DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

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

February 20, 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 policy letters. (See Enclosure #2 to this letter.) This letter is the eleventh in this managed care series.

The purpose of this letter is to provide guidance on BBA requirements for provision of information to managed care enrollees and potential enrollees and the effective dates of BBA managed care provisions

This letter pertains to provisions regarding Medicaid managed care that are contained in sections 4701(a) and 4710 of the BBA. Section 4701(a) sets forth requirements for the information that must be provided to beneficiaries regarding their enrollment or potential enrollment in managed care entities. Section 4710 establishes effective dates for the managed care provisions in the BBA.

As discussed in the State Medicaid Directors Letter dated January 14, 1998, the BBA contains new definitions of the entities with which States may contract in Medicaid managed care programs. The term managed care entity (MCE) is defined as either a managed care organization (MCO)--an organization with a prepaid, risk-comprehensive contract (i.e. HMOs, organizations with section 1876 or Medicare+Choice contracts, provider sponsored organizations, or any other public or private organization meeting the statutory requirements), or a primary care case management (PCCM) provider (i.e. a physician, physician group practice, or other entity which contracts with the State to provide PCCM services). This distinction is significant because some of the following requirements apply to all MCEs, some only to MCOs, and others are dependent upon the authority under which a State operates its managed care program, i.e., on a voluntary basis or with mandatory enrollment through either a section 1915(b) or 1115 waiver or under the State plan amendment (SPA) option authority.

Provision of Information

Under approved waiver programs, HCFA has always required that beneficiaries be fully informed of the choices available to them in enrolling with an MCE. As a result of the BBA, these requirements are now spelled out in statute, which now describes the kind of information which must be made available to Medicaid enrollees and potential enrollees, and requires that this information, and all enrollment notices and instructional materials related to enrollment in MCEs, be in a format which can be easily understood by the individuals to which it is directed. This rule applies to all States, enrollment brokers, and MCEs.

Specifically, all MCOs are required to make the following information available to enrollees and potential enrollees on request:

1. The identity, locations, qualifications, and availability of participating providers;

2. The rights and responsibilities of enrollees;

3. The procedures available to enrollees and providers to challenge or appeal the failure of the MCO to cover a service;

4. All items and services that are available to enrollees that are covered either directly or through a method of referral and/or prior authorization.

Either the State or the MCO must also provide a written description of any benefits to which the enrollee is entitled, but which are not made available through the MCO. This notice must include information on where

and how an individual may obtain these benefits.

PCCM providers are required to provide enrollees with information on how to challenge or appeal the failure of the PCCM to cover an item or service.

The BBA also includes a specific information requirement for States that implement mandatory managed care programs under the SPA option in section 1932(a)(1)(A). On an annual basis (or upon request), States implementing SPA managed care programs must provide in a comparative or chart-like form, a list of all available MCEs which includes the following information for each MCE:

1. The benefits covered by the MCE and any cost sharing amounts imposed;
2. The MCE's service area; and
3. To the extent available, any quality and performance indicators for the services covered by the MCE.

The BBA does not require this chart for managed care programs with voluntary enrollment or programs operating under a waiver authority, but we encourage States to use such a chart for these purposes.

Effective Dates

Except for provisions containing a specific alternative date, the BBA provisions in sections 4701 through 4709 apply to contracts entered into or renewed on or after October 1, 1997. "Entered into or renewed" in this context refers to when contracts are signed by both the State and the MCE. A discussion on how this provision on the effective dates of contract requirements interacts with the BBA provision on application to section 1915(b) and 1115 waivers will follow in a subsequent letter.

Enclosure #1 includes a full list of effective dates and some questions and answers on these provisions that have been raised in discussion with various groups regarding these changes. 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: Lee Partridge, American Public Welfare Association

Jennifer Baxendell, National Governors' Association

Joy Wilson, National Conference of State Legislators

All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

HCFA Press Office

Enclosure #1 QUESTIONS AND ANSWERS ON INFORMATION REQUIREMENTS EFFECTIVE DATES AND APPLICATION TO WAIVERS

1. What is the interaction between the information required for MCOs and the comparative chart required for SPA option managed care programs?

The requirements are somewhat different, in part because the one is based upon the type of contractor (an MCO), and the other is the authority under which the State operates the managed care program (through a State plan amendment). Thus, one requirement does not replace the other, and may in fact supplement it. If a State were contracting with MCOs to operate an SPA managed care program, both provisions would apply. A State could use the chart format to offer the necessary information regarding participating MCOs, but would not be required to do so.

If a State only contracted with PCCMs in its SPA managed care program, then the information required of MCOs would not apply. However, the State would be required to provide information on the rules governing PCCM grievances and appeals, in addition to the other information required on the comparative chart.

The comparative chart is required only when a State uses SPA authority to implement its managed care program. However, States may find such a chart to be a useful tool in educating beneficiaries about their options in other managed care settings.

2. What types of information must be made available regarding provider qualifications?

This requirement is intended to provide managed care enrollees and potential enrollees sufficient information to make an informed choice with respect to their enrollment with an MCO, including specific information on the health care practitioners available to them. The requirement for information on provider qualifications applies specifically to the primary care and specialty care providers in the MCO, and should include at a minimum such information as area of specialty, board certification, and any special areas of expertise that would be helpful to individuals deciding whether to enroll with the MCO.

3. What are the effective dates for provisions other than those described in the letter?

Below are listed the effective dates for each provision in the managed care chapter of the BBA:

Provision	**Effective Date**
PCCM Option (Sec. 4702)	Services furnished on or after 10/1/97
75:25 Repeal (Sec. 4703)	Contracts on or after 6/20/97
Quality Standards (Sec. 4705)	1/1/99
Solvency Standards (Sec. 4706)	Contracts entered into or renewed on or after 10/1/98 (or three years after enactment for MCOs with full risk contracts as of that date)
Sanctions for Noncompliance (Sec. 4707(a))	Contracts entered into or renewed on or after 4/1/98
Limits on FFP for Enrollment Brokers (sec.4707(b))	Amounts expended on or after 10/1/97
6-Month Guaranteed Eligibility (Sec. 4709)	10/1/97

4. How and when will existing contracts be required to come into compliance with the new BBA provisions?

Contracts signed by both parties prior to 10/1/97 will not be affected by the new provisions until they are subsequently renewed. At the time such a contract is renewed, it will need to comply with the BBA provisions in effect as of the date the renewal is entered into. Thus, it will not be necessary for a State to amend existing approved contracts that were entered into prior to 10/1/97.

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

4701 Choice, MCE Definition, Repeal of 75/25, 1/14/98 4703 and Approval Threshold 4708(a)

4705 External Quality Review 1/20/98

4704(a) Mental Health Parity 1/20/98

4701(a) Enrollment, Termination, and 1/21/98 Default Assignment

4702 PCCM Services Without Waiver 1/21/98

4707(a) Sanctions for Noncompliance 2/20/98