

Memorandum

**Re: Final Medicaid Managed Care Rules
Medicaid Managed Care Sanctions, Part 438, Subpart B
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Date: March 10, 2001

Below is a review of the changes contained in the state's responsibilities provisions of the final with comment period regulations. This memo summarizes the proposed rules and notes the changes that have been made. It does not present a full discussion of the statute and proposed regulations. For fuller explanation of the proposed rules and NHELP's suggestions concerning each proposed rule, see Health Advocate No. 194 (Fall 1988); for similar discussions of the statute, see Health Advocate No. 190 (Fall 1997).

This subpart implements 42 U.S.C. § 1396u-2(a)(3) and (4) of the Act. Under the statute, a state is required to allow an individual at least two choices when requiring the individual to choose a managed care entity (MCE). 42 U.S.C. § 1396u-2(a)(3)(A). The state need not provide a choice of two MCEs for individuals living in rural areas if the state gives that individual a choice of at least two physicians or case managers (to the extent that two are available) and permits the individual to obtain medical care from any other provider in "appropriate circumstances." 42 U.S.C. § 1396u-2(a)(3)(B). The statute requires the state to permit an individual enrolled with an MCE to terminate enrollment: (1) for cause, (2) during the 90-day period beginning the date the individual receives notice of enrollment, and (3) at least every 12 months thereafter. 42 U.S.C. § 1396u-2(a)(4)(A). The state must provide notice of termination rights at least 60 days before each annual enrollment opportunity. 42 U.S.C. § 1396u-2(a)(4)(B). The state is also required to establish enrollment priorities in the case of an MCE that does not have sufficient capacity to enroll all individuals seeking enrollment. Such priorities must preserve priority for individuals already enrolled. 42 U.S.C. § 1396u-2(a)(4)(C). A default enrollment process is required to enroll individuals who did not enroll with an MCE. The default MCE chosen by the state must not be out of substantial compliance with the relevant parts of the Act and must be one that takes into consideration maintaining existing provider-individual relationships or relationships

with providers that serve Medicaid recipients. If maintaining such relationships are not possible, the MCE must be one that takes into account the equitable distribution of default enrollees among qualified MCEs. 42 U.S.C. § 1396u-2(a)(4)(C).

Throughout this discussion of subpart B, where the proposed rule referred to "managed care entities" (MCEs), the final rule generally makes more specific references to Managed Care Organizations (MCOs) Prepaid Health Plans (PHPs) and Primary Care Case Management Systems (PCCMs). This makes the applicability of some of the requirements of Subpart B clearer. See Analysis and Response to Public Comments on Proposed Rule, *Federal Register*, vol. 66, no. 13; Friday, January 16, 2001 at p. 6257.

§ 438.50 State Plan requirements

This section has been substantially reorganized, and contains some new provisions.

Final version of subsection (a) provides that a state plan requiring Medicaid recipients to enroll in MCEs must comply with the section, unless the state imposes such a requirement as part of a demonstration project under Section 1115 of the Medicaid Act ("the Act") or under a waiver granted under Section 1915(b) of the Act. The exception for demonstration projects and waivers was not explicitly stated in the proposed rule.

A newly-added subsubsection requires state plans to specify "the process the State uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the State Plan has been implemented." Section 438.50 (b)(4).

The final version of the rule contains some additional requirements for assurances that the state must make. The proposed version required the state to provide a number of assurances, including assurances that all risk contracts would comply with the upper limit of payment

restrictions imposed by Section 447.361. The final version requires that the state make all of the same assurances required in the proposed rule, [\(1\)](#) but adds a requirement regarding risk contracts. Subsection (c)(6) requires that the state's Medicaid plan provide assurances that the state meets the applicable requirements of Section 438.6(c) with respect to payments under risk contracts, and 447.362 with respect to payments under any non-risk contracts.

The final version of subsection (d) describes limitations on enrollment. These limitations were described in proposed rule 438.52(b) and are essentially unchanged. The rule provides that Indians who are members of federally recognized tribes cannot be required to enroll in an MCO or PCCM unless the MCO or PCCM is the Indian Health Service, Indian health program or an Urban Indian program. The reference to an Urban Indian program is new, and was added to make it explicit that Urban Indian programs are part of the exception for programs operated expressly for Indians

The final version of subsection (e) describes the rule for priority for enrollment, and is essentially the same as proposed rule 438.56(c). The final version, instead of making reference to "MCEs" instead refers to an "MCO or PCCM." The final version of subsection (f) contains the rules for enrollment by default. This was contained in proposed rule 438.56(d). The final version replaces references to "MCEs" with reference to "MCOs and PCCMs." It makes no mention of PHPs. The final version also includes a new provision that the state cannot enroll recipients by default in an MCO or PCCM that is subject to an intermediate sanction of the type described in 438.702(a)(4). [\(2\)](#) Again, no mention is made of PHPs.

§ 438.52 Choice of MCOs, PHPs and PCCMs

This final version again replaces references to MCEs with reference to "MCO, PHP or PCCM." In addition, a number of more substantive changes have been made.

Under the final version, a state may limit a rural area resident to a single MCO, PHP or PCCM system under programs authorized under Section 1932(a) of the Act, or under waivers under Section 1115 of the Act, or Section 1915(b) of the Act. In the proposed rule, this exception was allowed under programs authorized by Section 1932(a) of the Act, and waivers under Section 431.55. Section 431.55 discusses waivers authorized pursuant to Section 1915(b) of the Act.

The definition of "rural area" has been simplified in the final version. The definition now simply provides that a rural area is any area other than an urban area as defined in the Medicare regulations at 42 C.F.R. § 412.62 (f). Final Section 438.52(3). The Medicare regulations define an urban area as: (1) A Metropolitan Statistical Area (MSA) or New England County

Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or (2) certain New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983. [\(3\)](#) 42 C.F.R. § 412.62 (f)(1)(ii). The proposed version had a more elaborate definition that also made reference to Census Bureau definitions and gave the state and HCFA the option of making their own definitions. These provisions did not make it to the final version. Accordingly, the state no longer has the power to change the federal definition.

Both the proposed and final versions of this section establish safeguards for recipients who are limited to only one MCO, PHP or PCCM system. It provides that the state must allow recipients certain choices within that one entity. Two changes have been made in the final version. The proposed rule requires states to allow the recipient to obtain services from a provider who is not a part of the MCE when the recipient has "an existing relationship" with a provider. Proposed Section 438.52(c)(2)(ii). The final version instead allows a recipient to choose a provider who is not a part of the network, "but is the main source of services to the recipient." Final Section 438.52(2)(ii)(B). In addition, the final version specifies that this particular exception applies only as long as that provider continues to be the main source of the service. *Id.* The final version also adds another condition under which a recipient may obtain services from a provider not in the network. The final regulation allows this when the recipient's primary care provider, or another provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately, and not all of the services are available within the network. Final Section 438.52(2)(ii)(D). An example -tubal ligation and caesarean section- is included. /

d.

The grievance provisions have also been amended to allow beneficiary complaint rights when their out-of-network rights are violated.

See

NHeLP Memorandum on Grievance and Appeals.

The final version includes a new subsection providing for limitations on changes between primary care providers. For recipients who only have the choice of single entity (i.e. rural residents), the state must allow a recipient to change between primary care providers to the same extent that a person may disenroll from an MCO, PHP or PCCM. Final Section 438.52(d).

The limitations on disenrollment are contained in section 438.56(c), which is discussed below. By analogy to section 438.56(c), it appears that section 438.52(d) requires that a state medicaid plan allow a person to change primary care providers when: (1) the enrollee was homeless or a migrant worker when enrolled and was enrolled in the MCO, PHP or PCCM by default, (2) a provider does not provide the service sought because of moral or religious grounds, (3) a person needs related services to be performed at the same time and the provider does not provide both services, and (3) other reasons including but not limited to poor quality of care, lack of access to services covered under the contract or if the provider is not experienced in dealing with the enrollee's health care needs.

§ 438.56 Disenrollment: Requirements and limitations

In the proposed rule, this section contained the rules for enrollment and disenrollment. The final version deals only with disenrollment.

The final version of the rule provides a blanket definition of applicability, stating that the provisions of this section apply to all managed care arrangements, whether mandatory or voluntary, and whether the contract is with an MCO, PHP or PCCM. Final Section 438.56(a). The proposed version had a more complex applicability provision, because the proposed version dealt also with enrollment. The change is stylistic and not substantive.

The proposed version contained no provision for the managed care entity to request disenrollment of a recipient. The final version provides that all MCO, PHP and PCCM contracts must specify the reasons that an MCO, PHP or PCCM may request disenrollment of an enrollee. Final Section 438.56(b)(1). The final version also forbids the entity from requesting disenrollment because of: (1) a change in the enrollee's health status, (2) the enrollee's utilization of medical services (3) the enrollee's diminished mental capacity, or (4) because of uncooperative or disruptive behavior resulting from the enrollee's special needs. However, the final version also provides that an MCO, PHP, or PCCM may disenroll such an uncooperative or disruptive recipient if that recipient's continued enrollment seriously impairs the entity's ability to furnish services to either that recipient or other enrollees. Final Section 438.56(b)(2). It also requires that the MCO, PHP or PCCM contracts specify the methods by which the entity

assures the state agency that it will only request disenrollment for reasons specified under the contract. Final Section 438.56(b)(3).

Both the proposed and final versions of the rules place limitations on a state's ability to restrict disenrollment and provide that contracts must allow for recipients to request disenrollment under certain circumstances. The final version of the rule adds two such circumstances. The final version provides that a contract must allow a recipient to request disenrollment upon automatic reenrollment, if temporary loss of Medicaid eligibility caused the recipient to miss the annual disenrollment opportunity. Final Section 438.56(c)(2)(iii). It also provides that a recipient must be allowed to request disenrollment when the state imposes a sanction granting enrollees the right to terminate enrollment without cause. Final Section 438.56(c)(2)(iv), referencing Final Section 438.702(a)(3) regarding sanctions.

The proposed version of this section had provided a special rule for recipients who resided in a rural area with only one MCE or who resided in an area with only one Health Insuring Organization. The proposed rule made the conditions for disenrollment from an MCE applicable to changes among individual physicians or primary care case managers. Proposed Section 438.56(3)(2). The final version of Section 438.56 does not contain this provision; however, the final version addresses the situation of enrollees who cannot choose between entities in Final Section 438.52(d), discussed above.

The final version of the rule governing procedures for requesting disenrollment allows the recipient to make a written or oral request for disenrollment. Final Section 438.56(d). This is an important change from the proposed version, which only provided for written requests. See Proposed Section 438.56(f)(1)(i). The final version no longer contains a provision requiring MCEs to submit a copy of a recipient's request for disenrollment to the state.

The final version adds an important section describing what must be considered good cause to allow disenrollment. First, if the enrollee was homeless or a migrant worker at the time of enrollment and was enrolled by default. Second, if the plan does not, because of moral or religious objections, cover the service the enrollee seeks. Third, if the enrollee needs related services to be performed at the same time, not all related services are available within the network and a provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Again, the example of a tubal ligation and caesarean section are used. Finally, the rule provides that other reasons can constitute good cause, "including but not limited to," poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with necessary health care needs. Final Section 438.56(c)(2)(i)-(iv).

The final version of the rule simplifies the provisions related to action on a request for disenrollment. The final version simply provides that an MCO, PHP or PCCM may either approve a request or refer it to the state. It then provides that if no determination is made in time for an enrollee to disenroll within the time specified in the rule, the disenrollment is considered approved. Final Section 438.56(d)(3). The proposed version was more confusing, but made reference, without specifics, to the state being required to act within a "reasonable" time. No such provision made it to the final version. However, the time line set in the final version, along with the provision that disenrollment can be automatic, is a more specific and probably better substitute.

The final version of the rules regarding MCO, PHP or PCCM action on a request, use of their grievance procedures and state action on a request do not contain provisions that are different from the proposed rule, but simply reorganizes the provision in a more understandable order. The final version has a separate subsection providing for the time limit for all procedures regarding disenrollment. It provides that the effective date of a disenrollment can be no later than the first day of the second month following the month in which a request was filed. If no determination was made in time, then the disenrollment would be considered approved. Final Section 438.56(e). The proposed version had a similar provision, but had two separate but identical sections, one applying to MCE determinations and one applying to state determinations. Proposed Section 438.56(f)(3) and (4). Also, the final version provides clarity as to the effective dates of disenrollment for both disenrollment for cause and disenrollment without cause. The proposed version of the rule could have been read to provide an effective date only for disenrollment for cause.

The final version of the section governing notice and appeals contains several substantive changes. First, the final version, while still requiring states restricting disenrollment to ensure that written notice of disenrollment rights goes out at least 60 days before each enrollment period, no longer has a separate requirement that such notice go out at least once a year. (This is probably redundant). Final Section 438.56(f)(1). The final version adds a requirement that enrollees *and their representatives* be provided with the notice. *Id.* (italics added). Also, instead of requiring the state to establish an appeals process for enrollees dissatisfied with a state determination that there was no good cause for disenrollment, as the proposed version did, the final version simply requires that the state ensure access to a state fair hearing. Final Section 438.56(f).

§ 438.58 Conflict of Interest Safeguards

This section is essentially unchanged in the final version. Reference in the proposed rules to an MCO has been changed to "MCOs and PHPs" and the cross reference to default enrollment procedures has been changed to reflect the change in numeration of that section.

§ 438.60 Limit on Payment to Other Providers

This section is worded differently in the final version, but the meaning remains the same. The proposed version provided that no payment be made for any service not furnished through the MCO if such services were available under the contract, except for emergency services and post-stabilization services. The final version refers to "MCOs and PHPs" and does not provide specifically for the types of services excepted in this rule. Instead, the final version simply makes an exception "where such payments are provided for in title XIX of the Act or 42 CFR."

§ 438.62 Continued Services to Recipients

The final version of this section adds a number of new provisions.

The proposed version contains only the general rule that the state must arrange for Medicaid services to be provided to any enrollee whose contract is terminated or is disenrolled for any reason other than ineligibility. In the final version, this becomes subsection (a), and a lengthy subsection (b) is added.

The final version of subsection 438.62(b) provides that the state must have a mechanism in effect that ensures continued access to services when an enrollee with ongoing needs is transitioned between fee-for-service and MCO, PHP, or PCCM, or between managed care entities. The reference to PHPs and PCCMs is new. The mechanism must apply to: (1) children and adults receiving SSI benefits, (2) children in title IV-E foster care, (3) recipients aged 65 or older, (4) pregnant women, (5) any other recipients whose care is paid for under risk-adjusted, high cost categories and (6) any other category identified by HCFA.

The final version also requires that the state notify an enrollee that a transition mechanism exists and explain how to access it. Final Section 438.56(b)(2). Finally, the state must ensure that ongoing health care needs are met during the transition period by ensuring that: (1) the enrollee has access to services consistent with the state plan and is referred to appropriate providers, (2) new providers are able to obtain copies of appropriate medical records and (3) that "any other necessary procedures are in effect."

§ 438.66 Monitoring Procedures

Minor changes have been made to this section. Again, reference to MCO in the proposed version is changed to "MCOs or PHPs." A reference to "termination" in the proposed rule is changed to "disenrollment." Other provisions have been slightly reworded but have the same meaning. Finally, a new catch-all provision requires that the state have in effect monitoring procedures for "all other provisions of the contract, as appropriate." Final Section 438.66(e).

§ 438.68 Education of MCOs, PHPs and PCCMs and subcontracting providers.

This is a new section. It requires that the state have in effect procedures for educating MCOs,

PHPs and PCCMs and any subcontracting providers about clinical and other needs of enrollees with "special health care needs."

¹ Both versions require the state to meet all applicable requirements of Section 1903(m), 1905(t) and 1932(a)(1)(A) of the Act; to meet all requirements of Part 438 with respect to all MCEs; to provide assurances that all contracts would meet the applicable requirements of parts 434 and 438 of the chapter, and that all MCO contracts would meet requirements of Section 1903(m) of the Act.

² This section provides for an intermediate sanction of the suspension of all new enrollment, including default enrollment. Section 438.702(a)(4).

³ Pub. L. 98-21, 42 U.S.C. 1395ww (note) These counties are: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. 42 C.F.R. § 412.62 (f)(1)(ii).