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Medicaid/CHIP Managed Care Regulations: Enhancing the Beneficiary Experience

by Tricia Brooks and Elizabeth Edwards

Georgetown University Center for Children and Families (CCF) and the National Health Law Program (NHeLP) have teamed up to bring advocates for children and low-income families critical information about the recently finalized Medicaid and CHIP managed care regulations. This paper is the third in the series, and it describes how the new rules enhance the beneficiary experience. Other briefs in this series include:

- Looking at the New Medicaid/CHIP Managed Care Regulations Through a Children's Lens, *which gives an overview of the rules with an appendix detailing which Medicaid provisions also apply to the Children's Health Insurance Program (CHIP).*
- Medicaid/CHIP Managed Care Regulations: Improving Consumer Information, *which covers new provisions for accurate, timely, accessible, and complete consumer information.*

Future briefs in the series will dive into other issues important to low-income families in greater detail by focusing on topics such as assuring network adequacy and access to services, advancing quality, and ensuring accountability and transparency. It is important to note at the outset that these new managed care rules lay out the minimum standards states must meet in Medicaid and CHIP, but they also provide health and legal advocates a tremendous opportunity to improve care delivery for low-income families through strategic engagement with states and health plans as the rules are implemented over the next few years. States can and should do more than adopt the minimum standards for children and families. This issue brief series will identify those opportunities for action.

Background

As managed care and particularly mandatory managed care programs have become the predominant model for delivering care in Medicaid, there has been a growing recognition of the need to provide potential enrollees with accurate and timely information about their managed care options, to enable and encourage an active choice of plans, and to ensure that automatic plan assignments are conducted thoughtfully. To this end, the modernization of federal Medicaid Managed Care regulations released in May 2016 seeks to enhance the beneficiary experience. The rules align enrollment and disenrollment processes in voluntary and mandatory managed care, and create a beneficiary support system that provides choice counseling and assistance in understanding managed care before and after enrollment. The rules also include specific requirements for supporting enrollees who use or want to use long-term services and supports through managed care (MLTSS).

States that have implemented the Children's Health Insurance Programs (CHIP) as a Medicaid expansion program, also known as M-CHIP, must follow the Medicaid rules. Separate CHIP programs are governed by different rules that may or may not mirror the Medicaid rules. Provisions that apply to separate CHIP programs are summarized at the end of this brief (see page 11).

Applies to states, enrollment brokers, MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities.

Timeline: Effective July 5, 2016

Choice of Plan or Primary Care Case Manager (§ 438.52)

Medicaid statute and rules have long required that a choice of managed care entities be available to individuals if they are required to enroll in managed care. Previously, this rule also applied to PCCMs but the new rule adjusts that expectation. The rule now reads that a choice of plans is required if enrollment in a MCO, PIHP, or PAHP is mandatory. However, for both PCCMs and PCCM entities, the new rule clarifies that choice applies at the provider level. In both types of PCCM arrangements, the individual must be able to choose between primary care case managers, as opposed to having a choice of PCCM programs or entities. (See the appendix for definitions of different managed care arrangements.)

Applies to MCOs, PIHPs, and PAHPs.

Exception for rural areas (§ 438.52(b))

States have always had the flexibility to limit a rural area resident to a single managed care plan. This provision is retained and applies to MCOs, PIHPs, and PAHPs, regardless of the authority (state plan option, § 1915 waiver, or § 1115 demonstration) under which the managed care plan operates. However, the new rules change the definition of rural area to be consistent with Medicare's county-based classification for Medicare Advantage plans, which defines areas as large metro, metro, micro, rural, or counties with extreme access considerations.[1] For the purposes of this rule, a rural area is any county designated as micro, rural, or a county with extreme access considerations.

Beneficiaries in areas designated as rural must have a choice of at least two primary care providers. Additionally, they must be able to obtain services from any other provider if: 1) the service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, or PAHP network; or 2) the provider is not in the network but is the main source of service to the beneficiary. In the latter circumstance, the provider must be given the opportunity to become a participating provider with the same requirements as other providers. If the provider chooses not to join the network, or does not meet the necessary qualifications, the enrollee must be given an opportunity to select a network provider. If no provider is selected, the enrollee will be transitioned to a network provider within 60 calendar days.

Enrollees in areas designated as rural may also obtain services from other non-participating providers under other circumstances:

- The only plan or provider available does not provide the service being sought on the basis of moral or religious objections.
- The primary care provider or other provider determines that the enrollee needs other services that would pose an unnecessary risk if received separately.[2]
- The state determines that other circumstances warrant out-of-network treatment.

For rural enrollees where only one managed care plan is available, the state may not limit changes between primary care providers that are more restrictive than those that apply to plan disenrollment (see discussion on disenrollment below).

TIP

The rule expressly gives states the flexibility to determine other circumstances that warrant out-of-network treatment. Encourage your state to engage stakeholders in establishing parameters that allow rural enrollees to seek care from a non-participating provider.

Applies to the state.

Timeline:

For contracts starting on or after July 1, 2018

Beneficiary Support System (§ 438.71)

In order to ensure that beneficiaries have appropriate support in choosing a managed care plan, states must have a beneficiary support system (BSS). The BSS must perform outreach to beneficiaries and be accessible in multiple ways, including in-person, phone, online, and via auxiliary aids and services when requested. It must provide choice counseling and help beneficiaries understand managed care both before and after enrollment. The BSS must also provide specific assistance to those who use or want to receive long-term services and supports (LTSS).

In providing choice counseling, the BSS must meet independence and conflict of interest standards required of enrollment brokers to ensure that the information provided is not influenced by a managed care plan or health care provider.[3] However, choice counseling may be performed by organizations that receive non-Medicaid funding to represent individuals at Medicaid hearings as long as there are appropriate protections in place to ensure the integrity of the choice counseling functions.

Choice Counseling (§ 438.2)

Choice counseling means the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care plans and primary care providers.

Beneficiary Support for LTSS (§ 438.71(d))

For beneficiaries who use or express a desire to receive long-term services and supports, a BSS performs additional functions. The BSS functions much like a customer service center in that it is a place for LTSS beneficiaries to report complaints about managed care plan enrollment, service coverage issues, and other matters. The BSS also provides LTSS beneficiaries education on their grievance and appeal rights within the managed care plans as well as assistance in navigating those processes. When a person requests this assistance, it may include appealing adverse decisions, such as a denial or decrease of a service, up to a state fair hearing. However, the BSS does not provide representation to the enrollee and instead may refer the enrollee to other resources for legal representation at a hearing. One of the other functions of the BSS is to review LTSS program and complaint data to help the state understand and resolve widespread issues in managed care for LTSS beneficiaries.

TIP

Encourage your state to engage stakeholders in developing and implementing the beneficiary support system. Advocate for your state to have a robust and responsive beneficiary support system that has the capacity to provide assistance in navigating the managed care system to all enrollees, and to not limit specific information and assistance to LTSS beneficiaries.

Applies to states, enrollment brokers, MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities.

Timeline: Effective July 5, 2016

Enrollment (§ 438.54)

Prior to the new rules, there was no federal guidance for voluntary enrollment in managed care and only limited federal guidance in regard to mandatory enrollment, which only required that a state have a default enrollment standard for MCOs and PCCMs. In the absence of specific federal regulatory provisions, states employed a variety of approaches to enrolling beneficiaries into voluntary and mandatory managed care programs. A review of these approaches revealed a need for an appropriate, minimum level of beneficiary protection and consistency across different types of managed care programs. For example, many states employed passive enrollment systems (described below) that required action to opt out of the assigned delivery system or plan. It is human nature to not take action when none is required, so it is no surprise that studies indicate that the share of enrollees who opt out is very low. Confusing notices and the lack of personalized assistance compounded the problem. As a result, individuals were often enrolled in a plan that did not best meet their needs.

The new regulations set basic federal standards for enrollment while continuing to allow state flexibility in designing enrollment processes. Importantly, the rules apply equally to both voluntary and mandatory managed care programs, regardless of the Medicaid authority under which the program operates.[4]

Applies to voluntary and mandatory managed care programs.

Informational Notices (§§ 438.54(c)(3) and 438.54(d)(3))

States must provide informational notices to each potential enrollee at the time the beneficiary becomes eligible to enroll voluntarily, or is required to enroll, in a managed care program. The notice must be provided within a timeframe that enables the potential enrollee to use the information to choose among delivery systems, plans, or providers, as applicable. The notices must clearly explain the implications of not taking action, and of accepting the assignment made by the state. The notices must also identify the choices available and provide clear instructions on how to select a delivery system or plan. Importantly, the notices must provide a comprehensive description of the length of the enrollment period, the 90-day without cause disenrollment period, and all other disenrollment options.

The informational notices must include the contact information for the BSS, which provides consumer information and choice counseling. These notices must also comply with the information requirements in § 438.10, which was the subject of the second brief in this series.[5]

Enrollment system (§ 438.54(b))

The state must have an enrollment system in place for both voluntary and mandatory managed care. In voluntary programs, beneficiaries can choose a managed care plan or receive services in fee-for-service (FFS). In mandatory managed care, beneficiaries are required to enroll in managed care in order to receive benefits.

Definitions

Voluntary managed care programs are those where one or more groups of beneficiaries have the option to enroll in managed care or receive benefits through the Medicaid fee-for-service program.

Mandatory managed care programs are those where one or more groups of beneficiaries must enroll in managed care. Non-exempt groups, including children, parents and other adults, can be mandated to enroll in managed care through any type of Medicaid authority, including a state plan amendment. To mandate enrollment of exempt groups—children with special health care needs or disabilities, children receiving foster care or adoption assistance, American Indians, Native Americans, and dual eligibles—states must receive § 1915(b) waivers or § 1115 demonstration approval.

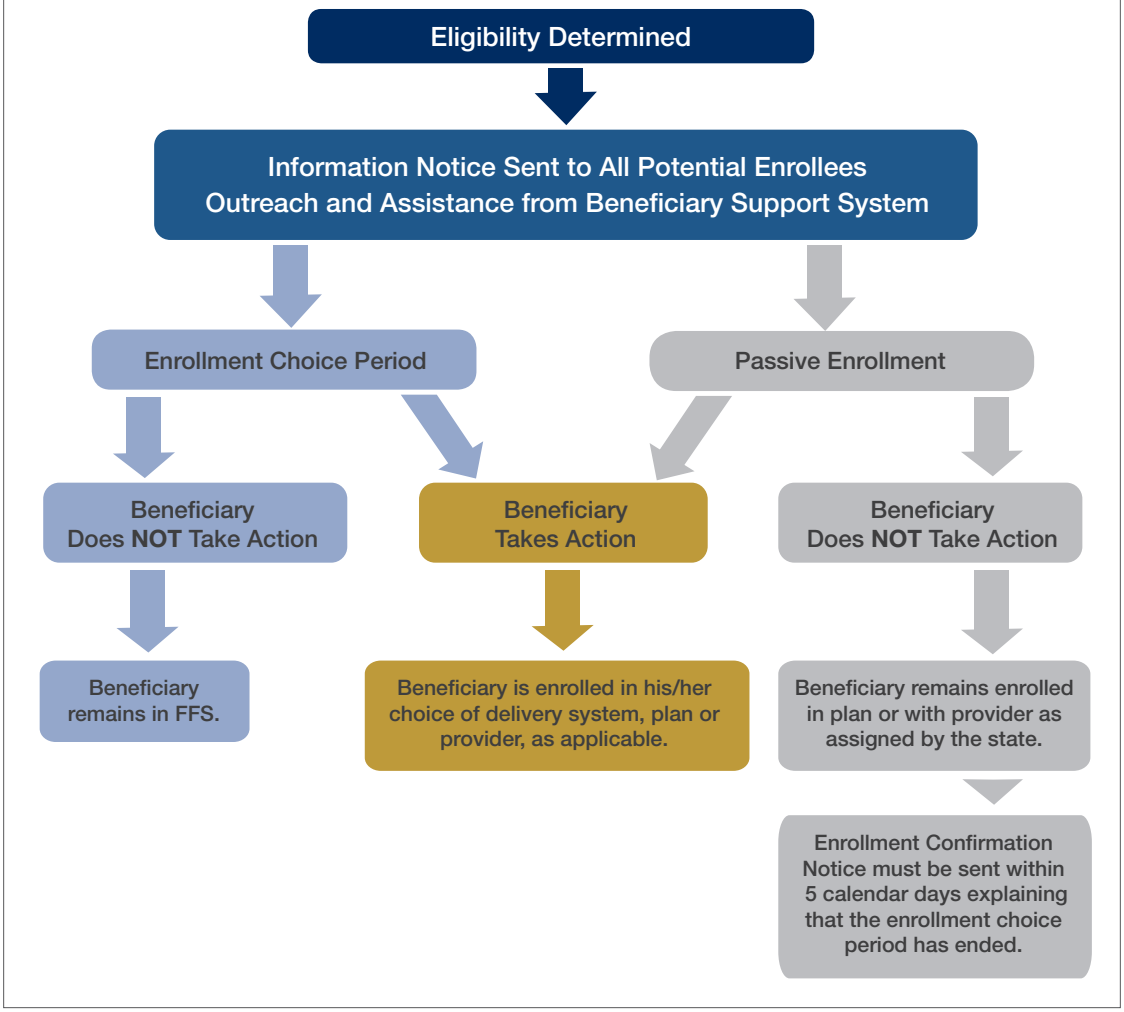
Voluntary Managed Care Programs (§ 438.54(c))

States must provide potential enrollees the opportunity to actively choose to receive services through managed care or the FFS delivery system. In doing so, the state may either provide an enrollment choice period while providing FFS benefits or employ a passive enrollment process.

An enrollment choice period gives a potential enrollee an opportunity to make an active choice of delivery system, plan or provider, as applicable, while services are delivered through the state's FFS delivery system. If the potential enrollee does not make an active choice during the enrollment choice period, the beneficiary will continue to receive services in FFS.

On the other hand, a ***passive enrollment system*** allows the state to immediately enroll a beneficiary into a specific plan or with a particular provider while simultaneously providing an enrollment choice period.. The potential enrollee may accept the plan or provider to which they were assigned, select a different plan or provider, or elect to receive services through the FFS delivery system. Beneficiaries who do not make an active choice during the time allowed by the state will remain enrolled in the plan assigned by the state. (See Figure 1.)

Figure 1. Voluntary Managed Care



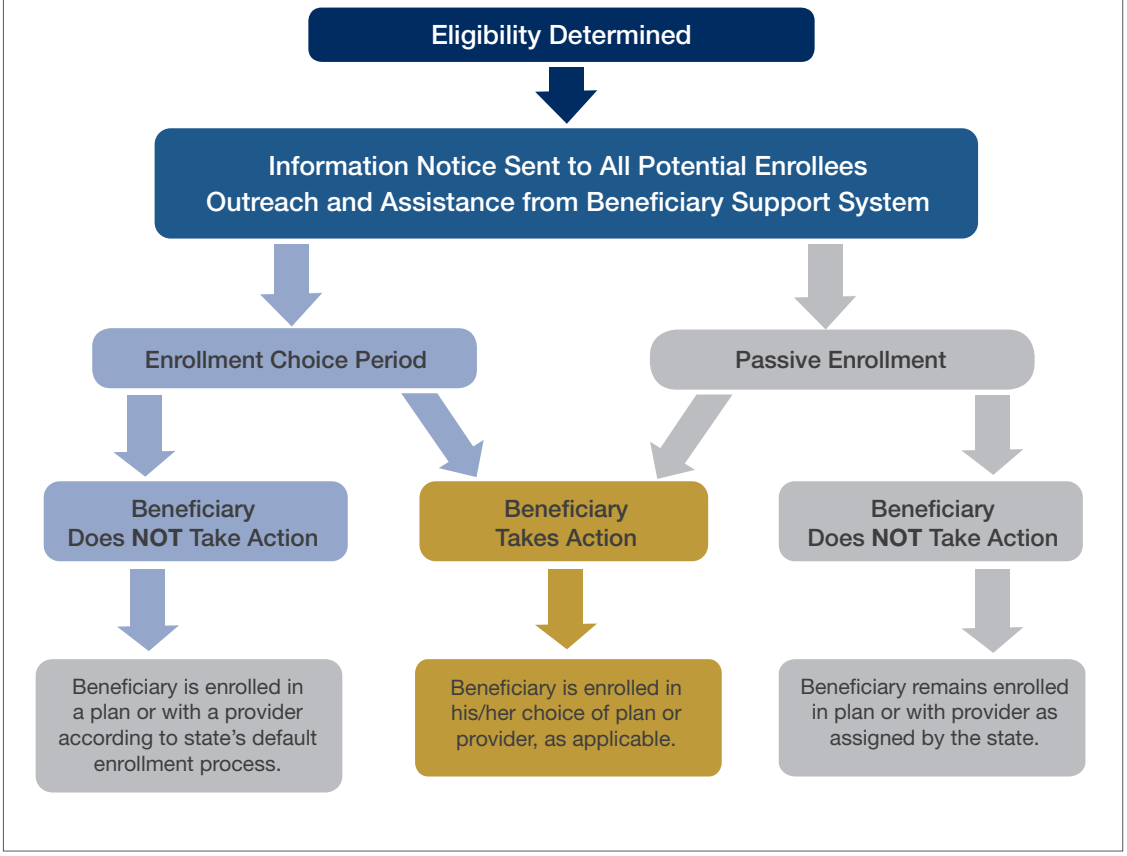
Mandatory Managed Care Programs (§ 438.54(d))

The rules for mandatory managed care programs align with the voluntary rules, with the key exception that beneficiaries do not have a choice of receiving benefits through a FFS delivery system. Just as described above, the state must have an enrollment system. If the state uses a passive process, the potential enrollee may either accept the assignment or select a different plan. If an active choice is not made in the time allowed by the state, the plan assignment will remain. If the state does not use a passive system, the individual will be automatically assigned to a plan according to the state's default process after the enrollment choice period has ended. (See Figure 2.)

TIP

The proposed rule would have required states to offer an enrollment choice period for 14 days, but this provision was not included in the final rule. Encourage your state to work with stakeholders to determine the amount of time that is reasonable for a consumer to understand their options to make an active choice, and to ensure that the BSS has the capacity to conduct outreach and assist all beneficiaries.

Figure 2. Mandatory Managed Care



Enrollment Priority and Enrollment by Default (§§ 438.54(c)(4-5)) and 438.54(d)(4-5))

The state's enrollment system must give priority to beneficiaries who are already enrolled in a particular plan or with a particular provider to continue enrollment if the plan or provider has limited capacity. If the state elects to use a passive enrollment process, it must assign beneficiaries to a 'qualified' MCO, PIHP, PAHP, PCCM, or PCCM entity. To be qualified, the program or plan must have the capacity to enroll beneficiaries and, in the case of an MCO, must not be subject to intermediate sanctions after being found in violation of federal Medicaid law.[6]

Whether a state assigns a plan upfront in a passive enrollment process, or after the beneficiary has not actively selected a plan or provider during the enrollment choice period—called ***enrollment by default***—the requirements for assigning plans are the same. Assignment of a beneficiary to a specific managed care plan or program must preserve existing provider-beneficiary relationships, or foster relationships with providers that have experience serving Medicaid beneficiaries. A provider-beneficiary relationship exists if the provider is the 'main source of Medicaid services for the beneficiary during the previous year.' To determine existing provider-beneficiary relationships, states may use records or encounter data from previous managed care enrollment or FFS experience, or contact the beneficiary.

If unable to maintain existing or traditional Medicaid provider-beneficiary relationships, the state must distribute the beneficiaries 'equitably' among the plans or entities. However, this does not necessarily mean that equal numbers of beneficiaries are enrolled in each plan. While the state may not arbitrarily exclude any plan or entity, it may consider additional criteria in assigning beneficiaries. These include the enrollment preferences of family members, previous plan assignments or selections, quality assurance and improvement performance, evaluation elements used in the procurement process, accessibility of provider offices for people with disabilities, and other reasonable criteria.

Encourage your state to engage stakeholders in determining the criteria for auto-assignment that is in the best interests of beneficiaries.

Enrollment Confirmation Notice for Voluntary Managed Care

If a beneficiary is passively assigned to a plan or provider, and does not make an active choice to be enrolled in the FFS program, the state must send a confirmation notice to the enrollee within 5 calendar days of the end of the enrollment choice period. The notice must state that the time to elect FFS enrollment has ended, and that the individual remains enrolled in the assigned plan for the remainder of the enrollment period until a specific disenrollment reason applies. The notice must clearly and fully explain the enrollee's right to disenroll within 90 days from the effective date of enrollment for any reason, or at anytime for cause (defined below). There is no corresponding notice requirement in mandatory managed care programs, although enrollees would typically receive enrollment information from the managed care plan along with insurance cards.

Applies to MCOs, PIHPs, PAHPs, and PCCM entities, whether enrollment is voluntary or mandatory.

Timeline: Effective July 5, 2016

Disenrollment § 438.56

Disenrollment requested by the plan (§ 438.56(b))

States may, but are not required to, allow plans to request disenrollment. If the state does, it must specify in the contract the reasons for such disenrollments. Importantly, plans may not request disenrollment because of adverse changes in an enrollee's health status; medical utilization; diminished mental capacity; or uncooperative or disruptive behavior resulting from his or her special needs, unless continued enrollment seriously impairs the entity's ability to furnish services to the enrollee or other enrollees. States must specify the methods by which the plan assures the agency that it is requesting disenrollment only for reasons permitted under the contract.

TIP Encourage your state to involve stakeholders in establishing the reasons and processes for which plans may request disenrollment so that beneficiaries who need strong continuity of care are not disenrolled by plans because their care is complex, difficult, or costly.

Disenrollment requested by the enrollee (§ 438.56(c))

If a state chooses to limit disenrollment, its contracts with plans must specify that an enrollee may disenroll at any time for cause. Enrollees may also disenroll without cause in the first 90 days of initial enrollment in a plan and at least once every 12 months, the latter of which is similar to open enrollment in private insurance. A state can use either the first day of enrollment in the managed care plan or the end of the 90 day period to begin the 12-month period so long as the enrollee is provided at least one opportunity to change their managed care plan without cause within 12 months from the selected date. Importantly, the final rule did not limit the 90-day without cause disenrollment period to one occurrence as originally proposed. Thus, enrollees may request disenrollment from successive plans within the initial 90 days of enrollment. Further, if the state imposes an intermediate sanction after a plan is found to be in violation of federal law, the enrollee may disenroll.[6]

Cause for disenrollment (§ 438.56(d)(2))

There are several reasons that enable an enrollee to request disenrollment at any time. Enrollees may disenroll if they move out of the plan's service area, or a service the enrollee needs is not covered by a plan because of moral or religious objections. Disenrollment is also allowed when an enrollee needs related services to be performed at the same time that are not available through in-network providers and the enrollee's primary care provider determines that receiving the services separately would post an unnecessary risk. Other reasons for disenrollment include poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's needs. MLTSS enrollees may also disenroll if they would have to change their residential, institutional, or employment supports if their provider leaves the network.

TIP The federal rules set the minimum standards for disenrollment. Encourage your state to engage stakeholders in developing a comprehensive list of allowable disenrollment reasons.

Disenrollment following automatic re-enrollment (§§ 438.56(g) and 438.56(c)(2)(iii))

The state plan may allow for automatic re-enrollment following a loss of Medicaid eligibility for 2 months or less. If a state elects this option, the provision must be included in the contract. In addition to the 90-day and 12-month enrollment periods, an enrollee may request disenrollment if they miss their annual disenrollment opportunity because of a temporary loss of Medicaid eligibility and are automatically re-enrolled upon regaining Medicaid eligibility.

Disenrollment procedures (§ 438.54(d)(1))

The enrollee (or his or her representative) must submit a written or oral request, as required by the state. States may also allow managed care entities to process disenrollment requests. However, the MCO, PIHP, PAHP, PCCM, or PCCM entity may not deny disenrollment requests—it must either approve the request or refer it the state.

The state must take action to approve or disapprove disenrollment requests received directly and those referred by the managed care entity. The determination must be made based on the reasons cited in the request; information provided by the managed care entity at the state's request; or any of the disenrollment for cause reasons noted above. The state may require that an enrollee seek redress through the managed care entity's grievance system before making a determination on the enrollee's disenrollment request. If the grievance process results in approval of the disenrollment by the managed care entity, the state is not required to make a determination.

Regardless of which procedures are followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the date of the request. If the managed care plan grievance process is required, it must be completed in time to allow the disenrollment (if approved) to occur no later than the effective date. If either the state or managed care entity fails to make a timely determination on a disenrollment request by the effective date, it is considered approved.

Work with your state to determine how it will monitor the timeliness of disenrollment requests and automatically approve requests that were not determined by the effective date. Encourage your state to implement ongoing processes to analyze disenrollment reasons, which may provide insight into problems with managed care that need attention.

Notice and appeals (§ 438.56(f))

If a state restricts disenrollment, it must provide enrollees with written notice including a thorough explanation of disenrollment rights at least 60 days before the start of each enrollment period. In particular, this applies to the end of the 12-month period. Enrollees who are denied disenrollment must also be granted timely access to a state fair hearing.

Timeline:
Effective
July 5, 2016

Enrollee Rights (§ 438.100)

The rights of enrollees are located throughout the rules and not just in this section. However, this section lists the general rights of an enrollee, including the right to:

- Receive information on the available treatment options and alternatives; and participate in healthcare decisions, including the right to refuse treatment;
- Not have restraint or seclusion used as discipline, retaliation, or a means of coercion;
- Privacy and access to medical records;
- Receive health care services according to the standards set for managed care plans;
- Be treated with dignity;
- Freely exercise individual rights without retaliation by the managed care plan or its networks for doing so; and
- Have managed care plans comply with federal and state laws, including non-discrimination provisions.

There are some limitations to the enrollee rights in this section, such as the right to privacy and access to medical records, which refer to the HIPAA requirements. However, this section incorporates protections from discrimination and emphasizes that enrollees not only drive their healthcare decisions, but that they have the information they need to make such decisions in a way that is appropriate to their condition and ability to understand. Enrollees also have options for resolving issues through the appeals and grievance process, as well as the state fair hearing process. More information on the appeals and grievances will be covered in the fourth explainer in this series.

Conclusion

The choice of plans or providers, as well as enrollment and disenrollment procedures, can be confusing to potential enrollees. The new rules seek to ensure that beneficiaries have ready access to assistance in choosing a plan, and that they clearly understand their choices and the procedures for enrolling or disenrolling. Combined with the comprehensive consumer information requirements discussed in the second brief in this series, the rules regarding choice, the beneficiary support system, enrollment, and disenrollment work together to provide key beneficiary protections and enhance the beneficiary experience.

Separate CHIP Program Provisions

States that have implemented CHIP as a Medicaid expansion program, also known as M-CHIP, must follow the Medicaid rules outlined above. Separate CHIP programs are governed by different rules that may or may not mirror the Medicaid rules.

Choice of Providers § 457.1201(j)

Unlike Medicaid, CHIP allows mandatory, prospective enrollment in managed care without a choice of plans. However, enrollees must be allowed to choose their own network provider, to the extent possible and appropriate, as required in Medicaid under § 438.3(l).

Beneficiary Support System

There is no corresponding requirement for CHIP programs to create a beneficiary support system.

Enrollment Process § 457.1210

CHIP programs must provide informational notices to potential enrollees. It must include the choice of plans or entities, explain how to select a plan or entity, and describe implications of not making an active choice. It must also explain the length of enrollment and applicable disenrollment policies.

If a state uses a default enrollment process to assign enrollees to a managed care plan or entity, such assignments must be to a qualified plan or entity. Similar to the Medicaid provisions, a qualified plan is one that has the capacity to enroll beneficiaries and is not subject to intermediate sanctions at § 438.702(a)(4). Additionally, default assignments must maximize existing provider-beneficiary relationships and equitably distribute beneficiaries among plans without arbitrarily excluding a plan or entity. The state may also consider other criteria in assigning plans similar to the Medicaid requirements at §§438.54(c)(7)(ii) and 438.54(d)(8)(ii). Beneficiaries who are already enrolled in a plan must be given priority over new enrollees if a plan has limited capacity.

The state must also send a confirmation of the enrollee's managed care enrollment within 5 calendar days, which clearly explains the enrollee's right to disenroll within 90 days from the effective date of the enrollment.

Disenrollment § 457.1212

CHIP programs must comply with and ensure, through its contracts, that each managed care entity complies with the disenrollment requirements in Medicaid (§ 438.56). Given that enrollment in managed care in CHIP can be mandated without a choice of plans, enrollees may find themselves without comparable options for disenrollment. Of note, provisions for a fair hearing in Medicaid should be read to refer to the corresponding review process in CHIP under §§ 457.1120 – 1190.

Appendix:
Definitions Applicable to Managed Care Entities

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is –

- A federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
- Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
  - Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
  - Meets the solvency standards of § 438.116.

Prepaid ambulatory health plan (PAHP) means an entity that –

- Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates;
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and,
- Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

- Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
- Does not have a comprehensive risk contract.

Primary care case management (PCCM) is a system whereby the state contracts with a primary care case manager to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries. Primary care case manager means a physician, a physician group practice or, at state option, any of the following: a physician assistant; a nurse practitioner; a certified nurse-midwife.

Appendix (cont'd): Definitions Applicable to Managed Care Entities

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the state –

- Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.
- Development of enrollee care plans.
- Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.
- Provision of payments to FFS providers on behalf of the state.
- Provision of enrollee outreach and education activities.
- Operation of a customer service call center.
- Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.
- Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- Coordination with behavioral health systems/providers.
- Coordination with long-term services and supports systems/providers.

Risk contract means a contract under which the contractor –

- Assumes risk for the cost of the services covered under the contract; and
- Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Nonrisk contract means a contract under which the contractor—

- Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in §447.362 of this chapter; and
- May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Endnotes

[1] The county designations are published annually in the Medicare Advantage Health Services Delivery (HSD) Reference file, which is accessible at the Medicare Advantage Applications page at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/.

[2] For example, a cesarean section and a tubal ligation.

[3] If an individual or entity provides choice counseling on the State's behalf under a memorandum of agreement or contract, it is considered an enrollment broker as defined in § 438.810(a) and must meet the independence and freedom from conflict of interest standards in § 438.810(b)(1) and (2).

[4] Mandatory managed care programs can operate pursuant to a variety of statutory authorities: § 1915(b) waivers, § 1115 demonstrations, or state plan options authorized by § 1932. Mandatory enrollment of exempt groups, which include children with special health care needs or disabilities, children receiving foster care or adoption assistance, American Indians, Native Americans, and dual eligibles, requires approval through a § 1915(b) waiver or § 1115 demonstration authority. Non-exempt groups, including children, parents and other adults, can be mandated to enroll in managed care.

[5] For information on the managed care regulations consumer information provisions, see T. Brooks and S. Somers, "Medicaid/CHIP Managed Care Rules: Improving Consumer Information," Georgetown Center for Children and Families, June 2016.

[6] There are several types of intermediate sanctions are described in § 438.702(a). Only § 438.702(a)(4) applies, which requires the suspension of all new enrollment, including default enrollment, after the date the Secretary or state notices the MCO of a determination or a violation of any requirement under SSA §§ 1903(m) and 1932.

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