**excerpted from Jane Perkins & Kristi Olson, An Advocate's Primer on Medicaid Managed Care Contracting, 31 CLEARINGHOUSE REV. 19 (May-June 1997).*

Brief Introduction to Medicaid Managed Care Contracting

To control Medicaid expenditures and expand access to health care, states are requiring Medicaid recipients to enroll in risk-based managed care programs. Although to date mandatory enrollment has affected mostly poor women and children, the behavioral health and disabled populations are increasingly being required to enroll.

While the details of these programs vary greatly, they share a notable characteristic: reliance upon contracts to define the rights and responsibilities of managed care organizations (MCOs), state purchasers, and Medicaid beneficiaries. The contract is a promise "for breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty."

The contract thus becomes a new and significant Medicaid document, building on the already existing array of legal requirements that protect beneficiaries-federal and state statutes, regulations, guidelines and case law; federal Medicaid section 1115 waivers; federal Medicaid section 1915(b) waivers; and the standards of voluntary accreditation organizations such as the National Committee for Quality Assurance (NCQA) and the joint Commission on the Accreditation of Health Clare Organizations.

As such, the managed care contract becomes an important legal document for Medicaid beneficiaries and their advocates. As with many other legal transactions, the contracting process contains both opportunities and snares.

Clearly written, consumer-oriented provisions may give the advocate a new legal claim when a client complains that needed services have been denied, delayed, or provided in a manner that is prohibited by the contract. In addition, participation in the contracting process offers advocates the opportunity to press their state to include consumer-oriented innovations that are tailored to the health care needs and delivery system of the state and that will improve access and quality of care.

On the other hand, these contracts present a number of potential land mines. States may include provisions that are too vague to be enforced when problems arise. The failure of a contract to reflect statutory requirements may lead to denials of required services and, at the very least, delay services as the parties argue over who has responsibility for payment the state, the MCO, or the beneficiary. For example, the contract may require the MCO to provide 'medically necessary" services but fail to make clear that, under the Medicaid Act, medical necessity is a legal term and not simply a clinical decisions In yet other instances, the state may inappropriately substitute the managed care contract for the rule-making process. The rule-making process, embodied in the state's Administrative Procedure Act (APA), offers opportunities for public notice and comment not necessarily followed under the contracting process. Moreover, the contract may include provisions that violate the constitutional rights of Medicaid beneficiaries, such as the right to due process when services are denied, terminated, or reduced. Of course, neither the state nor the man aged care organizations have the authority to remove or alter beneficiaries' constitutional rights.

Clearly, legal aid and consumer advocates need to become familiar with the content of Medicaid managed care contracts and with the contracting process. Consumer advocates who can engage in administrative advocacy on these contracts should do so. Otherwise the details will be decided upon by state purchasers and the MCOs both of whom may be negotiating primarily on the basis of cost rather than cost and quality.

How to Obtain the Contract

An obviously essential element of effective advocacy is to obtain copies of existing and/or draft contracts. This can be easier said than done, however. First, the advocate needs to determine the types of contracting documents that are being used. These may include contracts for medical managed care, behavioral health managed care, and a health benefits manager. Copies of all of these contracts should be obtained. In states that use RFPs, it is important to get a copy of the RFP in addition to the contract, because the contract typically incorporates the provisions of the RFP.

Unfortunately, some states will release their model contracts and RFPs only through a public records act request. Most states, however, will provide a copy of the model contract and RFP upon request. Although not yet common, some states have begun posting the contracts on their home page on the world wide web. Access to your state can be accomplished as follows: http://www.state.__(insert two letter abbreviation for your state)__.us.

As noted above, the model contracts and RFPs are the prototypes for the actual contracts that are signed by the state and the MCO and the subcontracts between the MCO and its network

providers. The actual signed contracts can differ from the model. For example, when capitation rates are being negotiated rather than set, the signed contracts will differ from one another, at least on the basis of cost. In addition to the model contract/RFP, then, the advocate optimally will want to obtain copies of the signed MCO contracts and subcontracts.

Unfortunately, MCOs have been loath to provide any of these documents to the public, claiming trade secret or commercial or financial information that is privileged or confidential. This claim, though largely untested, is suspect. First, much of the information in the contract does not represent a trade secret or commercially privileged information such as customer lists, marketing strategies, and financial protections. And because most state's public records acts are modeled after the federal Freedom of Information Act, they provide for truly privileged information to be redacted from otherwise discoverable documents. More importantly, even if they do contain trade secrets, these contracts should be subject to disclosure because the public records act privilege should apply only to transactions between private persons. It would "defy logic" to conclude that these contracts belong solely to parties acting in a private transaction. Rather, they embody the promises of both a public governmental entity the state Medicaid agency and the parties contracting to serve as agents of the state MCOs and network providers. Thus, disclosure of these contracts should be viewed simply as "a cost of doing business with the Government." Unfortunately, most state Medicaid agencies have not been forceful allies with consumers in favor of public disclosure. The issue of public disclosure will likely be the subject of future litigation.

Essential Review

Is the contract consistent with:

- Federal Medicaid Act
- Federal regulations (including 42 C.F.R. §§ 434 et seq.)
- HCFA, State Medicaid Manual (especially Part 5 Early and Periodic, Screening, Diagnosis and Treatment)
- 1915(b) and/or 1115 waiver approval letters (including terms and conditions)
- 1115 protocol and representations by the state in the waiver application
- State Medicaid statute and regulations
- Federal and state case law precedents

Checklist for Analysis of Managed Care Contracts

The tension between flexibility and prescription will be a continuous part of Medicaid managed care contracting. While flexibility in achieving program goals and desired outcomes is certainly needed, there are constitutional and statutory provisions that must be implemented. Moreover, the contract must reflect an understanding of the affected Medicaid populations and their special needs.

This section of the primer describes provisions that advocates should look for when they review Medicaid managed care contracts. In answering these questions, advocates should look for a "yes" answer.

Advocates can consult the recent study by The George Washington University Center for Health Policy Research when developing language to implement these provisions. The Center's Nationwide Study of Medicaid Managed Care Contracts is a two volume document quoting a range of state contract provisions on almost every aspect of managed care contracting. The National Health Law Program also has developed a number of model provisions and is available to assist with reviewing and commenting on contracts.

Threshold Issues

- Does the implementation schedule allow adequate time for consumers and advocates to review, investigate, and comment on the draft contract with "due diligence"?
- Are the RFP and/or draft contract readily available for consumers and advocates?
- Does the implementation schedule allow adequate time for the provisions of the contract to be implemented by the MCOs that are awarded contracts?
- Does the implementation schedule allow adequate time for the provisions of the health benefits manager contract to be implemented?
- Are the provisions of the contract mandatory for all subcontracts?

Marketing

- Does the contract prohibit direct (e.g. door-to-door) marketing?
- Is the MCO prohibited from offering financial incentives to induce members to enroll?
- Is the MCO prohibited from engaging in misleading or confusing marketing practices?

Education and Enrollment

- Does the contract describe the MCO's responsibility and the state's responsibility for education and outreach?
- Is the MCO required to provide members with an enrollee handbook that contains descriptions of available providers and member rights and responsibilities?
- Is the state required to pre-clear written materials and to monitor educational activities undertaken by the MCO?
- 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 TTY and telecommunication devices, braille, large print, and cassette?
- Does the contract describe how members who do not select an MCO will be assigned to one?
- 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)

- Does each enrollee have the freedom to choose a PCP from among the MCO's participating providers?
- Does each family member have the option to choose their own PCP?
- Does the MCO allow members with disabilities, chronic conditions or complex conditions to choose a specialist as their PCP?
- Does the contract specify time frames for the recipient to select a PCP?
- Are members with disabilities given extra time to select a PCP?
- Is the MCO required to inform members of the time frames and the consequences for failing to act within that time?
- Does the contract describe how the MCO will assign PCPs to members who do not choose one?
- Are enrollees permitted to change their PCP without cause at any time?
- Does the contract describe how the MCO will ensure continuity of care if the member's PCP leaves the MCO's network?
- 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?

Initial Assessments and Ongoing Care

- 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? And if case is reduced or terminated, does the contract provide for the member to receive a due process notice, including rights to continued benefits?
- 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?
- 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

- Does the MCO allow members with disabilities, chronic conditions, or complex conditions to select a specialist as their PCP?
- 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?
- Is the MCO required to provide access to specialists with pediatric/adolescent expertise for every child or adolescent needing specialty care who requests one?

Essential Community Providers/Coordination with Agencies

- 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, children's tertiary care facilities, and presumptive eligibility providers?
- Is the MCO required to contract or develop coordination and referral agreements with: Women, Infant and Children (WIC) programs, early intervention programs, child welfare programs, state mental health agency, state substance abuse agency, special education programs, teen pregnancy and parenting programs?

Access and Availability Standards

- Does the contract require the MCO to guarantee 24 hour, 7 day/week accessibility to qualified providers?
- Does the contract require a patient to FTE primary care physician ratio that takes into account the physician's participation in several MCOs and the physician's commercial market caseload?
- Is the MCO required to provide a pediatrician/adolescent medicine specialist who meets travel standards for every child or adolescent who requests a pediatrician/adolescent medicine specialist as their PCP?
- Does the contract specify primary care availability standards no greater than twenty (20) minutes for members in urban areas and thirty (30) minutes for members in rural areas?
- Is routine care available within ten (10) days?
- Is specialty care available within three (3) weeks?
- Is emergency care available immediately and at the nearest facility, regardless of whether that facility participates in the MCO's network and regardless of whether the care is prior authorized?
- Is urgent care available within twenty-four (24) hours?
- Does the contract specify maximum in-office waiting times?
- 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 Service

- Does the contract clearly delineate which of the services included in 42 U.S.C. § 1396d(a) are the responsibility of the MCO?
- Is the responsibility for transportation clearly specified and does the definition of transportation incorporate 42 C.F.R. § 440.170(a)?
- Does the contract specify that the MCO is responsible for juvenile court-ordered treatment involving covered services?
- Is the responsibility for medical services contained in Individualized Family Service Plans and Individualized Education Plans clearly specified?
- Does the contract require case management services to facilitate needed medical, educational, social and other services?
- Does the contract require coverage of interdisciplinary team treatment?
- Does the contract require coverage of access to clinical studies?
- Does the contract define the following terms consistent with federal/state statutes and regulations: medical necessity, family planning, EPSDT, case management, and transportation?

- Does the contract define emergency according to the prudent lay person standard and 42 U.S.C. § 1395dd at the time care is sought?
- Are members able to self-refer for family planning, obstetrical, gynecological, mental health, and substance abuse services?

- Is the MCO prohibited from imposing prior authorization restrictions beyond those that were allowed under fee-for-service?

EPSDT

- Does the contract incorporate federal and state statutes and regulations concerning EPSDT?
- Does the contract 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)?
- Does the contract clearly delineate whether the state or the MCO is responsible for EPSDT outreach and informing?
- Does the contract prohibit the MCO from placing caps and other quantitative limits on the number of services a child can receive?
- Is the MCO required to report encounter data so as to allow accurate completion of the HCFA Form 416?
- Is the MCO prohibited from requiring prior authorization for EPSDT screens?
- Is the MCO required to meet and exceed 80 percent EPSDT participation?
- 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

- Is the definition of medical necessity clear in all contracts and subcontracts?
- Is it clear that the MCO will be responsible for providing medically necessary covered services as required by law?
- Does the definition of medical necessity allow the treating physician to determine whether or not the care is medically necessary?
- 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))?
- 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?

Family Planning Services

- Does the contract allow members to obtain family planning services from any provider, in or out of the network, without a referral?
- Is the MCO required to inform members, including adolescents, of access to family planning services, in or out of network, without a referral?
- Is the MCO required to keep family planning services confidential, even if the patient is a minor?

Special Needs

- Does the contract explicitly require the MCO to comply with the Americans with Disabilities Act and Title VI of the Civil Rights Act?
- 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?
- Does the contract require the MCO to employ multi-cultural and multi-lingual staff, representative of the racial and ethnic diversity of its members?
- Does the contract prevent discrimination on the basis of health status, illness, or perceived needs?
- Is the MCO required to make special accommodations for children in foster care, children in state custody, adopted children, and homeless individuals?
- Does the contract address the ability of minors to consent to medical treatment without parental consent?

Due Process

- Are the MCO and its participating providers required to post due process rights in a conspicuous location in the reception area of each provider?
- Is the MCO required to inform members how to obtain assistance in filing a grievance and of the potential availability of free legal services?
- Is the MCO required to notify members of timeframes for in-plan grievance procedures, state fair hearings, and expedited reviews?
- Is the MCO required to inform members of their right to pursue a state fair hearing without exhausting MCO grievance procedures?
- Is the timeframe for an in-plan grievance procedure no more than 30 days?
- Is there an expedited review process, and does it provide for a decision within 72 hours?
- 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?
- Does the required notice explain why the service was denied, reduced, or terminated and give the specific legal support for that action?

- Does the required notice explain the right to continued services pending a final decision?
- Does the required notice explain the right to seek a second opinion at the cost of the MCO?
- Does the required notice explain the due process rights, including the right to pursue a state fair hearing without exhausting MCO grievance procedures?
- If a service is denied, reduced, or terminated and the MCO fails to provide 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

- Does the contract prohibit financial arrangements between the MCO and its providers that may inappropriately limit care?
- Does the contract prohibit gag clauses in MCO sub-contracts?
- Does the contract require the MCO to report administrative costs and profits as separate line items? Place a cap on MCO profits? A cap on administrative costs?
- Does the contract have higher capitation rates for members with more extensive needs?
- Does the contract incorporate state insurance department solvency requirements and federal solvency requirements, 42 C.F.R. § 434?
- Is cost-sharing proscribed?
- Does the contract require the MCO to meet state insurance/licensing certification standards?
- Does the contract require NCQA accreditation for MCOs?
- 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?
- Are specific conditions and services defined legally and clinically and grouped into actuarially manageable service packages for which prices can be set?
- Will participating plans be required to show that they are investing capital inimprovement of services, treatment protocols, and development of best practices?

Public Disclosure

- Is the MCO required to publicly disclose compensation arrangements?
- Is the MCO required to publicly disclose the disenrollment rate from the MCO?

- Is the MCO required to publicly disclose its profit level?
- Is the MCO informed that the results of state consumer satisfaction surveys and external audits will be publicly disclosed?
- Is the MCO informed that the number, type, and resolution of complaints and formal legal actions will be publicly disclosed?
- Is the MCO informed that data regarding compliance with performance measures will be publicly disclosed?

Reporting Requirements

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

- 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?
- If mental health and substance abuse services are included, does the contract anticipate improvement in the penetration and duration of these services?
- Does the state withhold a percentage of the capitation rate until the MCO demonstrates that minimum performance standards have been met?
- Is the MCO required to implement a quality assurance and improvement plan?
- Is the MCO's contracting status measured against reported HEDIS 3.0 data?
- Does the contract incorporate the quality assurance measures contained in the Health Care Financing Administration's Quality Assurance Reform Initiative (QARI)?
- Is the MCO required to review the performance of its contracting providers and to ensure the correction of any deficiencies?

Consumer Involvement

- Does the contract notify the MCO that the state will conduct an annual consumer satisfaction survey?
- Does the contract notify the MCO of the availability of an independent hotline for members to call with problems, questions, and complaints?
- Is the MCO required to provide a consumer relations office for member questions, problems, and complaints?
- Is the MCO required to report complaints to an independent ombudsprogram?
- Is the MCO required to hire member advocates to assist members?
- Is the MCO required to include consumers in work groups, advisory boards, or other "accountability" loops?
- Does the contract require the MCO's written information and materials to be pretested by consumers to ensure that the material is appropriate?
- Is the MCO required to employ Medicaid recipients?

Enforcement

- Does the contract explicitly recognize Medicaid recipients as the intended third party beneficiaries of the contract?
- Does the contract explicitly recognize Medicaid recipients as the intended third party beneficiaries of subcontracts and provider agreements entered into by the MCO?
- Does the contract broadly specify the state's right to recoup payments, impose withholds and 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)

- Does the HBM contract emphasize face-to-face counseling?
- 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?
- Are benefit counselors required and/or given incentives to have a low default rate?
- Are timeframes communicated to the recipient for selection of an MCO?
- Are individuals with disabilities given extra time to select an MCO?
- Does the HBM contract describe the default assignment process?
- Does each family member have the option to choose an MCO of their own?
- 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?
- 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?

- 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?
- Does the contract specify the responsibility of the state and the HBM for EPSDT outreach and informing?
- Does hiring of health benefits counselors reflect the cultural and linguistic population begin served?
- Does the contract exclude the health benefits counselor from complaint and dispute resolution activities?