficiary who is disenrolled only because of a loss of Medicaid eligibility for a period of two months or less.

§438.58–Conflict of Interest safeguards.

States must have in effect safeguards against conflict of interest on the part of state and local officers and employees and agents of the state who have responsibilities of relating to the managed care entities.

§438.62–Continued services to enrollees.

(a) The state agency will arrange for Medicaid services to be provided without delay to any Medicaid enrollee of a managed care entity whose contract is terminated or who is disenrolled for any reason other than ineligibility for Medicaid.

(b) A state should have in effect a **transition of care policy** to ensure continued access to services during a transition from FFS to an MCO, PIHP, PAHP, PCCM or PCCM entity or transition from one managed care entity to another. The transition of care policy must include:

- The enrollee has access to services consistent with the access they previously had, and they will retain their current provider for a period of time if they are not in the provider network.
- The enrollee is referred to appropriate providers of service that are in the network.
- Requests for historical utilization data from new managed care entities is shared fully and timely in compliance with federal and state law by previous covering entities including the state in relation to those individuals transitioning from FFS.
- The enrollees' new providers are able to obtain copies of the enrollee's medical records.

The state must require their contracted managed care organizations to implement the transition of care policy and at least meet the state defined policy. The state should make the policy publicly available and provide instructions to enrollees and potential enrollees on how to access continued services upon transition.

Inclusion in the quality strategy–At a minimum, the transition of care policy should be described in the quality strategy and explained to individuals in the materials to enrollees.

(c) Applicability date. *This section applies to the rating period for contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities beginning on or after July 1, 2018.*

§438.66–State monitoring requirements.

(a) General requirement. This expands state agency monitoring systems for all managed care programs, to include the performance of each MCO, PIHP, PAHP, and PCCM entity in at least the following areas:

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

(c) State monitoring activities for performance improvement. Adds new language requiring states to use data collected from its monitoring activities to improve the performance of its managed care program, including, at minimum: enrollment and disenrollment trends in each managed care plan; member grievance and appeal logs; provider complaint and appeal logs; findings from the state's EQR process; results from any enrollee satisfaction survey; performance on required quality measures; medical management committee reports and minutes; the annual quality improvement plan for each managed care plan or entity; audited financial and encounter data submitted by each plan; MLR summary reports; customer service performance data; and data related to LTSS.

(d) State assessment of managed care entity organizational readiness. Adds new language requiring state programs, whether voluntary or mandatory, to assess the readiness of each contracted managed care plan:

- At least 3 months prior to implementation of any contract when the plan has not previously contracted with the state; when the plan will expand the eligibility groups it services; when the plan will expand the benefits it offers; or, when the plan will expand its service area.
- The assessment must be submitted to CMS for the agency to make a determination that the contract or contract amendment is approved.
- Readiness reviews must include both desk reviews of documents and on-site reviews, and must assess the ability and capacity of the managed care plan to perform satisfactorily in the areas identified above.
- On-site reviews must include interviews with managed care entity staff and leadership that manage key operational areas.

(e) States must submit to CMS each no later than 180 days after each contract year, a report on each of its managed care programs, that includes:

- managed care plan-specific data on:
  - financial performance,
  - encounter data reporting,
  - enrollment and service area expansion,
  - modifications of covered benefits,
  - availability and accessibility of covered services, and
  - performance on quality measures.

These reports must be posted on the state's Medicaid website.

- For states operating their managed care program under a section 1115(a) waiver, submission of an annual report required by the Special Terms and Conditions of the program will be deemed to satisfy the requirements of the final rule, provided that the report includes the information specified in the requirements.
- The program report must provide information and an assessment of the operation of the managed care program, including at a minimum:
  - financial performance,
  - encounter data reporting,
  - enrollment and service area expansion,
  - grievance, appeals, and state fair hearings for the managed care program,
  - availability and accessibility of covered services including network adequacy standards,

- modifications to, and implementation of benefits covered under the contract with the state,
- evaluation of the managed care entity performance on quality measures, and
- results of any sanctions or corrective action plans imposed by the state to improve performance.

§438.68–Network adequacy standards.

(a) General rule. Requires states that deliver Medicaid services through managed care entity contracts to develop and enforce network adequacy standards consistent with the following requirements:

(b) Provider–specific network adequacy standards:

a. **Time & distance standards**–states must develop time and distance standards for the following categories of providers:
   i. Primary care providers, and behavioral health (mental health and substance use disorder) for both pediatric and adult populations,
   ii. Obstetrics & gynecology (OB/GYN),
   iii. Specialist, adult and pediatric,
   iv. Hospital,
   v. Pharmacy,
   vi. Pediatric dental, and
   vii. Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS.

b. **Long-term Services & Supports (LTSS)**–For contracts which cover LTSS, state must develop time and distance standards for provider types in which an enrollee must travel to the provider to receive services, and network adequacy standards other than time and distance standards for LTSS providers that travel to the enrollee to deliver services.

c. **Scope of network adequacy**–Standards should include all geographic areas covered by the managed care program or, if applicable, the contract between the state and the managed care entity. States are permitted to have varying standards for the same provider type based on geographic areas.

(c) Development of network adequacy standards

a. **Key elements**–states must consider **at a minimum** the following key elements in developing network adequacy standards:
   i. The anticipated Medicaid enrollment,
   ii. The expected utilization of services,
   iii. The characteristics and health care needs of specific Medicaid populations covered in the managed care entity contract,
   iv. The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services,
   v. The numbers of network providers who are not accepting new Medicaid patients,
   vi. The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees,
   vii. The ability of network providers to communicate with limited English proficient enrollees in their preferred language,
   viii. The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
   ix. The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

b. Additional considerations should include the following:
   i. Elements that would support an enrollees choice of provider,
   ii. Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee,
   iii. Other considerations that are in the best interest of the enrollees that need LTSS.

(d) Exceptions process. Any exceptions permitted by the state to the provider-specific network standards developed, the standards the exception will be evaluated and approved must be:

a. Specified in the managed care entity contract,
b. Based, at a minimum, on the number of providers in the specialty practicing in the managed care entity service area.

States that grant an exception must monitor enrollee access to that provider type on an ongoing basis.

(e) Publication of network adequacy standards. Network adequacy standards should be published on the state Web site, and should be made available at no cost to enrollees with disabilities in alternative formats or through the provision of auxiliary aids and services.

§438.70–Stakeholder engagement when LTSS is delivered through a managed care program.

States must ensure that the views of beneficiaries and other stakeholders are solicited and addressed during the design, implementation, and oversight of a state's managed LTSS program.

§438.71–Beneficiary support system.

(a) The final rule requires states to develop and implement a beneficiary support system that provides support to the beneficiary prior to and after enrollment in a managed care entity.

(b) Elements of the support system. A beneficiary support system must include at a minimum, choice counseling, assistance understanding managed care, and assistance for enrollees who use or express the desire to receive LTSS. The support system should perform outreach to beneficiaries and or their representatives and be accessible in multiple ways. CMS is intentionally differentiating the beneficiary support system from long-term care ombudsman programs, as not al; traditional ombudsman activities may be eligible for Medicaid funding.

(d) Functions specific to LTSS activities. The final rule imposes new conditions that must be met for the state to claim FFP. The LTSS-specific beneficiary support system should provide at a minimum: (1) an access point for complaints and concerns about the managed care entity enrollment access to covered services; (2) education on enrollees' grievance and appeal rights; (3) assistance navigating the grievance and appeals process; (4) and review and oversight of LTSS program data to provide guidance to the State Medicaid Agency on the identification, remediation and resolution of systemic issues.

§438.74–State oversight of the minimum MLR requirement.

(a) State reporting requirement. Requires states to annually submit to CMS a summary description of the reports received from their contracted managed care entities. The summary description should include at a minimum: the amount of the numerator; the amount of the denominator; the MLR percentage achieved; the number of member months; and any remittances owed by the managed care entity for that MLR reporting year.

(b) Repayment of federal share of remittances. If the state requires a managed care entity to pay remittances, the state must reimburse CMS for an amount equal to the federal share of the remittance, taking into account applicable differences in the federal matching rate.
If remittance is owed, the state must submit a separate report describing the methodology used to determine the state and federal share of the remittance with the report.

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[i] **Section 1115 Research and Demonstration Projects**–Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services (HHS) may waiver Medicaid requirements contained in Section 1902 (including but not limited to what is known as

freedom of choice of provider, *comparability* of services, and *statewideness*). States use this waiver authority to change eligibility criteria to offer different service packages or a combination of services in different parts of the state, to cap program enrollment, and to implement innovative service delivery systems, among other purposes.

[ii] **Section 1915(b) Managed Care/Freedom of Choice Waivers**–Section 1915(b) of the Social Security Act permits states to establish mandatory managed care programs or otherwise limit enrollees' choice of providers.

[iii] https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Network_Criteria_Guidance.PDF