Medicaid Managed Care Final Regulations: Older Adults

Issue Brief No. 6

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This issue brief will review selected provisions in the final rule, *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability* implementing the requirements governing network adequacy and access to services in Medicaid managed care.[1] We also include recommendations to help state advocates ensure robust implementation of these provisions in their states. These recommendations are highlighted throughout and also listed at the end of this brief.

Introduction

Nearly three-quarters of all Medicaid enrollees are now in some kind of managed care program. While states had historically been slower to enroll older adults in managed care, the pace of enrollment for this population has dramatically increased in recent years. The same is true for enrollees receiving long-term services and supports (LTSS); states are now enrolling more of these populations (including many seniors) into managed care LTSS programs, often referred to as MLTSS. As populations of older adults (and/or LTSS services) moved into managed care, the applicable Medicaid managed care regulations, implemented in 2002, became out-of-date and inadequate to ensure access to care for seniors (and other populations). In 2015, HHS released proposed regulations to modernize the managed care regulations, and in May 2016 HHS finalized them, including many provisions that are critical to older adults.[2]

Most provisions of the new regulations are not immediately effective. While a few are effective immediately, most become effective in 2017 and some are not in effect until later years. However, it is important for aging advocates to learn about the new regulations now, because they will soon shape care for seniors dramatically, and more practically, states have already begun work to implement the regulations. Therefore, it is important

[1] *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. 27,498-27,901 (May 6, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] *Ibid.*

for aging advocates to understand the content and consider opportunities to influence key definitions and state implementation processes.

Enrollment and Disenrollment (§§ 438.52, 438.54, 438.56)

Older adults face numerous barriers when attempting to enroll and disenroll from managed care coverage. As a general rule, the regulations require that individuals have a choice of at least two managed care plans, though there are exceptions for rural areas.[3]

The new regulations require that, regardless of whether a state is using a voluntary or mandatory managed care program, individuals receive informational notices at the time they are first eligible to enroll in sufficient time to select among their options.[4] The notices must explain the implications of decisions, identify options, provide instructions, explain the enrollment and disenrollment timeframes, meet accessibility requirements (including use of large print taglines), and provide contact information for the beneficiary support system (described later).[5] These provisions increase the likelihood that older adults will understand their options, the consequences of their choices, and ultimately make more informed decisions.

State Advocacy Tip

Older adults in Medicaid managed care must receive timely and accessible informational notices that explain their health care options and provide all kinds of important information. Aging advocates should ensure that states implement this requirement for informational notices, including all of the information required under the regulations.

The regulations also set out some important requirements for disenrollment processes. States are not required to limit the freedom of enrollees to disenroll, but managed care plans encourage states make use of state authority to limit disenrollment, and many states choose to set limits on freedom to disenroll. Disenrollment rights are critical because sometimes a senior needs to change plans due to a change in medical status, a change in plan networks, or some other factor.

[3] 42 C.F.R. §§ 438.52(a) and (b).
[4] 42 C.F.R. §§ 438.54(c)(3) and (d)(3).
[5] 42 C.F.R. §§ 438.54(c)(3) and (d)(3).

If a state limits disenrollment, the regulations require them to allow a senior full freedom to disenroll within the first 90 days after enrollment or receiving notice of enrollment, whichever is later.[6] This means, for example, that if a senior accidentally enrolls in a Medicaid plan that her doctor does not accept, she is guaranteed at least a 90-day window to disenroll or switch plans. Seniors must also have full freedom to disenroll at least once a year during an annual enrollment/disenrollment window and they may also be allowed to enroll under certain circumstances if their plan is sanctioned for malfeasance.[7]

Enrollees also have the right to disenroll "for cause" *any time* that certain triggers apply, for example, when the senior moves out of the plan's service area.[8] "For cause" disenrollment triggers that may be most important for seniors include "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."[9] The regulations also have a for cause trigger specific to managed LTSS enrollees, in circumstances where a provider exiting the managed care plan's network would disrupt the enrollees residence or employment.[10] These provisions should give many seniors the option to disenroll if their health care needs are not being met, though many situations (such as a standard medical necessity denial) will not trigger the disenrollment right.

The regulations also clarify that managed care plans are generally prohibited from disenrolling a senior simply "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."[11]

In addition, the regulations require that passive and default enrollment systems "seek to preserve existing provider-beneficiary relationships," which is defined as a provider who was the "main source of Medicaid services for the beneficiary during the prior year."[12] The regulations also prioritize relationships with providers that have experience with Medicaid enrollees.[13] Since the recent trend is for large transitions of seniors into managed care through passive enrollment, these standards should help support continuity of care for seniors in those transitions.

[6] 42 C.F.R. § 438.56(c)(2)(i).
[7] 42 C.F.R. §§ 438.56(c)(2)(ii) and (c)(2)(iv).
[8] 42 C.F.R. § 438.56(2).
[9] 42 C.F.R. § 438.56(2)(v).
[10] 42 C.F.R. § 438.56(2)(iv).
[11] 42 C.F.R. § 438.56(b)(2).
[12] 42 C.F.R. §§ 438.54(c)(6) and (d)(7).
[13] 42 C.F.R. §§ 438.54(c)(6) and (d)(7).

Beneficiary Support System (§ 438.71)

The new regulations require states to create an important new beneficiary support system that "provides support to beneficiaries both prior to and after enrollment" into managed care.[14] This new system promises to support older adults that struggle to navigate the complexities of managed care.

Specifically, the beneficiary support system must provide independent choice counseling (for example, helping a senior select the best plan for her), assistance in understanding managed care, and special support for individuals using or interested in using long-term services and supports.[15] The beneficiary supports system must outreach to beneficiaries and be accessible, including via auxiliary aids and services.[16] For individuals using or interested in LTSS, the beneficiary support system must be an access point for complaints, provide education on appeal and grievance rights, provide assistance with appeal and grievances processes, and help identify and resolve systemic LTSS problems.[17]

State Advocacy Tip

States must implement new Beneficiary Support Systems that will provide assistance to older adults prior to and after enrollment. Aging advocates should make sure their states fully implement Beneficiary Support Systems, including ensuring that they are truly independent, accessible, and help identify systemic LTSS problems.

Network Adequacy[18] (§§ 438.68, 438.206)

While the current regulations have vague requirements for managed care plans to have adequate provider networks, the new regulations require states to set specific time and distance standards for numerous provider types, including primary care, behavioral health, specialist care, hospital, pharmacy, and some LTSS services.[19] In developing the standards, the state must consider population characteristics and needs as well as network providers' ability to ensure physical access, reasonable accommodations, and accessible equipment for Medicaid

[14] 42 C.F.R. § 438.71(a).
[15] 42 C.F.R. §§ 438.71(b)(1) and (c).
[16] 42 C.F.R. § 438.71(b)(2).
[17] 42 C.F.R. § 438.71(d).
[18] For full analysis of network adequacy in the new regulations, *see* Abbi Coursolle, NHeLP, *Medicaid Managed Care Regulations: Network Adequacy & Access*, (May 26, 2016), *available at* www.healthlaw.org/publications/search-publications/Brief-3-MMC-Final-Reg.
[19] 42 C.F.R. § 438.68(b).

enrollees with physical or mental disabilities.[20] These standards must be published on the state's website and available in hard copy and accessible formats upon request.[21] If faithfully implemented, these requirements should ensure older adults have access to the full set of providers they need to stay healthy. Ultimately, state managed care contracts "must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities."[22]

Network adequacy for LTSS is a complex issue. Some LTSS services, such as adult day services, are typically provided at a provider site. Such services are covered by the network adequacy standards described above. However, other LTSS services, such as home attendant services, are typically provided in the home (or community-based setting) and thus provider time and distance standards are inapposite. For such in-home or in-community LTSS services, CMS will require states to develop network adequacy standards, but has provided states with discretion to determine the most appropriate standards for those services.[23] Advocacy will be critical to ensure state standards are meaningful. In designing these standards, states must consider the standard network adequacy factors as well as LTSS-specific factors, including supporting choice of providers, strategies to support enrollees' integration into the community, and any other considerations that promote the best interest of enrollees who use LTSS.[24] In the regulation's provisions on network adequacy, HHS also adopts the term health care "provider" (replacing "professional") to be more inclusive of the full range of providers enrollees depend upon, including LTSS providers.[25] Taken together, these provisions may begin to counter the serious problems seniors currently face arranging prescribed LTSS.

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State Advocacy Tip

The regulations require states to develop LTSS network adequacy standards, but allow states wide discretion in setting the content of the standards. Aging advocates will need to press their states to ensure the standards are rigorous and provide meaningful access to the full range of LTSS needed by older adults.

[20] 42 C.F.R. § 438.68(c)(1).
[21] 42 C.F.R. § 438.68(e).
[22] 42 C.F.R. § 438.206(c)(3).
[23] 42 C.F.R. § 438.68(b)(2)(ii).
[24] 42 C.F.R. § 438.68(c)(2).
[25] 42 C.F.R. § 438.2. *See also* discussion at 81 Fed. Reg. 27,753-54.

In addition to having needed providers geographically available to them, seniors must also be able to see those providers without excessive delays. The Medicaid regulations include requirements for states to provide timely access to care, however these standards do not establish specific limits on waiting times, accordingly, this is an issue where additional advocacy is needed.[26] The new regulations do provide strong requirements that will ensure seniors can see out-of-network providers when none are available in network, and that individuals will not be charged out-of-network fees in such circumstances.[27] The new regulations also include continuity provisions to allow individuals to continue to see out-of-network providers during coverage transitions if they are at risk of hospitalization or institutionalization.[28] This policy will be important to enforce considering the current trend of at-risk seniors and persons with disabilities being transitioned into new managed care LTSS systems.

A frequent source of problems for older adults and other consumers is the inability to identify what providers are covered by their insurance. The new regulations require plans to electronically post provider directories (and provide hard copies upon request) and regularly update them.[29] As discussed further below, the directories must also provide information about the accessibility of providers and accommodations.[30]

The new rules considerably strengthen states' responsibilities to monitor and enforce network adequacy, including "provider network management, including provider directory standards" and the "availability and accessibility of services, including network adequacy standards."[31] Finally, the new regulations also include extensive provisions mandating states to ensure their contracts with managed care plans require coordination and continuity of care for enrollees.[32]

Long-term Services and Supports (LTSS) (§§ 438.70, 438.110, 438.330, 438.340)

Availability of LTSS is a critical service issue for seniors as they are enrolled into Medicaid managed care in growing numbers. Fortunately, in addition to the network adequacy provisions discussed above, the regulations include several important provisions to improve access to LTSS in managed care.

The new regulations implement a notable requirement for states to establish an LTSS stakeholder group when LTSS are delivered through managed care. This stakeholder group must include beneficiaries and their representatives, and include them in the "design, implementation, and oversight" of MLTSS programs.[33] Additionally, "[t]he composition of the stakeholder group and frequency of meetings must be sufficient to

[26] 42 C.F.R. § 438.206(c)(1).
[27] 42 C.F.R. §§ 438.206(b)(4) and (b)(5).
[28] 42 C.F.R. § 438.62(b).
[29] 42 C.F.R. §§ 438.10(c)(3),(h)(1), and (h)(3).
[30] 42 C.F.R. § 438.10(h)(1).
[31] 42 C.F.R. §§ 438.66(b)(10) and (b)(11).
[32] 42 C.F.R. § 438.208.
[33] 42 C.F.R. § 438.70.

ensure meaningful stakeholder engagement."[34] The regulations also include a corollary requirement for managed care plans to establish a member advisory group of individuals receiving LTSS (and their representatives) that is similar to the populations served.[35]

State Advocacy Tip

Under the regulations, states will be required to establish a stakeholder group for LTSS in managed care. Beneficiaries and their representatives must be included in design, implementation, and oversight of LTSS programs. Aging advocates should make sure states establish LTSS stakeholder groups and actively involve beneficiaries and their representatives.

Because Medicaid managed care plans have not traditionally included LTSS, existing Medicaid managed care quality assessment mechanisms have been ill-suited to evaluate LTSS service delivery.[36] These systems were largely designed for more clinically-focused care outcomes and have not well-captured LTSS considerations such as independence and quality of life. CMS attempts to correct this gap by addressing LTSS quality in the new regulations.

The definition of "health care services" was expanded to include "long-term services and supports," and the definition of "outcomes" was expanded to include "functional status [and] satisfaction or goal achievement that result from health care or supportive services."[37]

The new regulations also require states to develop a comprehensive state quality strategy for Medicaid managed care.[38] That quality strategy must include a review of required mechanisms to identify individuals in need of LTSS or who have special health care needs.[39] The quality strategy also must contain "goals and objectives" which factor in the health of all populations and a plan to "identify, evaluate, and reduce" health disparities on various factors including age and disability.[40] The regulations require states to ensure that

[34] 42 C.F.R. § 438.70.
[35] 42 C.F.R. § 438.110.
[36] For full analysis of quality in the new regulations, *see* David Machledt and Wayne Turner, NHeLP, *Medicaid Managed Care Final Regulations: Quality and Transparency*, (June 10, 2016), *available at* www.healthlaw.org/publications/search-publications/Brief-4-MMC-Final-Reg.
[37] 42 C.F.R. § 438.320.
[38] 42 C.F.R. § 438.340.
[39] 42 C.F.R. § 438.340(b)(9).
[40] 42 C.F.R. §§ 438.340(b)(2) and (b)(6).

managed care plans themselves implement quality assessment programs that include "[m]echanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs" and "[m]echanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan."[41] The regulations also require states to identify performance measures for "quality of life, rebalancing, and community integration for LTSS."[42]

Nondiscrimination[43] (§§ 438.3, 438.10)

Older adults may disproportionately have chronic illnesses, functional limitations, or disabilities. Historically, some managed care plans engaged in practices that discriminated against such high-need individuals.

The new regulations clarify that all managed care contracts must comply with long-standing nondiscrimination laws protecting older adults and persons with disabilities, as well as with new nondiscrimination standards created in the Accordable Care Act.[44] The regulations also specifically prohibit enrollment discrimination "on the basis of health status or need for health care services."[45] Of course, the prohibitions on discrimination in the regulations also protect older adults who may face discrimination on the basis of numerous factors unrelated to their age or health condition, such as race, ethnicity, national origin, immigration status, language, gender, sexual orientation, and gender identity.[46]

The new regulations include provisions to require that plan materials be accessible to individuals needing alternative formats. Broadly speaking, the regulations require that plan information be "readily accessible" to enrollees, which includes compliance with nondiscrimination standards for disability.[47] More specifically, all written plan materials, such as provider directories, enrollee handbooks, and important notices, must be made available in alternative formats at no cost to enrollees.[48] Plans must provide auxiliary aids and services, and must also include large print (at least 18-point font) tag lines with TTY/TDY telephone numbers and plan member services contacts.[49] The accessibility requirements for plan materials also include protections for individuals with limited English proficiency that will benefit many older adults who do not speak English as a first language.[50]

[41] 42 C.F.R. §§ 438.330(b)(4) and (b)(5).
[42] 42 C.F.R. § 438.330(c)(1)(ii).
[43] For full analysis of health equity in the new regulations, *see* Mara Youdelman, NHeLP, *Medicaid Managed Care Final Regulations and Health Equity*, (May 6, 2016), *available at* www.healthlaw.org/publications/search-publications/Brief-1-MMC-Final-Reg.
[44] 42 C.F.R. § 438.3(f)(1). The long-standing protections include "[t]he Age Discrimination Act of 1975; the Rehabilitation Act of 1973; [and] the Americans with Disabilities Act of 1990 as amended," and the new standard in the Affordable Care Act, at § 1557.
[45] 42 C.F.R. § 438.3(d)(3).
[46] 42 C.F.R. § 438.3(f)(1).
[47] 42 C.F.R. §§ 438.10(a) and (c).
[48] 42 C.F.R. §§ 438.10(d)(3) and (d)(6).
[49] 42 C.F.R. §§ 438.10(d)(3) and (d)(6).
[50] 42 C.F.R. § 438.10(d).

The regulations also include provisions to ensure that managed care plan provider directories help older adults and other individuals identify providers that are physically accessible to them. Plans "must make available in paper form upon request and electronic form… [w]hether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment."[51]

The regulations set standards for managed care plan marketing materials. In the regulation preamble, CMS explains that managed care plan compliance with anti-discrimination requirements prohibits plans from using marketing materials to target or avoid any populations based on "perceived health status, cost, or for other discriminatory reasons."[52] More explicitly, the regulations require that states must review plan marketing materials in consultation with an advisory committee that includes consumers and plans cannot distribute any materials until they obtain state approval.[53] The regulations also prohibit plans from door-to-door or telephonic marketing (including "cold-calls") and require plans to "[s]pecify the methods by which" they ensure that marketing materials "are accurate and [do] not mislead, confuse, or defraud" consumers.[54]

Medicaid managed care plans often apply short-term authorization periods to services which an older adult might need on a permanent, ongoing basis to treat a chronic disease, disability, or functional impairment. This may create a significant barrier to effective and continuous care; for example, consider an older adult with no prospect for improved function that must have a home health aide prescription re-authorized on a monthly basis. The regulations require that "services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports."[55] In the regulation preamble, CMS notes it's previously stated expectation that "states monitor [managed care plan] compliance with setting reasonable authorization periods."[56]

State Advocacy Tip

Managed care plans sometimes use unreasonably short authorization periods for older adults who have permanent or long-term conditions. Aging advocates should press their states to ensure that states have a plan to monitor this and managed care plans are in fact setting reasonable authorization periods.

[51] 42 C.F.R. § 438.10(h)(1)(viii).
[52] *See* 81 Fed. Reg. 27504, citing 42 C.F.R. § 438.3(f)(1).
[53] 42 C.F.R. §§ 438.104(b)(1)(i) and (c).
[54] 42 C.F.R. §§ 438.104(b)(1)(v) and (b)(2).
[55] 42 C.F.R. § 438.210(a)(4)(ii)(B).
[56] 81 Fed. Reg. 27632.

The managed care regulations also include a provision requiring states to develop a managed care quality strategy that includes a plan to "identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status."[57]

Appeals and Grievances[58] (§§ 438.400 et seq.)

When older adults are denied needed care, it is essential that they have recourse to an appeals process to challenge harmful actions. The new Medicaid managed care regulations make several important changes to due process.

The regulations define new types of plan decisions or actions that are appealable, such as decisions about the setting where care is provided or the cost-sharing associated with a service.[59] This will help ensure seniors have access to appeals for a wider range of health plan actions that may cause them harm.

The new regulations include an "exhaustion" requirement, meaning older adults (and others) *must* file an appeal with a managed care plan's internal appeals process (that is, "exhaust" the plan's appeals option) prior to filing an independent appeal with the state.[60] This is a new policy, as some states currently allow individuals to skip the plan appeal (no exhaustion requirement) and go directly to the independent state appeal. NHeLP opposed this new requirement, since consumers may in some circumstances prefer to avoid an appeal with a plan that they feel will not faithfully or swiftly adjudicate their appeal.

However, the regulation also includes two new improvements. First, the internal plan appeal process can only include one level of appeal.[61] Some plans currently subject individuals to two redundant internal appeals steps. Second, the regulations allow "deemed exhaustion" – which allows individuals to skip the internal plan-level appeal if the plan fails to comply with notice and hearing requirements in the appeals process.[62] This creates an incentive for plans to follow the rules, and creates an exception protecting consumers if plans do not comply.

The regulations also include a new provision that NHeLP has fought for consistently over the past years. The provision helps guarantee that older adults will receive benefits while an appeal is pending. Under the law, older adults who are receiving a Medicaid service and later have that service denied or reduced can continue to receive that service until the Medicaid agency issues a final decision, as long as they file a prompt appeal. This allows them to maintain the service at the current level while the merit of the appeal is reviewed. For example, if an older adult is receiving 40 hours a week of home attendant care, and her managed care plan attempts to

[57] 42 C.F.R. § 438.340(b)(6).
[58] For full analysis of due process in the new regulations, *see* Jane Perkins, NHeLP, *Medicaid Managed Care Final Regulations Grievance & Appeals Systems*, (May 12, 2016), *available at* www.healthlaw.org/publications/search-publications/Brief-2-MMC-Final-Reg.
[59] 42 C.F.R. § 438.400(b) ("Adverse benefit determination").
[60] 42 C.F.R. § 438.402(c).
[61] 42 C.F.R. § 438.402(b).
[62] 42 C.F.R. § 438.402(c)(1)(i)(A).

reduce the hours to 30 per week, she should be able to preserve the 40 hours per week for the *full* duration of the administrative process, even if the appeal takes months to resolve. Although this should be required under Medicaid law and the U.S. Constitution, a flaw in the current managed care regulations has allowed some plans to only continue benefits during *part* of the appeal, relying on the argument that they are only required to continue the service until the end of the current authorization period. This is problematic because many LTSS, such as home care services, are often authorized in authorization periods, such as 60-day increments. In such cases, the senior only receives continuing benefits until the 60 day authorization expires – and after that she loses the services in dispute during the remainder of the appeal, even if it takes months more. Under the new regulations, HHS finally corrects this long-standing flaw, requiring that individuals continue to receive services during the *full* timeframe of their appeal, regardless of authorization periods used for prescribing the services.[63]

State Advocacy Tip

States and managed care plans may be unprepared to comply with new regulations requiring plans to cover on-going services for the full duration of an appeal when a timely appeal is filed. State advocates should make sure their states prepare to enforce the new requirements and monitor whether plans in fact comply.

The regulations also require that managed care plans must give older adults "any reasonable assistance" in completing forms and other procedural steps to file a grievance or appeal, including auxiliary aids and toll-free numbers that are accessible to people with disabilities.[64]

Finally, the regulation also includes protections for individuals who need expedited access to care. Grievances and appeals must be resolved as expeditiously as the enrollee's health condition requires, and within 72 hours for "expedited appeals," which are appeals in which the "standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function."[65]

Conclusion

The new Medicaid managed care regulations contain many provisions that will shape access to care for older adults for many years or possibly decades. It is imperative that aging advocates understand these provisions and

[63] 42 C.F.R. § 438.420.
[64] 42 C.F.R. § 438.406(a).
[65] 42 C.F.R. §§ 438.408 and 438.410.

take an active role in their states' implementation of the new regulations. A number of opportunities also exist for state advocates to strengthen or clarify the final regulations. NHeLP recommends that state advocates monitor development of policies, contracts, practices, and implementation to ensure that:

- Older adults receive timely and accessible informational notices that explain their health care options and provide the required information;
- States implement a broad definition of "for cause" disenrollment rights to protect older adults receiving poor quality of care or a lack of access to covered services or experienced providers;
- States implement new Beneficiary Support Systems that will provide assistance to older adults prior to and after enrollment;
- States develop strong network adequacy time and distance standards for the range of providers for which they are required to develop such standards;
- States to develop LTSS network adequacy standards that are rigorous and provide meaningful access to the full range of LTSS needed by older adults;
- States establish a stakeholder group for LTSS in managed care that includes beneficiaries and their representatives in the design, implementation, and oversight of LTSS programs;
- State quality measurement systems comply with numerous regulatory requirements to improvement the evaluation of quality for LTSS;
- Managed care plan communications and marketing materials are accessible to and do not discriminate against older adults;
- States have a plan to monitor the authorization periods set by managed care plans and that the authorization periods are reasonable considering the needs of older adults;
- States come into compliance with a new "deemed exhaustion" requirement, allowing enrollees to skip the plan level of appeals if the plan does not comply with notice or hearing requirements; and
- States and managed care plans comply with new regulations requiring plans to cover on-going services for the full duration of an appeal when a timely appeal is filed.