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

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

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 eighth in the managed care series and relates to new sections 1932(a)(4) and 1905(t) and amended section 1903(m) of the Social Security Act (as enacted in BBA section 4701). The BBA modifies existing requirements that apply to the enrollment and disenrollment of Medicaid beneficiaries in managed care entities.

The new law requires States to permit beneficiaries enrolled in managed care entities (MCEs) to terminate or change their enrollment for cause at any time. Beneficiaries must also be permitted to disenroll without cause within the first 90 days of an enrollment period of up to 12 months, and annually thereafter. For the first time outside of section 1115 waivers, however, the enrollment period during which individuals may be locked into an MCE may extend up to 12 months. Section 1932(a)(4) also contains specific requirements for the process of enrollment in programs with mandatory enrollment that operate under the State plan amendment authority (as described in our letter to you dated December 17, 1997).

Prior to the BBA individuals were permitted to disenroll without cause as of the beginning of the first calendar month following a full calendar month after submitting the request to disenroll. In effect this was considered to be a 30-day lock-in. With Federally-qualified HMOs and certain other limited types of organizations, States were permitted to enroll individuals for periods of up to six months, except for the first 30 days of the enrollment period when unlimited disenrollment was permitted. Lock-in periods exceeding 6 months in Federally-qualified HMOs or 30 days in other types of HMOs were permitted only under section 1115 demonstrations, where HCFA authorized lock-ins of up to 12 months.

In addition to extending the maximum enrollment period from 6 months to 12 months, the BBA:

1. Applies this lengthened enrollment to all managed care entities (MCEs)--managed care organizations (MCOs) and primary care case managers (PCCMs)--rather than a specific type of HMO;
2. Provides for a 90-day period at the beginning of an individual's enrollment during which he or she may disenroll without cause;
    - Requires that beneficiaries be notified of their ability to disenroll or change plans at the end of their enrollment period at least 60 days before the end of that period; and
    - Eliminates all previous statutory provisions on enrollment and termination of enrollment.

These provisions apply to enrollment and disenrollment with all types of MCEs in all Medicaid managed care programs with the exception of section 1115 demonstrations, where a State may elect to continue the enrollment and disenrollment processes as set forth under the terms and conditions of the State's approved waiver. The provisions are effective with respect to contracts entered into or renewed on or after October 1, 1997.

This section of the BBA also contains the following requirements for the enrollment process where States utilize the State plan amendment authority in section 1932(a)(1) to implement managed care on a mandatory basis:

1 Individuals already enrolled with an MCE must be given priority to continue that enrollment where the MCE does not have capacity to enroll all individuals seeking enrollment under the program; and

2 States must establish a default enrollment process under which individuals who do not elect an MCE during their enrollment period are assigned to one that meets the requirements of section 1903(m) or 1905(t), and this process must take into consideration:

(a) the maintenance of existing provider-individual relationships or relationships with traditional Medicaid providers; and

(b) where maintaining such relationship is not possible, equitably distributing these individuals among available qualified MCEs.

As mentioned above, these requirements are limited to programs established under the State plan amendment authority for mandatory managed care enrollment.

Enclosed is a further explanation of this provision in the form of questions and answers that have been raised in discussions with various groups regarding these changes. If you have any questions regarding this provision, please contact Bruce Johnson on (410) 786-0615.

Sincerely,

/s/

Sally K. Richardson Director

Center for Medicaid and State Operations

Enclosure

cc:

Jennifer Baxendell, National Governors Association

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HCFA HCFA Press Office

Enclosure #1

Questions and Answers on BBA Enrollment and Disenrollment Provisions Sections 1932(a)(4), 1903(m)(2)(a), and 1905(t) of the Social Security Act

1. **When do the 90-day period for disenrollment without cause and the 12-month lock-in periods begin?**

The language in the statute indicates that the 90-day period is to begin on the date the individual receives "notice of such enrollment. . ." However, we recognize that a literal application of this starting date makes this provision extremely difficult for States to administer and potentially disadvantages the beneficiary as well, since it could reduce the amount of time in which he or she could disenroll without cause while actually enrolled in the MCO (as in most cases beneficiaries are notified of their enrollment prior to the date on which they must begin receiving services from their MCE).

Consequently, we are applying this provision so that both the 90-day period and the 12-month enrollment period begin on the same day--the date the individual is actually enrolled in and must receive services through the MCO. The only exception to this rule would be in the rare instance where the beneficiary receives notice of enrollment in the MCO after he or she is actually enrolled. In this instance, the 90 days would begin on the latter of the date they are enrolled or the date they receive notice of their enrollment.

2. **Does the 90-day period for disenrollment without cause apply to every enrollment period or to just the initial one?**

We believe that the language in section 1932(a)(4) regarding the 90-day period for disenrollment without cause is meant to apply to an individual's enrollment with an entity rather than basing it upon his or her Medicaid eligibility. Thus, beneficiaries are entitled to a 90-day "without cause" period for disenrollment any time they are enrolled in a different MCE. This would apply to the individual's initial period of enrollment and to any subsequent enrollment periods where their MCE has changed.

The BBA provides for a notice of termination rights under which an enrollee must be informed of his or her ability to terminate or change enrollment at least 60 days before the end of each enrollment period. This 60-day period gives individuals the opportunity to change MCEs effective with the end of their enrollment period. Where they choose to remain in the same plan, they have had their opportunity for disenrollment without cause and declined it. Where they change plans, however, this would provide the enrollee with an opportunity to try out the new MCE and determine whether they wish to remain enrolled through the enrollment period.

We recognize that this policy gives an individual the opportunity to abuse the system by exercising his or her right to disenroll without cause during the first 90 days of enrollment with every available MCE. Once returning to an MCE in which they were previously enrolled, the 90 day period would have begun when they initially enrolled, and would likely have expired. However, we have been advised that further restricting the application of the 90-day without cause period would not comply with the statutory language.

3. **How do the BBA's disenrollment requirements apply to health insuring organizations (HIOs) and the rural exception programs as described in section 1932(a)(3), where there is no alternative MCE?**

Section 1932(a)(4) permits individuals to disenroll at any time for cause and during annual enrollment periods thereafter. This is problematic when only one option exists, such as with the rural and HIO exceptions cited above. Under these exceptions to the general rule, disenrollment and changes in enrollment must be permitted from individual physicians or case managers. Thus individuals may disenroll from their current primary care provider, but still must continue as an enrollee in the managed care program. This would make it unnecessary for a State to operate a parallel FFS system for those individuals who disenroll.

4. For the purpose of default assignment, how are the terms "existing provider-individual relationships" and "providers that have traditionally served beneficiaries under this title" defined?

In applying the default assignment provision under section 1932(a)(1) programs, States are required to establish an enrollment process which takes into consideration existing provider/individual relationships and traditional Medicaid providers, and where these are not possible, utilize an assignment process which equitably distributes enrollees among qualified, available MCEs.

For the purpose of implementing this provision, a beneficiary would be considered to have an existing provider-individual relationship if there was a provider who has been the main source of care for the beneficiary within the last year. A traditional provider is defined as one who has been treating any Medicaid beneficiaries in the past year and has demonstrated expertise and experience in dealing with the Medicaid population through participation in the Medicaid program.

5. What must a State do to comply with the requirement to "take into consideration" existing provider-individual relationships and relationships with traditional providers, in default assignments?

Except where States have a fee-for-service experience or prior MCO enrollment data regarding an individual beneficiary, it will be very difficult to establish a provider/individual relationship for default assignment purposes. In order to establish whether any relationship exists, the State should first check its FFS payment records to see if the individual had any prior utilization with a particular provider. Where the State has no recent claims for a particular beneficiary, the State should ask the individual for the names of providers from whom they receive services and whether they would wish to continue this relationship. Where the beneficiary provides a response and the provider participates and has capacity, use the information in the individual's assignment. This could be to any of several plans in which a provider participates. Such a process may not often work since these are individuals who are not choosing an MCE on their own.

Where the State has no recent claims history, cannot get a response from the beneficiary, or the named provider does not participate, the State has met the requirement and consideration must be given to "traditional providers" as defined above.

Where no traditional providers are available, remaining individuals are to be equitably distributed among qualified MCEs with adequate capacity.

6. Can a State differentiate among types of MCEs in distributing default enrollees , e.g. by only assigning default enrollees to MCOs in a managed care system that includes both MCOs and PCCMs?

Section 1932(a)(4)(D) clearly requires an "equitable" distribution of default enrollees "among qualified managed care entities available to enroll such individuals. . ." Caps may be placed on an MCE's total enrollment (based upon its capacity). But a State may not arbitrarily exclude MCEs from the default assignment process if they are otherwise qualified and have capacity.

7. Are there any circumstances in which States can still use default assignment mechanisms based on such things as points scored in a procurement process as the basis for assigning these enrollees to a plan?

Yes. The BBA provisions regarding enrollment priorities and the default enrollment process apply ONLY to mandatory managed care programs operating under the State plan authority contained in section 1932(a)(1)(a) of the Act. Default assignment mechanisms in section 1915(b) waivers or 1115 demonstrations need not comply with this provision.

8. What is the impact of default enrollment on the lock-in provision; i.e., is default assignment considered to be "election" of a plan?

Yes, the lock-in provision previously contained in section 1903(m)(2)(a)(vi) contains the same language (i.e., "individuals who have elected to enroll with the plan. . .") that is in the new BBA requirement on disenrollment. The provision has always been applied to individuals who were default-assigned as well as those who actually elected to enroll in their plans. Thus we believe that this practice may be continued.

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)

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