

The managed care contracts between the state Medicaid agency and managed care organizations have become a new and significant legal document. In business law, the period during which the parties review a contract and investigate characteristics of the other party is known as "due diligence." Advocates need to exercise due diligence on behalf of their clients as managed care contracts are being drafted, negotiated, and renegotiated.

The first step is to obtain a copy of the draft model contract or request for proposal. The state Medicaid agency should make this available to you upon request. Although not yet common, some states are posting these documents on their home pages on the World Wide Web, which you can access through: [http://www.state.__\(insert two letter state abbreviation\).us](http://www.state.__(insert two letter state abbreviation).us).

Skim the contract for a sense of what it covers. Then compare the specific provisions in the document against the Advocacy Checklist, which includes questions that Protection & Advocacy programs should ask when reviewing Medicaid contracts. In answering these questions, you should look for a "yes" answer. You can prepare written comments and suggestions to the state Medicaid agency based on the answers to the checklist. If at all possible meet in person with key personnel regarding your comments and suggestions. These key personnel include not only state Medicaid administrators, but depending on the services and populations affected by the contract, can include maternal and child health and mental health/substance abuse personnel as well.

The following are provisions that advocates should look for when they review Medicaid managed care contracts. In answering these questions, advocates should look for a "yes" answer.

Threshold Issues

1. Does the implementation schedule allow adequate time for consumers and advocates to review, investigate, and comment on the draft contract? _____

2. Are the RFP and/or draft contract readily available for consumers and advocates?

3. Does the implementation schedule allow adequate time for the MCOs that are awarded contracts to implement the contract provisions? _____

4. Does the implementation schedule allow adequate time for the provisions of the health benefits/enrollment manager contract to be implemented? _____

5. Are consumers involved in "readiness" reviews of MCOs? _____

6. Are the provisions of the contract mandatory for all subcontracts? _____

Marketing

7. Does the contract prohibit direct (e.g. door-to-door) marketing? _____

8. Is the MCO prohibited from offering financial incentives to induce members to enroll?

9. Is the MCO prohibited from engaging in misleading or confusing marketing practices?

10. Is the MCO prohibited from discriminating against individuals based on disability or need for health care services in their marketing? _____

11. Does the contract describe clear sanctions for violations of marketing guidelines?

Education, Enrollment, and Disenrollment

12. Does the contract describe the MCO's responsibility and the state's responsibility for education and outreach? _____

13. Does the contract provide that the state Medicaid agency (or an independent enrollment manager or broker) will be responsible for enrollment and/or automatic assignment and prohibit discrimination based on health status or actual or perceived need for services? _____

14. Is the MCO required to supply members with an enrollee handbook that contains descriptions of available providers and member rights and responsibilities? _____

15. Is the state required to review and authorize written materials distributed by the MCO and to monitor educational activities undertaken by the MCO? _____

16. Is the MCO required to provide member material orally and in writing, at a reading level set by the state, and in the recipient's primary language and in alternative formats, including (teletypewriter) TTY and telecommunication devices, braille, large print, and cassette?

17. Does the contract describe how members who do not select an MCO will be assigned to one? Does the process maintain existing relationships, to the extent possible, and take into consideration geographic access and the ability of the MCO to meet language, cultural, and health care needs? (See question 100). Does the process favor MCOs that provide high quality care? _____

18. Does the contract provide that the state Medicaid agency will be responsible for disenrollment and prohibit disenrollment by the MCO based on a missed appointment or copayment or an adverse change in health status, diagnosis or perceived diagnosis, expected or actual treatment costs, or the enrollee's attempt to exercise his/her rights under a grievance or complaint system? _____

Selection of Primary Care Provider (PCP)

19. Does each family member have the option to choose her or his own PCP from among the MCO's participating providers? _____

20. Does the MCO allow members with disabilities, chronic conditions or complex conditions to choose a specialist as their PCP? Are members informed that they may select a specialist as their PCP? If the MCO network does not include the appropriate specialist, may the member receive care from an out-of-network provider? _____

21. Does the contract ensure that children and adolescent are able to see a pediatrician or adolescent medicine specialist as their PCP? _____

22. Does the contract specify time frames for the recipient to select a PCP? Are members with disabilities given extra time to select a PCP? _____

23. Is the MCO required to inform members of the time frames and the consequences for failing to act within that time? _____

24. Will each member be provided with a list of all participating providers, including specialists, who can be selected as PCPs? _____

25. Does the contract describe how the MCO will assign PCPs to members who do not choose one? _____

26. Are enrollees permitted to change their PCP with cause at any time? _____

27. Does the contract describe how the MCO will ensure continuity of care if the member's PCP leaves the MCO's network? _____

28. Are pregnant women allowed to receive primary care from their current provider, regardless of whether their current provider is in the MCO's network, until 60 days postpartum?

29. Are there provisions allowing people with disabilities to maintain their current providers for a period of time to ease the transition process? _____

Initial Assessments and Ongoing Care

30. Is the MCO required to honor ongoing plans of care initiated prior to enrollment until the enrollee is evaluated by her or his PCP and a new plan of care is established? Is the PCP required to consult with the appropriate specialists in making these treatment plan evaluations? And if care is reduced or terminated under the new plan of care, does the contract provide for the member to receive a due process notice, including rights to continued benefits? _____

31. Is the MCO required to provide a face-to-face initial health assessment for all new members within the first sixty (60) days of enrollment? _____

32. For members known or appearing to be pregnant, is the MCO required to provide a face-to-face initial health assessment within fifteen (15) days of enrollment? _____

Specialists

33. Does the MCO allow members with disabilities, chronic conditions, or complex conditions to select a specialist as their PCP? _____

34. Does the contract provide for "standing referrals" to specialists (instead of requiring prior authorization for each visit) for individuals with ongoing treatment needs? _____

35. Is the MCO required to provide access to specialists with pediatric/adolescent expertise for every child or adolescent who needs and requests specialty care? _____

36. If the MCO cannot provide a choice of at least two (2) specialists or sub-specialists, including pediatric sub-specialists, qualified to meet the particular needs of the individual, is the MCO required to pay for the service out-of-network if the member requests a non-participating specialist? _____

Essential Community Providers and Coordination with Agencies

37. Is the MCO required to sub-contract with:

School-based health clinics? _____

Federally qualified health clinics? _____

Rural health clinics? _____

Traditional mental health care providers? _____

Title X providers? _____

Local health departments? _____

Homeless clinics? _____

Teen clinics? _____

Migrant health clinics? _____

Adult and children's tertiary care facilities? _____

Presumptive eligibility providers? _____

38. Is the MCO required to contract or develop coordination and referral agreements with:

Women, Infant and Children (WIC) nutrition programs? _____

Early intervention programs? _____

Child welfare programs? _____

State mental health agencies? _____

State substance abuse agencies? _____

Special education programs? _____

Teen pregnancy and parenting programs? _____

Access and Availability Standards

39. Does the contract require the MCO to guarantee 24-hour, seven-day-per-week access to qualified providers? _____

40. Does the contract specify maximum patient-to-full time equivalent (FTE) primary care physician ratio that takes into account the physician's participation in several MCOs and the physician's commercial patients? _____

41. Is the MCO required to make available a pediatrician/adolescent medicine specialist who meets travel standards for every child or adolescent who requests a pediatrician/adolescent medicine specialist as his or her PCP? _____

42. Does the contract specify primary care availability standards no more than 20 minutes for members in urban areas and 30 minutes for members in rural areas? _____

43. Is routine care available within ten days? _____

44. Is specialty care available within three weeks? _____

45. Is emergency care available immediately and at the nearest facility, whether or not that facility participates in the MCO's network and whether or not the care has been approved in advance by the MCO? _____

46. Is urgent care available within 24 hours? _____

47. Does the contract specify maximum in-office waiting times? _____

48. Is the MCO responsible for ensuring that members whose primary language is not English and members with special medical needs have access to primary care providers and specialists qualified to meet their needs? _____

Scope of Services

49. Does the contract clearly delineate which of the services included in 42 U.S.C. § 1396d(a) are the responsibility of the MCO? _____

50. Is the responsibility for transportation clearly specified and does the definition of transportation incorporate 42 C.F.R. § 440.170(a)? _____

51. Does the contract specify that the MCO is responsible for juvenile court-ordered treatment involving covered services? _____

52. Is the responsibility for medical services contained in Individualized Family Service Plans and Individualized Education Plans clearly specified? _____

53. Does the contract require case management services to facilitate needed medical, educational, social and other services? _____

54. Does it require coverage of interdisciplinary team treatment? _____

55. Does it require coverage of access to clinical studies? _____

56. Does the contract define the following terms consistent with federal/state statutes and regulations: medical necessity, family planning, EPSDT, case management, and transportation?

57. Does the contract define emergency according to the prudent lay person standard and 42 U.S.C. § 1395dd at the time care is sought? _____

58. Are members able to self-refer for family planning, obstetrical, gynecological, mental health, and substance abuse services? _____

59. Is the MCO prohibited from imposing prior authorization restrictions beyond those allowed under fee-for-service? _____

60. If a drug formulary is allowed, does the contract require a simple process for obtaining prescription drugs not on the formulary? _____

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

61. Does the contract incorporate federal and state statutes and regulations concerning EPSDT? _____

62. Does it incorporate Part 5 of the HCFA State Medicaid Manual (which delineates requirements for screens, e.g. lead testing, health education, and age-appropriate laboratory tests)? _____

63. Does the contract clearly delineate whether the state or the MCO is responsible for EPSDT outreach and informing? _____

64. Does the contract prohibit the MCO from placing caps and other quantitative limits on the number of services a child can receive? _____

65. Is the MCO required to report encounter data so as to allow accurate completion of the HCFA Form 416? _____

66. Is the MCO prohibited from requiring prior authorization for EPSDT screens? _____

67. Is the MCO required to meet and exceed 80 percent EPSDT participation? [1](#) _____

68. Does the contract require the MCO to meet national professional standards of care as articulated by the American Academy of Pediatrics, Advisory Committee on Immunization Practices, American College of Obstetricians and Gynecologists, American Medical Association Guidelines for Adolescent Preventive Screening, and American Academy of Child and

Adolescent Psychiatry's Work Group on Quality Issues? _____

Medical Necessity

69. Is the definition of medical necessity clear in all contracts and subcontracts? _____

70. Is it clear that the MCO will be responsible for providing medically necessary covered services as required by law? _____

71. Does the definition of medical necessity provide that the treating physician will determine whether the care is medically necessary? _____

72. Does the contract recognize and incorporate EPSDT and Medicaid definitions of medical necessity (42 U.S.C. § 1396d(r)(5) and 42 C.F.R. § 440.230(b))? _____

73. Does the contract include a separate definition of medical necessity for behavioral health care that is consistent with federal and state law and that recognizes the role of member/family, least restrictive treatment settings, and wraparound services? _____

74. Does the contract require the MCO to pay for an independent second opinion when the MCO or the MCO physician determines that a service, treatment, or equipment is not medically necessary for a person with a chronic or disabling condition or disease? _____

Family Planning Services

75. Does the contract allow members to obtain family planning services from any provider, in or out of the network, without a referral? _____

76. Is the MCO required to inform members, including adolescents, of access to family planning services, in or out of network, without a referral? _____

77. Is the MCO required to keep family planning services confidential, even if the patient is a minor? _____

Special Needs

78. Does the contract explicitly require the MCO to comply with the Americans with Disabilities Act, the Rehabilitation Act, and Title VI of the Civil Rights Act? Is compliance required of all subcontractors? _____

79. Does the contract require the MCO to provide information both orally and in writing in the recipient's primary language and in alternative formats, including TTY and telecommunication devices, braille, large print and cassette? _____

80. Does the contract require the MCO to employ multicultural and multilingual staff, representative of the racial and ethnic diversity of its members? _____

81. Does the contract prevent discrimination on the basis of health status, illness, or perceived needs? _____

82. Is the MCO required to make special accommodations for children in foster care, children in state custody, adopted children, and homeless individuals? _____

83. Does the contract address the ability of minors to consent to medical treatment without parental consent? _____

Due Process

84. Are the MCO and its participating providers required to post a description of due process rights in a conspicuous location in the reception area of each provider's office? _____

85. Is the MCO required to inform members how to obtain assistance in filing a grievance and of the potential availability of free legal services? _____

86. Is the MCO required to notify members of timeframes for plan grievance procedures, state fair hearings, and expedited reviews? _____

87. Is the MCO required to inform members of their right to a state fair hearing without exhausting MCO grievance procedures? _____

88. Is the timeframe for a plan grievance procedure no more than 30 days? _____

89. Is there an expedited review process for urgent health matters, and does the process provide for a state decision within 48 hours? _____

90. Is the MCO required to provide notice to the member and the member's representative, if applicable, any time a service is denied, reduced or terminated? _____

91. Does the required notice explain why the service was denied, reduced, or terminated and give the specific legal support for that action? _____

92. Does the required notice explain the right to continued services pending a final decision? _____

93. Does the required notice explain the right to seek a second opinion at the MCO's cost? _____

94. Does the required notice explain the due process rights, including the right to a state fair hearing without exhausting MCO grievance procedures? _____

95. If a service is denied, reduced, terminated, or delayed and the MCO fails to give adequate and timely notice, is the MCO required to provide the complete service (unless the member's primary care provider or specialist, as appropriate, indicates that the service would not be in the member's best interest)? _____

Financial and Organizational Requirements

96. Does the contract prohibit financial arrangements between the MCO and its providers that may inappropriately limit care? _____

97. Does the contract prohibit gag clauses in MCO sub-contracts? _____

98. Does the contract require the MCO to report administrative costs and profits as separate line items? Does the contract place a cap on MCO profits? A cap on administrative costs?

99. Does the contract have higher capitation rates for members with more extensive needs?

100. Are payment methodologies structured to reward MCOs that develop expertise in caring for individuals who need enabling services (e.g., transportation, translation) or who have expensive health care needs? _____

101. Does the contract incorporate state insurance department solvency requirements and federal solvency requirements, 42 C.F.R. § 434? _____

102. Is cost sharing proscribed? _____

103. Does the contract require the MCO to meet state insurance/licensing certification standards? _____

104. Does the contract require NCQA accreditation for MCOs? _____

105. Does the contract incorporate and implement federal physician incentive plan rules, 42 C.F.R. § 434.67? Does the contract require the MCO and its sub-contractors to notify members of the incentive plans that are being used? _____

106. Are specific conditions and services defined legally and clinically and grouped into actuarially manageable service packages for which prices can be set? _____

107. Will participating plans be required to show that they are investing capital in improvement of services, treatment protocols, and development of best practices? _____

Public Disclosure

108. Is the MCO required to disclose compensation arrangements to the public? _____

109. Is the MCO required to disclose the disenrollment rate from the MCO? _____

110. Is the MCO required to disclose its profit level? _____

111. Is the MCO informed that the results of state consumer satisfaction surveys and external medical and financial audits will be publicly disclosed? _____

112. Is the MCO informed that the number, type, and resolution of complaints and formal legal actions will be publicly disclosed? _____

113. Is the MCO informed that data regarding compliance with performance measures will be publicly disclosed? _____

Reporting Requirements

114. Is data stratified for gender, race, disability, and age? Do the sampling techniques account for the cultural and linguistic populations served by the MCO? (For example, if 20 percent of the MCO enrollment is African American and the MCO is measuring mammography screening, then 20 percent of the mammography percentage should be African American as well). [2](#) _____

115. Does the contract require focused studies and 100 percent chart reviews of persons with special health care needs? _____

116. Is the MCO required to adhere to the reporting requirements specified in the Health Plan Employer Data and Information Set (HEDIS) 3.0? _____

Quality and Performance Improvement Goals

117. Does the contract include outcome measures and performance goals for EPSDT, emergency room utilization, cultural competence, and coordination of non-capitated/out-of-MCO services? Do outcomes improvements anticipate closing the disparity in health status between white and minority members? _____

118. If mental health and substance abuse services are included, does the contract anticipate improvement in the penetration and duration of these services? _____

119. Does the state withhold a percentage of the capitation rate until the MCO demonstrates that minimum performance standards have been met? _____

120. Is the MCO required to implement a quality assurance and improvement plan? _____

121. Is the MCO's contracting status measured against reported HEDIS 3.0 data? _____

122. Does the contract incorporate the quality assurance measures contained in HCFA's Quality Assurance Reform Initiative (QARI)? [3](#) _____

123. Is the MCO required to review the performance of its contracting providers and to ensure the correction of any deficiencies? _____

Consumer Involvement

124. Does the contract notify the MCO that the state will conduct an annual consumer satisfaction survey? _____

125. Does the contract notify the MCO of the availability of an independent hotline for members to call with problems, questions, and complaints? _____

126. Is the MCO required to provide a consumer relations office for member questions, problems, and complaints? _____

127. Is the MCO required to report complaints to an independent ombudsprogram? _____

128. Is the MCO required to hire member advocates to assist members? _____

129. Is the MCO required to include consumers in work groups, advisory boards, or other "accountability" loops? _____

130. Does the contract require the MCO's written information and materials to be pretested by consumers to ensure that the material is appropriate? _____

131. Is the MCO required to employ Medicaid recipients? [4](#) _____

Enforcement

132. Does the contract explicitly recognize Medicaid recipients as the intended third party beneficiaries of the contract? _____

133. Does the contract explicitly recognize Medicaid recipients as the intended third party beneficiaries of subcontracts and provider agreements entered into by the MCO? _____

134. Does the contract broadly specify the state's right to recoup or withhold payments, impose corrective action plans, suspend further enrollment, exact damages, or terminate the contract for noncompliance with the terms of the contract and other legal documents? _____

Contracts with Health Benefit Managers (HBMs)

135. Does the HBM contract emphasize face-to-face counseling? _____

136. Does the contract require the HBM to maintain and communicate accurate information regarding the participating and available primary and specialty care providers and their locations and business hours? _____

137. Are benefit counselors required and/or given incentives to have a low default/automatic assignment rate? _____

138. Are timeframes communicated to the recipient for selection of an MCO? _____

139. Are individuals with disabilities given extra time to select an MCO? _____

140. Does the HBM contract describe the default assignment process? Does the process maintain existing provider relationships to the extent possible and take into account geographic access and the ability of the MCO to meet the language, cultural, and health care needs of the

individual? _____

141. Does each family member have the option to choose his or her own MCO, particularly where different MCOs are necessary to ensure that family members with disabilities or special needs can continue existing provider relationships? _____

142. Are recipients whose membership in an MCO is terminated due to ineligibility automatically re-enrolled in the same MCO upon resumption of eligibility within ninety days, unless the recipient selects a new MCO? _____

143. Is the HBM required to provide information written and orally in the recipient's primary language, at a state-set reading level, and in alternative formats, including TTY and telecommunication devices, braille, large print, and cassette? [5](#) _____

144. Does the contract specify whether the state or the HBM is responsible for outreach and education to Medicaid-eligible individuals who have not enrolled in Medicaid, especially children and adolescents? _____

145. Does the contract specify the responsibility of the state and the HBM for EPSDT outreach and informing? _____

146. Does hiring of health benefits counselors reflect the cultural and linguistic population being served? _____

147. Does the contract exclude the health benefits counselor from complaint and dispute resolution activities? _____

Notes

1. Eighty percent was the performance target for 1995. U.S. Dep't of Health and Human Services Health Care Financing Administration, State Medicaid Manual § 5360 (November 1993).
2. Statistics regarding health status show a wide disparity between whites and minorities. For discussion of research on racial disparities in the delivery of health care, *see, e.g.*, National Health Law Program, *Racial Discrimination in America's Health Care System*, 27 Clearinghouse Rev. 371 (Special 1993). Public disclosure of data, by race, will encourage MCOs to narrow racial disparities. These reporting requirements will also allow for more effective enforcement of Title VI of the Civil Rights Act, which prohibits federal fund recipients (such as Medicaid-participating MCOs and providers) from engaging in activities that have the effect of discriminating on the basis of race, color, or national origin. 42 U.S.C. § 2000d; 45 C.F.R. § 80 et seq.
3. U.S. Dep't of Health and Human Services, Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States (July 6, 1993) (includes measures related to internal quality assurance, physician credentialing, clinical and health service indicators, and external quality review).
4. See 42 U.S.C. § 1396a(a)(4)(B) (requiring state Medicaid agencies to provide for the training and effective use of staff, "with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aids in the administration of the plan, and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients.")
5. For a checklist of questions that the health benefits manager's educational materials should address, *see* National Health Law Program, Questions that Patient Educational Materials Need to Answer (1996)(available from National Health Law Program, Los Angeles, Ca.).