Overview of Medicaid Managed Care Provisions in the Balanced Budget Act of 1997

Prepared by

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The Center on Budget and Policy Priorities

for
The Kaiser Commission on the Future of Medicaid

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The Balanced Budget Act of 1997 (P.L. 105-33) dramatically expands the authority of state Medicaid agencies to provide covered health care services through managed care organizations (MCOs). The Act enables states, without obtaining waivers from the Secretary of Health and Human Services, to require most Medicaid beneficiaries to enroll in MCOs that do business only with the Medicaid program. It also allows states, again without obtaining waivers, to limit the number of participating Medicaid MCOs. These provisions are likely to have a major effect on access to covered hospital and physician services by low-income women and children and other Medicaid beneficiary populations[1]. The implications of these provisions for beneficiaries, for states, for "safety net" hospitals and clinics, and for MCOs are the focus of this analysis. The budgetary and policy context in which these changes were enacted is discussed elsewhere[2].

1. SUMMARY

The Balanced Budget Act did not launch the shift of Medicaid from fee-for-service to managed care. That transition has been under way for several years, prompted largely by state efforts to restrain Medicaid

[1] CBO, *Budgetary Implications of the Balanced Budget Act of 1997*, August 12, 1997. CBO does not attribute any federal savings to these provisions. In CBO's view, the only budget effect of the legislation's Medicaid managed care provisions is to increase federal spending somewhat ($0.1 billion over five years and $0.3 billion over ten) due to the requirement that Medicaid MCOs pay for hospital emergency visits whenever a "prudent layperson" would seek emergency care.

[2] Andy Schneider, *Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33*, Center on Budget and Policy Priorities, Revised, September 8, 1997. www.cbpp.org/908mcaid.htm.

expenditure growth and nurtured by federal waivers[3]. A recent Urban Institute analysis finds that between 1991 and 1996, enrollment of Medicaid beneficiaries in managed care nationally grew from 9.5 percent to 40.1 percent of total Medicaid enrollment[4]. Even before passage of the Balanced Budget Act, CBO projected that, between fiscal years 1996 and 2002, federal matching payments to Medicaid MCOs would increase, on average, more than 15 percent annually, from $7 billion, or 11 percent of federal spending on Medicaid benefits, to $17 billion, or 14 percent[5].

[3] For a detailed state-by-state survey of the scope of Medicaid managed care, see Jane Horvath et al., *Medicaid Managed Care: A Guide for States, 3rd Edition*, National Academy for State Health Policy, January 1997.

[4] Stephen Zuckerman, Alison Evans, and John Holahan, *Questions for States as They Turn to Medicaid Managed Care*, Urban Institute, August, 1997.

[5] CBO Memorandum, *Behind the Numbers: An Explanation of CBO's January 1997 Medicaid Baseline*, April 1997, p. 9.

What the Balanced Budget Act has done is to alter fundamentally the managed care policy options available to states under the federal Medicaid statute. In the past, states that wanted to require Medicaid beneficiaries to enroll in MCOs that do business mainly or exclusively with Medicaid had to obtain a waiver from the Secretary of Health and Human Services (HHS). Under the Balanced Budget Act, they will now be able to do so without seeking a waiver. State managed care initiatives currently rely heavily on the use of mostly Medicaid MCOs. In 1996, for instance, 7.7 million Medicaid beneficiaries were enrolled in 355 fully capitated managed care plans in 35 states, according to a recent analysis by Mathematica Policy Research. Of these, 3.6 million, or 48 percent, were in 156 managed care plans in which Medicaid beneficiaries accounted for more than 75 percent of total enrollment.[6] The Balanced Budget Act gives states the flexibility to rely more heavily on MCOs that primarily or exclusively enroll Medicaid beneficiaries. These could include MCOs that are for-profit, MCOs that are owned by non-profit or public "safety net" providers, as well as MCOs specializing in particular services like mental health.

Under the Act, states that want to limit Medicaid beneficiaries living in urban areas to a choice between two MCOs can do so without seeking a waiver from the Secretary of HHS. States can also restrict beneficiaries living in rural areas to a single MCO. In either case, all the MCOs that a state allows to participate may do business primarily or exclusively with Medicaid. For this purpose, the managed care plans with which the state contracts can be fully capitated — that is, at financial risk for providing hospital, physician, and other covered services to Medicaid beneficiaries — or a primary care case manager (PCCM), which does not assume financial risk for the provision of covered hospital services.

[6] Suzanne Felt-Lisk and Sara Yang, "Changes in Health Plans Serving Medicaid, 1993-1996," *Health Affairs*, September/October 1997, at 127.

This new authority translates into additional bargaining power for state Medicaid programs vis-a-vis managed care plans. States can use this leverage to obtain more favorable rates from participating plans and to limit participants to those that demonstrate the highest levels of quality in services provided. However, this bargaining power can also raise the financial rewards to winning MCOs substantially, by limiting competition, thus giving each MCO a far larger market share and a heftier revenue stream. The Medicaid managed care business can be extremely lucrative.[7] The potential for favorable results in the Medicaid market has attracted venture capital firms, where, as a rule of thumb, the expected rate of return is roughly one and one-half to three times the normal market rate of return.[8] This venture capital will help finance new entrants into the Medicaid managed care market as well as the expansion of firms already participating.

One attraction of Medicaid managed care as an investment opportunity is that the conversion of Medicaid beneficiaries into mandatory MCO enrollees creates large monthly flows of capitation payments. An MCO with a mandatory enrollment of, say, 30,000 Medicaid-eligible women and children at an average capitation rate of $90 per month will realize a monthly cash flow of $2.7 million and annual revenues of $32.4 million without accounting for interest. The prospect of such large revenue streams -- and the potential returns to be realized in the Medicaid managed care business -- are likely to prove highly attractive in many states. As new entrants seek to acquire market share and incumbent plans attempt to protect or expand their existing positions by bringing financial and other resources to bear, the state Medicaid contracting process requires careful monitoring to assure its integrity.

The Medicaid managed care business is not always financially rewarding. There is considerable variation from state to state in the Medicaid payment and regulatory policies toward MCOs. This in turn produces variations in the attraction of Medicaid as a business proposition for managed care plans. A recent review of Medicaid managed care in the trade press indicates that some investor-owned MCOs have either halted new Medicaid enrollment or withdrawn from the Medicaid market altogether in a number of states, including Arizona, Illinois, New York, Ohio, Oregon, and Tennessee. The article attributes this trend primarily to low Medicaid payment rates.[9]

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[7] A recent report on a Medicaid-only MCO operating in Philadelphia found that between 1989 and 1996, the organization had generated pretax profits of $119 million (a return of 7,600 percent on a $200,000 investment, according to a 1994 audit), and had paid its four founders a total of $26.8 million in bonuses. Craig McCoy and Karl Stark, "An HMO Finds Lots of Money in Poverty," *Philadelphia Inquirer*, August 3, 1997. A recent review of a Medicaid MCO contract by the HHS Inspector General found that one contractor realized a profit of $22.9 million over a three-year period, exceeding the IG's "benchmark for reasonableness" by $4 million. Office of Inspector General, Department of Health and Human Services, *State of Wisconsin's Medicaid Managed Care Program Financial Safeguards*, February 1997, p. 3.

[8] For example, venture capital firms have invested $38 million in Americaid Community Care, which targets the Medicaid market in large urban areas like Houston and Chicago. A managing partner of Acacia Venture Partners of San Francisco, which has invested $5.5 million in Americaid, believes that Medicaid is "an exciting market, one largely ignored by the large, commercial HMOs." Debra Gordon, "Virginia Beach-based HMO Takes the Medicaid Gamble," *The Virginian-Pilot*, July 26, 1997.

[9] The article quotes a health stock analyst as follows: "States have gotten reckless in cutting rates because they couldn't care less about the Medicaid population. Only the worst HMOs, those that desperately need Medicaid will stay in." Harris Meyer, "Medicaid: States Serve Up a Real Turkey," *Hospitals and Health Networks*, November 20, 1997, p. 22.

The Balanced Budget Act alters the statutory options available to states with respect to Medicaid managed care, but it does not change the sometimes conflicting interests of states in pursuing this policy path. On the one hand, states have an interest in ensuring that their low-income families have access to basic health care services. Medicaid managed care, when properly implemented, can improve both the accessibility and quality of basic health care services for Medicaid beneficiaries, particularly in those communities in which the quality and continuity of fee-for-service care are substandard.

On the other hand, states want to limit their Medicaid expenditures. The shift from fee-for-service to managed care enables them to curb Medicaid spending on a per beneficiary basis without formally and publicly narrowing the benefits package that they offer under their Medicaid programs. States also have an interest in limiting per beneficiary payments to MCOs and allowing the MCOs to narrow the covered services enrollees actually get. How these sometimes conflicting interests are resolved will vary from state to state.

This analysis describes the new legal and policy framework within which the shift of state Medicaid programs from fee-for-service to managed care will take place over the next few years. The analysis does not duplicate section-by-section summaries of the Balanced Budget Act's Medicaid managed care provisions.[10] Instead, it focuses on those provisions that are likely to have the most influence in shaping the transition to managed care and its impact on Medicaid beneficiaries:

- standards relating to state procedures for contracting with MCOs,
- standards for MCO organizational qualifications,
- standards relating to Medicaid payment rates for MCOs,
- standards relating to accessibility and quality of care in MCOs,
- beneficiary protections,
- accountability of MCOs for compliance with these standards, and
- provisions affecting safety net providers.

[10] For a summary section-by-section overview, see Sara Rosenbaum and Julie Darnell, *A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1996 (P.L. 105-33) With Prior Law*, Kaiser Commission on the Future of Medicaid, September 1997. For a detailed section-by-section analysis, see National Health Law Program, National Center for Youth Law, National Senior Citizens Law Center, and Center for Medicare Advocacy, *The Balanced Budget Act of 1997 — Reshaping the Health Safety Net for America's Poor*, October 1997 at www.healthlaw.org.

The interpretation of many of these provisions here is necessarily preliminary, since as of December 19, 1997, the Health Care Financing Administration (HCFA) has issued administrative guidance to the states or to MCOs with respect to only some of these amendments.[11]

2. MEDICAID MANAGED CARE: AN OVERVIEW

[11] This guidance currently takes the form of letters to state Medicaid Directors. Copies are available on the HCFA Website, www.hcfa.gov.medicaid/bbahmpg.htm.

Managed care, as the term is used in Medicaid, includes two basic types of arrangements.[12] Under fully capitated arrangements, an MCO assures full financial risk for a defined set of services in exchange for a fixed payment per enrollee per month. Under primary care case management arrangements, the state pays a small ($3) monthly fee per enrollee to "gatekeeper" physicians who are not at financial risk, but who control access to specialist care or hospital services. Of the Medicaid beneficiaries enrolled in managed care in 1996, about one-third were covered through PCCM arrangements; 13 states used the PCCM form of Medicaid managed care exclusively. Nationally, however, Medicaid enrollment in fully capitated MCOs grew by more than 60 percent between 1995 and 1996.[13] CBO projects that federal Medicaid spending on fully capitated MCOs will grow, on average, by 15 percent annually for the next five years.[14] Because two-thirds of Medicaid managed care enrollees are already in fully capitated MCOs — and because this proportion is likely to grow in the future as more states seek to restrain Medicaid spending growth — this overview focuses primarily on MCOs that assume financial risk for the provision of inpatient hospital, physician, and other covered Medicaid benefits. (Part 10 discusses the implications of provisions relating to PCCMs for beneficiaries living in rural areas.)

Enrollment in fully capitated MCOs puts beneficiaries at risk for underservicing. The General Accounting Office (GAO) has noted that, "[i]n contrast to fee-for-service care — where the incentive is to oversupply services to increase revenues — capitated managed care, with its fixed payment system, contains incentives to provide fewer services to maximize short-term profits.[15] The risk of underservicing is greater when beneficiaries are required to join MCOs that enroll only Medicaid eligibles and that are totally dependent on the state agency with which they contract for their revenues. Although beneficiaries can disenroll from their MCO with cause, under the Balanced Budget Act their only option may be to enroll in another comparable MCO. If the state limits its capitation rates in order to contain its Medicaid spending, MCOs that depend exclusively on Medicaid for their revenues may respond by reducing services to enrollees

The vast majority of Medicaid enrollees in fully capitated MCOs — 85 percent to 90 percent in CBO's estimation — are children and women of child-bearing age. As of 1995, few states had enrolled significant numbers of elderly or disabled beneficiaries in managed care, even though these populations account for the

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[12] Current HCFA regulations, 42 CFR 434.2, also define a category of Prepaid Health Plans (PHPs). These are entities that contract on a capitated basis but not with respect to inpatient hospital care and not with respect to more than two covered Medicaid services, such as physician care and diagnostic services. PHPs account for only 2 percent of all Medicaid managed care enrollment as of June 1996. Kaiser Commission on the Future of Medicaid, "Medicaid and Managed Care," *Medicaid Facts*, November 1997.

[13] Stephen Zuckerman, Alison Evans, and John Holahan, *Questions for States as They Turn to Medicaid Managed Care*, Urban Institute, August 1997, at p. 2.

[14] CBO, *Behind the Numbers: An Explanation of CBO's January 1997 Medicaid Baseline*, April 1997, p. 9.

[15] GAO, *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort*, May 1997, p. 7.

largest proportion of Medicaid spending and potentially offer the greatest opportunity for cost savings.[16] A recent Kaiser Medicaid Commission analysis estimates that of the $9.9 billion in Medicaid payments to MCOs in 1995, 63 percent were made on behalf of children, 10 percent on behalf of disabled beneficiaries, and 1 percent on behalf of elderly beneficiaries.[17]

[16] Among the reasons are the Medicare statutory protections to which many elderly and disabled Medicaid beneficiaries are entitled. See Judith Feder, Georgetown University Institute for Health Care Research and Policy, Medicare/ Medicaid Dual Eligibles: Fiscal and Social Responsibility for Vulnerable Populations, Kaiser Commission on the Future of Medicaid, May 1997, pp.13-15.

[17] Diane Rowland, *National Perspectives on Medicaid Managed Care*, Kaiser Commission on the Future of Medicaid, November 13, 1997, p. 12.

The mandatory enrollment of children in MCOs has important implications for their access to services covered under Medicaid. The core Medicaid children's benefit — early and periodic screening, diagnostic, and treatment (EPSDT) services — is an effort to ensure access to a broad range of preventive care and to medically necessary treatment services. MCOs have a financial incentive to emphasize the provision of these services because they are at risk for caring for those enrolled children whose medical conditions have not been identified and treated early. A recent HHS Inspector General report concludes, however, that six of ten children enrolled in Medicaid MCOs receive no EPSDT services and that, among those who do, fewer than one in three gets them on a timely basis.[18]

3. STATUTORY PATHWAYS TO MANDATORY MEDICAID MANAGED CARE

States have long had the option of offering Medicaid beneficiaries the choice of enrolling in managed care as an alternative to fee-for-service. Statutory authority to require such enrollment has evolved over time. Before the Balanced Budget Act was passed, two statutory pathways were available to state Medicaid programs to require beneficiaries to enroll in MCOs: section 1915(b) waiver authority and the section 1115 waiver authority. (The section references are to the Social Security Act.) The Secretary has used these authorities to waive the basic "freedom of choice" provision, under which all Medicaid beneficiaries may seek covered services from any physician, hospital, or MCO that participates in the program. Besides leaving these two waiver authorities intact, the Balanced Budget Act adds an additional statutory pathway — section 1932.[19] That section allows states to require beneficiaries to enroll in MCOs without obtaining a waiver of the freedom of choice provision from the Secretary.

SECTION 1915(B) WAIVERS

Section 1915(b) waivers are most commonly used by states to require beneficiary enrollment in MCOs. As of January 1997, HCFA had approved one or more of these waivers in each of 42 states. To receive them, states must demonstrate that their proposal is "cost-effective and efficient," and that its restrictions on beneficiary choice do not "substantially impair access to covered services of adequate quality where medically necessary." HCFA has interpreted these statutory requirements in application and renewal forms that states seeking waivers must submit for approval. The waivers have a two-year term and are renewable.

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[18] HHS Inspector General,*Medicaid Managed Care and EPSDT*,OEI-05-93-00290, May, 1997.

[19] Section 4710 of the Balanced Budget Act provides that "nothing in [the Act's provisions relating to Medicaid managed care] shall be construed as affecting the terms and conditions of any waiver, or the authority of the Secretary of Health and Human Services with respect to any such waiver, under section 1115 or 1915 of the Social Security Act." The provisions relating to MCO contracts with federally qualified health centers are not subject to this construction clause.

Under the terms of 1915(b) waivers, states may require beneficiaries to choose among two or more MCOs. However, MCOs formerly could not do business exclusively with Medicaid. They were subject to the statutory "75/25" rule. This rule provided that Medicaid and Medicare beneficiaries could account for no more than 75 percent of an MCO's enrollment, because section 1915(b) did not give the Secretary the authority to waive this requirement.[20] The Balanced Budget Act repealed the rule.

SECTION 1115 WAIVERS

Section 1115 gives the Secretary of HHS broad research and demonstration authority with respect to cash assistance and social services as well as to Medicaid. Broader in scope than the section 1915(b) waiver, it allows the Secretary to waive both the 75/25 rule and the beneficiary freedom of choice provision. States must establish that their demonstration, which lasts for five years and may, under the Balanced Budget Act, be extended for another three, is budget neutral from the federal government's standpoint — i.e., that it will not result in higher costs to the federal government than would be incurred in the absence of the initiative. As of May 1997, ten states had implemented section 1115 Medicaid managed care demonstration projects (Arizona, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont). Another five states had received section 1115 waivers, but had not implemented them (Florida, Illinois, Kentucky, Maryland, and Massachusetts). In all of these cases, the state requested -- and the Secretary approved -- a waiver of the 75/25 rule.[21]

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[20] The 75/25 rule was enacted in 1976 as a 50/50 rule in response to widespread marketing abuses and diversion of federal Medicaid funds by managed care plans in California. To protect Medicaid beneficiaries against MCO denials of covered services, the 1976 legislation also required that beneficiaries enrolled in MCOs be allowed to disenroll without cause upon one month notice. The 50/50 rule was amended in 1981 to a less restrictive 75/25 formulation. The Secretary of HHS was authorized to waive the 75/25 rule for up to 3 years in the case of any MCO that demonstrated it was making 'continuous efforts and progress' toward achieving compliance with the rule."

[21] Sara Rosenbaum and Julie Darnell, *Statewide Medicaid Managed Care Demonstrations under Section 1115 of the Social Security Act: A Review of the Waiver Applications, Letters of Approval and Special Terms and Conditions*, Kaiser Commission on the Future of Medicaid, May 1997, at p. 27.

SECTION 1932

Section 1932 of the Social Security Act permits states to require beneficiaries to enroll in managed care without a waiver from the Secretary. Instead, the state files an amendment to its Medicaid plan. The amendment, like the plan itself, is ultimately subject to Secretarial approval for the state to receive federal matching funds.[22] In contrast to the waiver authorities, section 1932 does not require states to demonstrate that their Medicaid managed care initiative is cost effective or budget neutral.

[22] In a letter to State Medicaid Directors dated December 17, 1997, HCFA has specified requirements for these state plan amendments for mandatory enrollment. Approval of a plan amendment is not, however, sufficient to trigger the flow of federal Medicaid matching funds. In the same letter, HCFA indicates that it "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)," before it will allow federal matching funds.

Section 1932 allows states to require most Medicaid beneficiaries, as a condition of receiving Medicaid, to enroll in Medicaid managed care organizations or in primary care case manager arrangements.[23] In urban areas, the state may limit the beneficiary to a choice between two PCCMs, or an MCO and a PCCM. In rural areas, the state may restrict the beneficiary to one MCO or to one PCCM, provided the beneficiary can choose between two physicians or two case managers (to the extent they are available in the area). The state must show that "such restriction does not substantially impair access to services." In either case, states can "lock in" beneficiaries to a particular MCO or PCCM for up to 12 months. Beneficiaries can disenroll during that period only if they can show cause to the satisfaction of the state. The 75/25 enrollment composition requirement is repealed and does not apply to any MCO or PCCM under section 1932.

Three groups of beneficiaries are exempt from mandatory enrollment in MCOs under section 1932. These are (1) children with special needs, including those receiving Supplemental Security Income benefits and foster care or adoption aid under Title IV-E; (2) Medicare beneficiaries, including "dual eligibles" (who get assistance from Medicare and Medicaid) and qualified Medicare beneficiaries; and (3) Indians.[24] People in these groups may enroll voluntarily in MCOs or PCCMs with which the state contracts. These groups are not exempt from mandatory enrollment in MCOs under the section 1915 or section 1115 waiver authorities.

4. STANDARDS FOR STATE-CONTRACTING WITH MEDICAID MCOs

[23] In general, under the legislation a Medicaid MCO is at financial risk for hospital as well as physician and laboratory service. A PCCM, in contrast, coordinates and monitors the provision of physician and laboratory services to enrollees.

[24] The legislation allows states to require eligible Indians to enroll in Medicaid MCOs or PCCMs only if the MCO or PCCM is an Indian Health Service entity, a tribally operated health program, or an urban Indian health program.

The Balanced Budget Act recognizes that there is a substantial — and growing — federal financial interest in the Medicaid managed care contracting decisions that states make. On average, 57 percent of the funds flowing through these contracts to Medicaid MCOs are federal. The amount of federal dollars involved — more than $7 billion annually — already far exceeds the entire budgets of many federal agencies, including those of the Centers for Disease Control ($2.3 billion in fiscal year 1997) and the Food and Drug Administration ($900 million in fiscal year 1997). That figure is projected to grow at a significantly higher rate. The contracts themselves involve tens to hundreds of millions of federal dollars over multi-year periods. Revenue streams of this size create pressure on the contracting process and the officials involved.[25] When the federal government lets contracts of this scale directly, certain standards apply to ensure the integrity of the contracting process generally and the responsible federal officials in particular.

The Balanced Budget Act extends these same standards to state procedures for contracting with Medicaid MCOs. Additionally, the Act applies federal conflict-of-interest prohibitions to state Medicaid programs generally. These affect not only state Medicaid contracting with enrollment brokers and independent external quality review organizations, but also state Medicaid contracting for any other functions the state elects to privatize, such as claims processing, maintenance of information systems, or rate setting. The Balanced Budget Act also sets minimum standards for entities, like brokers, or procedures for "default" or "auto" enrollment that potentially could determine the flow of federal and state funds to Medicaid MCOs. It is clear that these standards apply to states implementing mandatory enrollment through the section 1932 pathway. Whether they will be applied to states with section 1915(b) or section 1115 waivers is uncertain.

CONFLICT-OF-INTEREST SAFEGUARDS FOR STATE MEDICAID MCO CONTRACTING

The Balanced Budget Act prohibits a state from entering into risk contracts with MCOs unless it has in effect conflict-of-interest safeguards with respect to officers or employees with responsibilities relating to such contracts. The safeguards must be "at least as effective as" the federal safeguards against conflicts of interest that apply to federal procurement officials with comparable responsibilities (found at section 27 of the Office of Federal Procurement Policy Act, 41 U.S.C. 423.) Included in the federal safeguards is a one-year prohibition against accepting compensation from a contractor whose contract exceeds $10 million under the procurement in which the official participated in any fashion. This requirement applies for contracts entered into or renewed on or after October 1, 1997.

CONFLICT-OF-INTEREST SAFEGUARDS FOR STATE MEDICAID PROCUREMENT GENERALLY

The Balanced Budget Act also imposes conflict-of-interest safeguards on state (and local) employees with Medicaid responsibilities other than those relating to MCO contracting. The safeguards apply to each state or local officer, employee, or independent contractor who is "responsible for selecting, awarding, or otherwise obtaining items and services under the [Medicaid program]." Presumably, this reaches people involved in

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[25] In one state, the head of the human services agency reportedly "intervened" on behalf of one of four managed care firms competing for Medicaid contracts in a review of the firms' proposals. The official "acknowledged...that he successfully urged the review committee to change the way it rated cost proposals" to the benefit of a firm headed by a former governor of the state. Mike Gallagher, "Medicaid Meddling Alleged," *Albuquerque Journal*, August 11, 1997. The same official recently resigned his position following newspaper reports that a firm he owned received nearly $30,000 from another company seeking to recover unreimbursed Medicaid claims. from the human services agency. Thomas J. Cole, "Welfare Chief Resigns," *Albuquerque Journal*, October 8, 1997.

contracting with private entities carrying out Medicaid administrative functions, including enrollment brokers, external quality review organizations, actuaries, and fiscal intermediaries and claims processing organizations. The safeguards must be "at least as stringent as" those applicable under section 27 of the Office of Federal Procurement Policy Act, 41 U.S.C. 423, to federal procurement officials with comparable responsibilities. These safeguards include the same prohibition on acceptance of compensation from a contractor described above. This provision is effective January 1, 1998.

Prior to the Balanced Budget Act, Medicaid law imposed federal criminal penalties on current and former state or local officers or employees "responsible for the expenditure of substantial amounts of funds" under Medicaid who either 1) participate in a program decision in which they have a financial interest or 2) within two years of termination of state or local employment, lobby the state or locality on a matter in which the individual participated "personally and substantively." The Balanced Budget Act expands the reach of these criminal sanctions to current or former officers or employees of "independent contractors" who are responsible for the expenditure of substantial amounts of Medicaid funds. Under HCFA's interpretation, an independent contractor for this purpose appears to include an MCO or PCCM providing health services as well as an enrollment broker or fiscal agent providing administrative services.[26]

ENROLLMENT BROKERS

Many states that are transitioning to managed care have contracted with firms known as enrollment brokers to tell Medicaid beneficiaries about their choice among MCOs and to enroll them in the MCO they choose. Under default enrollment rules discussed below, brokers also may enroll beneficiaries who do not make a choice into a state specified MCO. The costs of these contracts are considered allowable administrative expenses subject to the normal 50 percent federal matching payment. Poor performance by enrollment brokers can lead to "widespread confusion among beneficiaries."[27]

To avoid bias in the enrollment function, which could lead to substantial financial gains for certain MCOs in the form of increased enrollment and higher capitation revenues, the Balanced Budget Act bars any federal matching payments for the cost of an enrollment broker unless three tests are met. First, the broker must be "independent of" any MCO or PCCM participating in the state's Medicaid program and of any health care provider that furnishes coverage or services in the same state in which the broker is under contract to carry out enrollment activities. Second, the broker must not have an owner, employee, consultant, or contractor who has "any direct or indirect financial interest" in any such MCO or PCCM or health care provider. Finally, the broker may not have any owners, employees, consultants, or contractors who have been excluded from

[26] HCFA has defined an independent contractor as "any independent entity that is not part of the Federal government and has a contract with a State to provide services." Letter from Sally K. Richardson, Director, Center for Medicaid and State Operations, HCFA, to State Medicaid Directors regarding waste, fraud, and abuse provisions, December 17, 1997.

[27] GAO, *Medicaid Managed Care: Delays and Difficulties in Implementing California's New Mandatory Program*, GAO/HEHS-98-2, October 1997, pp. 11- 21.

participation in Medicaid or Medicare; subject to a civil monetary penalty for violating Medicaid or Medicare rules; or debarred by any federal agency.

DEFAULT ENROLLMENT RULES

The Balanced Budget Act requires states electing to mandate enrollment in MCOs under section 1932 to establish a default enrollment process meeting certain standards. Default or auto enrollment occurs when, given a choice among two or more MCOs, Medicaid beneficiaries do not make a selection but instead are assigned to a plan. (This can occur when an enrollment broker performs poorly.) Default enrollment can have important commercial implications, because the number of beneficiaries not choosing can be high.[28] These default enrollees bring with them to the MCOs to which they are assigned monthly capitation payments. If the default rate is high enough, the default enrollment rules can effectively allocate market share among participating MCOs. Indeed, if an MCO's capitation revenue from default enrollment is substantial, the MCO might be less vigilant about quality and accessibility of services for Medicaid beneficiaries. These commercial implications underscore the importance of the impartial default enrollment rules and procedures.

Under the Balanced Budget Act standards, a state may not assign default enrollees to MCOs that fail to comply with their Medicaid contract or with regulatory standards. The process must consider enrolling default beneficiaries so as to maintain existing relationships between patients and providers, and with providers that traditionally have served Medicaid beneficiaries, such as many public and children's hospitals and community health centers. If these relationships cannot be maintained because the MCO is at capacity or the existing or traditional providers are not affiliated with any of the participating MCOs, the process must attempt to distribute default enrollees equitably among participating MCOs that have the capacity. Finally, the conflict-of-interest safeguards described above apply also to MCO officers and employees responsible for the default enrollment process. Together, these provisions should help curb the use of default enrollment to steer business to certain Medicaid MCOs.

5. PAYMENT RATES FOR MEDICAID MCOs

To give states additional flexibility and to achieve federal savings, the Balanced Budget Act repealed or phased out several federal minimum payment standards for various types of providers, including hospitals, nursing homes, federally-qualified health centers (FQHCs), and pediatricians and obstetricians. The Act did

[28] Preliminary reports indicate that default enrollment rates vary widely from state to state but can be as high as 80 percent. For a discussion of the issues associated with the measurement and interpretation of these rates and the implications of default enrollment for beneficiaries, see Kathleen Maloy, Sara Rosenbaum, et al., *A Preliminary Study: The Role of Autoenrollment in Mandatory Medicaid Managed Care*, Center for Health Policy Research, George Washington University, October 1997, p. 3.

not, however, alter the federal minimum standard with respect to payments to MCOs. It did clarify the treatment of extra payments to disproportionate share (DSH) hospitals.

ACTUARIALLY SOUND RATES

The Balanced Budget Act kept the requirement that MCOs and other entities entering into risk contracts with state Medicaid agencies be paid on an actuarially sound basis.[29] Although this payment standard has been in federal statute since at least 1981, HCFA has not interpreted it in regulation or in guidelines. HCFA has, however, published a regulation imposing an upper limit on capitation payments under a risk contract. That regulation, 42 CFR 447.361, requires that such payments not exceed the cost of providing the services covered by the contract on a fee-for-service basis to "an actuarially equivalent nonenrolled population group." The Act leaves this regulatory upper payment limit intact. Administration of this limit could be problematic in states that enroll most or all of their beneficiaries in MCOs. At issue is how the fee-for-service equivalent cost will be derived if there are no nonenrolled population groups or if none of these groups is actuarially equivalent. Another question concerns the policy logic of imposing an upper limit if doing so would make the capitation rates actuarially unsound.

PAYMENTS TO DISPROPORTIONATE SHARE HOSPITALS

More than 60 percent of the gross federal Medicaid savings in the Balanced Budget Act — $10.4 billion over the next five years — come from limiting federal matching payments for special reimbursement to Medicaid DSH hospitals, facilities that serve numerous Medicaid and uninsured patients.[30] These special payments are commonly made by states on a fee-for-service basis directly to DSH hospitals. The amounts involved are substantial: CBO projects that even after the reductions under the Act, federal Medicaid DSH payments will total $49 billion over the next five years. These funds can make the difference between solvency and financial instability for high-volume Medicaid providers. As states shift their Medicaid programs to managed care and stop paying hospitals on a fee-for-service basis for treating Medicaid patients, the disposition of the DSH payments associated with these patients becomes an important issue. The Balanced Budget Act specifies that DSH payments may not be incorporated into capitation rates to MCOs, but instead must

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[29] For a detailed analysis of actuarial methodologies and procedures used by 15 states to develop Medicaid capitation rates for low-income women and children enrolled in MCOs, see Renee Schwalberg, Health Systems Research, Inc., *The Development of Capitation Rates under Medicaid Managed Care Programs: A Pilot Study*, Henry J. Kaiser Family Foundation, November 1997.

[30] See Andy Schneider, Stephen Cha, and Sam Elkin, *Overview of Medicaid "DSH" Provisions in the Balanced Budget Act of 1997, P.L. 105-33*, Center on Budget and Policy Priorities, September 3, 1997, available on www.kff.org.

continue to be paid directly to the DSH hospitals.[31] The Act further stipulates that DSH payments not be taken into account in determining capitation rates to MCOs.

[31] An exception is made for DSH payments made pursuant to a payment arrangement in effect on July 1, 1997, a grandfather provision that apparently is intended to allow Alabama and Wisconsin to continue to funnel their DSH payments through MCOs.

The implementation of these payment provisions will have a major effect on the ability of MCOs to provide covered services of acceptable quality to enrolled Medicaid beneficiaries. The adequacy of payment rates is particularly important for MCOs that enroll only Medicaid beneficiaries and have no other revenue source. As discussed earlier, MCOs that do business only with Medicaid can be very profitable. On the other hand, if the capitation rates paid to a Medicaid-only MCO are not sufficient to cover the MCO's cost of efficiently providing covered services to the particular beneficiaries who have enrolled in it, the MCO has few choices. It can delay the provision of covered services, subtly encourage the sickest and most costly enrollees to disenroll, delay or reduce or deny payments to contracting hospitals and physicians for services rendered to enrollees, or lay off some of its own staff. Although setting actuarially sound capitation rates can be difficult, particularly for disabled populations, adequate rates are an essential (but not sufficient) condition for adequate access and adequate quality care in the context of mandatory beneficiary enrollment into Medicaid MCOs.[32]

6. ORGANIZATIONAL QUALIFICATIONS FOR MEDICAID MCOs

The Balanced Budget Act contains several provisions that speak to the fiscal and organizational integrity of Medicaid MCOs. As the Kaiser/Commonwealth Low-Income Coverage and Access Project found in the case of Florida, there is a greater risk of substandard care for Medicaid beneficiaries if state Medicaid programs contract with undercapitalized, inexperienced firms that are not held to the same regulatory standards as MCOs seeking to enter the commercial market.[33] This observation carries particular weight in the policy context of mandatory enrollment and limited beneficiary choice among MCOs. When beneficiaries cannot "vote with their feet" by disenrolling if they are dissatisfied with the care they receive from an MCO, it is critical that the MCOs in which they are enrolled are fiscally and organizationally sound.[34]

ORGANIZATIONAL QUALIFICATIONS

Under the Balanced Budget Act amendments, a state may contract on a risk basis with "any public or private organization," including a health maintenance organization (HMO), an "eligible organization" with a

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[32] See Tony Dreyfus, Richard Kronick, Carol Tobias, *Using Payment to Promote Better Medicaid Managed Care for People with AIDS*, National Academy for State Health Policy, July 1997.

[33] "Flexible requirements allowed individual investors or providers to start plans with relative ease. However, the inexperience of many plan owners along with a lack of oversight led to reported quality of care problems and marketing abuses. It also led to high administrative costs associated with startup and a desire to generate high returns on investment. Long-term damage from employing this strategy was mitigated because many startups were acquired by more experienced and highly capitalized plans as the three-year limit on commercial enrollment grew close and state oversight was improved." Marsha Gold, Anna Aizer, and Alina Salganicoff, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Florida*, Kaiser/Commonwealth Low-Income Coverage and Access Project, January, 1997, at xi.

[34] Beneficiaries have the right to disenroll for "cause" at any time, but the burden is on the enrollee to demonstrate "cause" to the state Medicaid agency. Current regulations at 42 CFR 434.28(e)(3) allow a state to require that Medicid enrollees first use the grievance process of the MCO from which they are seeking to disenroll before receiving a determination of "cause" from the state, except where "imminent risk of permanent damage to a recipient's health" is alleged.

Medicare risk contract, a "Medicare+Choice organization" with a Medicare contract, or a "provider-sponsored organization (PSO)" that meets accessibility and solvency standards. An HMO qualified under Title XIII of the Public Health Service Act is deemed to have met solvency and accessibility standards.

With respect to solvency, the statute requires the organization to meet state-established solvency standards for private HMOs or be licensed or certified by the state as a risk-bearing entity. These standards limit the extent to which states can set lower capitalization requirements for MCOs entering the Medicaid market only. More rigorous than those under previous law, these solvency standards do not apply to organizations that are not responsible for providing inpatient hospital and physician services, to public entities, to organizations where solvency is guaranteed by the state, or to organizations controlled by FQHCs. In all cases, however, the organization must ensure that Medicaid beneficiaries are not liable for the organization's debts if it becomes insolvent.

As for accessibility, the Balanced Budget Act makes no change from prior law. Organizations must still make services "accessible" to Medicaid enrollees in their service area to the same extent these services are available to Medicaid beneficiaries who not enrolled. Note that the new "quality assessment and improvement strategy" required by the Balance Budget Act must include standards for access to care (see page 21).

The new organizational standards apply to contracts entered into or renewed on or after October 1, 1997, and the new solvency requirements, to those entered into or renewed on or after October 1, 1998. MCOs that were contracting with state Medicaid agencies when the Act was passed on August 5, 1997, have until August 5, 2000, to comply with the new solvency requirements. In effect, this grandfather provision gives Medicaid MCOs in states with lower capitalization requirements an extra two years to meet standards that will apply new entrants.

AFFILIATION WITH DEBARRED OR EXCLUDED INDIVIDUALS OR ORGANIZATIONS

The federal Medicaid statute has for many years prohibited states from using federal Medicaid dollars to contract with MCOs that have ownership, employment, consulting, or contractual relationships with anyone who has been convicted of certain crimes or who has been excluded or otherwise sanctioned by Medicare or Medicaid for fraud or abuse. For example, an MCO cannot have an owner, officer, director, agent, or managing employee who has been convicted of a crime related to neglect or abuse of patients; to fraud, theft, embezzlement, or other financial misconduct; or to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. The same prohibition against contracting with the state Medicaid agency applies to an MCO if any of these individuals have been subject to civil sanctions, such as exclusion from Medicare or Medicaid or civil monetary. If the MCO wants to participate in Medicaid, the organization must sever its relationships, direct or indirect, with such individuals.

The Balanced Budget Act reinforces these provisions by prohibiting Medicaid MCOs and PCCMs from knowingly having an employment, consulting, or other agreement with anyone who has defrauded a federal agency other than HCFA. Such individuals may not be directors, officers, or partners of the MCO. Further, they cannot own more than 5 percent of the equity in the MCO, nor can they be employees of or consultants to the MCO. Subject to these restrictions are individuals who have been debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities of any federal agency, as well as

"affiliates" of entities who have been debarred, suspended, or otherwise excluded.[35] The Balanced Budget Act also authorizes but does not require states to exclude from its Medicaid program any individual or entity (including an MCO) convicted of a felony for an offense that which the state agency determines is "inconsistent with the best interests of beneficiaries."[36]

PRIOR FEDERAL APPROVAL OF STATE MCO CONTRACTS

Risk contracts between state Medicaid agencies and MCOs under which more than $1 million will be expended are subject to prior approval by the Secretary of HHS. (The Balanced Budget Act raised the threshold for approval from $100,000 to $1 million effective in 1998 and indexed it to the consumer price index for subsequent years.) As a practical matter, this threshold is likely to trigger prior federal review of virtually all state Medicaid MCO contracts. Because it is easier to deny a contract to a substandard MCO than to terminate an existing one (the Balanced Budget Act requires states to provide a hearing to an MCO before termination), the approval mechanism offers an opportunity to protect Medicaid beneficiaries from mandatory enrollment in substandard MCOs. At a minimum, the Secretary could delegate to HCFA or the Inspector General the responsibility for making certain there are no criminal convictions or civil actions on the record of any MCO owner, manager, employee or consultant.[37]

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[35] See Executive Order No. 12549, Debarment and Suspension of Participants in Federal Programs (Feb. 18, 1986). 45 CFR 76.105 provides that "persons are affiliates of each other if, directly or indirectly, either one controls or has the power to control the other, or, a third person controls or has the power to control both."

[36] HCFA has indicated that States "have the flexibility" to make this determination. Letter from Sally K. Richardson, Director, Center for Medicaid and State Operations, HCFA, to State Medicaid Directors regarding waste, fraud, and abuse provisions, December 17, 1997.

[37] As of December 19, 1997, the Secretary has not chosen to do so. In a letter to State Medicaid Directors dated December 17, 1997, HCFA makes clear that States seeking to implement mandatory managed care enrollment under section 1932 must obtain advance approval from HCFA of contracts with MCOs. States must show that the contracts meet "all statutory and regulatory requirements" but HCFA does not elaborate on these. HCFA approval may be based on a "model/draft contract," so long as the final contract with the MCO does not contain "any substantive changes" from the model/draft version.

7. ACCESS AND QUALITY STANDARDS FOR MEDICAID MCOs

Ensuring the accessibility and quality of Medicaid covered services is particularly important in the context of mandatory enrollment of beneficiaries in just two (or, in rural areas, one) MCOs that do business only with Medicaid. Like other managed care plans paid on a risk or capitated basis, Medicaid MCOs have a financial incentive to reduce beneficiary use of covered services. The lower the Medicaid capitation rate in relation to the cost of caring for the enrolled Medicaid population, the greater the savings to the state, and the greater the incentive on the part of the MCO to reduce service use. In the case of a Medicaid-only MCO, the organization has no countervailing incentive to maintain accessibility and quality at sufficiently high levels to attract and retain commercial enrollees from private employer groups. Further, because Medicaid beneficiaries have little (or, in rural areas, potentially no) choice among MCOs, they are less able to express dissatisfaction by disenrolling from MCOs that arbitrarily deny access to needed covered services.

The development of accessibility and quality performance standards for Medicaid MCOs, and the measurement of compliance with those standards, is evolving. The results of a three and one-half year demonstration (1993-1995) of HCFA's Quality Assurance Reform Initiative (QARI) in three states (Minnesota, Ohio, and Washington) suggest there is a "conceptual framework" for "an effective system for monitoring and improving quality of care for Medicaid managed care enrollees."[38] Evaluators found that QARI's conceptual framework— combining quality assurance programs internal to MCOs with annual external review of quality of care in the MCOs — made it easier for state agencies and health plans to identify and address quality improvement issues. The evaluators could not, however, determine whether QARI actually ensured adequate quality care to Medicaid MCO enrollees or improved their quality of care. HCFA is overseeing the development of a set of quality standards for managed care plans participating in Medicaid or Medicare. These standards, known as the Quality Improvement System for Managed Care (QISMC), are slated for publication in draft form by the end of 1997. HCFA may use them to implement the Balanced Budget Act's requirement, described below, that the Secretary develop quality standards for state quality assessment and improvement "strategies."

QUALITY STANDARDS IN MANDATORY ENROLLMENT STATES WITHOUT WAIVERS

In states electing to mandate enrollment of Medicaid beneficiaries in MCOs under the new section 1932 state option, participating MCOs are subject to several access and quality standards and processes.

Adequate Capacity and Services

An MCO must provide "adequate assurances" to the state and the Secretary that, with respect to a service area, it offers "an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area" and that it "maintains a sufficient number, mix, and geographic distribution of providers of services." The Secretary is to specify the time and manner in which these assurances are to be given.

Financial Incentives for Physicians

[38] Suzanne Felt-Lisk and Robert St. Peter, *The Quality Assurance Reform Initiative (QARI) Demonstration for Medicaid Managed Care Final Evaluation Report*, Mathematica Policy Research, Inc., September 1997, at 17.

The financial arrangements between MCOs and their affiliated physicians vary widely, from salary to discounted fee-for-service to partial capitation. The MCO has a financial incentive to shift as much risk as possible to its affiliated physicians so that they will reduce beneficiary use of expensive hospital, diagnostic, and specialist services. Because these financial arrangements could influence the clinical decisions made by physicians practicing in managed care settings, both the federal Medicaid statute and the Medicare law have limited the extent to which risk contractors under Medicaid or Medicare can impose financial incentives on their affiliated physicians to deny or withhold services. The Balanced Budget Act retains this statutory protection.

Encounter Data

Encounter data document all services that an individual beneficiary receives. As the GAO has emphasized, these data "provide states more flexibility to detect problems in beneficiary care by identifying patterns of service use by individual beneficiaries and services provided by individual providers."[39] The Balanced Budget Act retained the requirement that all risk contracts between states and MCOs provide for "sufficient encounter data to identify the physician who delivers services to patients." The Act facilitates compliance with this requirement by further requiring that each physician furnishing services to Medicaid beneficiaries enrolled in an MCO has a unique identifier. The Act also upgrades the requirements for Medicaid management information systems (MMIS) that states must use in administering their programs. Under these upgraded requirements, as of January 1, 1999, state systems will have to have the capacity to transmit claims data electronically in a format specified by the Secretary.[40] The format must include "detailed individual enrollee encounter data."

External Independent Review

Before the Balanced Budget Act was passed, the federal Medicaid statute required states to provide for an annual review of "the quality of services furnished" under each risk contract between the state and an MCO. To promote objectivity, the review must be performed by an entity independent of the state Medicaid agency and external to the MCO. Peer review organizations (PROs), which conduct utilization and quality reviews under Medicare; organizations that are not PROs but that meet PRO performance standards; and private

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[39] General Accounting Office, *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort*, GAO/HEHS-97-86, May 1997, p. 15.

[40] HCFA has encouraged those State Medicaid agencies that do not already submit claims data electronically consistent with the Medicaid Statistical Information System (MSIS) to do so earlier than January 1, 1999. Letter from Rachel Block, Center for Medicaid and State Operations, to State Medicaid Directors, September 15, 1997.

accreditation bodies may all qualify as external quality review organizations. In general, the federal government matches the cost of this annual review at a 75 percent rate. These reviews have been an important source of information about Medicaid MCO performance for state and federal regulators, investigative journalists, and beneficiary advocates.[41] The Balanced Budget Act retains this statutory external independent review requirement, which continues to apply to all risk contracts with MCOs, whether enrollment is voluntary or mandatory.

The Act also adds another review requirement in the context of the section 1932 state option to mandate beneficiary enrollment in MCOs. Under the new requirement, each risk contract with a Medicaid MCO must provide for an annual external independent review by a "qualified independent entity." The Secretary of HHS is to establish a "method" for identifying these entities; whether this method includes organizational qualifications or performance standards is unclear. The cost of these new quality reviews, like the cost of the preexisting reviews, will be matched by the federal government at a 75 percent rate. After January 1, 1999, the new quality reviews are to be conducted using protocols developed by an independent quality review organization under contract to the Secretary of HHS "in coordination with" the National Governors' Association. The development and use of national quality protocols for Medicaid managed care could promote consistency of reviews among different external review organizations and comparability of results among MCOs within states and among states.

Results of the new external independent reviews will be public. The statute specifies that results "shall be available" to participating health care providers, enrollees, and potential enrollees of the MCO subject to review. The only restriction on disclosure is that the results not reveal the identity of any individual patient. The results may, however, disclose the identities of individual hospitals, physicians, and other providers affiliated with the MCO, as well as of the MCO itself.

While states do not have the authority to withhold the results of the new quality reviews from the public, they can exempt certain MCOs from these reviews altogether. At their option, states may forego the new quality review for any MCO that has contracted with the state Medicaid program on a risk basis for the previous two years. Thus, a state that has contracted with one or more MCOs for two years and continues to contract with the same organizations does not need to conduct a new independent external quality review. In addition, a state may forego a new quality review for any MCO that also contracts with the Medicare program as an HMO, a Competitive Medical Plan (CMP) or a Medicare+Choice organization. A state may also limit the new quality review of an MCO that has been accredited by a private accreditation organization to avoid duplication of review activities conducted as part of the accreditation process.

[41] Access to data collected by external quality review organizations in Florida enabled investigative reporters to publish MCO-specific rates of hospital use and physician visits by Medicaid enrollees and to document very low service use rates at particular MCOs, raising issues as to accessibility and quality of care at those plans. Fred Schulte and Jenni Bergal, "Managed Health Care Foundering in Florida," *Sun-Sentinel*, November, 1995.

This new external quality review requirement does not apply until after the Secretary establishes the method for identifying entities that are qualified to conduct the reviews. The Act does not specify when the Secretary must do this. Until then, the preexisting quality review requirement continues to apply. It is unclear whether the Secretary will continue to apply the preexisting requirement after the new quality reviews are triggered. It is also unclear what role, if any, external quality reviews will play in the quality assessment and improvement strategies (described below) that states are required to develop and implement. What is clear, however, is that if states opt to make external independent quality reviews inapplicable to the MCOs with which they contract, an important source of information about the performance of Medicaid MCOs will be lost to beneficiaries, to state officials, and to the Secretary.

Quality Assessment and Improvement Strategy

The Balanced Budget Act requires that states that contract on a risk basis with Medicaid MCOs develop and implement a "quality assessment and improvement strategy." The strategy must be "consistent with" standards established by the Secretary of HHS in consultation with the states. The Secretary is required to establish these standards by August 5, 1998. Until the Secretary's standards are effective, quality assurance guidelines used by the Secretary in administering section 1915(b) waivers apply.[42]

The strategy must include standards for access to care. Under these standards, covered services must be "available within reasonable time frames and in a manner that ensures continuity of care." The legislation also calls for "examination of other aspects of care and service directly related to the improvement of quality of care," but it is unclear whether this examination equates to standards for quality improvement. The QISMC that HCFA is developing may serve as the basis for these standards.

[42] Under section 1915(b), the Secretary may not waive beneficiary freedom of choice unless the Secretary finds that any restrictions on beneficiary choice of provider do not "substantially impair" beneficiary access to covered services of adequate quality where medically necessary. HCFA's interpretation of this standard occurs in the "Streamlined Waiver Application Form," which states must submit for a section 1915(b) capitated waiver program. The form requires that states specify, among other things, the standards for internal quality assurance programs that they will apply to participating MCOs, the mechanisms they will use to monitor compliance with these standards, the entities the state will use to conduct annual independent external quality reviews of MCOs, and what measures these reviews will use in determining access to care. The text of 1915 (b) (1) waiver applications with instructions is available at www.hcfa.gov/medicaid/1915app.htm.

In addition to standards, the strategy must also include procedures for monitoring and evaluating "the quality and appropriateness" of care and services to enrollees. These monitoring procedures must reach "the full spectrum" of Medicaid beneficiary populations enrolled. The procedures must also require MCOs to submit quality assurance data to the state. In general, the data and information set to be used in this submission is whatever the Secretary has specified for use under Medicare.[43] Uniformity in quality assurance data reporting will enable states and HCFA to compare the performance of Medicaid MCOs within and among states. However, the Secretary is also authorized to allow a state to use an alternative quality assurance data and information set.

Quality Standards in Mandatory Enrollment States With Waivers

States using either one of the two waiver pathways to mandatory enrollment of Medicaid beneficiaries in MCOs may be subject to a different set of access and quality standards and processes than those electing the nonwaiver pathway through the section 1932 state option. The Balanced Budget Act expressly provides that its amendments relating to Medicaid managed care are not to be construed as "affecting the terms and conditions of any waiver...under section 1115 or 1915 of the Social Security Act." It is unclear whether the Secretary will limit this exemption to waivers in effect on enactment, or whether the Secretary will extend the exemption to subsequent renewals of such waivers or to new waivers granted after enactment.

Section 1915(b) waivers

Any restrictions on beneficiary choice of provider under these waivers may not "substantially impair" beneficiary access to covered services of adequate quality where medically necessary. HCFA has interpreted this standard with a set of guidelines contained in the application that states seeking these waivers must file. The guidelines require states to specify the standards they will apply to internal quality assurance programs for participating MCOs, how they will monitor compliance with these standards, and the measures that the annual independent external quality reviews of MCOs will use in determining access to covered services. As discussed above, these guidelines will apply to states for purposes of implementing the quality assessment and improvement strategy until the Secretary establishes new standards.

Section 1115 waivers

[43] HCFA has required all Medicare risk contractors to submit the Health Plan Employer Data and Information Set (HEDIS 3.0) developed by the National Committee for Quality Assurance. The results of the first round of submissions are expected to be released by the close of 1997. Although HEDIS 3.0 includes performance measures relevant to employers, to Medicare, and to Medicaid, HCFA has not required the submission of HEDIS 3.0 data by Medicaid MCOs.

There is no statutory access or quality standard for the statewide Medicaid demonstration waivers granted under this authority. Each waiver is negotiated separately with each state and potentially could incorporate different quality assurance requirements. The Secretary has the authority to waive some or all of the quality requirements enacted in the Balanced Budget Act if, in the Secretary's judgment, the waiver would be "likely to assist in promoting the objectives of" the Medicaid statute. To date, HCFA has consistently denied state requests to waive the regulatory requirement for periodic medical audits of Medicaid MCOs.[44]

8. BENEFICIARY PROTECTIONS

The Balanced Budget Act weakens the single most important protection for Medicaid beneficiaries: the right to choose from among physicians or MCOs willing to participate in the program. It allows states to limit most beneficiaries to a choice between two MCOs in urban areas and to a single MCO in rural areas. It does not require that in either case the MCOs give beneficiaries a choice among primary care physicians. Nor does it require that in either case the MCOs contract with physicians, hospitals, or clinics that traditionally have served low-income families and with whom Medicaid beneficiaries may have established a patient-provider relationship. The contrast between this statutory policy and the Act's Medicare+Choice provisions could not be more striking.

The Act also allows states to impose cost-sharing requirements — deductibles, copayments, and coinsurance — on Medicaid beneficiaries enrolled in MCOs to the same extent as they are allowed to impose cost-sharing requirements on Medicaid beneficiaries covered on a fee-for-service basis. Under these general rules, "nominal" (as defined by the Secretary in regulations, 42 CFR 447.50) cost sharing may be imposed on most classes of beneficiaries for most types of covered services. Children under 18 and pregnant women are exempt as are emergency care and family planning services. These same rules and exemptions would apply in the context of MCO enrollees.

The primary purpose of cost-sharing requirements in public (or private) health care coverage is to deter the unnecessary use of services. It is well-documented that the imposition of cost sharing on the poor reduces the use of health care services, whether medically necessary or not. Yet MCOs are already paid in a manner that gives them incentives to curb unnecessary utilization, and they must as a practical matter be organized to do so effectively or they are unlikely to remain in business. Imposition of cost-sharing requirements in the context of MCOs would therefore appear to be redundant with an MCO's utilization control mechanisms (e.g., gatekeeper physicians and prior authorization). Unless the state lowers its capitation rate to the MCO, it will be the MCO rather than the state Medicaid program that will benefit financially from drop in usage resulting from the imposition of cost-sharing on Medicaid beneficiaries.

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[44] Of the ten states that had implemented section 1115 Medicaid waivers as of May 1997, seven requested a waiver of the regulatory requirement for periodic medical audits; in each instance, HCFA denied the request. Sara Rosenbaum and Julie Darnell, *Statewide Medicaid Managed Care Demonstrations Under Section 1115 of the Social Security Act*, Kaiser Commission on the Future of Medicaid, May 1997, Table 4, p. 5.

Nonetheless, the Act does contain provisions intended to protect beneficiaries required to enroll in MCOs from underservicing. A number of these provisions, including those relating to organizational integrity, actuarially sound payments, and access and quality standards, are discussed elsewhere in this analysis. This part focuses on provisions that address specific issues that MCOs can present for Medicaid beneficiaries. Many of these beneficiary protections must be incorporated into all risk contracts between a state Medicaid agency and an MCO and are potentially enforceable by Medicaid enrollees as "third-party beneficiaries" to the contract.[45] (For a complete listing of such provisions, see Appendix A.) Whether these provisions, along with the other statutory safeguards described elsewhere, will effectively protect the access of MCO mandatory enrollees to medically necessary covered services is unclear.

- ***Information about covered services.*** Medicaid MCOs must make available, on request, to enrollees and potential enrollees information relating to (1) the identity and locations of affiliated providers, (2) enrollee rights (and responsibilities), (3) appeals procedures for enrollees in the event of the MCO's failure to cover a services and (4) the items and services the MCO covers and those it does not.

- ***Protections against marketing abuses.*** MCOs and their agents or subcontractors are prohibited from distributing marketing material that is false or materially misleading or that has not been approved in advance of distribution by the state. They may not conduct door-to-door, telephonic, or other "cold call" marketing of enrollment to Medicaid beneficiaries.

- ***Protection against liability in event of insolvency.*** MCOs may not hold Medicaid-eligible enrollees liable for organization debts in case of organizational insolvency or failure to receive payment from the state.

- ***Protection against "balance billing."*** MCOs and their subcontractors are prohibited from billing Medicaid-eligible enrollees for services in excess of the amounts for which the MCO is allowed to bill the state or the subcontractor is allowed to bill the MCO.

- ***Financial incentive arrangements for physicians.*** The financial incentive arrangements that the MCO uses for its physicians must meet the same minimum standards as apply to such arrangements in the case of Medicare risk contractors under section 1876. (These standards are designed to protect enrollees against excessive incentives on the part of physicians to delay or withhold needed care.)

- ***"Gag rule" prohibition.*** Contracting MCOs may not restrict physicians or other health care professionals from advising their patients about their medical conditions or diseases and the care or treatment required, regardless of whether the contract covers such care or treatment.

- ***Disenrollment.*** The MCO must allow a Medicaid beneficiary to disenroll for cause at any time and without cause during the first 90 days following enrollment and at least every 12 months

[45] Jane Perkins and Kristi Olson, National Health Law Program, "An Advocate's Primer on Medicaid Managed Care Contracting," 31*Clearinghouse Review*19 (May/June 1997).

thereafter. This has the potential to function as an "escape valve" for beneficiaries in egregious situations.

9. ACCOUNTABILITY OF MEDICAID MCOs FOR COMPLIANCE WITH STATE AND FEDERAL STANDARDS

Prior to the Balanced Budget Act, accountability of Medicaid MCOs for the accessibility and quality of the services they contracted to deliver was often problematic. The contracts between the state Medicaid agencies and the Medicaid MCOs vary widely in the specificity with which they articulate the duties of the contracting MCOs, raising issues of enforceability.[46] Regulatory and contractual standards were sometimes unenforced.[47] The state agencies responsible for monitoring and enforcing compliance — the Medicaid agency and the Medicaid Fraud and Abuse Control Unit — were often understaffed and lacking in managed care expertise.[48] The responsible agencies at the federal level — HCFA and the Inspector General of the Department of HHS — tended to defer to these same state agencies in defining, monitoring, and enforcing compliance by the MCOs with which they contracted. Finally, the governing federal statute did not contain sufficient accountability mechanisms, and the potential of private "whistle-blower" lawsuits to curb fraudulent conduct by Medicaid MCOs had not been explored.[49]

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[46] Sara Rosenbaum et al., *Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts*, George Washington Center for Health Policy Research, February 1997, at www.chcs.org/analysis.htm.

[47] An investigation of the implementation of Medicaid managed care in California found that "in dozens of interviews with health-care experts and in state records reviewed by The Times, state regulators drew sharp criticism for failing to adequately screen the HMOs or for overlooking important information about their past performances." David Oemos, "Medi-Cal Matter," *Los Angeles Times*, July 21, 1996.

[48] See General Accounting Office, *Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan*, GAO/HEHS-95-87, April 28, 1995.

[49] The "qui tam" provisions of the Federal False Claims Act, 31 U.S.C. 3729 et seq., authorize lawsuits by private citizens against contractors who have defrauded the federal programs such as Medicaid and Medicare and permit the whistle-blowers to recover 15 to 25 percent of the government's recovery resulting from the information they provide.

The Balanced Budget Act does not by itself correct these problems, and it will not necessarily improve accountability on the part of Medicaid MCOs to enrolled beneficiaries for the accessibility and quality of covered services. But the Act does contain some provisions that, if implemented, hold some promise for maintaining MCO accountability even in the context of mandatory enrollment of beneficiaries:

SPECIFICATION OF BENEFITS

Effective with respect to contracts entered into or renewed on or after October 1, 1997, state Medicaid agency contracts with MCOs must "specify the benefits the provision (or arrangement) for which the entity is responsible." This requirement provides the basis for enforcement against MCOs of contractual obligations relating to the delivery of covered services in exchange for monthly Medicaid capitation payments.[50] Enforcement can occur through both the state Medicaid agency as a party to the contract and through private actions brought by Medicaid-eligible enrollees as third-party beneficiaries to the contract.[51] (For a summary of other performance standards that states must incorporate into Medicaid MCO contracts, see Appendix A). Specifications of benefits could also help resolve some of the issues raised by full or partial "carve outs" of mental health and other benefits.[52]

GRIEVANCES AND APPEALS

The Balanced Budget Act requires that each Medicaid MCO establish an internal grievance procedure under which a Medicaid-eligible enrollee, or a provider on the enrollee's behalf, has the opportunity to "challenge the denial of coverage of or payment for" Medicaid benefits. It is unclear whether and how this requirement will alter the previous regulatory requirement (42 CFR 434.32) that MCOs have an internal grievance procedure approved by the state that provides for prompt resolution of disputes. What is clear, however, is

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[50] HCFA has emphasized that "the contract must include provisions that address the responsibility of the [MCO] to furnish care and services when medically necessary in sufficient detail to ensure that beneficiaries receive needed services to which they are entitled under the contract." Letter from Sally K. Richardson, Director, Center for Medicaid and State Operations, HCFA, to State Medicaid Directors regarding specification of benefits, December 17, 1997.

[51] Jane Perkins and Kristi Olson, National Health Law Program, "An Advocate's Primer on Medicaid Managed Care Contracting," 31 *Clearinghouse Review* 19, May-June 1997.

[52] See Chris Koyanagi and Jennifer Stevenson, Bazelon Center for Mental Health Law, *Assessing Approaches to Medicaid Managed Behavioral Health Care*, Kaiser Commission on the Future of Medicaid, July 1997.

that regardless of the contours of an MCO's internal grievance procedures, they do not substitute for the timely "fair hearing" before an impartial hearing officer to which every Medicaid beneficiary, whether or not enrolled in an MCO, remains entitled under the Medicaid statute and the U.S. Constitution[53].

DISCLOSURE OF RESULTS OF EXTERNAL INDEPENDENT QUALITY REVIEW

Medicaid MCOs are currently subject to an annual external quality review by an independent organization, as discussed in Part 7. Effective in 1999, these reviews are to be conducted using national protocols to allow comparison of results, which will be public information available to enrollees and potential enrollees. Although some provisions in the Balanced Budget Act will allow many MCOs to avoid this review, the Act does enable states to use the disclosure of quality review results to encourage MCOs to improve their performance. As discussed in section 4, in states that seek to implement mandatory managed care enrollment under section 1932, the Act prohibits the "default" or "auto" enrollment of beneficiaries in MCOs that have been found to be out of substantial compliance with statutory or contractual requirements. In the case of Medicaid MCOs that rely on default enrollees for revenues, the potential loss of these revenues could provide an incentive for compliance.

STATE INTERMEDIATE SANCTIONS

The Balanced Budget Act requires that, with respect to Medicaid MCO contracts entered into or renewed on or after April 1, 1998, states must "establish" intermediate sanctions as an alternative to end a contract in cases of non-compliance. In general, though states do not have to impose such sanctions, they must have the authority to do so in certain circumstances. One is when an MCO "fails substantially to provide medically necessary items and services (under law or under such organization's contract with the state) to an enrollee covered under the contract." Another is if the MCO "misrepresents or falsifies" information provided to the state or the Secretary (for example, listing as a participating physician someone with whom the MCO does not actually have a subcontract or affiliation agreement.

The intermediate sanctions that a state must have the authority to exercise in such cases include imposing civil monetary penalties (up to $25,000 for each failure to provide covered services); permitting beneficiaries to disenroll without cause; or suspending new enrollment or payment for Medicaid enrollees. In addition, states must be able to appoint temporary management in instances of "continued egregious behavior" by an MCO or "a substantial risk to the health of enrollees." States must permit beneficiaries to disenroll from an MCO and appoint temporary management if the MCO repeatedly fails to meet statutory and contractual requirements.

FEDERAL INTERMEDIATE SANCTIONS

The Balanced Budget Act leaves in tact the Secretary's previous authority to impose intermediate sanctions on noncomplying MCOs. These sanctions include civil money penalties of up to $100,000 per violation and the denial of federal matching payments to states for capitation payments for new Medicaid enrollees in noncomplying MCOs. For example, the Secretary may impose a civil money penalty of up to $25,000 for each instance in which an MCO "fails substantially" to provide medically necessary items and services to an enrolled beneficiary as required under law or under the MCO's contract with the state, if the failure to provide care has a "substantial likelihood of adversely affecting" the beneficiary. The availability of an independent

[53] Daniels V. Wadley, 926 F. Supp. 1305 (M.D. Tenn., May 14, 1996).

federal remedy assures that if a particular state Medicaid agency declines to take enforcement action in such circumstances, the federal government has the authority to intervene.

10. PRIMARY CARE CASE MANAGEMENT OPTION AND RURAL BENEFICIARIES

Prior to the enactment of the Balanced Budget Act, primary care case management organizations were the preferred delivery system in rural areas for states trying to shift their Medicaid programs from fee-for-service to managed care. As of June 1996, PCCMs accounted for about 59 of the 511 operational Medicaid managed care plans and covered more than 4 million Medicaid beneficiaries, or about 30 percent of the 13.3 million in managed care. Many of these PCCMs were operating in rural areas under section 1915(b) waivers. Generally, PCCMs do not assume financial risk for the provision of covered services to enrollees.[54] Instead, they are paid a small monthly fee for each enrollee for approving and monitoring the provision of hospital and specialist services to enrollees. The medical care provided by the primary care physician "gatekeepers" in PCCMs is normally paid on a fee-for-service basis.[55] The absence of capitation is one reason that some medical associations strongly favor the PCCM model to the MCO model of Medicaid managed care.[56]

The Balanced Budget Act does not amend the 1915(b) waiver authority itself. States will still be able to apply for such waivers to require beneficiary enrollment in PCCMs in rural or urban areas. The Act expressly provides that its Medicaid managed care amendments are not to be construed to affect "the terms and conditions of any waiver, or the authority of the Secretary of Health and Human Services with respect to any such waiver, under [section 1915]." It is unclear how the Secretary will exercise 1915(b) waiver authority in the future. While the Secretary probably will continue to use the same guidelines in effect under the waivers before the Act was passed, the Secretary is not precluded from modifying them. (As discussed above, the Act designates the 1915(b) waiver guidelines as placeholders while the Secretary develops standards for state quality assessment and improvement strategies.) To the extent that any of the PCCMs

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[54] HCFA interprets the Balanced Budget Act to allow partial capitation of PCCMs, which it describes as "a limited risk contract for no more than two mandatory services." Letter from Sally K. Richardson, Center for Medicaid and State Operations, to State Medicaid Directors regarding section 1932 (a), December 17, 1997.

[55] *Medicaid Facts: Medicaid and Managed Care*, Kaiser Commission on the Future of Medicaid, June 1997.

[56] Marsha Gold, Barbara Foot, and Marsha Lillie-Blanton, *Managed Care and Low-Income Populations: A Case Study of Texas*, Kaiser/Commonwealth Low-Income Coverage and Access Project, March 1997, pp. 14-15, 37.

enter into risk contracts with state Medicaid programs for the coverage of hospital or other services, they will presumably be subject to the same contractual standards as apply to MCOs under the Act.

For states that want to require Medicaid beneficiaries to enroll in PCCMs, the Balanced Budget Act creates a new option under section 1932. This option enables states to require most Medicaid beneficiaries to enroll in such arrangements. (The two groups of beneficiaries exempted from mandatory enrollment are children with special needs, including those in foster care, and Medicare beneficiaries). Unlike the 1915(b) waiver route, this option does not require prior Secretarial approval, nor does it necessitate renewing that approval every two years. Instead, states need to file a state Medicaid plan amendment that meets the statute's requirements.

The Balanced Budget Act also creates a new option for states that want to offer PCCMs to their Medicaid beneficiaries on a voluntary enrollment basis. It does this by creating a new optional benefit category — "primary care case management services." These it defines as "case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager" — a physician, physician group practice, or an entity employing or contracting with physicians. Federal matching funds are available for this optional benefit at the same rate as a state receives for physician and clinic services, and for other benefits covered under Medicaid.

The section 1932 mandatory enrollment option allows states to require beneficiaries living in a "rural area" to enroll in a single PCCM selected by the state if two conditions are met. (The term rural area is not defined, and the Secretary has issued no guidance on this.) First, the PCCM must allow each beneficiary to choose between at least two physicians *or* at least two "case managers." (The term case manager is not defined, although it seems to mean someone other than a physician.) HCFA may either choose to specify a nurse practitioner, certified nurse-midwife, or physician assistant, as "primary care case manager," or leave this definition to the states. Some rural beneficiaries thus could be required to join PCCM organizations that do not offer them access to a primary care physician.

Secondly, the PCCM must allow the beneficiary to obtain covered services from any other provider "in appropriate circumstances." These circumstances are to be established by the state under regulations of the Secretary. As in the case of mandatory enrollment in MCOs, beneficiaries can be locked into a PCCM arrangement for a 12-month period, with disenrollment only for cause (other than during the first 90 days). The PCCMs may enroll Medicaid beneficiaries exclusively and do not need to serve a commercial population.

Whether a state elects to offer PCCM services on a voluntary or mandatory basis, these services must be provided under a "primary care case management contract" with the state Medicaid agency. This is not a risk contract that a state agency would enter into with an MCO and it is not subject to all of the statutory requirements applicable to MCO risk contracts summarized in Appendix A. However, there is substantial overlap.

- ***Accessibility.*** PCCM enrollees must be able to reach the service delivery site within a "reasonable time" using "available and affordable" modes of transportation.

- ***Adequate capacity.*** There must be sufficient numbers of physicians and other "appropriate" health care practitioners affiliated with PCCM directly or through referrals to ensure that services can be furnished to enrollees "promptly and without compromise to the quality of care."

- ***Emergency services.*** The PCCM must have "reasonable and adequate" hours of operation, including "24-hour availability of information, referral, and treatment with respect to medical emergencies." In addition, the PCCM must provide coverage for emergency services under the same "prudent layperson" standard that applies to Medicaid MCOs and Medicare+Choice plans.

- ***Discrimination based on health status.*** The PCCM is prohibited from discriminating in enrollment, disenrollment, or reenrollment on the basis of a Medicaid beneficiary's health status or need for health care.

- ***Marketing fraud.*** PCCMs are prohibited from distributing "false or materially misleading" marketing materials and may not engage in door-to-door or telephonic marketing to Medicaid beneficiaries.

Notably, PCCMs are not subject to the new requirement for an internal grievance procedure, the new annual external independent quality reviews, or the new state quality assessment and improvement strategies — all of which will be applicable to Medicaid MCOs. In addition, there is no standard relating to the adequacy of reimbursement to the PCCM or its physicians and other practitioners comparable to the statutory requirement that payments to MCOs be made on an "actuarially sound" basis. In fact, the Balanced Budget Act repeals the prior law requirement that spoke to the adequacy of physician payment rates.[57] Moreover, PCCM contracts of any amount are not subject to prior approval by the Secretary of HHS as are MCO risk contracts over $1 million in value.

Because PCCMs do not assume financial risk for providing covered services to enrollees, they have less of a financial incentive to deny medically necessary care than entities operating under an MCO risk contract. Nonetheless, the lack of any requirement for internal quality assurance programs or external quality reviews, combined with the absence of any requirement concerning adequate physician payment, could raise quality of care issues in circumstances where rural beneficiaries are required to enroll in a single PCCM. Unless the states elect to integrate their PCCMs into the reporting and monitoring systems applicable to Medicaid MCOs, neither the states nor HCFA will have any information — from external quality reviews, quality assurance data, or other sources — to compare the performance of PCCMs with other PCCMs or with MCOs within the same state. Rural beneficiaries in particular may find themselves without useful information regarding the quality of care in the PCCM in which the state is requiring them to enroll.

11. IMPLICATIONS FOR SAFETY NET PROVIDERS

[57] Section 4713 of the Balanced Budget Act repeals section 1926 of the Social Security Act, which required states to demonstrate annually that their Medicaid payment rates to physicians for pediatric and obstetrical services were adequate to ensure program participation by a sufficient number of practitioners. Section 1926 also required that state payment rates to MCOs "take into account" these payment rates for pediatric and obstetrical services.

Medicaid's transition from fee-for-service to managed care has enormous implications for safety net providers — those hospitals and clinics that deliver basic health care to large numbers of the uninsured. Medicaid has been a major revenue source for many of these providers, because it has reimbursed for the care and services they deliver to low-income patients who, without Medicaid coverage, generally would have no other source of payment. The revenues from these Medicaid patients often allow these hospitals and clinics to maintain the staffing, equipment, and other capacity to serve the uninsured. Loss of some or all of these Medicaid revenues due to lower payment rates for beneficiaries or to their diversion elsewhere could lead to the contraction of service capacity or, in extreme cases, closure of safety net facilities. As a result, the uninsured in these communities will have much greater difficulty in accessing needed care.

Current state practices and policies with respect to safety net providers vary. A 1996 survey by the National Academy of State Health Policy found that, in the 38 states with Medicaid risk contracting programs, 30 states reported that federally-qualified health centers participated as contractors or subcontractors in these programs; 22 states reported that community health centers or rural health clinics participated; and 256 states reported that local health departments participated. The survey found that few states reported requiring Medicaid MCOs to contract with any particular safety net providers.[58]

The Balanced Budget Act does not articulate a clear policy for the support of safety net providers. It contains some provisions intended to give states the ability to reduce Medicaid payments to these providers, and it contains some provisions intended to protect these providers from harm at the hands of Medicaid MCOs. The policies toward "safety net" hospitals differ from those toward "safety net" clinics. In each case, the real-world impact of these changes will vary from community to community and state to state.

DISPROPORTIONATE SHARE HOSPITALS

The Balanced Budget Act contains a number of provisions designed to achieve federal savings by reducing Medicaid reimbursement to hospitals generally, and to "disproportionate share" hospitals like public and children's hospitals in particular. The Act repeals the so-called Boren amendment, which required "reasonable and adequate" payments to hospitals for inpatient care delivered to Medicaid patients. (This change is not likely to have much effect on hospital Medicaid revenues in states with high managed care penetration because, under HCFA interpretation, MCOs were not subject to the Boren amendment in setting payment rates to affiliated hospitals.) The Act still requires states to make additional payments to hospitals serving high volumes of Medicaid or uninsured patients, but it limits the federal Medicaid matching funds available for these DSH payments in each state.[59]

The Act does not require Medicaid MCOs to contract with DSH hospitals or, if they elect to do so, to pay them any particular rate or to guarantee them a certain volume of patient referrals. In general, the Act leaves it to Medicaid MCOs and DSH hospitals to work out any affiliations, subject to the following constraints.

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[58] Jane Horvath and Neva Kaye, *Medicaid Managed Care: A Guide for States, 3rd Edition*, National Academy for State Health Policy, 1997, pp. I-19 - 1-20.

[59] Andy Schneider, Stephen Cha, and Sam Elkin, *Overview of Medicaid "DSH" Provisions in the Balanced Budget Act of 1997, P.L. 105-33*, Center on Budget and Policy Priorities, September 3, 1997, available on www.kff.org., the Web site of the Kaiser Commission on the Future of Medicaid for which the analysis was prepared.

(As in the case of other MCO performance standards, these provisions do not apply in states currently operating section 1115 waivers or under current section 1915(b) waivers.)

DSH Payments

States must make DSH payments directly to DSH hospitals rather than funneling them through MCOs.[60] Direct payment is obviously beneficial to DSH hospitals, as it eliminates any possibility of delay or diversion of DSH payments by an MCO.

Emergency Services

Both MCOs and PCCMs must provide coverage for emergency services "without regard to prior authorization or the emergency care provider's contractual relationship with" the MCO or the PCCM. Emergency services are defined broadly as those needed to "evaluate or stabilize" an emergency medical condition that a "prudent layperson" could reasonably expect to require immediate medical attention. This requirement should protect DSH hospitals from MCOs that might deny payment to unaffiliated hospital emergency rooms for care provided to Medicaid enrollees (even though the cost of that care is part of the MCO's Medicaid capitation rate). It applies to MCO or PCCM contracts entered into or renewed on or after October 1, 1997.

Timely Payments

MCOs must pay hospitals and other health care providers on a timely basis for services provided to those Medicaid enrollees who are covered under their risk contract with the state. As with state Medicaid reimbursement to fee-for-service providers, timely means that the MCO pays 90 percent of "clean" claims (for which no further substantiation is required) within 30 days and 99 percent within 90 days. This requirement should help protect DSH hospitals from cash flow problems resulting from long delays in payment by MCOs for emergency care or other covered services, whether or not the hospital is affiliated with the MCO whose enrollee it treats.

Default Enrollments

As described in section 4, the Act contains provisions related to "default" or "auto" enrollment in the case of states implementing mandatory managed care under section 1932. These provisions require that states, in the process of enrolling beneficiaries who do not choose among the MCOs offered to them, "take into consideration maintaining . . . relationships with providers that have traditionally served [Medicaid] beneficiaries." DSH hospitals are not expressly referenced, but they are surely among the providers that have "traditionally" served beneficiaries. In states that implement this provision, it could make DSH hospitals attractive as affiliates to those managed care plans seeking to increase the number of beneficiaries they enroll through the default enrollment process.

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[60] An exception is made for "payment arrangements" in effect on July 1, 1997, which appears to apply to Alabama and Wisconsin.

Liberalized Solvency Requirements

The Act's provisions relating to emergency services and timely payments should be helpful to DSH hospitals that are not themselves MCOs. For those DSH hospitals that choose to operate as an MCO, capitalization and cash reserve requirements relating to state insolvency standards for health maintenance organizations or insurers may be a concern. The Act specifies that, as a general rule, MCOs meet state-established solvency standards for private HMOs or be state-certified as a "risk bearing entity." However, two exceptions are relevant to DSH hospitals. First, any organization that is a "public entity" is not subject to the solvency standards applicable to private HMOs or risk bearing entities; this is obviously relevant to DSH hospitals operated by counties or localities. Second, any DSH hospital, public or private, that qualifies as a "provider-sponsored organization" is exempt from these solvency standards. Presumably, a DSH hospital could qualify as a PSO under the new Medicare provisions in the Balanced Budget Act or under relevant state law.

FEDERALLY-QUALIFIED HEALTH CENTERS

As in the case of Medicaid DSH hospitals, the Balanced Budget Act contains changes designed to reduce federal spending on payments to federally qualified health centers. Among these are federally funded community and migrant health centers, health clinics run by Indian tribes or urban Indian organizations, and urban or rural primary care clinics that meet the requirements applicable to community health centers but do not receive federal grant funds. These requirements include providing primary care services to people living in an FQHC's service area, regardless of their ability to pay. Though the Act retains the current legal requirement that state Medicaid programs cover the services provided by FQHCs, it phases out the requirement that states pay FQHCs at a rate that fully reflects their costs of delivering care to Medicaid patients. CBO assumes that states will take advantage of this flexibility to reduce payments to FQHCs, yielding some federal savings as well.

States may choose to cover FQHC services through contracts with MCOs or "carve out" these services from these contracts. In either case, the Act does not require MCOs to contract with FQHCs, nor does it address the terms of any contractual arrangements MCOs might elect to enter into with FQHCs. The Act does, however, include a few provisions that should help to maintain the fiscal viability of FQHCs as state Medicaid programs transition to managed care. (In contrast to the situation with respect to DSH hospitals, these provisions appear to apply in states operating under section 1115 or section 1915(b) waivers.)

Payment Rates

Under current law, state Medicaid programs must cover the services provided by FQHCs and must pay participating FQHCs 100 percent of the cost of delivering covered services to Medicaid patients. The Act phases out this requirement beginning in fiscal year 2000, when states are allowed to pay only 95 percent of costs. The phase-out continues through fiscal year 2003, when states are permitted to pay only 70 percent of costs, and then repeals the requirement altogether effective October 1, 2003. During this same "transitional" period — October 1, 1997 through October 1, 2003 — the Act sets forth two requirements related to reimbursement of FQHCs subcontracting with Medicaid MCOs.

First, MCOs that enter into contracts with FQHCs must make payments on behalf of Medicaid enrollees treated by the FQHCs that are "not less than the level and amount of payments" the MCO would make for the same services if delivered by another provider within the MCO's network. Second, the Act requires the state

Medicaid program to supplement, on a quarterly basis, the payment made by the MCO to the FQHC, so that the total amount the FQHC receives for treating the MCO's enrollees equals what it would be entitled to get had the patient been a fee-for-service beneficiary. For example, if in fiscal year 1999 the MCO paid its FQHCs 90 percent of cost, the state would have to provide the other 10 percent. These requirements do not guarantee the FQHC any defined volume of Medicaid patients or any aggregate amount of Medicaid revenues. But they do, however, attempt to ensure that, during the transition period, FQHCs do not receive less for treating MCO Medicaid enrollees than for beneficiaries in fee-for-service arrangements.

Timely Payments

The requirements for timely payment by MCOs to DSH hospitals described above also apply to FQHCs. Thus, MCOs must pay 90 percent of the clean claims submitted by FQHCs for covered services provided to MCO Medicaid enrollees within 30 days of receipt, and 99 percent within 90 days of receipt.

Default Enrollment

As with DSH hospitals, the Act provides for default enrollment processes that have the potential to give some priority to FQHCs. The Act requires that states using the section 1932 route to mandatory managed care assign beneficiaries that do not choose among MCOs offered to them in a way that "takes into consideration maintaining existing provider-individual relationships or relationships with providers that have traditionally served [Medicaid] beneficiaries." FQHCs have patient relationships with many Medicaid beneficiaries and have traditionally served them. MCOs that contract with, or are owned by, FQHCs, could potentially benefit from this statutory standard by enrolling beneficiaries (including patients who they have served in the past) who have failed to select an MCO.

Liberalized Solvency Requirements

As with DSH hospitals, the Act provides for liberalized solvency requirements for FQHCs that want to operate their own MCOs rather than contract with MCOs owned by hospitals or other providers or by investors. (Currently, FQHCs own or operate between 20 and 30 Medicaid MCOs; in six states, these MCOs have the largest Medicaid enrollment.) The Act provides that the solvency standards generally applicable to MCOs — those set by the state for private HMOs or for risk bearing entities — do not apply to an MCO that "is or (is controlled by)" one or more FQHCs and that meets solvency standards "established by the State for such an organization."

CONCLUSION

Implementation of the Medicaid managed care provisions of the Balanced Budget Act presents HCFA and the states with a daunting set of implementation issues. HCFA, which is also responsible for implementing the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), the Medicare provisions of the Balanced Budget Act, and the new Child Health Block Grant, will have significant new responsibilities with respect to Medicaid. A major task will be to issue administrative guidance on these managed care provisions, as well as monitor and enforce state and MCO compliance with that guidance. HCFA action on these Medicaid managed care provisions, is particularly important: without timely federal guidance and monitoring, in some states federal Medicaid dollars may inadvertently finance the underservicing of low-income women and children and other Medicaid beneficiaries who have been required to enroll in MCOs that do business only with Medicaid.

From the state standpoint, the Balanced Budget Act provides broad new flexibility with respect to mandatory managed care. However, the Act also establishes a number of new federal requirements that may make state Medicaid agencies more accountable for their expenditure of federal Medicaid managed care funds. One is a reinstatement of the requirement for federal prior approval of all state managed care contracts in excess of $1 million. Another concerns new conflict-of-interest rules governing state officials involved in Medicaid managed care contracting. Yet others involve new management information system reporting requirements and a new requirement to develop a quality assessment and improvement strategy consistent with federal standards. The extent to which these requirements actually improve the performance of state agencies and ultimately the performance of contracting MCOs depends largely on how clearly and effectively HCFA (and the HHS Inspector General) implement these requirements.

A critical first-priority issue for both HCFA and the Inspector General is the availability of accurate, policy-relevant data. Currently, most states do not report on a quarterly basis the number of beneficiaries enrolled in MCOs or the cost of those enrollees. Similarly, states generally do not report such information by beneficiary group (e.g., children, adults, disabled, or elderly) or by type of managed care arrangement (e.g., MCO or PCCM). Without this basic information, it is extremely difficult for federal officials or policy analysts to monitor the Medicaid program's transition to managed care.[61] The Secretary of HHS has the statutory authority to require such information; the Medicaid statute has long required state Medicaid agencies to "make such reports, in such form and containing such information, as the Secretary may from time to time require." This authority was augmented by provisions of the Balanced Budget Act relating to upgrading the state Medicaid management information systems. As the amount of federal Medicaid matching funds flowing through Medicaid MCOs increases, it will become even more essential that the Secretary use this authority to gain a current understanding of the expenditure of those funds and the patterns of enrollment of Medicaid beneficiaries.[62]

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[61] As analysts at the Urban Institute recently noted, "Existing national data sources tell us very little about who [Medicaid beneficiaries enrolled in managed care] are, what types of services they use, and how much was spent on these services. As more beneficiaries are enrolled into managed care plans, this problem will be exacerbated." David Liska et al., *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1990-1995*, Kaiser Commission on the Future of Medicaid, November 1997, p. xiii.

[62] In connection with the implementation of the Child Health Block Grant, HCFA has issued Medicaid reporting forms calling for the number of unduplicated children and adults enrolled in managed care arrangements, as well as Medicaid

Ultimately, the test of the Balanced Budget Act's Medicaid managed care changes will come not during the nation's current economic expansion, but when regional or national economic growth slows significantly, driving down state revenues and increasing the number of people enrolled in MCOs. Will the fiscally pressed states maintain capitation rates high enough to enable even MCOs made up exclusively of Medicaid beneficiaries to provide covered services? If states freeze or even reduce Medicaid capitation rates, how will MCOs react? Will these MCOs leave the program altogether, or will they begin to reduce or withhold covered services from their enrollees? Whatever the response, how will beneficiary access to care, beneficiary health status, and the fiscal capacity of safety net providers be affected? The answers to these questions will not be known for several years. In the interim, careful monitoring of Medicaid's shift from fee-for-service to managed care will be essential to assess and refine the Balanced Budget Act's provisions.

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payments to MCOs. HCFA, *Financing Provisions of the Child Health Insurance Program (CHIP) and Related Medicaid Program Provisions*, December 5, 1997 Draft, Forms HCFA-64EC, HCFA-64-EA, and HCFA-37.3.

APPENDIX A

STANDARDS FOR STATE CONTRACTS WITH MEDICAID MCOs

Regardless of the statutory pathway a state elects to follow in requiring Medicaid beneficiaries to enroll in fully capitated MCOs, certain federal standards apply.[63] These standards are articulated in section 1903(m) of the Social Security Act, which permits federal matching payments to MCOs on a capitation or other risk basis for inpatient hospital care and other covered Medicaid services only if the state and the MCO enter into a contract that holds the MCO to certain standards of performance. As Rosenbaum and her colleagues have observed, the specification and enforcement of the terms of this contract between a state and an MCO have profound implications for the access of Medicaid beneficiaries to covered services and the quality of the services they receive.[64] A poorly drafted contract may not be amenable to effective enforcement, allowing Medicaid funds to flow to poorly performing MCOs.[65] Similarly, a well-drafted but unenforced contract can also result in poor performance on the part of an MCO.

CONTRACT STANDARDS FOR MEDICAID MCOs

The Balanced Budget Act substantially expands the minimum Medicaid MCO contract standards required by federal law. These following standards are effective for contracts entered into or renewed on or after October 1, 1997.

- ***Organizational qualifications.*** The contracting MCO must be one of the following: a "health maintenance organization"; an "eligible organization" with a contract with the Medicare program; a "Medicare+Choice organization" with a contract with the Medicare program; a "provider-sponsored organization"; or "a public or private organization" that makes services "accessible" to Medicaid beneficiaries and has made "adequate provision against the risk of insolvency."

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[63] Even though the Secretary's waiver authority under section 1115 is broad, it seems unlikely that it would be exercised to waive basic contracting rules designed to ensure the program's fiscal integrity or the quality and accessibility of the core services that it covers.

[64] Rosenbaum et al.,*Negotiating the New Health Care System: A Nationwide Survey of Medicaid Managed Care Contracts*, George Washington Center for Health Policy Research, February 1997, at www.chcs.org/analysis.htm.

[65] Jane Perkins and Kristi Olson, National Health Law Program, "An Advocate's Primer on Medicaid Managed Care Contracting," 31 Clearinghouse Review 19 (May/June 1997).

- ***Actuarially sound payments.*** Capitation payments to the MCO must be made on an "actuarially sound basis," a term that the statute does not define.

- ***Audits.*** The Secretary and the state or their designees must have "the right to audit and inspect any books and records of the entity and of any subcontractor relating to the ability to bear financial risk, the services performed under the contract, or the determinations of amounts payable under the contract."

- ***Nondiscrimination.*** The MCO may not discriminate among Medicaid beneficiaries on the basis of their health status or requirements for health care services in enrollment, reenrollment, or disenrollment.

- ***Disenrollment.*** The MCO must allow a Medicaid beneficiary to disenroll for cause at any time and without cause during the first 90 days following enrollment and at least every 12 months thereafter.

- ***Emergency care.*** The MCO or the state must reimburse hospitals and other providers not affiliated with the MCO for care provided to Medicaid enrollees because the services "were immediately required due to an unforeseen illness, injury, or condition."

- ***Disclosure.*** The MCO must provide "full and complete" information as to the identity of each person with an ownership or control interest in the MCO or in any subcontractor in which the MCO has a 5 percent or greater ownership interest. The MCO must also disclose certain related party transactions.

- ***Federally qualified health centers (FQHCs) and rural health clinics (RHC).*** If an MCO has entered into a subcontract with an FQHC or RHC to provide services, the MCO must pay the subcontractor at least the "level and amount of payment" that the MCO would pay for such services if the provider were not an FQHC or RHC.

- ***Financial incentive arrangements for physicians.*** The financial incentive arrangements that the MCO uses for its physicians must meet the same minimum standards as apply to such arrangements in the case of Medicare risk contractors under section 1876. (These standards are designed to protect enrollees against excessive incentives on the part of physicians to delay or withhold needed care.)

- ***Encounter data.*** The MCO must maintain sufficient patient encounter data to identify the physician who delivers services to Medicaid beneficiaries.

- ***Section 1932 requirements.*** The contract and the MCO must comply with the "applicable" requirements of section 1932. At a minimum, these include:

  Specification of benefits. The contract must specify the benefits that the MCO is responsible for providing (or making arrangements for the provision of).

  Emergency services. In addition to the emergency care requirement described above, a Medicaid MCO must provide coverage for emergency services under the same guidelines as apply to Medicare managed care plans.

"Gag rule" prohibition. Contracting MCOs may not restrict physicians or other health care professionals from advising their patients about their medical conditions or diseases and the care or treatment required, regardless of whether the contract covers such care or treatment.

Protection against "balance billing." MCOs and their subcontractors are prohibited from billing Medicaid-eligible enrollees for services in excess of the amounts for which the MCO is allowed to bill the state or the subcontractor is allowed to bill the MCO.

External independent quality review. Contracting MCOs are subject to an annual external review of the "quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract." The reviews are to be conducted by a "qualified independent entity." After January 1, 1999, these reviews are to be conducted using protocols developed by an independent quality review organization selected by the Secretary. States have the option of waiving this review requirement with respect to MCOs that contract with Medicare or that have had a Medicaid contract in effect for the two previous years.

Timely payments to providers. MCOs must make payment to health care providers for items and services covered under the contract with the state and delivered to enrolled Medicaid beneficiaries on a timely basis (i.e., 90 percent of "clean" claims should be paid within 30 days of receipt). MCOs and providers may agree to an alternate payment schedule.

OTHER FEDERAL MINIMUM STANDARDS FOR MEDICAID MCOs

The Balanced Budget Act contains additional standards that clearly apply to Medicaid MCOs but that are not expressly linked to the terms of the contracts between state Medicaid agencies and MCOs. The Health Care Financing Administration has not yet determined whether any of these standards will be applied to MCOs through contract.[66] These additional standards relating to enrollees are:

- ***Information to enrollees.*** Medicaid MCOs must make available, on request, to enrollees and potential enrollees information relating to (1) the identity and locations of affiliated providers, (2) enrollee rights (and responsibilities), (3) appeals procedures for enrollees in the event of the MCO's failure to cover a services, and (4) the items and services the MCO covers.

- ***Grievance procedures.*** Each MCO must establish internal grievance procedures under which enrolled Medicaid beneficiaries or their providers can challenge the denial of coverage or payment.

- ***Adequate capacity and services.*** Each MCO must provide adequate assurances that it has the capacity to serve the expected enrollment in a service area.

[66] HCFA has indicated that states seeking to implement mandatory managed care programs under section 1932 must include in their state plan amendments "assurances" relating to default enrollment and to the provision of information to beneficiaries. Letter from Sally K. Richardson, Center for Medicaid and State Operations, to State Medicaid Directors, December 17, 1997.

- ***Enrollee liability for payment.*** MCOs may not hold Medicaid-eligible enrollees liable for the debts of the organization in the event of organizational insolvency or failure to receive payment from the state.

- ***Maternity care and mental health standards.*** Medicaid MCOs must comply with the standards of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) relating to minimum hospital stays for deliveries and parity in limitations on mental health benefits.

- ***Quality standards.*** Guidelines relating to quality assurance that currently apply under section 1915(b)(1) waivers are to apply to Medicaid MCOs until the Secretary, in consultation with the states, establishes quality assurance standards. These standards, which are to be completed by August 5, 1998, are to be used by the states in developing and implementing a "quality assessment and improvement strategy" which is to take effect on January 1, 1999.

- ***Affiliations with individuals debarred by federal agencies.*** Medicaid MCOs may not knowingly have a management, ownership, employment, or consulting relationship with an individual who has been debarred, suspended, or otherwise excluded from participating in Medicaid, Medicare, or any other federal program.

- ***Marketing restrictions.*** MCOs and their agents or subcontractors are prohibited from distributing marketing material that is false or materially misleading or that has not been approved in advance of distribution by the state, and may not conduct door-to-door, telephonic, or other "cold call" marketing of enrollment to Medicaid beneficiaries.

- ***Physician identifiers.*** Every physician providing services to eligible enrollees in Medicaid MCOs is required to have a unique identifier to facilitate monitoring for fraud and abuse.

APPENDIX B

INDEX TO STATUTORY PROVISIONS RELATING TO MEDICAID MANAGED CARE

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- Demonstration..... 1115
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