Operational Policy Letter #61

Department of Health and Human Services

Health Care Financing Administration

Center for Health Plans and Providers

Medicare Managed Care

November 25, 1997

50/50 ENROLLMENT POLICY

The BBA in section 4002(j) changed the 50/50 enrollment composition requirement in section 1876 of the Social Security Act to: (1) consider only Medicare members for 50% of the enrollment composition, and (2) permit waiver of the 50/50 requirement when it is "in the public interest". These changes are effective immediately, and all 50/50 enrollment composition requirements are eliminated for contract periods beginning on or after January 1, 1999. There is no enrollment composition requirement under the new Medicare+Choice program created by the BBA.

This memorandum describes the overarching policy questions we addressed and our interpretation of the new enrollment composition requirements. The policy in this document considered the following:

Policy Questions

1. **What should be the process and criteria for a waiver of 50/50 requirements?** Since enrollment composition requirements are eliminated in approximately one year, we chose to limit the interim waiver process requirements as much as possible. Our standards for "in the public interest" criteria draw on a number of provisions that have been included in our A-19s in the past and a number of bills that were never enacted.
2. **Should we interpret the new 50/50 composition requirements in such a manner as to allow us to consider Medicaid only HMOs for Medicare contracts under the new formula?** The BBA, as we read it, will allow Medicaid only plans to potentially qualify for Medicare contracts. After analysis and discussion, we decided to allow the "other" 50% of enrollees to be any combination of Medicaid and/or commercial enrollment. This interpretation, besides being the most defendable, has little or no real world effect, since current contractors already meet the 50/50 requirements and no new 1876 applicants will be accepted after June 1, 1998. Under Medicare+Choice, there are no enrollment

composition requirements, thus Medicaid only plans will be able to apply without restriction or waiver requests. We have interpreted, however, that Medicaid only plans must use their Medicaid payment to establish the Medicare ACR.

Clarification and Implementation of New Provisions

After considering these questions, the following describes the BBA's new waiver authority and revised 50/50 enrollment composition rules:

- **Waiver of the 50/50 Requirement:** The new waiver authority allows the Secretary to waive the 50/50 requirement for Medicare risk and cost contracts beginning January 1, 1997, "if the Secretary determines that it is in the public interest."
- **Revision to the existing rule:** The BBA also amended the enrollment composition rule to provide that the 50% limit applies only to Medicare eligible individuals. Prior to this revision, which was effective upon enactment, individuals eligible for Medicaid also counted towards the 50% limit; which, necessitated the remaining enrollees (50% or more) to be commercial members. This enrollment composition revision allows Medicaid managed care organizations to seek Medicare contracts as long as all other applicable requirements are met.

Effective immediately, all 1876 cost and risk plans and new applicants may submit a request for waiver of the 50/50 composition requirement because it is in the public interest to waive the requirements. Plans also continue to be eligible for waivers on the grounds that more than 50% of the population served in the area by the organization is entitled to Medicare or Medicaid, or the organization is owned or operated by a government entity.

- A waiver request based on "public interest" must be requested with documentation that supports one or more of the following criteria:
    A. The organization serves a medically underserved rural or urban area, or
    B. the organization (or parent company) demonstrates a long-term business and community service commitment to the geographic area, or
    C. the organization believes that a waiver is necessary to promote managed care choices in an area with limited or no managed care choices.
- Also, documentation must demonstrate a history of adherence to quality and/or performance standards such as:
    A. a Medicare or Medicaid contract in the waiver area of at least three years, or the organization (or parent company that controls the organization) has entered into Medicare contracts for at least three years in other geographic areas, and
    B. documentation that the organization is in good standing, and has complied with all applicable contract requirements for quality and performance standards, e.g. PRO review and HEDIS requirements, or

C. if the organization is a new applicant, the organization must agree to comply with any additional monitoring requirements that may be established by the Secretary.

- HCFA will inform plans of the waiver determination.

Also, all minimum enrollment standards, i.e., a minimum of 5,000 enrollees in nonrural HMOs and 1,500 enrollees in rural HMOs, still apply as appropriate. These standards may be found in 42 CFR 417.413 for 1876 plans and §1857(b) for Medicare+Choice plans. In the case of a Medicaid only managed care plan, Medicaid payment will serve as the basis for the initial community rate for purposes of developing Medicare benefits and beneficiary premiums (see 42 CFR 417.594).

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