



**Center for Medicaid and State Operations**

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SHO # 09-008  
CHIPRA # 4

August 31, 2009

Dear State Health Official:

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act (the Act). CHIPRA ensures that States are able to continue their existing CHIP programs and provides funding to expand health insurance coverage to additional low-income, uninsured children. The purpose of this letter is to provide general guidance on implementation of section 403 of CHIPRA, which applies several elements of section 1932 of the Act (Medicaid managed care rules) to State CHIP managed care programs. We have also included a set of questions and answers to provide further information about these provisions in CHIP.

**Medicaid Managed Care Requirements Applied to CHIP Managed Care Delivery Systems**

Section 2103(f) of the Act, as amended by section 403 of CHIPRA, requires State CHIP programs to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; 1932(a)(5), Provision of Information; 1932(b), Beneficiary Protections; 1932(c), Quality Assurance Standards; 1932(d), Protections Against Fraud and Abuse; and 1932(e), Sanctions for Noncompliance.

CHIP programs operating a managed care delivery system must comply with section 2103(f) of the Act with respect to all managed care contracts entered into or renewed as of July 1, 2009. States that operate a managed care delivery system under a title XIX Medicaid expansion program are considered to be in compliance with section 1932 of the Act. However, States that operate a title XXI program, either separately or as part of a combination program, are now required to apply these provisions to their separate CHIP plans. Application of these provisions to CHIP managed care delivery systems may require program modifications as described in this letter.

As CHIP managed care contracts are extended, renewed, or substantively amended on or after July 1, 2009, they must include the specified provisions of section 2103(f) of the Act and must be submitted to the appropriate Centers for Medicare & Medicaid Services (CMS) Regional Office for review and approval. Although prior contract approval is not required, CMS recommends that States submit these contracts at least 60 days prior to the desired effective date, if possible, in order to avoid any Federal compliance actions associated with operating contracts that do not meet the new requirements in section 2103(f) of the Act.

CMS also encourages States to submit draft versions of new managed care contracts to the appropriate Regional Office so that any concerns about meeting Federal requirements can be identified and addressed expeditiously. This approach will facilitate CMS oversight of compliance with these new requirements, and minimize the risk of Federal compliance actions in the event that a managed care contract does not meet these requirements.

### **Specific Subsections of Section 1932 of the Act Applicable to CHIP Managed Care Delivery Systems**

Below is a general overview of the key provisions in section 1932 of the Act that are applicable to CHIP managed care delivery systems beginning July 1, 2009.

#### **1932(a)(4) - Process for Enrollment and Termination and Change of Enrollment**

Under this subsection, an individual enrolled in a managed care entity (MCE) is allowed to disenroll from the MCE at any time for cause or, if without cause, during the 90 days after enrollment. After the initial 90 days, the individual must be given the right to disenroll from the MCE without cause at the end of each enrollment period and at least every 12 months thereafter. Additionally, States must notify individuals enrolled in a MCE of their disenrollment rights at least 60 days before each annual enrollment opportunity.

Because section 1932(a)(4) gives individuals the right to disenroll from their MCE but still be eligible to receive benefits, States will be required to have at least two MCEs or an MCE and an alternate delivery system to provide CHIP benefits. An alternative delivery system could include a fee-for-service (FFS) option. States that currently offer only one delivery system may consider contracting with an additional MCE, creating an FFS option, or contracting with some or all of their State's existing Medicaid provider network. Since the requirement for choice of managed care entity in section 1932(a)(3) does not apply to CHIP, States do not need to offer alternative delivery systems at the time of enrollment. However, enrollees need to have an alternative available in which to enroll if they choose to disenroll from their current MCE. CMS will work with States as described below in coming into compliance with this requirement.

#### **1932(a)(5) - Provision of Information**

This subsection requires enrollment notices and informational and instructional materials for enrollees and potential enrollees that are in an easily understood language and format. A managed care organization (MCO) must make available to all enrollees and potential enrollees information about its providers, enrollee rights and responsibilities, grievance and appeal procedures, and information on covered items and services. Finally, an enrollee must be informed in writing, either before or at the time of managed care enrollment, about any benefits available to the enrollee that will not be available through the managed care entity and how and where these benefits can be obtained.

#### **1932(b) - Beneficiary Protections**

This subsection provides specific information on enrollee protections. First, a managed care contract must specify the benefits for which the MCE is responsible, and require coverage for an

emergency medical condition, and any needed emergency services, without regard to prior authorization or limitation to emergency facilities that contract with the MCE. An “emergency medical condition” exists when a prudent layperson could reasonably expect that lack of immediate medical attention will result in placing the health of a person in serious jeopardy, risk serious impairment to bodily functions, or risk serious dysfunction of any bodily organ or part.

Further, an MCO may not:

1. Prohibit or restrict a health care professional from advising a patient about treatment options, regardless of whether benefits for such care or treatment are provided under the contract, if the health care professional is acting within his or her lawful scope of practice. To the extent that this prohibition would result in an MCO having to pay for counseling, or a service to which it objects on moral or religious grounds, the MCO must advise enrollees at enrollment or within 90 days of a policy change that it will not pay for such counseling or service.
2. Discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider’s license or certification, solely based on such license or certification. However, the MCO may limit provider inclusion to maintain quality of care and to control costs consistent with the needs of its enrollees and its responsibility to provide access to covered services to them.
3. Make enrollees liable for payments to providers for covered services provided under its policy other than approved co-payments and deductibles.
4. Permit providers to bill an enrollee for MCO-covered benefits in the event the MCO becomes insolvent.

Finally, an MCO must offer enrollees an internal grievance procedure under which enrollees may challenge the denial of coverage or payment for health care benefits; provide assurances to State and Federal officials that, within its service area, it has the capacity to serve its expected enrollment, that it maintains an adequate number, mix and distribution of providers, that it offers an appropriate range of services and access to preventive and primary care services for the expected population; and that it will comply with certain maternity and mental health requirements contained in title XXVII of the Public Health Service Act.

### **1932(c) - Quality Assurance Standards**

This subsection requires a systemic quality program for MCOs. Specifically, a State that uses MCOs to provide CHIP benefits must develop and implement a Quality Assessment and Improvement Strategy for those services. The strategy must address access standards, quality improvement, and monitoring procedures, and be revised periodically as appropriate.

Further, an MCO must undergo an annual review of its quality of care by a qualified and competent independent external reviewer as legally defined. The results of the review will be made available to the general public and MCOs which are accredited by recognized national accrediting organizations may be eligible to be exempt from some portion of the annual review.

CMS encourages States to develop a single quality strategy that addresses both the Medicaid and CHIP managed care programs. CMS further anticipates that the annual MCO review under CHIP will be similar to the External Quality Review, which Medicaid MCOs undergo annually.

#### **1932(d) – Protections against Fraud and Abuse**

This subsection prohibits an MCE from knowingly having as a Director, Officer, Partner, or Shareholder, a person or affiliate of a person with more than 5 percent ownership that has been excluded from participation in Medicaid, Medicare, or other government procurement programs. Nor may the MCE employ, consult, or otherwise compensate any such person. If a State finds that the entity has violated this requirement, it will notify the Secretary of Health and Human Services of the violation and the Secretary, in consultation with the State and the Inspector General, will decide if the entity's contract will continue.

Marketing materials produced by MCEs may not be distributed without the prior approval of the State, and may not contain misleading information. Approved marketing materials should be made available throughout the service area served by the entity. The entity may not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing to procure enrollees. The entity may not seek to influence potential enrollees to purchase any other unrelated insurance in any marketing document or contact.

State employees who handle contracts with MCOs are required to abide by conflict-of-interest standards that are as effective as Federal conflict-of-interest standards in awarding MCO contracts. Finally, MCOs shall require their participating physicians to have Unique Physician Identity Numbers.

#### **1932(e) – Sanctions for Noncompliance**

Intermediate sanctions, short of contract termination, shall be developed by the State and be available for use when dealing with entities that fail to provide covered, necessary care to enrollees; charge fees which are not permitted; discriminate among enrollees; misrepresent facts to enrollees or State and Federal program officers; or violate marketing rules. The sanctions will include civil monetary penalties, the appointment of temporary new management, allowing enrollees to terminate without cause, suspension of new enrollment, and suspension of State payment. All of these sanctions may only be imposed subject to the appeal rights for the entity.

#### **Implementation**

This guidance is offered in order to assist States in planning for application of these provisions to CHIP managed care contracts beginning July 1, 2009. Additional policy guidance will be forthcoming on this issue, and CMS will work with States to help them implement these provisions in a manner that is consistent with the statute.

CMS is developing a Notice of Proposed Rulemaking outlining proposed regulations that would: (1) require States to amend the CHIP State plan to assure compliance with the provisions of section 2103(f) of the Act as necessary; (2) condition Federal financial participation (FFP) for CHIP managed care contracts on the contract's compliance with the new requirements of section

2103(f) of the Act; and (3) provide more definitive guidance on the application of section 2103(f) in a manner similar to title XIX regulations at 42 CFR Part 438. States shall continue to comply with all other provisions of the Act in the administration of the State plan under title XXI until final regulations are effective.

Section 3(b) of CHIPRA provides that the Secretary of Health and Human Services may extend the date by which a State must implement any provision if the Secretary determines that State legislation is required in order for a State's CHIP plan to be in compliance with the provision.

If your State requires such legislation, please submit to your CMS regional office a letter to that effect as soon as possible. The letter should include a reference to the provision in question, the reason State legislation is required for compliance, and the date the State will implement the provision. States with annual legislative sessions have until the first day of the first calendar quarter after the close of the first regular session of the State legislature that begins after February 4, 2009. For States with biennial legislative sessions, each year of the session is considered to be a separate regular session for this purpose.

In addition, section 3(d)(2) of CHIPRA provides that FFP shall not be denied to a State which made a good faith effort to comply with the requirements in this Act prior to the issuance of any guidance or regulations implementing the provisions in question. Finally, in situations where a State may still have difficulty coming into compliance with these provisions, CMS will develop a corrective action plan (CAP) with actions and target dates for State compliance. FFP will not be denied as long as a State makes a good faith effort to comply and implements any CAP required. We will consider the issues advanced by these CAPs further as we develop the regulations implementing this provision.

We encourage all States that operate a separate CHIP program with a managed care delivery system to begin a dialogue with their CMS regional office and with the Medicaid program in their State to assess potential coordination between the two programs in order to maximize administrative efficiencies and facilitate more rapid compliance with these requirements.

If you have any questions on the information provided in this letter, please contact Ms. Dianne Heffron, at 410-786-3247.

Sincerely,

/s/

Cindy Mann  
Director

Enclosure

cc:

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**Enclosure**

**APPLICATION OF MEDICAID MANAGED CARE REQUIREMENTS TO CHIP**

***IMPLEMENTATION***

**Question 1: How will CMS interpret the requirement that State plans “provide for the application” of the referenced subsections of section 1932 “in the same manner” as such subsections apply to the States and managed care organizations under title XIX?**

Answer: Section 403 of CHIPRA requires State CHIP programs to apply specified provisions of section 1932 of the Social Security Act (the Act) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations (MCOs) under title XXI of the Act “in the same manner” as these provisions apply under title XIX of the Act. We interpret the requirement that these be applied “in the same manner” as under the Medicaid program to mean that we should apply the same interpretations of these statutory requirements that we have adopted for the Medicaid program to the CHIP program, and should enforce these requirements, as so interpreted, in the same manner under the CHIP program that we do under Medicaid.

Therefore, most of these requirements must be included in contracts between States and managed care entities that are newly implemented, extended, renewed, or substantively amended after July 1, 2009. Other provisions may be required in CHIP State plans, and some will be required in both. CMS will review and approve all State plan amendments and managed care contracts and work with States to assure compliance with these requirements. We encourage States to contact CMS and work with their own Medicaid managed care staffs as they add these requirements into their State plans and managed care contracts.

**Question 2: The section 1932 provisions apply to the CHIP program as a whole, and are not limited to those programs which use a managed care delivery system. Is the State expected to assume responsibility for all activities that managed care entities and enrollment brokers are required to perform under section 1932?**

Answer: No. These provisions apply only to those CHIP programs that use a managed care delivery system and provide CHIP benefits through managed care entities.

**Question 3: Will CMS provide a Question & Answer and/or a CHIPRA Managed Care Contract Requirements Check List like they did when States were required to incorporate Medicaid managed care Balanced Budget Act requirements into our Medicaid MCO contracts? These guidance documents were invaluable.**

Answer: Yes. We are in the process of developing a similar type of check list.

**Question 4: Will there be managed care exemption requirements in CHIP for Native Americans or Alaska Natives (Section 1932(a)(1)(C) of the Social Security Act)?**

Answer: No. The exemption for Native Americans and Alaska Natives was not one of the provisions that Congress extended to CHIP managed care programs. Section 1932(a)(1)(C) of the Act exempts members of federally recognized tribes from mandatory enrollment in a Medicaid managed care program that a State operates under the authority of its State plan through section 1932, except where Indian health care providers (IHCPs)—i.e. Indian Health Service, Tribal, or Urban Indian providers, are participating providers in the managed care network. States that operate a managed care program under the authority of a Medicaid waiver or demonstration project may elect to enroll Native Americans and Alaska Natives on a mandatory or voluntary basis. States with CHIP managed care programs also have this option.

However, section 5006(d) of ARRA added the new section 1932(h) of the Social Security Act, which was effective as of July 1, 2009, and applies consistent rules governing the treatment of Indians, IHCPs, and Indian Managed Care Entities that are part of a State’s Medicaid managed care program under title XIX. These rules also apply to CHIP managed care programs. CMS will be issuing a State Health Officials letter providing guidance on this provision in the near future.

***ENROLLEE CHOICE OF MANAGED CARE ENTITY***

**Question 5: How will section 1932(a)(4) – Enrollment & Disenrollment, apply to CHIP? Will rural areas be exempt?**

Answer: The new law does not include a specific exemption for rural areas. The enrollment and disenrollment provisions in 1932(a)(4) require programs to:

- Permit an enrollee in a managed care plan to disenroll at any time for cause, or without cause during the 90 days after notice of enrollment. After the initial 90 days, the enrollee must be given the right to disenroll without cause at least every 12 months thereafter.
- Give enrollees notice of their disenrollment rights at least 60 days before each annual enrollment opportunity.

By adding the section 1932(a)(4) provision for the process of enrollment and termination and change of enrollment, States will be required to have more than one option available for CHIP enrollees. While CHIPRA did not require States to offer more than one *managed care* option, States that have CHIP managed care entities (MCEs) must offer either an alternate delivery system (*e.g.*, FFS) or a minimum of two MCEs.

**Question 6: How will the application of section 1932(a)(5) – Enrollee Information to CHIP – differ from the current requirements of 42 CFR 457.110?**

Answer: The enrollee information requirements under the Federal regulations at 42 CFR 438.10 that implement section 1932(a)(5), are generally more comprehensive than the cited CHIP requirements. However, in complying with the CHIP information requirements, many States



appear to already meet the requirements in section 1932(a)(5). The 1932(a)(5) requirements include the following:

- Enrollment notices and materials for enrollees must be in an easily understood language and format.
- The State or MCE must make available to all enrollees and potential enrollees information about its providers, enrollee rights and responsibilities, grievance and appeal procedures, and information on covered items and services.
- A State shall, on or before an individual beneficiary enrolls with a managed care entity, inform the enrollee in a written and prominent manner of any benefits available to the enrollee that will not be available to the enrollee through the enrolling entity. This notice must also advise the enrollee where he or she may obtain these benefits elsewhere.

CMS intends to publish a Notice of Proposed Rulemaking that will contain additional directions and guidance on the implementation of these requirements.

**Question 7: Section 1932(d)(3) prohibits managed care organizations from entering into contracts with a State unless the State has in effect conflict of interest safeguards with respect to officers and employees of the State with responsibilities relating to contract with such organization that “are at least as effective as” certain Federal safeguards. How will CMS determine whether State conflict of interest safeguards are at least as effective as Federal safeguards?**

Answer: The State must have safeguards against conflicts of interest on the part of the State and local officers, employees, and agents of the State who have responsibilities relating to contracts with managed care entities or the default enrollment process. The State’s conflict of interest safeguards must be at least as effective as those specified in section 27 of the Office of Federal Procurement Policy Act. All State conflict of interest safeguards will be measured against the provisions of that Act. We encourage States to contact CMS and to work with their own Medicaid staffs as they apply these safeguards to CHIP.

**Question 8: In Medicaid, CMS interprets section 1932 as requiring managed care organizations to provide States with encounter/claims data. Does this interpretation now apply to CHIP?**

Answer: Yes.

**Question 9: Can States claim an enhanced match for that portion of their actuarially-equivalent capitation rate in managed care contracts that represents the portion of the rate attributable to the cost of translation services (i.e., similar to family planning services)?**

Answer: CHIP managed care programs operating under title XXI authority will receive the usual enhanced Federal matching rate for managed care program expenditures that States receive under title XXI. Section 201 of CHIPRA provides an enhanced matching rate of 75 percent for States that provide translation/interpretation services. States will be permitted to claim the enhanced

match for that portion of the capitation rates paid to MCEs that can be documented as attributable to the cost of translation and interpretation services under the contract. CMS will work with States to develop an allowable methodology to collect the information necessary to claim this higher matching rate for the eligible portion of their managed care payment rates.