**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Health Care Financing Administration**

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

December 30, 1997

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 fourth in this managed care series.

The provisions presented in this letter pertain to an array of provisions, including beneficiary protections, solvency standards and contract administration. HCFA believes these provisions to be self-implementing and the purpose of this letter is to provide you with official notice of the provisions.

**Beneficiary Protections**

Currently, federal law provides certain protections to Medicaid beneficiaries in the fee-for-service program. The BBA extends two of these protections to Medicaid enrollees in managed care organizations (MCOs). First, the Medicaid enrollee cannot be held responsible for payment liabilities incurred by the MCO. For example, if the MCO were to become bankrupt, the Medicaid enrollee would not have to assume the responsibility for the MCO's debts, or if the provider fails to receive payment from the MCO, the Medicaid enrollee cannot be held responsible for these payments. The second beneficiary protection extended allows for criminal penalties to be charged against anyone who knowingly and willfully charges for services under the MCO contract at a rate in excess of the rate specified in the MCO's contract. This provision ensures that the Medicaid enrollee and provider of services to the Medicaid enrollee will not be charged excessive rates that have not already been disclosed in the contract.

Three BBA provisions pertain indirectly to the Medicaid enrollee. These provisions serve to establish sound practices for the MCO to follow so that the provision of health services to the Medicaid enrollee is not compromised. The BBA extends the same Medicaid State plan requirement for timely payment of claims to Medicaid MCOs. Contracts with the MCOs must now include this requirement that providers of items or services under the contract receive their payments in a timely manner. A certain percentage of claims must be paid within a specified number of days as stipulated by the Federal statute. In addition, the managed care entity must notify the appropriate State agency of any individuals in a managed care entity that have a five percent or more ownership or controlling interest in the entity. The purpose of this provision is to extend this requirement to primary care case managers. Also, a MCO may not enter into a contract with the State, unless the State has in effect conflict-of-interest safeguards relating to State officers and employees having responsibilities over contracts with the MCO or the default enrollment process now established for MCOs. The State rules must be at least as effective as the federal rules. This provision will ensure that there is no undue influence or preference given to a MCO because of a State employee having an interest in that MCO.

**Contract Administration**

Under current law, there are certain services and items for which Federal financial participation (FFP) is not available under fee-for-service. In order to assure consistency, the BBA specifies that FFP is not available for these items or services if they are provided by a managed care entity.

Previously, Medicaid MCOs could not impose cost-sharing or copayments on enrollees. Now, under the authority of the BBA, MCOs may apply copayments and cost-sharing to enrollees in the same manner allowed in fee-for-service.

**Solvency Standards**

Finally, with respect to solvency standards imposed on the MCO by the State, current law requires that each MCO make adequate provision to the State that it will not become insolvent and that Medicaid enrollees cannot be held liable for payment of the MCO's debts if it should become insolvent. This provision has been slightly changed under the BBA to indicate that MCOs should meet the solvency standards that the State establishes for its private MCOs or should be licensed by the State as risk-bearing entities. It is up to the discretion of the State to determine what these standards entail. However, this provision does not apply to MCOs that do not provide inpatient and physician services, are public entities,

have solvency guaranteed by the state, or are federally qualified health centers (FQHC) or organizations controlled by a FQHC that meet the solvency standards already established for such centers.

More detailed descriptions of the statutory provisions and effective dates for these provisions are provided in the attached document.

If members of your staff have any questions about this letter or the BBA provisions described, please have them contact Kristin McGinn on (410) 786-4581, or by e-mail at kmcginn@hcfa.gov.

Sincerely,

/s/

Sally K. Richardson

Director

Center for Medicaid and State Operations

Attachment

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 Joy Wilson - National Conference of State Legislatures HCFA Press Office

**Attachment**

**Protecting Enrollees Against Liability for Payment (SSA 1932(b)(6)) -- BBA 4704(a)**

Section 1932(b)(6) of the Social Security Act ("Act") requires each managed care organization (MCO) to protect enrollees from certain payment liabilities. As a result, no Medicaid MCO can hold an enrollee liable for the following:

- The debts of the MCO if it should become insolvent.
- Payment for services provided by the MCO if the MCO has not received payment from the State for the services, or if the provider, under contract or other arrangement with the MCO, fails to receive payment from the State or MCO.
- The payments to providers that furnish covered services under a contract or other arrangement with the MCO that are in excess of the amount that normally would be paid by the enrollee if the service had been received directly from the MCO.

These protections must be included in contracts entered into or renewed (i.e., signed by both parties) October 1, 1997 or later.

**Protection of Enrollees Against Balance Billing Through Subcontractors (Amends SSA 1128B(d)(1)) -- BBA 4704(b)**

Section 1128B(d)(1) of the Act authorizes criminal penalties to providers in the case of services provided to an individual enrolled with a managed care organization under contract under section 1903(m) of the Act which are charged at a rate in excess of the rate permitted under the organization's contract.

Section 1128B(d)(1) of the Act states that whoever knowingly and willfully charges, for any service provided to a patient under a State plan approved under title XIX or under a managed care organization contract under 1903(m) of the Act, money or other consideration at a rate in excess of the rates established by the State or contract shall be guilty of a felony and upon conviction shall be fined no more than $25,000 or imprisoned for no more than five years, or both.

These protections must be included in contracts entered into or renewed (i.e., signed by both parties) October 1, 1997 or later.

**Assuring Timeliness of Provider Payments (SSA 1932(f)) -- BBA 4708(c)**

Section 1932(f) of the Act requires that contracts with Medicaid managed care organizations must provide that payment to affiliated health care providers for items and services covered under the contract are made on a timely basis, consistent with the claims payment procedures described in section 1902(a)(37)(A) and the implementing Federal regulation at 42 CFR 447.45, unless the health care provider and organization agree to an alternative payment schedule. Section 1902(a)(37)(A) sets forth the State plan requirement for timely payment of claims and this new section makes it clear that the same timely payment provision applies to Medicaid managed care organizations.

This provision applies to contracts entered into or renewed (i.e., signed by both parties) October 1, 1997 or later.

**Application of Disclosure Requirements to Managed Care Entities (Amends SSA 1124(a)(2)(A)) -- BBA 4707(c)**

Section 1124(a)(2)(A) of the Act is amended to include a managed care entity as a "disclosing entity." The managed care entity must now notify the appropriate State agency of any individuals in a managed care entity that have a five percent or more controlling ownership or controlling interest in the entity.

The statute reads that, as a condition for the approval or renewal of a contract or agreement the disclosing entity must supply the Secretary or appropriate State agency under Title XIX with full and complete information as to the identity of each person with an ownership or control interest in the entity in which the individual has, directly or indirectly, a five percent or more ownership interest.

This provision applies to contracts entered into or renewed (i.e., signed by both parties) October 1, 1997 or later.

**State Conflict-of-Interest Safeguards in Medicaid Risk Contracting (SSA 1932(d)(3)) -- BBA 4707(a)**

Section 1932(d)(3) of the Act requires that: Medicaid managed care organizations cannot enter into contracts with any State, unless the State has in effect conflict-of-interest safeguards with respect to its officers and employees who have responsibilities relating to contracts with such MCOs or the new default enrollment process. These safeguards must be at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

This provision applies to contracts entered into or renewed (i.e., signed by both parties) October 1, 1997 or later.

**Clarification of Application of FFP Denial Rules to Payments made Pursuant to Managed Care Entities (Amends SSA 1903(i)) -- BBA 4708(d)**

Section 1903(i), which prohibits certain services from being eligible for FFP, is amended. Services or items described in sections 1903(i)(1), (2), (16), (17) and (18) are not eligible for FFP if they are provided by a managed care entity, just as they are not eligible for FFP provided directly by the State. FFP is not available for the following:

- Organ transplants, unless the State plan provides written standards for the procedure that provide that similar individuals are treated alike and that restrictions on facilities that may provide organ transplant procedures are consistent with accessibility of high quality care.
- Any item or service (other than emergency services) if either the individual or physician is excluded from participation under title V, XVIII or XIX.
- Any amount expended for home health care services unless the agency or organization providing the services provides the State agency, on a continuing basis, a surety bond in the form specified under section 1861(o)(7) of the Act (for home health services furnished on or after January 1, 1998).

**Permitting Same Copayments in Health Maintenance Organizations as in Fee-For-Service (Amends SSA 1916(a)(2)(D) and 1916(b)(2)(D)) -- BBA 4708(b)**

Sections 1916 (a)(2)(D) and 1916(b)(2)(D) of the Act are amended to eliminate the prohibition on cost-sharing for services furnished by health maintenance organizations. Copayments and cost-sharing may now be applied in the same manner as permitted in fee-for-service.

This provision applies to contracts entered into or renewed (i.e., signed by both parties) October 1, 1997 or later.

**Solvency Standards (Amends SSA 1903(m)(1)) -- BBA 4706**

Section 4706 amends section 1903(m)(1) of the Social Security Act by adding a new section, which provides additional requirements for a managed care organization (MCO) in meeting solvency standards. Under current law, MCOs must make adequate provision against the risk of insolvency to the satisfaction of the State and provide that Medicaid beneficiaries enrolled with the organization are not held liable for the debt of the MCO in the case of its insolvency. The new section specifies that, effective for Medicaid managed care contracts entered into or renewed (i.e., signed by both parties) October 1, 1998 or later, MCOs are required either to meet the same solvency standards set by the states for private MCOs or to be licensed or certified by the state as a risk-bearing entity. The requirements of this section do not apply under any of the following circumstances:

- The MCO does not provide inpatient and physician services.
- The MCO is a public entity.
- The MCO's solvency is guaranteed by the state.
- The MCO is (or is controlled by) a federally qualified health center and meets the solvency standards set by the state for such organizations.

These solvency requirements do not apply to fully capitated MCOs under contract as of the date of enactment of the BBA until three years after the date of enactment of the BBA, i.e. August 5, 2000.

## 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

4704(a) Marketing Restrictions 12/30/97