State Medicaid Manual
Part 2 - State Organization and General Administration

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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NEW/REVISED MATERIAL--EFFECTIVE DATE: February 17, 2000

Section 2087.9, Compliance With and Disclosure of Information on Physician Incentive Plan (PIP) Regulations, Adds a new section to implement the requirements in §1903(m)(2)(A)(x) and §1903(m)(5)(A)(v), as enacted by the Omnibus Budget Reconciliation Act of 1990, for Physician Incentive Plans in Prepaid Health Care Organizations.

The information which must be disclosed in the transactions listed in subsection B between an HMO and a party in interest includes:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

You may require that the information on business transactions be accompanied by a consolidated financial statement for the HMO and the party in interest.

Your contracts with HMOs must contain a provision requiring the reporting of this information to you. If the contract is being renewed or extended, the HMO must disclose information on business transactions which occurred during the prior contract period. If the contract is an initial contract with Medicaid, but the HMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the HMO's business transactions must be reported.

2087.7 Audit and Inspection Rights.--The contract must give you and HCFA certain audit rights. Include in all contracts provisions which allow you and HCFA access to any books, documents, papers, and records of the contractor which are directly pertinent to that specific contract, for the purpose of making an audit, examination, excerpts, and transcriptions. This includes audit and inspection authority for a State authority and HCFA of any books and records of the HMO (and of any subcontractor) that pertain (1) to the ability of the entity to bear the risk of financial losses or (2) to services performed or determinations of amounts payable under the contract. (See §1903(m)(2)(A)(iv) of the Act.)

2087.8 Encounter Data.--HMOs must maintain sufficient patient encounter data to identify the physician who delivers services to Medicaid patients. (See §1903(m)(2)(A)(ii) of the Act.) You must include a provision to this effect in contracts established after the systems for unique physician identifiers (see §1902(x) of the Act) are in place.

2087.9 Compliance With and Disclosure of Information on Physician Incentive Plan (PIP) Regulations.--Section 4731 of the Omnibus Budget Reconciliation Act of 1990 amended §§1903(m)(2)(A) and 1903(m)(5)(A) of the Social Security Act (the Act) to set forth requirements for Federal financial participation (FFP) in expenditures for contracts with a prepaid health care organization that operates a physician incentive plan, and to specify sanctions and civil money penalties for noncompliance with such requirements. Under implementing regulations at 42 CFR 434.70(a), FFP is only available for payments to Medicaid managed care organizations (MCOs) that are in compliance with the physician incentive plan (PIP) requirements included under 42 CFR 422.208 and 422.210. For the purpose of this section, use of the term MCO includes health maintenance organizations, health insuring organizations (as defined in 42 CFR 434.2), and all other organizations referenced in the definition of a Medicaid managed care organization in §1903(m)(1)(A) of the Act. 42 CFR 422.208(c) permits MCOs to operate PIPs only if: 1) no specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee; and 2) the disclosure, computation of substantial financial risk, stop-loss protection, and enrollee survey requirements of this section are met. The PIP regulation applies to all MCOs, including health insuring organizations (HIOs) subject to §1903(m) of the Act, and any of their subcontracting arrangements that utilize a PIP in their payment arrangements with individual physicians or physician groups

A. Definitions.--

Bonus - A payment that a physician or entity receives beyond any salary, fee-for-service payment, capitation, or returned withhold. Quality bonuses and other compensation that are not based on referral levels (such as bonuses based solely on care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk.

Capitation - A set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Intermediate Entity - An entity that contracts with an MCO and, in turn, subcontracts with physicians and at least one physician group for the provision of services. An individual practice association (IPA) is considered an intermediate entity only if it contracts with one or more physician groups.

Payments - The amount an MCO pays physicians or physician groups for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of this subpart.

Physician Group - A partnership, association, corporation, or other group that distributes income from the practice among members or contracts only with individual physicians. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Physician Incentive Plan - Any compensation arrangement between an MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid recipients enrolled in the MCO.

Pooling - Calculation of a panel size through aggregating any combination of commercial, Medicare or Medicaid patients.

Referral Services - Any speciality, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish.

Risk Threshold - The maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. The risk threshold is 25%.

Stop-Loss Protection - Stop-loss protection is coverage designed to limit the amount of financial loss experienced by a health care provider. PIP regulations require that physicians and physician groups be protected from risk beyond the stop-loss threshold. This can be done in one of two ways:

1) the MCO can retain the risk beyond the stop-loss threshold in its direct provider contracts; or 2) an MCO, intermediate entity, physician or physician group can reinsure the risk over the stop-loss threshold through a reinsurance carrier. Stop-loss must cover at least 90% of the costs over the stop-loss threshold, on either a per member per year or an aggregate basis. The per member per year threshold varies based on panel size.

Substantial Financial Risk - An incentive arrangement based on referral services that place the physician or physician group at risk for amounts beyond the risk threshold. The risk threshold is 25%.

Withhold - A percentage of payments or set dollar amount that an organization deducts from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician or physician group, depending on the specific predetermined factors.

B. State Contracts with MCOs.--All MCO contracts must contain the requirements for PIP disclosure at 42 CFR 422.210. The contract should contain provisions specifying that:

o The MCO may operate a PIP only if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

o The MCO must provide the information on its physician incentive plans to any Medicaid client, upon request, as specified in subsection C. State enrollment materials or MCO handbooks must annually disclose to enrollees their right to adequate and timely information related to physician incentives.

o The MCO must disclose information specified in the PIP regulations to you (and to HCFA upon request). The disclosure must contain the information listed in subsection C in sufficient detail to enable you to determine whether the incentive plan complies with the PIP requirements.

o MCOs that have physician incentive plans placing a physician or physician group at substantial financial risk for the cost of services the physician or physician group does not furnish, must assure that the physician or physician group has adequate stop-loss protection.

o MCOs that have physician incentive plans placing a physician or physician group at substantial financial risk for the cost of services the physician or physician group does not furnish, must conduct surveys of enrollees and disenrollees. You may, at your option, conduct these surveys on behalf of MCOs.

C. Information to be Disclosed.--

1. To the State Agency by the Plans.--Each MCO must provide you with information concerning its physician incentive plans as required or requested. The disclosure must contain the following information in sufficient detail to enable you to determine whether the incentive plans comply with the requirements specified in this section. Disclosure must be provided for all MCO contracts that include physician services (i.e., MCO makes the payments under the contract), all intermediate entity contracts that include physician services (i.e., intermediate entity makes the payments), and for physician group contracts (i.e., physician group makes the payments) where the physician group is at substantial financial risk. You may require MCOs to submit the information using the Office of Management and Budget (OMB) approved disclosure forms, or using forms developed by you that contain all required disclosure elements. The required disclosure elements are:

o Whether referral services (i.e., those services not provided directly by the party being paid under the contract) are included in an incentive plan. (Note: If the incentive plan only covers services furnished by the physician or physician group, disclosure of other aspects of the plan need not be made.)

o The type of incentive arrangement; for example, withhold, bonus, capitation.

o A determination of the percent of payment under the contract that is based on the use of referral services. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus would be included. If the calculated amount is 25% or less, disclosure of the remaining elements in this list is not required, as there is not substantial financial risk.

o Panel size, and if patients are pooled, pooling method used to determine if substantial financial risk exists. (See subsection D.)

o Where stop-loss requirements apply, assurance that the physician or physician group has adequate stop-loss protection, including the type of coverage (e.g., per member per year, aggregate), the threshold amounts, and any coinsurance required for amounts over the threshold.

o Where enrollee/disenrollee survey requirements apply, the survey results.

You must obtain MCO disclosure of the first five required physician incentive disclosure items listed above **prior** to approval of the initial contract. In addition, you must obtain disclosure information upon contract renewal date or annual anniversary date, or upon request by you or HCFA. (See 42 CFR 434.70(a) and 422.210.) The sixth PIP disclosure item, the survey results, are due 3 months after the end of the contract year or upon request by HCFA.

If the contract with the MCO is an initial contract with Medicaid, but the MCO has operated previously in the commercial or Medicare markets, information on physician incentive plans for the year preceding the initial contract period must be disclosed. If the contract is an initial contract with Medicaid, but the MCO has not operated previously in the commercial or Medicare markets, the MCO should provide assurance that the provider agreements that they sign will meet HCFA and State requirements (i.e., there is no PIP; there is a PIP but no SFR; there is a PIP and SFR so stop-loss and survey requirements will be met). For contracts being renewed or extended, the MCO must provide PIP disclosure information for the prior contracting period's contracts.

Note that when MCOs are updating PIP disclosures annually, they must disclose to you whether PIP arrangements have changed from the previous year. Where arrangements have not changed, a written assurance that there has not been a change is sufficient. This also applies when MCOs analyze the PIP arrangements in their direct and downstream contracts to determine which disclosure items are due from their contractors. MCOs are expected to maintain the current written assurances and the prior periods' documentation so that the materials are available during on-site reviews.

2. To HCFA by the State Agency.--An attestation of the receipt of the required disclosure items must be submitted when an initial or renewed contract is submitted to HCFA for approval or by the end of the quarter during which the anniversary date of a multi-year contract occurred. The attestation can be provided with submission of copies of the information received by you from the MCOs, or on a form of your own design containing the appropriate information and agreed to by the regional office (RO).

3. To Medicaid Recipients by the MCO--An MCO must provide the following information to any Medicaid enrollee or potential enrollee who requests it:

o Whether the MCO uses a physician incentive plan that affects the use of referral services;

o The type of incentive arrangement;

- Whether stop-loss protection is provided; and

- If the MCO was required to conduct a survey, summary of the survey results.

D. Pooling of Enrollees.--

1. General.--The physician incentive regulations require stop-loss protection at specific levels when physicians have substantial financial risk for referrals. Under certain circumstances, the regulations allow the pooling of enrollees for purposes of meeting the stop-loss requirements. The regulations provide for two types of pooling: 1) pooling across coverage groups; and 2) pooling across coverage groups and MCOs .

In order to pool enrollees, the following conditions must exist:

- It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group;

- The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled;

- The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled;

- The distribution of payments to physicians from the risk pool is not calculated separately by patient category; and

- The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

MCOs should use their best judgement in determining whether arrangements are considered comparable.

2. Pooling Across Coverage Groups.--Medicaid members may be pooled with Medicare and commercial members to calculate the panel size if: 1) the risk arrangements are comparable; and 2) incentive payments are not calculated separately for the enrollees pooled.

For example, a large physician group contracts with an MCO for Medicare, Medicaid, and commercial lines of business. The contracts for all lines of business pay primary care capitation plus 50% of any surplus left in one specialty professional and institutional risk pool. Since there are not separate risk pools for each line of business, these enrollees may be pooled to determine the panel size for the required stop-loss thresholds. The critical factors are comparable risk terms, and lack of a separately calculated settlement or bonus for the groups being pooled.

3. Pooling Across Coverage Groups and MCOs --The second type of pooling permitted by the regulations applies to intermediate entities and large provider groups only. Intermediate entities and physician groups may pool members enrolled with more than one MCO if: 1) comparable risk is spread across all members pooled; and 2) incentive, settlement or bonus payments are not made separately for the enrollees pooled. In essence, in order to pool enrollees, the risk must be spread across the enrollees pooled. This means that a deficit for the cost for providing services to one group of enrollees is covered by a surplus from the cost of providing services to another group of enrollees. These requirements effectively limit the circumstances under which this type of pooling may be done to intermediate entities or large provider groups receiving either full capitation, or partial capitation with no risk pools held by the MCO, from several MCOs for comparable services. If one or more MCOs holds a risk pool, the settlement or bonus from the risk pool is, by definition, calculated separately, so this type of pooling cannot be done.

An example of this type of pooling would be a large clinic system (called an "intermediate entity" in the PIP rules) that is fully capitated from three MCOs to provide Medicaid services and, perhaps for other lines of business as well. This clinic system then pays primary care capitation to four different clinics, and holds one professional specialty risk pool and one institutional risk pool for all four clinics. At the end of the contract year any risk pool surpluses are distributed proportionately to the clinics based on the number of member-months for each clinic. In this example, the risk is truly spread across all the enrollees served by this clinic system, so the panel size for the stop-loss threshold requirements is the total number of enrollees. If the risk pools were kept separately for each clinic, then each clinic's enrollees would determine the stop-loss threshold for that clinic because the settlement or bonus for each clinic is calculated separately.

E. Calculation of Substantial Financial Risk (SFR).--Substantial financial risk exists when more than 25% of the payment for physician services under a contract depends on the use of referral services, and the panel size is not more than 25,000 enrollees. There are several ways this can happen, but some common examples include:

o Capitation that includes specialty professional and/or institutional services, and more than 25% of the capitation payment is for services not provided directly by the person or entity being paid under the contract.

o Capitation or fee-for-service payment with additional funds held in one or more risk pools for specialty professional and/or institutional services from which a bonus or settlement is made if there is surplus at the end of the contract period. There may or may not also be a requirement for the contractor to cover any risk pool deficits.

o Capitation for all professional services, with more than 25% of the capitation payment withheld to fund a specialty professional risk pool, the balance (if any) of which is returned at the end of the contract period.

Stop loss and survey requirements (see subsection F) apply to both physicians and physician groups that have SFR for referrals. When a physician group is at SFR, it is necessary to determine if the individual physicians in the group are also at SFR. If so, stop-loss requirements would apply to the individual physicians, and could be different than those for the group.

Federal regulations require that MCOs calculate the percent of potential payment based on the use of referral services. Potential payment means the maximum amount theoretically possible to be paid under the terms of the contract or arrangement, not just what is likely to be paid. The following are examples of how SFR would be calculated:

1. The MCO pays a large physician group capitation for all services covered under the state contract with the MCO (full capitation). The capitation payment includes $25 per member per month (PMPM) for primary and specialty care, $40 PMPM for institutional care, and $20 PMPM for all other services.

SFR calculation for physician group payment:

$85 PMPM Maximum potential payment ($25+40+20)
- 25 PMPM Services provided directly by group
$60 PMPM Amount at risk for referrals

Risk Level: 70% (60/85) of maximum potential payments are at risk for referrals
If panel size is < 25,000, physician group is at SFR for referrals and must comply with stop-loss and survey requirements.

SFR for the individual physicians in the group must also be determined, since the physician group is at SFR.

Downstream PIP arrangements:

This physician group pays its physicians a salary. Physicians are not eligible for a year end bonus. If the group has any surplus funds at the end of the year, they are applied to a capital reserve fund.

SFR calculation for individual physicians:
Risk Level: 0%
Downstream physician is not at SFR for referrals.

2. The MCO pays a physician group capitation for direct services only at $20 PMPM. The MCO also holds another $60 PMPM in a risk pool used to make fee-for-service payments for specialty physician services not provided by the group, institutional services, and pharmacy. If the risk pool has a deficit at the end of the year, the MCO covers the deficit. If the risk pool has a surplus, the MCO pays 50% of the risk pool surplus to the physician group.

SFR calculation for physician group payment:

$50 PMPM maximum potential payment ($20 PMPM + ($60/2))
- 20 PMPM minimum potential payment
$30 PMPM amount at risk for referrals

$30 PMPM amount at risk for referrals
$50 PMPM maximum potential payment

Risk Level: 60% of maximum potential payment at risk for referrals
SFR for referrals.

Downstream PIP arrangements - Physician Group to Physician:

The physician group pays each of its physicians an annual salary. In addition, if the physician group receives a year-end payment from a surplus in the risk pool (i.e., a bonus), it is distributed to physicians based on each physician's share of the annual total member-months of enrollment.

SFR calculation for physician payment:

$100,000 annual salary
+ 108,000 ($30 PMPM X 3,600 member months)
$208,000 maximum potential payment

$108,000 amount at risk for referrals
$208,000 maximum potential payment

Risk Level: 52% of maximum potential payment at risk for referrals

Substantial Financial Risk. These physicians are each at substantial financial risk for referrals.

F. MCO Requirements if a Physician/Group is at SFR -- If an MCO places a physician/group at substantial financial risk, the MCO is required to:

o Assure that the physicians/groups have adequate stop-loss protection as required by 42 CFR 422.208(f); and

o Conduct enrollee surveys as required by 42 CFR 422.208(h).

An MCO that contracts with an intermediate entity (e.g., an individual practice association or physician hospital organization) and which bases compensation to its contracting physicians or physician groups on the use or cost of referral services furnished to Medicaid recipients must also disclose the information listed in subsection C and meet the requirements listed in this subsection.

1. Stop-Loss Protection.-- PIP regulations require that physicians and physician groups be protected from risk beyond the stop-loss threshold on either a per member per year basis or an aggregated basis with one threshold for the total costs of all enrollees (42 CFR 422.208(f)(2)). This can be done in one of two ways: 1) the MCO can retain the risk beyond the stop-loss threshold in its direct provider contracts; or 2) an MCO, intermediate entity or physician/group can reinsure the risk over the stop-loss threshold through a reinsurance carrier. Stop-loss protection must cover at least 90% of the costs over the stop-loss threshold (called a deductible), on either a per member per year or an aggregate basis.

a. Per Member Per Year Stop-Loss Protection.--To determine whether stop-loss requirements apply to a physician or physician group, the panel size must first be determined. In determining patient panel size, patients may be pooled using one of the methods below.

o For an intermediate entity, a physician or physician group: Pooling any combination of commercial, Medicare, or Medicaid patients enrolled in a specific MCO.

o For an intermediate entity or physician group that contracts with more than one MCO: Pooling together of patients enrolled with all MCOs.

Stop-loss thresholds can be either separate for professional and institutional services, or combined for all services. The requirement thresholds depend on the panel size as follows:

Panel Size	Combined Deductible	Separate Deductibles	
		Institutional	Professional
1- 1,000	$ 6,000	$ 10,000	$ 3,000
1,001- 5,000	30,000	40,000	10,000
5,001- 8,000	40,000	60,000	15,000
8,001-10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
>25,000	N/A	N/A	N/A

In determining the appropriate panel size to use for determining the stop-loss requirements that apply to an individual physician who is at SFR and is part of a physician group, it is important to understand how the physician's risk is spread. A physician can be at SFR, but have the risk spread across all patients in the group. For example, a payment made to an individual physician from a group's referral risk pool may be based on the physician's proportion of enrollment. When this is true, the individual physician's risk is pooled, and the correct panel size for applying stop-loss protection requirements is the group's panel size. When the individual physician's risk is spread across all group enrollees, the group's stop-loss protection also protects individual physicians.

Intermediate entities are not subject to stop-loss requirements. However, if physician/groups are placed at SFR by the intermediate entity (IPA,PHO, etc.), then the physician/group is required to have stop-loss protection. The stop-loss protection might be provided at the intermediate level, i.e., the level at which risk is spread. Pooling is permitted by physician groups under intermediate entities if all five pooling criteria listed above are met.

Example of per member per year stop-loss protection for a physician/group at SFR:

Panel size of group, after pooling its commercial and Medicaid members of "XYZ" MCO, has 5,000 members. Physician group has purchased stop-loss reinsurance which has a single, combined deductible of $30,000 and covers 90% of the costs over $30,000.

XYZ Member, a Medicaid patient of the group, received referral services which total $45,000 for the contract year. The reinsurance payment the group can claim for this patient is computed as follows:

Cost of referral services for patient = $45,000
Less limit for panel size of 5,000 mbrs - 30,000
Excess referral costs = $15,000

Stop-loss insurance covers 90% of $15,000, or $13,500

b. Aggregate Stop-Loss Protection.--If aggregate stop-loss is provided, it must cover at least 90% of the costs of referral amounts that exceed 25% of potential payments.

Example of aggregate stop-loss protection for a physician/group that is fully capitated for all services:

Yearly estimated capitation payments = $360,000

SFR threshold is 25% of $360,000, or $90,000
Stop-loss protection must cover 90% of amounts over $90,000

Example of a physician/group that is capitated for direct services only, and receives 50% of any surplus remaining in a referral service risk pool at the end of the year:

Yearly estimated capitated payments = $100,000
Referral risk pool amount set aside by MCO is $350,000
Maximum potential payment from referral risk pool is $175,000
Maximum potential payment is $100,000 plus $175,000 ($275,000)
SFR threshold is 25% of maximum potential payments, or $68,750
Stop-loss protection must cover 90% of amounts over $68,750

2. Recipient Survey.-- 42 CFR 422.208(h) requires organizations operating incentive plans placing physicians or physician groups at SFR to conduct annual surveys of enrollees. The surveys can alternatively be done at the State level. Surveys must include: 1) all current Medicaid enrollees in the organization and those that have disenrolled for reasons other than loss of eligibility; relocation; failure to pay premiums or other charges; abusive behavior; or retroactive disenrollment; or 2) a valid statistical sample of current Medicaid enrollees and disenrollees.

According to 42 CFR 422.208(h)(4), enrollee surveys must be conducted no later than 1 year after the effective date of the contract and at least **annually** thereafter as long as physicians or physician groups are placed at SFR for referral services. The survey must address enrollees/disenrollees

satisfaction with the quality of services, and their degree of access to the services. Medicare contracting MCOs will meet the survey requirement via a HCFA sponsored survey conducted by the Agency for Health Care Policy and Research through their Consumer Assessments of Health Plans Study (CAHPS) process. You have the authority to utilize the Medicaid version of CAHPS to meet the survey requirement. MCOs, upon completion of an approved survey tool, will be expected to compile, analyze, and summarize survey data within a reasonable period of time (generally within 3 months) and submit the results to you. (See subsection C.)

NOTE: If disenrollment information is obtained from all recipients at the time of disenrollment, or if a survey instrument is administered to a sample of disenrollees, your current method will meet the disenrollee survey requirements for the contract year.

G. State Agency Monitoring Section.--Federal regulations at 42 CFR 434.70 stipulate that an MCO which contracts with you must comply with the PIP related regulatory requirements. If the MCO subcontracts for the provision of services to Medicaid beneficiaries, the PIP requirements related to subcontracts must also be met. You are required to assure such compliance by the MCO and subcontractors. Suggested methods for assuring compliance include annual review of PIP terms disclosed by MCOs, contract review and on-site review of documentation.

H. Provision of Annual Written Report Summarizing PIP Findings.--After you receive the required PIP information from the MCOs, you must submit a report to HCFA. You may choose the format in which the report is organized and designed (e.g., written format, table format). However, in order to facilitate timely review by the HCFA RO, at a minimum, the following categories of information/ issues should be addressed in the report.

o Are you receiving disclosure materials from MCOs on a schedule that allows for review and timely submission to HCFA for approval of contracts?

o When Physicians are at SFR, do you:

- Ensure that MCOs include a description of PIP and the right to access this information in its beneficiary notices?

- Ensure that MCOs (or you, at your discretion) track disenrollment, including voluntary disenrollment?

- Ensure that annual satisfaction surveys of enrollees (CAHPS or other) are conducted?

- Ensure that annual satisfaction surveys of voluntary disenrollees (OIG or other) are conducted?

- Require proof of adequate stop-loss protection?

In addition to the above information, you should submit a summary of the disclosure information. Summary information should, at a minimum, include: 1) a listing of contracted plans; 2) the number of MCO contracts and the number of related subcontracts for each MCO that have an arrangement putting physicians at SFR; 3) the plans from which surveys will be required; 4) any compliance issues that have been encountered by you on the part of the plans (listed by plan); and 5) the corrective action plan or expected resolution for each compliance issue listed under 4.

I. Sanctions.--42 CFR 434.70(b) provides that HCFA may withhold FFP for any period during which: 1) you fail to meet State plan requirements pertaining to PIP regulations, 2) either party to a contract substantially fails to carry out the terms of the contract, or 3) you fail to obtain from each MCO contractor proof that it meets the PIP requirements set forth at 422.208.

42 CFR 434.67(a)(5) states that intermediate sanctions (42 CFR 434.67(e), denial of payment) may be imposed on an MCO with a risk comprehensive contract which fails to comply with any of the requirements of 42 CFR 422.208, or fails to submit to you its physician incentive plans as required or requested in 42 CFR 434.70.

42 CFR 434.67(b)(1) requires that you notify HCFA when you determine that an MCO with a risk comprehensive contract has committed a violation of the PIP requirements. Unless HCFA reverses or modifies your determination within fifteen (15) days of receipt, it becomes HCFA's determination as outlined in §1903(m)(5)(A) of the Act. Upon HCFA's final agreement with you, you must send written notice to the affected MCO with a copy to the Office of the Inspector General stating the nature and basis of the proposed sanction. You must allow the MCO fifteen (15) days from the date the MCO receives the notice to rebut the findings. The MCO may be allowed a fifteen (15) day extension upon HCFA's receipt of a credible explanation of its necessity prior to the end of the original fifteen (15) days notice. An extension is not granted if HCFA determines that the organization's conduct poses a threat to enrollees' health and safety.

You must conduct an informal reconsideration, if the MCO submits a timely response to the agency's notice of sanction. The evidence provided by the MCO must be reviewed by an agency official who did not participate in the initial sanction recommendation. A concise written decision must be composed which sets forth the factual and legal basis for this decision. Your decision is then forwarded to HCFA and becomes HCFA's decision unless a determination is made within fifteen (15) days to reverse or modify the reconsidered decision. If HCFA modifies or reverses the agency's decision, the agency sends the MCO a copy of HCFA's decision.

Generally, a sanction is effective fifteen (15) days after the date the MCO is notified of the decision to impose the sanction. If an MCO seeks reconsideration, the reconsideration is effective on the date specified in HCFA's reconsideration notice. If HCFA and the agency determine the MCO's conduct a threat to enrollees' health and safety, the sanction may be made effective on a date prior to issuance of the decision.

In accordance with 42 CFR 1003.103(f)(1)(vi), the OIG may impose a civil money penalty of up to $25,000 for each determination by HCFA that a contracting organization has failed to comply with 42 CFR 422.208 and 434.70. Civil money penalties may be imposed on the organization in addition to, or in place of the imposed sanctions.

2088. ENROLLEES AND BENEFITS

2088.1 Potential Enrollees.--The contract must identify the types of Medicaid recipients whom the HMO can enroll. The HMO must agree to enroll these persons in the order in which they apply. The contract may stipulate a maximum number of Medicaid recipients who may be enrolled at any one time and that the HMO must enroll less than 75% Medicare and Medicaid enrollees. (See §§2086.8 through 2086.14.)

2088.2 Limiting Enrollment to Eligibility Categories.--The HMO may limit enrollment to a single eligibility category or combination of categories such as AFDC or SSI recipients, optional categorically needy or medically needy recipients. Or, the HMO may be required to enroll all categories of eligibles.

2088.3 HMOs for Specific Health Needs.--As set forth in §2090.4, HMOs are prohibited from restricting enrollment (and from disenrolling) based upon the expectation that an applicant or enrollee will require frequent or high cost care. The HMO may target enrollment to subcategories such as pregnant women, the mentally ill or AIDS patients. Targeting specific groups is permissible as long it does not have the effect of screening out higher risk Medicaid recipients who might be expected to utilize health care services at a higher than average level or who appear likely to require more expensive health care services. HMOs designed to serve the needs of the previously cited subcategories actually target populations expected to utilize health care services at a higher than average level. Some states have rate structures for clients with special needs. If you anticipate developing an HMO of this type in your State, contact HCFA for assistance.

2088.4 Services Which HMO Provides.--The contract must specify the amount, duration and scope of the medical services which the HMO provides. Any service normally available under Medicaid not covered by the HMO must be available to the recipient under FFS.

Substantive changes may occur under FFS during a contract year. Address provisions for such changes in an HMO contract which defines benefits that must be offered in terms of the services provided. For instance, if the HMO is to offer all drugs included in the Medicaid formulary and an expensive new drug is added to the formulary, this may be handled several ways. The contract may be written to require the HMO to (1) absorb the cost of additional services, (2) provide additional service with an adjustment to its capitation rate, or (3) provide the additional services and receive an FFS payment rate.

The HMO may provide services in addition to those available in the State Plan. You and the HMO decide what, if any, additional services are offered. As long as your payments to the HMO for providing Medicaid covered services do not exceed the cost you would incur in providing those services (see §2089.3), you are entitled to FFP in the full amount of such payment even if the HMO is required under its contract to provide additional services for no additional payment. In other words, if the additional service is part of the total package of benefits, and the total HMO payment is under the FFS-UPL for the Medicaid covered services, it is permissible. (See 42 CFR 434.6(a)(4) and 447.361.)

2088.5 Freedom of Choice for Family Planning Services.--Sections 1902(a)(23)(B) and 1905(a)(4)(C) of the Act and 42 CFR 431.51(b) require that a person's enrollment in an HMO does not restrict the choice of the provider from whom the person may receive family planning services and supplies. You must cover family planning supplies and services provided by any qualified provider, even though the individual is enrolled in an HMO and the provider does not contract with the HMO. This means that the recipient may obtain family planning services and supplies from outside of the HMO without an HMO referral, even if the HMO contracts with Medicaid to provide the same services. For the family planning services and supplies provided outside the HMO, you have three options. You may hold the HMO responsible for covering such services by making FFS payments to non-plan providers. You may cover out-of-plan services while the HMO covers in-plan services. Or, you may cover all family planning services directly on a FFS basis. In all three cases, adjust the HMO's capitation payments accordingly.

Through a revision created by OBRA 1987, States are allowed to guarantee up to six months of eligibility in certain HMOs. If the HMO contracts to provide family planning services and supplies, the guaranteed eligibility provision allows the HMO enrollee to continue to receive family planning services and supplies from providers outside the HMO.