Medicaid Managed Care Final Rule
Beneficiary Protections: Informing & Authorization Requirements

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CMS Overview of Strengthening Communications with Enrollees: The Final Rule "[e]xpands managed care plans' ability to communicate with beneficiaries by permitting states and managed care plans to use a range of electronic communication methods, including email, texts, and website posting for the dissemination of required information, while ensuring that beneficiaries are able to obtain paper materials upon request and at no cost."[i]

Key Section #1: Information Requirements (42 CFR §438.10): The implementation date is July 1, 2017. This section updated requirements for both Department of Health Care Services (DHCS) and county Mental Health Plans (MHPs) in the following areas: information requirements and content, language and format, member handbook, and provider directories. Current MHP contractual requirements related to beneficiary informing are found in Exhibit A, Attachment I, of the MHP contract (p. 13 of the MHP contract boilerplate).[ii]

Key Requirements in 42 CFR §438.10[iii]	
DHCS Responsibility	***MHP Responsibility***
Utilize its beneficiary support system to provide information (§438.10(c)(2)).	Provide information to the potential enrollee. May be provided electronically if requirements in §438.10(c)(6) are met.
Operate a website that either directly or by linking to individual MHP websites that includes enrollee handbook, provider directory, and drug formulary (§438.10(c)(3)).	Have mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the MHP (§438.10(c)(7)).
Develop and require MHPs to use shared definitions for managed care terminology, model enrollee handbooks, and model enrollee notices (§438.10(c)(4)).	Make written materials that are critical to obtaining services available in the prevalent non-English languages [in the county], including at a minimum: Provider Directories; Handbooks; Appeal and Grievance Notices; and Denial and Termination Notices. Alternate formats (i.e. Braille or Audio) and Auxiliary Aids (i.e. TTY/TDY and American Sign Language) must be made available upon request at no cost. (§438.10(d)(3)).
The State must ensure, through its contracts, that each MHP provides the required information in this section to each enrollee (§438.10(C)(5)).	Provide each enrollee with an enrollee (member) handbook, with elements specified in §438.10(g).
	The MHP must make available in paper form upon request, and electronic form, the provider information specified in §438.10(h). Additional provider directory requirements: • Must be updated at least monthly and the electronic provider directories must be updated no later than 30 calendar days after the Plan receives updated provider information

Key Requirements in 42 CFR §438.10[iii]	
DHCS Responsibility	***MHP Responsibility***
	• Must be made available on the MHP's website in a machine readable file and format
	MHPs must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt of the termination notice, to each enrollee who received his or her care from, or was seen on a regular basis by, the terminated provider (§438.10(f)).

Key Section #2: Coverage and Authorization of Services (42 CFR §438.210)

- The implementation date is July 1, 2017.
- Updates current rule on coverage and authorization of services:
  - Provisions related to coverage found in §438.210(a)
  - Authorization requirements found in §438.210(b)
  - Requirements related to notices found in §438.210(c)
  - Timeframes found in §438.210(d)
- Terminology for notices changed from "Notice of Action" to **"Notice of Adverse Benefit Determination."**
  - Notices must meet the requirements outlined in §438.404 (Subpart F – Grievance and Appeals).
- Timeframe changes for expedited authorization decisions.
  - For cases in which a provider indicates, or the MHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MHP must make an **expedited authorization decision and provide notice** as expeditiously as the enrollee's health condition requires and **no later than 72 hours after receipt of the request for service** (§438.210(d)(2)(i)).
  - The MHP may extend the 72-hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest (§438.210(d)(2)(ii)).
- Current MHP contractual requirements related to authorization of services are found in Exhibit A Attachment I of the MHP contract (p. 5 of the MHP contract boilerplate).

Other Related Sections

- Continued Service to Enrollees (§438.62) - Implementation date is July 1, 2018
  - The State agency must arrange for Medicaid services to be provided without delay to any Medicaid enrollee and have in effect a transition of care policy to ensure continued access to services when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
- Subpart F – Grievance and Appeals System (§438.400-438.424)
  - See CBHDA Fact Sheet "Beneficiary Protections: Subpart F – Grievance and Appeals System"

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[i] Medicaid and CHIP Managed Care Final Rule (CMS 2390-F). *Strengthening the Consumer Experience.* April 25, 2016. Accessed via: https://www.medicaid.gov/medicaid/managed-care/downloads/strengthening-the-consumer-experience-fact-sheet.pdf

[ii] MHP Contract Boilerplate. 2013-2018. Accessed via: http://www.dhcs.ca.gov/services/MH/Documents/2013-2018_MHP_Contract.pdf

[iii] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability (CMS-2390-P). Accessed via the Federal Register: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf