Summary Comparison of the January 2001 Final, the August 2001 Proposed and the June 2002 Final BBA Medicaid Managed Care Regulations on Reproductive Health Access

January 2001 Final Rule 66 Fed. Reg. 6228 (Jan. 19, 2001), 42 C.F.R. §§ xx.	**August 2001 Proposed Rule** 66 Fed. Reg. 43614 (Aug. 20, 2001), 42 C.F.R. §§ xx.	**June 2002 Final Rule** 67 Fed. Reg. 40989 (June 14, 2002), 42 C.F.R. §§ xx.
Information: Enrollees and Potential enrollees be provided information on how to access benefits available under the state plan, but not covered under the contract. January §§ 438.10(d)(2)(ii)(E), (e)(2)(xii).	Maintains requirement, except that health plans do not have to provide any information on where and how to obtain information about services which the plans do not provide due to moral or religious objections. State must provide information. Proposed §§ 438.10(e)(2)(ii)(E), (f)(6)(xii).	Same. State or contract representative must provide information to potential enrollees. State, contract representative, or managed care plan must provide information to enrollees, about the extent to which, and how, enrollees may obtain benefits, including family planning, from out-of-network providers; and on how and where to access any benefits available under state plan, but not included in contract. State must provide information on how/where to obtain benefits to which managed care plan has moral/religious objection. §§ 438.10(e)(2)(ii)(E), (f)(6)(xii); 438.102(a)(2), (c).
Information: Certain required information (i.e. scope of benefits available under the state plan, but not covered under the contract and where and how to obtain carved-out services) to be provided to potential enrollees. Information provided when beneficiary first becomes eligible for Medicaid.	Need only provide *summary* with more detail upon request. Provision of information when beneficiary becomes eligible for or required to enroll in a managed care plan, thus delaying when beneficiaries obtain information. Proposed §§ 438.10(e)(1)(i), (e)(2)(ii).	Same. Information provided by state or contract representative. §§ 438.10(e)(1)(i), (e)(2)(ii). States have option of providing more detailed information. 67 Fed. Reg. at 41013.

January §§ 438.10(d)(1)(ii), (d)(2)(ii).		
Information: Enrollees to obtain information upon enrollment and annually thereafter. Health plans responsible for providing information. January § 438.10(e)(1)(i).	Provision of information upon enrollment. Notice on right to request information annually, instead of automatic provision of information. Deletes reference of responsible party for providing information. Thus, presumably, State must decide. Proposed § 438.10(f)(2).	Same. Clarifies option for state, contract representative, or managed care plan to provide information upon enrollment and annual notice. State must provide information annually on disenrollment rights and 60 days prior to each enrollment period, if restricted enrollment. Managed care plans must provide information on termination of providers. Final § 438.10(f).
Information: Enrollees to get information on the extent to which and how enrollees may obtain benefits, including family planning, from out-of-plan network providers, but health plans don't have to provide information about services with respect to services to which they object due to moral or religious objections, only about where to get information about these services. January § 438.10(e)(2)(vi).	Same, except deletes requirement that health plans provide information about how to get information about services that they do not provide. Proposed § 438.10(f)(6)(vii).	Same. Preamble clarifies that enrollees of all managed care programs (unless the obligation were ever waived under an 1115 waiver) are to receive information regarding accessing services from out-of-network providers, including family planning services. Final § 438.10(f)(6)(vii); 67 Fed. Reg. at 41016.
Information: Information specifically on pharmaceuticals, on how to obtain continued services during transition from fee-for-service to managed care or from one managed care plan	Requirements deleted. Proposed §§ 438.10(f)(6)(iv), (f)(6)(v), (g).	Same. Final §§ 438.10(f)(6)(iv), (f)(6)(v), (g).

to another, and on fact that individual entitled to represented by counsel during an appeal. January §§ 438.10(e)(2)(i), (e)(2)(x), (e)(2)(xiii); 438.414(b)(5).		
Information: Health plans to give enrollees written notice 30 days prior to the effective date of any significant change and within 90 days of a change in policy, with the 30 day time line having precedence. January §§ 438.10(e)(ii); 438.102(c)(1)(ii).	Same. Proposed §§ 438.10(f)(4); § 438.102(c)(1)(ii).	Same. Except notice can be given by state, contract representative, or managed care plan. State has flexibility to determine what is □significant□ change in, e.g., restrictions on freedom-of-choice, services available under state plan but not under contract, and other information required under § 438.10(f)(6). Health plans which adopt policy to not provide services due to moral or religious objections must provide notice to potential enrollees before and during enrollment and to enrollees within 90 days after adopting the policy, with the overriding rule of the state, the contract representative or the managed care plan to provide information at least 30 days before the effective date of the policy. Final §§ 438.10(f)(4); 438.102(b)(1)(ii)(B).
Information: Enrollees must be told of any limits on freedom of choice among network providers. January § 438.10(e)(2)(v).	Same. Includes explanation that this includes limits by choosing subnetworks under contract with the plan and an explanation on how to request a referral from an affiliate provider not included in the subnetwork. Proposed § 438.10(f)(6)(ii); 66	Same. While did not include proposed rule preamble discussion in text of rules, did affirm that if there are restrictions within networks, the beneficiary must be informed of these restrictions as part of the information received.

	Fed. Reg. at 43624	Final § 438.10(f)(6)(ii); 67 Fed. Reg. at 41015.
Information: Right to disenroll – no provision.	Adds provision requiring States to notify enrollees of their disenrollment rights at least annually and at least 60 days prior to each open enrollment period. Proposed § 438.10(f)(1).	Same. Except modifies the requirement to inform enrollees 60 days prior to each open enrollment period to apply only to those states in which there is lock-in enrollment for 90 days or more. Final § 438.10(f)(1); 67 Fed. Reg. at 41014.
Marketing: Marketing protections apply to potential enrollees and current enrollees. January § 438.104.	Marketing protections for potential enrollees only. Proposed § 438.104	Same. Final § 438.104
Marketing: State option to impose sanctions on plans that falsify or misrepresent information to an enrollee, potential enrollee, or provider. January § 438.700(b)(5).	Same. Proposed § 438.700(b)(5)	Same. Final § 438.700(b)(5).
Enrollee-Provider Communication: Health plans prohibited from limiting communication regarding enrollee's health status, medical care, treatment options and information needed to decide among treatment options; the right to participate in decisions about his or her health care; and the risks, benefits and consequences of treatment and non-treatment. January § 438.102(b)(1).	Same. Proposed § 438.102(b)(1).	Same. Final § 438.102(a)(1).
Enrollee-Provider Communication: Lists	Includes same list.	Same. List of health care professionals moved to Final §

medical professionals to whom anti-gag rule applies. January § 438.102(a).	Proposed § 438.102(a).	438.2.
Enrollee-Provider Communication/Moral Religious Provision: Health plans do not have to provide, reimburse for, or provide coverage of a counseling or referral service to which the health plan objects on moral or religious grounds. Proposed § 438.102(b)(3).	Same. January § 438.102(b)(2)	Same. Final § 438.102(a)(2).
Enrollee-Provider Communication/Moral Religious Provision: Health plans using opt out must provide individuals with information on how to get information about carved-out services. January § 438.102(c)(2).	Deleted. Proposed § 438.102(c)(2).	Same. Final. §§ 438.102(b)(2).
Enrollee-Provider Communication/Moral Religious Provision: State made responsible for making state plan services which are not included in the contract from other sources and to provide enrollees with information on how and where to obtain these services, including how transportation is provided. Preamble directed states to make services available through direct fee-for-service payment or through contracting with another organization. January § 438.206(c).	Deleted. State's responsibility to ensure continued access discussed in preamble only. Proposed § 438.206; 66 Fed. Reg. at 43629.	Same. Preamble also states that providers are not precluded from providing information on how and where to obtain services. Final § 438.102(c); 67 Fed. Reg. at 41025, 41026.

Enrollee-Provider Communication/Moral Religious Provision: Health plan must inform state of any policy to exclude counseling or referral services due to moral or religious grounds at the time of plan's application for Medicaid contract; whenever plan adopts policy during term of contract. January § 438.102(c)(1)(i).	Same. Proposed § 438.102(c)(1)(i).	Same. Final § 438.102(b)(1)(i).
Enrollee-Provider Communication/Moral Religious Provision: Plan to provide notice to enrollees and potential enrollees within specific time frames about such policy. State to retain responsibility of informing enrollees about how and where to obtain services. January § 438.102(c)(1)(ii).	Same. Proposed § 438.102(c)(1)(ii).	Same. Final § 438.102(b)(1)(ii), (c).
Disenrollment: Cause to disenroll at any time includes plan does not provide service due to moral or religious objections; enrollee needs related services (e.g. cesarean section and tubal ligation) to be performed at the same time, not all related services are available within the plan network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; other reasons, such as poor quality, lack of access to contract services, or lack of access to providers	Same. Proposed § 438.56(d)(2).	Same. Preamble states that States may include other reasons, such as homelessness, for disenrollment for cause. Final § 438.56(d)(2); 67 Fed. Reg. at 41022.

experienced in enrollee's health care needs. January § 438.56(d)(2).		
Free-Choice of Provider: Enrollees have right to a free choice of provider for family planning services. January § 431.51(a)(4), (5), (6).	Same. Proposed §§ 431.51(a)(4), (5), (6).	Same, except does not apply to PIHPs and PAHPs. The federal statute extends this right to beneficiaries enrolled in entities "similar to" MCOs and PCCMs. However, these similar entities are not clearly defined in the law. 42 U.S.C. § 1396a(a)(23). The reference to "similar entities" was deleted from the federal regulation by these Final rules. Final § 431.51(a)(4), (5), (6).
Out-of-Network Access: If health plan cannot provide necessary contract services, services must be adequately and timely covered out-of-network for as long as health plan is unable to provide them. Preamble explained that this pertains to "related services" as well. January § 438.206(d)(5), 66 Fed. Reg. at 6262.	Same, except related services not addressed. Also, where January rules required States to directly ensure compliance, proposed rules require only that States ensure through their contracts with health plans. Proposed § 438.206(b)(4).	Same. Additional language added to require States to "[r]egularly monitor and evaluate the MCO and PIHP compliance with the standards." Final § 438.204(b)(3). The fact that CMS imposes the requirement to provide on out-of-network access in these circumstances on PAHPs as well suggests that PAHPs were inadvertently omitted from the states' obligation to monitor. See Final § 438.206(b)(4); 67 Fed. Reg. at 41036.
Out-of-Network Access: Out-of-Network access is not to result in additional costs to the enrollee. January § 438.206(d)(8).	Same. Proposed § 438.206(b)(5).	Same. Preamble explains that health plan is responsible for negotiating payment to out-of-plan provider to which enrollee is referred. Does not address out-of-plan family planning providers that enrollee accesses on own. Final § 438.206(b)(5); 67 Fed.

		Reg. at 41038.
Out-of-Network Access/Rural: Out-of-network access permitted where service or type of provider not available within the health plan. January 438.52(b)(2)(ii)(A).	Same, except "type of provider" limited to mean "in terms of training, experience, and specialization" with no consideration of other access issues such as geographic access or waiting times for appointments. Proposed § 438.52(b)(2)(ii)(A).	Same. Final § 438.52(b)(2)(ii)(A).
Out-of-Network Access/Rural: Out-of-network access for individuals with pre-existing relationships with a provider that is the primary source of care for as long as the provider continued to be the main source of the service. This would have included pregnant women who would have started prenatal care with an out-of-network provider. January § 438.52(b)(2)(ii)(B).	Out-of-network access for pre-existing providers limited to 60days, then enrollee must choose (or be assigned) a network provider, unless the out-of-network provider joins the health plan. Proposed § 438.52(b)(2)(ii)(B).	Same. Thus, pregnant women whose providers do not choose or do not quality to join health plan must find other network provider. Final § 438.52(b)(2)(ii)(B).
Out-of-Network Access/Rural: Right to access out-of-network providers when (1) the only plan or provider available does not, because of moral or religious objections, provide the service the enrollee seeks; (2) where the recipient's primary care provider or other provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately (e.g., tubal ligation and c-section) and not all of the related services are available within the network; or (3) the State determines	Same, except preamble says that, except for (1), the state need not have a fee-for-service system and that enrollees can just choose another provider within the health plan. This, in effect, would undermine the out-of-network access and the right to disenroll for cause. Proposed §§ 438.52(b)(2)(ii)(C), (b)(2)(ii)(D), (b)(2)(ii)(E); 66 Fed. Reg. at 43627.	Same. Preamble clarifies that State is not relieved from FFS in order to comply with out-of-network access. Final §§ 438.52(b)(2)(ii)(C), (b)(2)(ii)(D), (b)(2)(ii)(E); 67 Fed. Reg. at 41021.

that other circumstances warrant out-of-network treatment. January §§ 438.52(b)(2)(ii)(C), (b)(2)(ii)(D), (b)(2)(ii)(E).		
Availability of Services: Each health plan is to pay particular attention to pregnant women and other individuals with special needs in maintaining and monitoring their provider network and to demonstrate that they have the sufficient numbers and types of providers to meet the anticipated volume and types of services enrollees will require when expanding its service area. January § 438.206(d).	Deleted. Proposed § 438.206(b).	Same. Preamble states that provision of specific groups need not be included because needs of all enrollees must be met through provider network. Final § 438.206(b).; 67 Fed. Reg. at 41037.
Direct Access to Women's Health Specialists: Female enrollees must have direct access to women's health specialists for routine and preventive care. Preamble also discusses (1) the rule applies to minors access; (2) this means that women should have access to any women's health specialist in the network, unless the specialists are not taking new patients; (3) the term "women's health specialists" includes providers that, due to education or clinical experience, are women's health specialists, including Obs, GYNs, nurse midwives, and nurse practitioners; (4) the scope of services that can be accessed	Same, except there is no mention of the issues discussed in the January rules' Preamble. Proposed § 438.206(b)(2).	Same. Preamble states that □routine and preventive□ is sufficient to categorize the types of services that women can access directly through a women□s health specialists. This was in response to commentors□ suggestions that the term be defined to include initial and follow-up visits for prenatal care, pap tests, family planning, and treatment of vaginal and urinary tract infections and STDs. Final § 438.206(b)(2); 67 Fed. Reg. at 41037.

includes initial follow-up visits for services unique to women such as prenatal care, mammograms, pap smears, and for services to treat genito-urinary conditions. January § 438.206(d)(2); 66 Fed. Reg. at 6305-06.		
Identification of Persons with Special Needs: Requires that pregnant women be identified among persons with special needs by the State and to identify these individuals to the health plans upon enrollment. January, § 438.208(b)(3); 66 Fed. Reg. at 6308.	Deleted. Proposed § 438.208(b).	Same. States have discretion to define and develop mechanism for identifying special needs groups. CMS believes that these will include individuals with □serious and multiple medical conditions.□ Final § 438.208(c)(1); 67 Fed. Reg. at 41043.
Screenings and Assessments: Differentiates "initial screening" and "comprehensive health assessment" (the latter done by appropriate medical personnel), and explains in preamble the expectation of health plans to use "best efforts" to screen each identified individual. January § 438.208(b)(3), (d); 66 Fed. Reg. at 6309.	Deletes distinction and deletes pregnant women from list of individuals who must be screened and requires "screens" only, which can be done by enrollment broker. Proposed § 438.208(c), 66 Fed. Reg. at 43635.	Deletes □screen□ and equates with □identification.□ Requires health plans to conduct assessments of individuals identified by the state, using appropriate health professionals. Groups identified as special needs and standards for assessments within State discretion to be developed with input of Medicaid beneficiaries and other stakeholders. Final §§ 438.208(c)(1), (c)(2); 67 Fed. Reg. at 41042, 41043.
Screenings and Assessments: Contains specific time frames in which screens and assessments must be done. January, § 438.208(d), (e).	Deleted. January § 438.208(d), (e).	Same. Within State discretion to develop in consultation with beneficiaries and other stakeholders. Final § 438.208(c); 67 Fed. Reg. at 41044.
Treatment planning: Sets forth rules for health plans to	Deleted. Requires States only to ensure that health plans have a	Same. Except deletes treatment plan developed only if health

develop and implement treatment plans for pregnant women and other enrollees with special needs. Treatment plan must be appropriate for the conditions identified; for a specific period of time and updated periodically; and specify a standing referral for an adequate number of direct access visits to specialists. Other requirements as well. January §§ 438.208(f), 66 Fed. Reg. at 6312	mechanism in place for individuals determined to have ongoing special conditions to have direct access to specialists, either through a standing referral or an approved number of visits. In addition, only if the health plan requires it, will a treatment plan be developed. Proposed § 438.208(d).	plan requests it. State given authority to determine extent to which treatment plans would be required to be addressed as component of quality strategy and to be developed with input from Medicaid recipients and other stakeholders. Final § 438.208(c)(3); 67 Fed. Reg. at 41045.
Liability and Cost Sharing: Enrollees may not be held liable for covered services including family planning. In preamble, discussion on how protections apply to out-of-network family planning, emergency and post-stabilization services, and out-of-network services obtained due to health plan's inability to meet enrollee's needs, for rural out-of-network access as permitted under the rules. January § 438.106; 66 Fed. Reg. at 6281-82.	Same, but no preamble discussion. Proposed § 438.106.	Same. Final § 438.106.
Liability and Cost Sharing: Any cost sharing must comply with fee-for-service cost sharing requirements, i.e. nominal cost sharing and no cost sharing for children and pregnant women, family planning, and emergency services. Preamble makes clear that there is no cost sharing for accessing emergency room services, even if it turns out not to be an	Same, except that there is no discussion clarifying cost sharing for non-emergency services access in the emergency room. Proposed § 438.108, 66 Fed. Reg. at 43630.	Same, except that preambles says that coverage of services sought in the emergency room may be denied entirely when the standards of § 447.53(b)(4) are not met. This provision exempts emergency room services from cost sharing there is a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate

emergency, under certain circumstances (e.g., sudden onset of a medical condition...). January § 438.108, 66 Fed. Reg. at 6282-83, *citing* 42 C.F.R. § 447.53.		medical attention could reasonably be expected to result in (1) placing the patient□s health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.□ However, there is no cost sharing □as long as the enrollee seeks emergency services that could reasonably be expected to have the above effects... even if the condition was determined not be an emergency.□ Final § 438.108; 67 Fed. Reg. at 41028.
Liability and Cost Sharing: Providers may not deny care due to an eligible individuals inability to pay for the cost sharing. January § 447.53(e).	Same. Proposed § 447.53(e).	Same. Final § 447.53(e)
Liability and Cost Sharing: Services accessed out-of-network due to health plan's inability to provide needed services may not result in greater cost to enrollee. Preamble makes clear that this applies to "related services" (i.e. c-section and tubal ligation). January, § 438.206(d)(8), 66 Fed. Reg. at 6303.	Same, except no discussion on related services. Proposed § 438.206(b)(5).	Same. Health plans responsible for negotiating payment with out-of-plan provider to which the plan made a referral. Final § 438.206(b)(5)
Specification of Contract Benefits: State contracts with MCOs, PHPs, and PCCMs must clearly specify those services for which the health plan is responsible for	Same, except exempts PCCM and PAHP contracts. Proposed, § 438.210(a).	Same. Final § 438.210(a).

providing. January § 438.210(a).		
Prior Authorization Requests: Health plans and subcontractors must have in place and follow written policies and procedures for processing prior authorization requests which reflect current standards of medical practice. January § 438.210(b)(1).	Same, except policies and procedures do not have to reflect current standards of medical practice. Proposed, § 438.210(b)(1).	Same. Except preamble disavows intent to imply that policies/practices contrary to current standards or medical practice are sanctioned or permitted by States or CMS and points to § 438.236 which requires plans (where appropriate) to adopt and disseminate practice guidelines to contracting providers. Final § 438.210(b)(1); 67 Fed. Reg. at 41049.
Limitations on Payments to Providers: In order for State to pay out-of-network providers for services included in the plan contracts, the State must make a reconciliation or adjustment to the capitation payments made to the health plan. January § 438.60; 66 Fed. Reg. at 6267.	Same. Proposed § 438.60.	
Confidentiality: In addition to following state and federal confidentiality and disclosure laws, the State must ensure health plan procedures to: • maintain medical records and information in a timely and accurate manner; • specify for what purposes the health plan uses the information and to what entities outside of the health plan, and for	Deleted. Now requires that States, through their contracts, ensure that health plans have procedures in place to meet HIPAA rules for medical records and other health and enrollment information identifying a particular enrollee. Proposed § 438.224.	Same. Final § 438.224.

what purposes, it discloses the information; • permit each enrollee to request and receive a copy of records and information pertaining to the enrollee and request that they be amended or corrected; • permit each enrollee to request and receive information on how the health plan uses and discloses information that identifies the enrollee. January § 438.224.		
Public Participation: States must specify in the state plan the process used to involve the public both in design and initial implementation of the program and the methods used to ensure ongoing public involvement. January § 438.50(b)(4).	Same. Proposed § 438.50(b)(4).	Same. Final § 438.50(b)(4); 67 fed. Reg. at 41019.