January 21, 1998

Dear State Medicaid Director:

This letter is another in a series of letters advising you on provisions contained in 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 the enclosed list.) This letter is the ninth in the managed care series and relates to
new sections 1905(t) and 1905(a)(25) of the Social Security Act (as enacted in BBA section 4702), which add primary care case management (PCCM) services to the list of optional Medicaid services in section 1905(a), and define PCCM services, identify who may provide them, and set forth requirements for contracts between PCCM providers and the State.

Prior to the BBA many States elected to implement a primary care case management system through a freedom of choice waiver under section 1915(b)(1) of the Act. However, this type of managed care entity could not operate in the absence of a waiver authority. Under the BBA provision, a State may elect to offer PCCM services under its State plan. These services include the locating, coordinating, and monitoring of health care services by a primary care case manager.

These primary care case managers (or PCCM providers) may be physicians, physician group practices, or other entities employing or having other arrangements with physicians to provide such services under contract with the State. A State may also elect to contract with nurse practitioners, certified nurse midwives, and/or physician assistants to perform this function.

PCCM services may be offered by a State as a voluntary option for beneficiaries by adding the service to those available under the State plan, or on a mandatory enrollment basis, either through the State plan amendment option for mandatory managed care under section 1932(a)(1), or (as prior to the BBA) through a waiver authority. An individual's enrollment and termination of enrollment in a PCCM provider are governed by the same provisions that apply to managed care organizations, whereby States must permit beneficiaries to terminate or change their enrollment for cause at any time. But, States may restrict disenrollment for the remainder of the enrollment period (which is not to exceed 12 months) after the first 90 days of an enrollment period.

Reimbursement to PCCM providers may be under fee-for-service, capitation, or other methodology approved by HCFA, as set forth in the contract between the State and the PCCM provider. This contract must also include provisions guaranteeing adequate hours of operation (including 24-hour availability of information, referral, and treatment for emergencies), arrangements with sufficient numbers of physicians and other health care professionals to assure prompt access and quality, and that enrollment will be restricted to individuals residing within a reasonable distance of the service delivery site. Contract requirements are described in full in the enclosed background material on this provision.

There is no prior approval requirement for these PCCM contracts. However, State plan amendments to offer PCCM services (either as an optional service with voluntary enrollment or under the State plan option for mandatory managed care) must contain assurances that the

contracts you enter into with PCCM providers will contain (at a minimum) all terms required under section 1905(t)(3), and describe the reimbursement methodology for PCCM providers.

Enclosed is a further explanation of this provision including definitions of terms used in this section of the BBA, a complete list of the minimum PCCM contract requirements, and some questions and answers regarding this provision. If you have any questions regarding this provision, please contact Bruce Johnson on (410) 786-0615.

Sincerely,

Sally K. Richardson Director Center for Medicaid and State Operations

Enclosures

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

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Enclosure #1 BACKGROUND ON PCCM SERVICES UNDER THE BBA

I. Definitions

A. Primary Care Case Management (PCCM) Services-- Case management related services, including the locating, coordinating, and monitoring of health care services provided by a PCCM Provider, under a PCCM Contract with the State.

B. PCCM Provider (or primary care case manager)--A physician, physician group practice, or an entity employing or having other arrangements with physicians to provide PCCM Services under contract with the State. At the State's option, nurse practitioners, certified nurse midwives, and physician assistants may also qualify as PCCM providers.

C. PCCM Contract--A contract between a PCCM provider and a State under which the provider agrees to locate, coordinate and monitor covered primary care (and other covered services as specified in the contract) for all Medicaid beneficiaries enrolled with the provider.

D. Primary care--For the purposes of this provision, primary care includes all health care services and laboratory services customarily provided by or through a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician in accordance with State licensure and certification laws.

II. PCCM Contract Requirements

All PCCM contracts must include the following provisions:

A. The PCCM will provide reasonable and adequate hours of operation, including the 24-hour availability of information, referral, and treatment with respect to medical emergencies;
B. The PCCM will enroll only those individuals residing sufficiently near a service delivery site to be able to reach that site within a reasonable time using available and affordable means of transportation;
C. The PCCM will provide for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract will be delivered promptly and without compromising quality of care;
D. The PCCM will not discriminate on the basis of health status or requirements for health care services in enrolling, disenrolling, or re-enrolling Medicaid beneficiaries;
E. The PCCM will permit individuals to disenroll in accordance with the provisions in section 1932(a)(4);
F. The PCCM will comply with other applicable provisions of Section 1932; and
G. A description of the reimbursement mechanism to be used in paying the PCCM.

III. Questions and Answers

A. What is considered a "reasonable time" for enrolled individuals to reach their PCCM service delivery site?

Under section 1915(b) waivers, States have been using existing distance and travel times under their unrestricted FFS programs to establish access standards under the waiver. Thus, there are different standards depending upon the area in which PCCMs and other MCEs operate. States most often have used one standard in urban areas and one in rural areas (and in some instances another for frontier areas). This is also how we would expect States to determine "reasonable time" standards in establishing the potential service areas of contracting PCCMs.

B. What types of reimbursement may be used for PCCMs?

The BBA does not address how PCCMs are to be reimbursed. In most section 1915(b) programs, PCCMs have been paid under a FFS arrangement with a case management fee. Nothing precludes a State from using different reimbursement arrangements such as capitation or bundled payments. However, any capitated contracts would have to be for a range of services that is less-than comprehensive (i.e. inpatient hospital and any other service listed in section 1903(m)(2)(a), or any three or more of those services). A risk comprehensive contract would make the entity an MCO

rather than a PCCM.

C Can PCCMs contract to provide and/or be responsible for other than primary care?

PCCMs are specifically required to undertake to "locate, coordinate, and monitor covered primary care. . ." under their contract with the State, but may also perform this function for other services as long as primary care is under the contract. Thus such things as dental or behavioral health carve-out contracts would not be covered under this provision.

Enclosure #2

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)

4707(a) 4707(c) 4708(b) 4708(c) 4708(d)

4701 Choice, MCE Definition, Repeal of 75/25, and Approval Threshold 1/14/98

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