DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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 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 (list of those already issued is attached). This letter is the fifteenth in the managed care series. Its purpose is to advise you of three provisions relating to beneficiary protections. Further guidance on each of the provisions will be forthcoming in regulations.

Protection of Enrollee-Provider Communications

Under current law, Medicaid beneficiaries are entitled to receive from their health care provider, the full range of medical advice and counseling that is appropriate for their condition. The BBA expands upon this basic right by explicitly precluding a managed care organization (MCO) from establishing restrictions that interfere with enrollee-provider communications. Under the provision, a covered health care professional who is acting within his/her scope of practice, must be permitted to freely advise a patient about his/her health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is covered under the contract with the MCO.

While the new law precludes MCOs from interfering with enrollee-provider communications, it does not require MCOs to provide, reimburse for, or provide coverage of counseling or referral services for specific services, if the MCO objects to the service on moral or religious grounds. (Please note, however, that States remain responsible for assuring access to all covered services). In these cases, the MCO must inform beneficiaries in writing of its policies before and during enrollment. If the MCO changes its policies with regard to a specific counseling or referral service, the organization must provide written notification to enrollees within 90 days of the change. The MCO determines the means of communication.

A covered health care professional means a doctor of medicine or osteopathy. The term may also include any of the following professionals if their services are covered under the contract: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Antidiscrimination of Providers

Under the BBA, an MCO may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an any willing provider law as it does not prohibit MCOs from limiting provider participation to the extent necessary to meet the needs of the organization's enrollees. This provision also does not interfere with measures established by an MCO that are designed to maintain quality and control costs consistent with the responsibility of the organization.

Demonstration of Adequate Capacity

Under the BBA, a Medicaid managed care organization (MCO) must provide States and HCFA with adequate assurances (in a time and manner determined by the HCFA) that the organization, with respect to its service area, has the capacity to serve the expected enrollment. The documentation submitted by an MCO must assure that the organization:

- offers an appropriate range of services and access to preventive and primary care services for the populations expected to be enrolled in such service area, and
- maintains a sufficient number, mix, and geographic distribution of providers of services.

Additional requirements relating to access are contained in the BBA's Quality provisions. Under these provisions, HCFA, in consultation with the States, will establish access standards and State quality assessment and improvement strategies will have to be consistent with those standards beginning January 1, 1999. While standards are under development under each provision, we intend to continue the existing process under 1115 and 1915(b) waiver programs for evaluating access. MCOs, in turn, should continue to supply the same type of documentation they currently submit to assure services are available in compliance with the standards included in approved waiver programs.

If you have any questions regarding these provisions, please contact Nicole Martin at 410-786-1068, or by e-mail at nmartin3@hcfa.gov.

Sincerely,

/s/

Sally K. Richardson
Director
Center for Medicaid and State Operations

Attachments

cc: All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge - American Public Welfare Association

Joy Wilson - National Conference of State Legislatures

Jennifer Baxendell - National Governors Association

HCFA Press Office

Attachment

Summary of Selected Medicaid Managed Care Provisions in the Balanced Budget Act of 1997

Protection of Enrollee-Provider Communications (BBA 4704(a) -- SSA 1932(b)(3))

Under a contract under section 1903(m) of the Social Security Act ("Act"), a Medicaid managed care organization (MCO) must not prohibit or otherwise restrict a covered health professional from advising his/her patient about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for that care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

The term "health care professional" means a physician (as defined in section 1861(r) of the Act) or other health care professional if coverage for the professional's services is provided under the MCO's contract for the services. A health care professional includes the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse, registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

The law does not require, and was not intended to require, a Medicaid MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the MCO objects, on moral or religious grounds, to a particular service being provided and if the MCO makes available information on its policies regarding that service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the MCO adopts a change in policy regarding such a counseling or referral service. The MCO determines the means by which it makes the information available.

Nothing in this provision affects the disclosure requirement under State law or under the Employee Retirement Income Security Act of 1974.

Antidiscrimination (BBA 4704(a) -- SSA 1932(b)(7))

A Medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This law shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

Demonstration of Adequate Capacity and Services (BBA 4704(a) -- SSA 1932(b)(7))

Each Medicaid MCO shall provide the State and Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization:

- offers an appropriate range of services and access to preventive and primary care services for the populations expected to be enrolled in such service area, and
- maintains a sufficient number, mix, and geographic distribution of providers of services.

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, and Approval Threshold 1/14/98

4703

4708(a)

4705 External Quality Review 1/20/98

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

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

4702 PCCM Services Without Waiver 1/21/98

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

4701(a) Provision of Information & Effective Dates 2/20/98

4710(a)

4704(a) Emergency Services 2/20/98

4704(a) Grievance Procedures 2/20/98

4707(a) Prohibiting Affiliations with Debarred Individuals 2/20/98