DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

January 14, 1998

Dear State Medicaid Director:

This letter is one in a series of letters that provides guidance on the implementation of the Balanced Budget Act of 1997(BBA). The BBA contains numerous provisions relating specifically to managed care. In order to provide guidance on these as quickly as possible, we are issuing a number of managed care State letters (list of those already issued is attached). This letter is the fifth in this managed care series.

This letter pertains to several provisions regarding Medicaid managed care that are contained in sections 4701, 4703, and 4708(a) of the BBA. These provisions are described below. On December 17, 1997 you were sent a letter describing the State plan option for managed care, which indicated that further clarification would be issued regarding some of the requirements under that provision. This letter represents additional clarification of BBA provisions on the types of managed care entities and requirements for beneficiary choice that were promised in that letter.

Definitions of Managed Care Entities

The BBA contains new definitions of the entities with which States may contract in Medicaid managed care programs. A "managed care entity" (MCE) is defined as either a managed care organization (MCO) or a primary care case manager (PCCM). The section of the Social Security Act which previously referred solely to HMOs and HIOs has been revised to include all of the following entities which operate under that authority as MCOs: HMOs, organizations with section 1876 or Medicare+Choice contracts, provider sponsored organizations, or any other public or private organization which meets the advance directive requirements, has a risk comprehensive contract, and meets the other requirements of the Statute.

Previously, PCCMs operated only as providers under freedom of choice or demonstration waivers. Now, as MCEs, States may contract with them in voluntary managed care programs or under the new State plan option for mandatory managed care.

The BBA did not address the status of prepaid health plans (PHPs). However, the authority to contract with PHPs remains in the Federal Regulations at 42 CFR Part 434. And, these non-risk and limited risk contractors may contract with States as PCCMs.

Requirement for Choice of Managed Care Entity

This new provision requires States to permit individuals to choose from not less than two managed care entities (i.e., managed care organizations or PCCMs). States do not need to implement multiple PCCM systems to meet the requirements of this provision, but only need to offer a choice of PCCM providers or combinations with other MCEs.

This requirement for choice generally reflects Medicaid policy prior to the BBA, and applies to managed care systems implemented by states under both the State Plan Amendment option and waiver authorities. However, this requirement for choice may be waived at the Secretary's discretion (through a waiver of the "freedom of choice" requirement as with certain section 1915(b) and 1115 waivers in the past.)

This provision also permits exceptions from the choice requirement in the following two situations:

1. in rural areas where an individual is permitted to choose from at least two physicians or case managers, and is permitted to obtain care from any other provider where determined by the Secretary to be appropriate (as defined in regulation); and

2. where the managed care entity in which the individual is enrolled is a health insuring organization

operating under specific statutory authority in which the individual has a choice of at least two providers.

Because the BBA requires that "appropriate circumstances" for out-of-plan services must be defined in regulation, the rural exception may not be implemented until that regulation is published, which we expect will to occur in mid-1998.

Change in the Threshold Amount for Prior Approval of MCO Contracts

Prior to the BBA, the Secretary's prior approval was required for all HMO contracts involving expenditures in excess of $100,000. Under the BBA, the threshold amount for which the Secretary's prior approval is required was increased to $1,000,000 for 1998. For subsequent years, this threshold amount will automatically be increased by the percentage increase in the consumer price index for all urban consumers over the previous year. This provision applies to all contracts entered into or renewed on or after October 1, 1997.

Elimination of 75/25 Composition of Enrollment Requirement

The BBA eliminates the composition of enrollment requirement that was previously a requirement for most HMO contracts. This provision is effective with respect to contracts signed on or after June 20, 1997. The composition of enrollment requirement for PHPs at 42 CFR 434.26 remains in effect unless and until that regulation is revised, although the State Medicaid agency may waive that requirement for good cause.

We are enclosing a listing of the statutory citations for each of these provisions. If you have any questions regarding these provisions, please contact Bruce Johnson in the Center for Medicaid and State Operations, on (410) 786-0615.

Sincerely,

/s/

Sally Richardson

Director

Center for Medicaid and State Operations

Enclosure

cc: All HCFA Regional Administrators All HCFA Associate Regional Administrators for Medicaid and State Operations Lee Partridge, American Public Welfare Association Jennifer Baxendell, National Governors' Association HCFA Press Office

BBA MANAGED CARE PROVISIONS AND STATUTORY CITATIONS

Definitions of Managed Care Entities

Section 1932(a)(1)(B) contains new definitions of the entities with which States may contract in Medicaid managed care programs.

- --"managed care entity" (MCE) is defined as either a managed care organization (MCO) as described in **section 1903(m)(1)(A)** of the Social Security Act or a primary care case manager (PCCM) as defined in new section 1905(t) of the Act.
- --MCOs are defined in **Section 1903(m)(1)(A)** to include all of the following entities which operate under the authority of section 1903(m): HMOs, organizations with section 1876 or Medicare+Choice contracts, provider sponsored organizations, or any other public or private organization meeting the requirements of section 1902(w) of the Act, which has a risk comprehensive contract and meets the other requirements of that section.
- --PCCMs which previously operated only as providers under section 1915(b) or 1115 waivers are defined in section 1905(t).

Requirement for Choice of Managed Care Entity

Section 1932(a)(3) of the Social Security Act requires States to permit individuals to choose from not less than two managed care entities (i.e., managed care organizations under **1903(m)** or PCCMs under **1905(t))**. This section contains 2 exceptions to the requirement for choice:

1. in rural areas where an individual is permitted to choose from at least two physicians or case managers, and is permitted to obtain care from any other provider where determined by the Secretary to be appropriate (as defined in regulation); and
2. where the managed care entity in which the individual is enrolled is a health insuring organization operating under specific statutory authority in which the individual has a choice of at least two providers.

Change in the Threshold Amount for Prior Approval of MCO Contracts

Section 1903(m)(2)(A)(iii) of the Social Security Act was amended by the BBA to increase the threshold amount requiring the Secretary's prior approval of all risk-comprehensive contracts with MCOs from the previous amount of expenditures in excess of $100,000 to expenditures in excess of $1,000,000 for 1998. For subsequent years, this threshold amount will automatically be increased by the percentage increase in the consumer price index for all urban consumers over the previous year. This provision applies to all contracts entered into or renewed on or after October 1, 1997.

Elimination of 75/25 Composition of Enrollment Requirement

Section 4703 of the BBA eliminates the former composition of enrollment requirement for HMOs, effective with respect to contracts signed on or after June 20, 1997, but the similar requirement for PHPs at 42 CFR 434.26 remains in effect until that regulation is revised.

BBA MANAGED CARE STATE LETTERS

Section Subject Date Issued

4701 SPA Option for Managed Care 12/17/97

4704(a) Specification of Benefits 12/17/97

4707(a) Marketing Restrictions 12/30/97

4704(e) Miscellaneous Managed Care Provisions 12/30/97 4704(h) 4706 4707(a) 4707(c) 4708(b) 4708(c) 4708(d)