



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

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

December 17, 1997

Dear State Medicaid Director:

This is another in a series of letters advising you on provisions contained in the Balanced Budget Act of 1997(BBA). This letter is in regard to new section 1932(a) of the Social Security Act (enacted in BBA section 4701), which permits States to enroll their Medicaid beneficiaries in managed care entities on a mandatory basis without section 1915(b) or 1115 waiver authority.

Under this provision, you may amend your State plan to require all Medicaid beneficiaries in your State to enroll with either a managed care organization or a primary care case manager, except for certain specified groups which are described in the enclosure to this letter.

We are enclosing a list of the information to be included in submitting a State plan amendment (SPA) to implement managed care under section 1932(a)(1)(A) of the Act.

HCFA approval of all MCO contracts under section 1903(m) of the Act is still required for these programs before Federal financial participation (FFP) can be awarded in payments under such contracts. In addition to existing section 1903(m) requirements, these contracts will be subject to new provisions contained in section 1903(m) and 1932 of the Act, including: increased beneficiary protections; quality assurance standards (effective 1/1/99); and timely payment requirements. Requirements on solvency (effective 1/1/98), marketing, and fraud and abuse have also been added through these amendments. We will be providing detailed guidance on these requirements and those in the attached list in the near future.

As with other SPAs, the effective date provisions contained in 42 CFR 430.20 and 447.256 will apply to SPAs under section 1932(a). SPAs thus may be effective the first day of the quarter in which your SPA is submitted to HCFA for approval.

However, before individuals may actually receive services under one of these programs, HCFA will need to verify that contracts between States and MCOs implementing these programs are signed by the State and MCO, meet all statutory and regulatory requirements, and are approved (at least in model or draft form). This will apply to all MCO contracts under section 1903(m) and represents a change from prior policy as set forth in section 2087.1 of the State Medicaid Manual.

We encourage States to submit model/draft MCO contracts to HCFA for review in order to expedite this process. The model/draft contracts need to contain all of the substantive portions of MCO contracts required by statute or regulation. Upon HCFA's approval of the model/draft final contract, States would then be free to negotiate with MCOs for final contracts.

A State wishing to implement its program based on submission of the model/draft contract may not make any substantive changes between HCFA approval of the model/draft contract and the final contract. To the extent there are no substantive changes, a State could begin implementation of the administrative processes of the SPA managed care program (e.g., beginning the enrollment process, negotiating with MCOs) at the time of the model/draft contract approval, assuming the State's SPA authority is effective as of that date. The actual delivery of services and the availability of FFP for services under the contract may not occur until the final contract is signed by the MCO and the State, but may be effective immediately upon signing, as long as substantial changes have not been made in the terms approved in the model contract. This principle applies to all MCO contracts, and will be effective as of the date of publication of the change in the State Medicaid Manual.

It is our hope that this new State option will provide increased flexibility for States while maintaining necessary beneficiary protections and assuring access and the delivery of quality care.

Sincerely,

/s/

Sally K. Richardson

Director

Center for Medicaid and State Operations

**Enclosure**

cc: Jennifer Baxendell, National Governors Association Joy Wilson, National Conference of State Legislatures Lee Partridge, American Public Welfare Association

**REQUIREMENTS FOR STATE PLAN AMENDMENTS TO IMPLEMENT MANDATORY MANAGED CARE PROGRAMS UNDER SECTION 1932(a)(1)(A) OF THE SOCIAL SECURITY ACT**

I. Assurances of the following:

- A. All requirements of sections 1903(m), 1932 and 1905(t) will be met.
- B. The option will NOT be used to enroll the following exempted populations:
  - 1. dual Medicare-Medicaid eligibles;
  - 2. Indians who are members of Federally-recognized tribes. and (3) children (under 19 years old) who are:
    - (a) eligible for SSI under Title XIX;
    - (b) described in section 1902(e)(3) of the Social Security Act;
    - (c) in foster care or other out-of-home placement;
    - (d) receiving foster care or adoption assistance; or
    - (e) receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V.

This assurance must include: (1) a definition of the individuals who would fall under this last category (item (3)(e) above) within your State; and (2) an explanation of how you will identify them for the purpose of making them exempt. We suggest that this definition be developed in consultation with the State Maternal and Child Health agency.

In developing this definition, you have the option of providing a more detailed definition, based upon a child's special health care needs. You may also develop a process whereby individuals who are not identified through the initial exemption process could request exemption based on special needs as defined in your State plan. This exemption process would not eliminate the need for you to develop an operational definition of this group and a process for making them exempt. Rather, the "self-declared" exemption process would be intended as a fall-back for individuals not identified initially through your State's operational definition.

- C. Individuals will have a choice of at least 2 managed care entities (MCEs)--managed care organizations (MCOs) under 1903(m)(1)(A) and/or primary care case managers (PCCMs) under 1905(t)--except where the State contracts with certain county-based HIOs. (Once regulations are published on implementing this provision, the exception will also be permitted in rural areas (under certain circumstances to be defined in regulation).
  - D. Beneficiaries will be permitted to disenroll at any time for cause and in the first 90 days of enrollment and at least every 12 months thereafter (without cause).
  - E. Default enrollment will be based upon maintaining prior provider-patient relationships, or where not possible, an equitable distribution among MCEs.
  - F. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among MCEs regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).
- II. Identify the methodology and processes you will utilize to verify that beneficiaries have access to an adequate number of geographically accessible providers under the program as required by section 1932(a)(1)(A)(ii).
- III. Identify the types of providers you will have contracts with under this option (MCOs and/or PCCMs) and provide assurances that all contracts with MCOs will comply with all pertinent sections of 1932 and 1903(m) of the Act.
- A. With respect to PCCMs, you must assure that the contracts you enter into with them will contain (at a minimum) all terms required under section 1905(t)(3), and indicate whether reimbursement will be made on a fee-for-service (FFS) or partial capitation, i.e., a limited risk contract for no more than two mandatory services under section 1905 of the Act.
    - 1. If any PCCM contracts are to be capitated, include an assurance that the actuarial soundness and upper payment limit requirements in 42 CFR 434.23 and 447.361 will be met and that the contract will comply with the PHP requirements in 42 CFR Part 434.