DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

March 23, 1998

Dear State Medicaid Director:

This letter is one of a series of State letters that provides guidance on the implementation of the Balanced Budget Act of 1997 (BBA).

The purpose of this letter is to provide further guidance to States concerning the guaranteed eligibility provision. We originally discussed this option for States, which is found in section 4709 of the BBA, in a State Medicaid Director's letter dated October 6, 1997. However, since that time, a number of questions have arisen concerning how this provision should be implemented. Since the BBA has expanded section 1902(e)(2) to include any individual enrolled in an Medicaid managed care entity (MCE), interest in this managed care provision has increased and consequently more States are now contemplating providing guaranteed eligibility for their managed population. We should point out that most of the questions relate to issues in section 1902(e)(2) that were not amended by the BBA, but instead have been brought to light because of the BBA expansion to all managed care entities.

The enclosure represents a explanation of this provision in the form of questions and answers. The questions have been raised in discussions with States and the Managed Care TAG. We believe our policy responses provide States with flexibility in determining how best to implement this provision. The list of questions, although not all inclusive, does represent a number of important issues that are meaningful to States as they implement the guaranteed eligibility provision. We will revise section 2090.13 of the State Medicaid Manual to reflect this new and expanded policy.

If you have questions regarding this provision, please contact Mark Ross of my staff on (410) 786-5855, or by e-mail at mross1@hcfa.gov.

Sincerely,

/s/

Sally K. Richardson
Director
Center for State Operations

Enclosure

cc:

All Regional Administrators

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QUESTIONS AND ANSWERS ON GUARANTEED ELIGIBILITY

I. Eligibility for the Guaranteed Eligibility Provision

1. **When does the 6 month period of guaranteed eligibility begin?**

   The guaranteed eligibility period begins on the date the Medicaid-eligible individual first enrolls with an MCO.

2. **What happens to an individual who is ineligible for Medicaid at the end of the 6-month period and becomes re-eligible for Medicaid at a later date?**

   If an individual has already had a period of guaranteed eligibility, States will have the option to either provide these individuals with another period of guaranteed eligibility, or limit guaranteed eligibility to a single period.

3. **What happens to an individual who remains Medicaid eligible, but switches plans? Can the State use a different guaranteed eligibility period for plan switchers than for other plan enrollees? Is the answer the same for an individual who changes plans without cause during his or her first 90 days of enrollment as for other plan switchers?**

   States will have a choice for individuals who change plans. States can: 1) limit guaranteed eligibility to 6 months after the individual first enrolls in an MCO, or 2) allow for multiple periods of guaranteed eligibility anytime an individual changes plans. If the State allows multiple periods of guaranteed eligibility, it must do so both for individuals who change plans within their first 90 days of enrollment as well as for other plan switchers.

4. **What happens to current Medicaid eligibles who are already in managed care when the State begins a guaranteed eligibility program; will they be entitled to receive a period of guaranteed eligibility?**

   Yes, provided the individual's enrollment in the entity is not more than 6 months earlier than the State's effective date of electing guaranteed eligibility. If a State has elected the guaranteed eligibility option, an individual's "6 months" of eligibility would begin with the month the individual enrolls in the entity as a Medicaid recipient. What this means is the individual would receive less than 6 months of guaranteed eligibility if the individual enrolled with entity prior to the State's election of this provision. The State would count towards the 6 months those months the individual was enrolled in managed care prior to the State's effectuating this provision.

5. **What happens to current Medicaid eligibles who have not been in managed care?**

   Individuals in FFS who enroll with a managed care entity will be entitled to 6 months of guaranteed eligibility. The law is clear in that it applies to all Medicaid eligibles who enroll in managed care.

6. **What happens to individuals who are in more than one managed care plan (e.g., acute care HMO and mental health carve-out); does the guaranteed eligibility provision apply to both entities?**

   If both plans meet the requirements of a managed care entity in 1902(e)(2), guaranteed eligibility would be extended to both plans. This situation is not likely to occur since the carve-out plan normally would not qualify as an MCO. Thus, if the mental health component is not part of the MCO benefit package, then the carve-out service would not be covered during the guaranteed period. Under section 1902(e)(2), services received during the guaranteed period are limited to the benefits provided by the managed care entity (see part II, question 2 below).

7. **Can States put limits on the types of individuals who can receive guaranteed eligibility? For example, can States offer it to adults and not children?**

   No. The law says that "in the case of an individual who is enrolled with a managed care organization..." Therefore, any individual who enrolls in a managed care entity is eligible for guaranteed eligibility.

II. Type of Managed Care Benefits

1. **Can PCCMs be excluded from the guaranteed eligibility provisions?**

   No. The law clearly puts PCCMs on equal footing with MCOs. The law provides the State with the option of providing this benefit for all MCEs, or not doing so at all. There is no authority in the statute to provide this benefit selectively.

2. **Section 1902(e)(2) limits the guaranteed benefits provided for under its authority to "benefits provided to the case individual as an enrollee" of the MCO "or by or through the case manager" in the case of a PCCM enrollee. With respect to PCCM arrangements, do the guaranteed benefits provided under this provision extend to services that do not require case-by-case authorization of the case manager, such as emergency services, dental or OB/GYN services received by a PCCM enrollee?**

   Yes. Services provided "by or through the case manager" extend to any benefits the case manager authorizes or refers, either on a case-by-case basis or as a "blanket" authorization. The scope of the "blanket" authorization is defined by the State. An example of a blanket authorization would be one which allows Medicaid beneficiaries to access emergency room or dental services without the need to consult a case manager.