An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

Acknowledgments

Executive Summary

Background and Overview

Study Methods and Findings

Contract Provisions

1. Identifying Contracts by Type of MCO, Elements of Group Sponsor Agreement or by Type of Group Sponsor

2. Classes of Services Covered By Contracts

3. The Duty to Treat Patients and Accept Patient Referrals

4. Prior Authorization of Covered Services

5. Access Standards and Treatment Time Lines

6. Referrals to, and Relationships with, Other Providers

7. Medical Necessity and Emergency Definitions

8. Enrollee Encounter Data and Eligibility Verification

9. Quality Management Systems

10. Capitation Agreements

11. Fee-for-Service Agreements

12. Coordination of Benefits

13. Term and Termination

14. Gag Clauses

15. Anti-Delegation Clauses

16. Indemnification Clauses

Informal Interviews with MH/SA Providers

Conclusion and Recommendations

Appendix A: Methodology

Appendix B: Tables

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Return to Reports on Contracting Page

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Executive Summary

This study represents a descriptive, point-in-time examination of the structure and content of provider network agreements between managed care organizations (MCOs) and community mental health and substance abuse (MH/SA) treatment and prevention agencies. This is not a study of the quality of managed care systems. Instead, this analysis is designed to assess provider contracts (one of the basic legal instruments on which the managed care system rests) and to identify the meaning of these instruments for MH/SA service providers, group purchasers, MCOs, individual consumers and their families, and public policy.

Background and Overview

As health care purchasers turn to managed care to control costs, access and outcomes, the American health care system is undergoing dramatic change which is not yet well understood. The legal heart of this transformation is the web of contracts among the major stakeholders: group purchasers, MCO plans and providers. These agreements create legally enforceable rights and duties, and govern the flow of tens of billions of dollars in annual health spending and affect the care of millions of MH/SA service consumers. It is critical that public policy makers, group purchasers, providers and consumers understand what these contracts provide, how they are structured and the way in which they ultimately may shape the health care system. Well designed, a contract should help promote access to care, limit costly and/or unnecessary care, encourage the use of lower-cost, preventive services and hold parties to the contract accountable

for achieving specified outcomes of care.

Contracts represent a series of related, legally enforceable promises. A contract articulates the rights and responsibilities of the parties to the agreement, the flow of funds, the assignment of clinical and administrative responsibilities through the health care system, and the distribution of clinical and financial risk. Under the rules of contract interpretation, the clearer the agreement, the more likely it is that a party to the agreement will be able to enforce its terms. Liability for ambiguity in agreements lies with the drafter of the agreement. In a health care system governed by principles of market law, it is essential for the drafter of an agreement (in this case the managed care organization) to retain as much discretion as possible over the terms of the agreement in order to protect its interests and those of its client (the group purchaser). This means the negotiation of contracts that give the company the power to exercise discretion over the provision of medical care and the expenditure of money.

Study Methods and Findings

For this analysis, we utilized contracts which were selected in a manner that would ensure proper representation from a base of more than 250 intact contracts (i.e., contracts which include all appendices and addenda) collected from community MH/SA agencies located throughout the country. All of the contracts were in effect at the time of their collection. Participating agencies were assured anonymity, and all contracts were stripped of identifying information prior to analysis in order to maintain the confidentiality of all of the parties in light of the proprietary nature of the agreements. In addition to reviewing contracts, we conducted informal interviews with several providers in order to learn more about their experiences in negotiating contracts.

Contract Provisions

1. Identifying Contracts by Type of MCO, Elements of Group Sponsor Agreement or by Type of Group Sponsor*:* Managed care contracts with community MH/SA agencies involve numerous types of managed care entities. Within the four corners of the contract, it often was not possible to identify the type of MCO whose contract was analyzed. Moreover, it also was not possible to ascertain whether the MCO offering the agreement was itself at financial risk for services or was instead administering a self-insured plan for a group sponsor which retained risk. Definitively answering questions related to corporate structure and risk contracting would have required us to breach confidentiality by querying the parties. It is important to note that we could find nothing in the structure of these contracts involving unknown corporations that significantly distinguished them from the "known" contracts.

While coverage, cost sharing, and certain network provider duties may vary from group purchaser to group purchaser, MCOs must be able to structure an efficient, manageable operation and establish reasonably consistent network participation terms and conditions that apply, in the larger MCOs, to tens of thousands of providers in the MCO's network. Basic coverage rules and treatment obligations, term and termination clauses, coordination of benefit clauses, risk sharing provisions, provisions related to utilization review and quality assurance,

and provisions related to the timing of payment and modification of contract terms are likely to be standardized, regardless of the particular group sponsor whose members the provider might serve. Indeed, our analysis found the contracts are strikingly similar in their basic provisions.

We also found that the provider contracts serve as general network participation agreements, not as agreements specific to a particular member group cared for by the MCO (e.g., Medicaid members, persons covered through a State employee health plan, etc). MCOs must be able to build networks of providers whose services they in turn sell to group sponsors or to other MCOs with whom they contract. This does not mean that the MCO does not assign specific member groups to specific providers. However, the generic nature of the contracts suggests that MCOs seek to obtain a general participation agreements from their providers.

2. Classes of Services Covered By Contracts: Contracts typically cover both mental health and substance abuse treatment services. The basic provider agreements cover a limited range of benefits and services. Almost no contracts covered the comprehensive range of services that MH/SA agencies are capable of offering. The contracts suggest MCOs tend to buy from community MH/SA agencies only specific interventions furnished by only certain categories of providers. Presumably, this is because the agreements MCOs negotiate with group purchasers are themselves limited in scope. Moreover, the services that are purchased from the CBOs by MCOs tend to be traditional forms of care (e.g., psychiatric services, outpatient care, and outpatient substance abuse treatment services) delivered by credentialed health professionals such as psychiatrists and Ph.D. psychologists. Less than one quarter of the contracts cover "bundled" outpatient MH/SA treatment services that might be furnished by more than one clinical staff member or health professional. Prevention services are almost never included as a basic contract service. Similarly, case management services, in-home therapy, community treatment for former patients of institutions, and substance abuse residential treatment are rarely purchased as part of the basic contract. In none of the provider agreements were issues addressed of cultural competence on the part of the provider or the availability of translation services.

Contracts reviewed frequently purchase the services of individual health professionals directly rather than purchase of care from the MH/SA agency itself. In these contracts the MH/SA agency is not a party to the agreement and has neither a service nor a financial relationship with the MCO. This practice has significant financial and organizational implications for community MH/SA agencies that previously received all-inclusive clinic rates for services furnished by their entire salaried staff.

3. The Duty to Treat Patients and Accept Patient Referrals: All of the contracts imposed on providers the duty to treat patients referred to them by the MCO. Only in rare instances did the contracts we studied permit providers to refuse to accept any particular patient into their practice or to discharge a patient from their program.

4. Prior Authorization of Covered Services. More than 80 percent of the contracts require that providers obtain prior authorization for one or more contract services. Rare do contracts specifically authorize primary care providers as to approve care. Ten percent of the contracts we reviewed give patients' primary care providers an explicit role in the prior authorization process. This suggests that MCOs typically retain the prime gatekeeping responsibility (i.e., the exercise of medical judgement regarding the need for specialty care). This is consistent with the obligation on MCOs to manage care, particularly the consumption of specialty services.

Requirements for prior authorization of services appear to apply both to emergency and non-emergency services in about half of the contracts. The other half of the contracts specifically exempt emergency MH/SA treatment from otherwise applicable prior authorization requirements. In these latter contracts, providers are required to seek MCO approval of an emergency service within 24 to 48 hours of admission.

5. Access Standards and Treatment Time Lines: The majority of the contracts reviewed do not contain treatment time lines as a contractual duty. Eighty-two percent are silent on the issue of timeliness of care. Supplementary provider manuals which are not formally attached to the contract may cover access standards. These manuals would be less legally enforceable than contractual agreements. In the eight contracts that explicitly set treatment time lines, no consistent patterns could be discerned in the range of time lines specified.

6. Referrals to, and Relationships with, Other Providers: With the exception of four contracts, service agreements either expressly limit referrals to providers within the network or else are silent or unclear on the matter. Standard insurance principles would exclude from reimbursable coverage any court-ordered treatment, as well as treatment ordered by public agencies such as schools or child welfare agencies, since the plan's medical staff (or contractors in instances where such determinations are allowed) had not determined the *medical necessity* of the care. Only a few contracts expressly require providers to maintain coordinating arrangements with other agencies as a basic contract duty. The absence of explicit coordination requirements appears to be consistent with MCOs' general pattern of retaining control over service and resource authorization.

7. Medical Necessity and Emergency Definitions: Thirty-six contracts expressly link coverage to a determination of medical necessity by the MCO. Two contracts specify that their medical necessity standards build on currently recognized placement criteria. Virtually none of the contracts articulate a separate medical necessity standard for children (such standards might be found in separate provider manuals). The majority of contracts (29) commit medical necessity determinations to MCO discretion. Only three (6%) contract expressly stated that the treating provider's judgement would be taken into account in the plan's determination. In only one contract was the provider's determination of medical necessity binding. This result would be consistent with MCOs' basic duty to the group purchaser to ensure that coverage is in fact necessary.

8. Enrollee Encounter Data and Eligibility Verification: Despite the growth in demand on the part of payers for data on access and utilization, only eight contracts specify that providers must furnish encounter data to plans. The majority of contracts are either silent or unclear on the issue. Because MCOs cannot pay for care unless patients are enrolled at the time services are furnished, it is not uncommon for contracts to specify pre-service eligibility verification requirements. Fifteen of 50 reviewed contracts contained such a requirement. However, only four specify that the MCO's eligibility verification services will be available on a 24 hour-per-day, 7-day-per-week basis.

9. Quality Management Systems: More than 80 percent of the contracts reviewed explicitly require participation in the contractor's quality management system.

10. Capitation Agreements: Only two contracts reviewed in this study contain capitation payment arrangements for one or more covered services. Of these, one includes a withhold arrangement. None includes a shared savings (i.e., "upside risk") clause. The capitation agreements which do appear in these documents appear to create significant financial risk in the provider.

11. Fee-for-Service Agreements: The overwhelming majority of the MCO/CBO contracts reviewed for this study (48 of 50) are fee-for-service arrangements. Of these, four contracts include withhold provisions, and two include shared savings arrangements. Agreements permit the MCO to make upward adjustments in withhold levels at any time.

12. Coordination of Benefits: Most contracts contain coordination of benefit clauses, which obligate the provider to bill legally liable third parties prior to billing the MCO. In only one contract is the onus of collection placed squarely on the plan.

13. Term and Termination: Contracts are equally likely to grant both providers and MCOs no-cause termination rights. MCOs are somewhat more likely to be able to terminate for cause. In the event of termination, an MCO retains the group members. A provider that elects to terminate the agreement can leave the relationship but would lose its access to the MCO's patients. About half of all contracts either require at least three months' notice prior to a no-cause termination or else do not address the matter, leaving the provider subject to whatever later rules are established. Post-termination treatment obligations are an important safeguard for enrolled

members of the plan so that members' can be safely transferred to another care arrangement. In a substantial minority of the contracts reviewed, the post-termination obligation extends indefinitely, regardless of the cause of the termination or the amount of time needed to effectuate a patient transfer.

14. "Gag" Clauses: Of all the contracts we reviewed, only two contained true clauses that could be construed as "gag" clauses (i.e., clauses that appear to prohibit providers from speaking to patients about coverage and treatment determinations made by the plan).

15. Anti-Delegation Clauses: Many of the contracts reviewed contain provisions that prohibit physicians under contract to the MCO from delegating any of their duties to any other member of the MH/SA agency's clinical staff. While these clauses technically are meant to deal with the legal and ethical problems arising from unilateral decisions on the part of providers to end their relationship with patients, the clauses also could be construed as effectively prohibiting the use of a health care team to provide covered services to patients.

Informal Interviews with MH/SA Agencies

During 1996 we also held informal discussions with 12 MH/SA agency directors or their staff regarding their experiences in negotiating managed care provider contracts. Most of the respondents considered that the contracting process had been open to negotiation. However, only half of the interviewees reported that they had all contract-related information before negotiating the terms of the agreements. The majority of respondents who did not have all relevant documents prior to negotiation reported that MCOs would not furnish them.

Less than half of all respondents reported obtaining a legal analysis before signing an agreement. Only one obtained an actuarial analysis. Half of all respondents indicated that they conducted a business analysis of contracts prior to signing them. The providers that did not obtain either business or legal assistance reported cost as a barrier. Only one quarter of respondents were members of provider networks that represented their interests on a collective basis.

Conclusion and Recommendations

This exploratory, point-in-time study of contracts between MCOs and community MH/SA agencies shows that despite a certain degree of difference, provider service agreements are strikingly similar in their structure. Contracts are carefully constructed legal instruments which MCOs have created to establish and maintain control over access, benefit utilization, practice patterns and costs. These contracts seek to retain MCO control over the movement of beneficiaries and funds throughout the network created by the MCO. The contracts shift financial risk from the MCOs to

their network providers in numerous ways, from eligibility verification systems that require providers to absorb the risk of erroneous eligibility determinations, payment provisions that do not contain specific time lines, coordination of benefit provisions that place responsibility for recovery of liability with the providers, post-treatment obligations and other provisions designed to control the flow of funds. These techniques are used by MCOs to ensure that the basic objective of the purchaser -- health care at the price it wants -- can be achieved, while shielding the MCO itself from financial risk (in the case of risk contracts) and from the loss of the group purchasers' business (in the case of administrative services contracts).

Managed care systems operate through a network of interlocking agreements among that can involve tens of thousands of contracts between an MCO and service providers. These agreements spell out basic coverage rules, service duties and financial obligations. The basic agreements can be tailored for individual group purchasers, but the process of adding on to the basic agreements for an a specific group purchaser can be difficult. This issue is a particularly pressing one for State Medicaid agencies, which tend to seek products that are relatively tailored to the needs of their populations. In cases in which the group purchaser's managed care expectations are significantly different from those reflected in the standard MCO/provider agreements, the purchaser may need to take additional steps to ensure that provider agreements accurately reflect its expectations and that providers are apprised of key differences. Otherwise group purchasers' expectations may be lost in the translation between the master contract and the point at which care is delivered.

The issue of provider response to these contracts inevitably arises. MH/SA providers may respond by forming stronger and larger provider networks in order to increase their negotiating leverage. Recent rulings of the Justice Department and the Federal Trade Commission may encourage such networks to develop. But even if provider networks are strengthened, purchasers and MCOs will continue to have strong bargaining advantages. Therefore, group purchasers and policy makers need to make choices. To the extent that a group purchaser values the services that an individual provider or class of providers can offer its members, it needs to specify its expectations regarding these providers in its MCO contract. Moreover, in the case of services that community based programs furnish and that group purchasers do not include in their coverage agreements, policy makers need to make deliberate funding decisions and develop an explicit means of paying for these services. The discounted payments that form the basis of most managed care contracts make the continued provision of non-insured services unrealistic in light of the disappearance of cross-subsidy capabilities.

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SAMHSA Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA)

An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

Background and Overview

The rapid transformation of the American health care system to managed care has altered the system profoundly. In their study of managed care organizations Jonathan Weiner and Gregory de Lissovoy describe its impact on the traditional relationships among the key stakeholders in the American health care system, health insurance sponsors, insurers, providers and patients:

> The 1980s witnessed an unprecedented change in the organization and financing of U.S. health care. At the onset of the decade, two major insurance arrangements existed, and one predominated. About 90% of working Americans and their dependents were covered by conventional "indemnity" health insurance plans purchased by employers as a benefit. Under a typical employment-linked plan, consumers were free to choose any available provider. Physicians, for their part, were faced with few constraints and practiced more or less as they wished. Insurance companies usually served as passive go-betweens: the intermediary between the employer and provider. With little scrutiny they paid bills submitted to them on a fee-for-service (FFS), retrospective basis. The government-sponsored insurance programs--Medicare and Medicaid-- were patterned directly after this traditional employee benefit model.
>
> The second major type of health insurance plan, the prepaid health maintenance organization (HMO) was the arrangement of choice for about 5% of all Americans in 1980. At that time, 80% of all HMO enrollees received care from so-called closed staff or group-model HMOs--where the physicians practiced in large, organized, multi-specialty group settings.
>
> By the end of the 1980s traditional insurance plans and established HMOs were joined by a stunning array of new health care financing and delivery entities. Collectively these plans (along with HMOs) came to be known as "managed care" plans. A common characteristic of the new managed care plans was the degree to which the roles of insurer and provider became integrated. Boundaries that once separated the two were blurred. *(Footnote 5)*

In 1995, approximately 15 years after the beginning of the growth period of the modern

managed care industry, more than 140 million privately insured Americans (78% of all privately insured persons) were members of managed care plans. As of 1996 40% of all Medicaid beneficiaries and ten percent of Medicare beneficiaries were enrolled in managed care arrangements. *(Footnote 6)* Widespread concerns among public and private group purchasers alike over the cost and quality of medical care served as the impetus for this transformation. Certain Federal laws, most notably the Employee Retirement Income Security Act, Federal anti-trust law, and the Medicare and Medicaid statutes, made the transformation legally possible. *(Footnote 7)*

There is no single definition of managed care. As used in this study, managed care denotes any health care arrangement in which a company (which may be organized as a health insurer, a health maintenance organization or some other type of risk-bearing entity or as a non-risk bearing plan administrator) contracts to provide or arrange for the provision of certain health benefits for a preset fee (a premium in the case of a risk contract or a fixed-term budget in the case of an administrative services agreement). Services in turn are furnished to members of the managed care plan through a network of health care providers and institutions who are selected by the managed care entity and whose practices are controlled to a greater or lesser degree by the entity. *(Footnote 8)*

There is great potential for variation in managed care. Managed care organizations can be loosely or tightly organized. They can contract with health care providers on either an exclusive or a non-exclusive basis. They can either assume financial risk for services covered under the agreement or act as non-risk-bearing third party administrators. Plans offered by managed care organizations can either restrict members to a specific group of providers for all services other than emergency care and authorized "non-network" services, or else can permit members to seek services for an additional fee from non-network providers and/or self-refer for covered services. A single managed care organization can offer multiple risk and non-risk product lines that vary depending on the desires and needs of the group purchaser. Depending on the type of product sold and the membership of the plan, a MCO can utilize one or more provider networks to deliver care or can use certain portions of its network for certain purchasers.

Regardless of the specific structure of the managed care arrangement, agreements between group health plan sponsors and managed care organizations reflect group purchasers' expectations that MCOs will perform certain basic functions:

- provide or arrange for the provision of services covered under the contract;
- select members of the provider network and to oversee the quality of their care;
- oversee the consumption of covered benefits by both members and network providers; and
- stay within budget (i.e., either the premium or the actuarial budgeted assumptions in the case of self insured group purchasers).

Managed care organizations carry out these expectations through a series of operational and management techniques which can include selective contracting, provider profiling, utilization review, the development of quality management standards and practice guidelines, conservation of financial resources, and the transfer of financial risk for cost overruns to network providers. *(Footnote 9)*

Managed care organizations may employ health care providers to carry out their service duties. As Weiner and de Lissovoy note, however, staff employee model HMOs represent a small proportion of the modern managed care industry. The more common model is one which a managed care company develops its service network through an extensive series of service agreements with independent contractors. Under this model which forms the basis of this study MCOs enter into agreements with a range of primary and specialty providers and institutions, as well as with other entities necessary to the enterprise. Courts have characterized these organizational arrangements as ones that create both direct and vicarious liability in the organizations for the quality of the care they furnish, much in the same manner that hospitals are held liable for the quality of their care. *(Footnote 10)* Because MCOs increasingly are considered liable for the quality of their care, they have a strong interest in selecting and retaining only those providers who agree to abide by the MCO's contract terms.

In light of the fact that the basic duties of MCOs are similar regardless of the specific type of managed care agreement they may enter into, it should not be surprising that their subcontractor agreements would also be similar. Moreover, because an MCO must execute many individual contracts in order to build its network, it is logical to expect a high degree of similarity in any individual company's contracts. *(Footnote 11)* This may be particularly true in markets with a significant over-supply of certain classes of providers, thereby making possible standard agreements developed on a non-negotiation basis. The obligation of managed care organizations to purchase aggressively is underscored by their agency relationship with their purchasers and the fact that at least one court has characterized the relationship between the MCO and individual members as that of a fiduciary. The similarity of basic duties, however, may be a particularly important finding for public purchasers and beneficiaries, who may desire to purchase a more comprehensive behavioral healthcare benefit than is common among commercial purchasers.

Finally, in a health care system governed by principles of market law, it is essential for the drafter of an agreement to retain as much discretion as possible over the terms of the agreement in order to protect its interest. Ambiguities in contract terms would be construed against the drafter, an outcome which MCOs cannot afford if they are to succeed in business. MCOs have a decided interest in forming good relationships with their providers in order to keep the quality of their product strong and may maintain informal agreements with their suppliers over issues such as medical decision-making powers and financial terms in order to encourage an atmosphere of trust and partnership. At the same time, however, MCOs have a strong interest in maintaining a position of strength in their formal relationships with their suppliers. This means the developing contracts that give companies the power to exercise discretion over the provision of behavioral healthcare and the expenditure of money. An MCO can be expected to offer its suppliers (in this case, providers) service agreements that are as advantageous to it as possible on the issues which lie at the heart of managed care: authority over allocation of financial resources; authority over the medical and coverage decision-making process; and the transfer of financial risk.

Footnotes

5 Jonathan Weiner and Gregory de Lissovoy, Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans, 18 J. Health Pol. Pol'y & Law 75,76-78 (Summer, 1993)

6 Prospective Payment Assessment Commission, Medicare and the American Health Care System: Report to Congress, June, 1996 [reprinted at] CCH Medicare /Medicaid Guide, Number 911 (June 20, 1996) at 19. (Hereinafter cited as ProPac/1996).

7 *Law and the American Health Care System* op. cit. Chapter 2.

8 *Law and the American Health Care System* , op.cit. Ch.2.

9 *Law and the American Health Care System*, op.cit.

10 *Law and the American Health Care System* op.cit. Chapter 3.

11 Indeed, we found great similarity in contracts in our earlier analyses of service agreements between managed care organizations and family practice providers furnishing primary medical care services, as well as agreements between managed care organizations and academic medical center physician groups.

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An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

Study Methods and Findings

In this part we present the principal findings from a point-in-time exploratory study of contracts between managed care organizations and community-based providers of MH/SA treatment and prevention services. This study builds on earlier unpublished work undertaken by the Center in 1994 through 1996, which analyzed contracts between MCOs and primary care medical practices located in medically underserved areas as well as contracts involving MCOs and academic medical centers. In these studies, which involved the review of several hundred contracts from around the country, we developed a basic approach to contract collection and analysis and presentation of findings. The instrument developed for the earlier study was modified and adapted for this study with the assistance of MH/SA experts.

For this analysis, we used contracts from a base of more than 250 intact contracts (i.e., contracts which include all appendices and addenda) collected from MH/SA agencies located throughout the country. We selected a total of 50 contracts representing different types of managed care organizational arrangements and involving MH/SA providers of varying size and locations. We also conducted a separate validation review using 90 additional contracts. (See Appendix A for a more detailed description of study design and methodology)

Contracts were elicited on a voluntary basis from community MH/SA agencies, a necessary limitation to the study given the unavailability of the data otherwise. All of the contracts collected were in effect as of their time of collection. *(Footnote 12)* Participating MH/SA agencies that submitted contracts were assured that all identification would be removed and their organization protected. The voluntary nature of provider participation in this study may represent a limitation of the analysis, although it is unclear in which direction the limitation would cut. Some providers might have elected to participate because they wished to share "bad" (i.e., disadvantageous) contracts. However, as we note below, many providers whom we subsequently interviewed felt that they had been able to negotiate at least some aspects of their agreement and did not appear to consider their agreements disadvantageous. Therefore, the contracts may be skewed toward more favorable instruments. Most importantly, however, is our finding that the contracts are extraordinarily similar in structure and content. This consistency across contracts diminishes concern about possible selection bias that could arise from voluntary participation. Tables accompanying these findings can be found in Appendix B. In addition to reviewing contracts, we conducted informal interviews with twelve providers in order to learn more about their experiences in negotiating contracts. These findings are separately reported below.

Contract Provisions

1. Identifying Contracts by Type of MCO, Elements of Group Sponsor Agreement or by Type of Group Sponsor.

Managed care contracts involving community MH/SA providers involve numerous types of entities. An HMO, an insurer offering a managed care product or an administrative services product, or a provider network selling its member services to multiple public and private group purchasers or HMOs may all negotiate contracts with a single community MH/SA agency. Within the four corners of the contract we analyzed, it often was not possible to identify the type of MCO that had agreements with specific MH/SA agencies. Table 1 indicates that 19 contracts (38%) clearly involved a managed care organization licensed as an insurer, IPA, PPO, or HMO and potentially able to sell services directly to one or more group sponsors. The remaining contracts involve entities whose corporate structures are unknown or unclear.

Just as it was not possible to identify the nature of the MCO from the contract itself, it also was not possible to determine from the structure and content of the contracts whether the MCO offering the agreement was itself at financial risk for services or was acting as an administrative services organization retained for a fee by a purchaser which retained risk. Definitively answering questions related to corporate structure and risk contracting would have required us to breach our confidentiality agreements with MH/SA providers.

We can only assume that our sample includes the most common forms of MCO/CBO contracts. We could find nothing in the structure of these contracts involving unknown corporations that significantly distinguished them from the "known" contracts.

What is striking about the contracts themselves is the similarity of their basic provisions.With the possible exception of payment rates for covered services, we could find no evidence of variation in the basic agreement by group payer. Basic coverage rules and treatment obligations, term and termination clauses, coordination of benefit clauses, risk sharing provisions, *(Footnote 13)* provisions related to utilization review and quality assurance, and provisions related to the timing of payment and modification of contract terms were applicable in these contracts regardless of the particular group sponsor whose members the provider might serve. Indeed, it probably would be impossible for an MCO to function smoothly were the terms of its provider contracts to vary significantly from purchaser to purchaser. MCO's provider contract appear to cover beneficiaries of numerous group health plans which contract with an MCO. This probably would be particularly true in the case of specialty providers such as MH/SA agencies, who over the term of the contract might see only a few members enrolled in any single group plan offered by the MCO.

Few of the contracts could be identified by specific group sponsor. By and large, the provider contracts serve as general network participation agreements, not as agreements specific to a particular group purchaser served the MCO (e.g., Medicaid members, persons covered through a State employee health plan, etc). *(Footnote 14)* MCOs look to build large networks of tens of thousands of providers whose services they in turn sell to group sponsors or to other MCOs with whom they contract. The generic nature of the contracts suggests that MCOs seek to establish basic agreements with providers in their networks, leaving the MCO free to market its product lines to numerous purchasers and assign beneficiaries to whichever provider it determines,

regardless of the particular group provider.

2. Classes of Services Covered By Contracts

Table 2 indicates that the typical contract covers both mental health and substance abuse treatment services. Prevention services are rarely included as a basic contract service presumably because they are seldom purchased by group sponsors. Contracts that cover exclusively mental health or exclusively substance abuse related services tend to be uncommon. The percentage of contracts that covered mental health and substance abuse treatment services was roughly equal (72% and 68%, respectively). (At least one contract was unclear regarding the types of services it covered).

Table 3 is one of the most important tables in the study. It shows the limited nature of, and wide variation in, the benefits and services covered in the basic provider agreements we studied. For any particular service category (which, as Table 3 reflects, can be described as a type of therapy, a site of service, a particular type of provider, or a particular type of intervention), no more than about one quarter of all contracts specified coverage. Almost no contracts covered the comprehensive range of services that community MH/SA agencies are capable of offering. MCOs apparently buy from community MH/SA agencies only selected types of interventions furnished by specific categories of MH/SA professionals.

The services that are purchased tend to be traditional forms of care (e.g., psychiatric services, outpatient care, and outpatient substance abuse treatment services).

There may be instances in which a provider handbook accompanying a particular group plan may identify additional services beyond those enumerated in the contract itself. Depending on how the provider handbook is termed in the contract (e.g., as an addendum to the basic contract or as a procedural guide for providers treating members of a certain group plan), the service may or may not be covered when furnished by the provider and the provider may or may not have a duty to furnish the service. If the provider manual is intended to operate as procedural only, then the provider would not be obligated to furnish services listed only in the handbook, since they are not part of the provider's basic contract with the MCO and are simply indicative of the services that may be available to members from *some* provider under contract to the MCO. Nor would the MCO be obligated to purchase the additional services from the provider if it elected to furnish them, since it did not specifically contract for the service. While the MCO itself would be under an independent duty to furnish all services listed in the group contract, the incorporation by reference of multiple group plan provider handbooks would not itself have a legal effect on the scope of services which the provider is obligated to furnish or the MCO is obligated to buy from the provider unless a supplemental contract specific to the group is negotiated. In none of the contracts we reviewed were there supplemental service agreements specific to a particular group purchaser. Indeed, in our contract review we noted repeatedly that the contracts called for manuals to be furnished to providers subsequent to their membership in the network and were not portrayed as part of the basic agreement.

Twelve contracts (slightly less than one quarter of all the contracts we reviewed) cover "bundled" outpatient substance abuse or mental health treatment services that might entail a range of

interventions for a particular diagnosis, to be furnished by more than one clinical staff member or health professional. Case management services are infrequently purchased as a distinct service. As Table 3 shows, halfway house programs, in-home therapy, community treatment for former patients of institutions, violence prevention, and other services are rarely purchased as part of the basic contract, nor did the contracts include addenda indicating that such services would be covered for certain group purchasers. (In the case of Medicaid managed care, the MH/SA provider may still be able to furnish the service on a covered basis to the extent that the Medicaid agency has elected to exempt these services from the scope of its agreement with its MCOs).

A number of the contracts involve the purchase of services of individual health professionals by a MCO rather than purchase of care from the MH/SA agency itself. In these contracts the MH/SA agency is not a party to the agreement and has neither a service nor a financial relationship with the MCO, since the MCO has elected to purchase the services of a single professional on the MH/SA agency's staff in lieu of contracting with the entity and its staff generally. This practice has significant financial and organizational implications for agencies that previously received inclusive rates for bundled services or for services provided by multi-disciplinary teams that included credentialed and non-credentialed clinicians.

In serving persons with serious mental illness and substance abuse disorders, the issues of language and cultural competence are very important. None of the contracts specifies in its service duties that providers be able to furnish care in such a fashion (although the company may presume the existence of such capabilities when it enters into an agreement with a community-based MH/SA agency). Moreover, some group health sponsors, e.g., State Medicaid agencies, require the provision of translation services as part of clinical treatment itself. Medicaid managed care contracts also may specify that services be furnished in a "culturally competent" fashion. In none of the provider agreements we inspected (including agreements that unambiguously covered Medicaid beneficiaries) did the agreement discuss issues of cultural competence on the part of the provider or the availability of translation services. These provisions might well be addressed in a provider manual to accompany the contract. However, depending on how references to a provider manual are drafted in the contracts, such manuals may or may not create binding substantive obligations on the provider.

3. The Duty to Treat Patients and Accept Patient Referrals

All of the contracts imposed on providers the duty to treat patients referred to them by the MCO. This duty is the essence of managed care, which requires MCOs to undertake to provide covered services through its providers. Only in rare instances did the contracts we studied permit providers to refuse to accept any particular patient into their practice or to discharge a patient from their program. *(Footnote 15)* None of the contracts reviewed guarantees a minimum number of patient referrals nor were there guarantees in contracts in which payment is made on a capitated basis and a sizable number of lives theoretically would have to be guaranteed to make the agreement financially viable for the MH/SA agency.

4. Prior Authorization of Covered Services

Table 4 indicates that the great majority (80 percent) of the contracts require that providers obtain prior authorization for one or more contract services. *(Footnote 16)* Table 5 indicates that in only 10% of contracts is the primary care provider explicitly identified in the contract the entity from whom prior authorization to furnish MH/SA services would be obtained. This suggests that, although primary care providers commonly are termed "gatekeepers", the true gatekeeping authority (i.e., the exercise of medical judgement regarding the access to specialty care) is generally retained by the MCO. This is consistent with the obligation on MCOs to manage access and use of care particularly of specialty services. *(Footnote 17)*

Prior authorization requirements frequently apply both to emergency and non-emergency services. Table 6 shows that only half of all contracts reviewed specifically exempted emergency MH/SA treatment from otherwise applicable prior authorization requirements. In these cases, review of an emergency service generally is required within 24 to 48 hours of admission.

The footnotes accompanying Table 6 show examples of the types of emergency prior authorization language contained in contracts. For example, one contract provides:

> In the event of a life-threatening emergency Consultant will immediately notify the Health Plan's 24-hour Special Care Center Emergency Line for instructions. Table 6, contract 34.04

This provision exemplifies a contract in which the provider is required to contact the plan prior to ordering an emergency admission. If the provider were to order the admission without first consulting the plan, either the provider (or the patient, if her membership agreement specifies that she may be liable for costs if plan coverage procedures are not followed by either herself or her provider) might be liable for the cost of the care. *(Footnote 18)* Moreover, liability theoretically could attach regardless of whether a subsequent review determined that the admission in fact was for an emergency condition. In other words, provisions such as the one which is set forth above impose unequivocal duties on the provider to contact the plan before taking any further action. Failure to contact the plan would be a breach of the contract, and the MCO potentially might be entitled to recover its costs (i.e., payment for the care) as well as other damages specified in the contract.

Prior authorization terms, as illustrated by the provision below, often are quite expansive in the scope of authority which is retained by the MCO and the limitations that are placed on provider treatment discretion:

Contract 71.02

BENEFIT LIMITATIONS - Neither Plan nor any Client Organization shall make payment for Facility services rendered to Covered Members which are, in the opinion of Plan, determined to be not Medically Necessary or which have not been authorized by Plan. Facility shall obtain specific authorization for reimbursement from Plan prior to providing Covered Services to a Covered Member. In the event that Facility determines that treatment services beyond the then current authorization are Medically Necessary, Facility shall obtain additional authorization for reimbursement from Plan prior to providing to a Covered Member any Covered Services exceeding the maximum that was authorized in the most recent authorization. In the event that Facility determines that a Covered Member requires Emergency treatment, Facility shall contact Plan to obtain authorization for reimbursement for such care. If a Covered Member's condition is so severe that it is not possible to contact Plan, Facility shall provide such services to the Covered Member or refer the Covered Member to the nearest appropriate emergency facility and shall notify Plan as soon as practical, but not later than eight (8) hours following such referral. Each Plan authorization for Covered Services shall expire upon the earlier of (I) the expiration date specified in the authorization or (ii) termination of the applicable Managed Care Agreement. Reimbursement for Covered Services is contingent upon final determination by Plan or the Client Organization at the time the claim is processed that the patient was eligible as a Covered Member at the time that services were delivered to the patient. In the event that Facility provides services to a patient who was not eligible as a Covered Member at the time services were delivered, Facility may bill the patient for such services. In the event that Facility disputes Plan's reimbursement authorization decision, Facility shall comply with Plan's grievance and appeals procedures. For purposes of

this paragraph, Plan shall mean Plan or its designee.

Table 7 shows that of 50 contracts reviewed, none (including those that require prior authorization of emergencies) contains time line standards binding the plan to respond to a request for prior authorization within a given time frame. Moreover, none of the contracts treats as approved a prior authorization request which is not acted upon within a specified reasonable time period.

5. Access Standards and Treatment Time Lines

Treatment time lines establish expectations by managed care organizations regarding the speed with which covered services will actually be furnished. Tables 8A and 8B indicate that the overwhelming majority of contracts reviewed in this study do not contain treatment time lines as a contractual duty. Eighty-two percent of contracts covering substance abuse treatment are silent on the issue of time lines, while a similar percentage of all contracts covering mental health services are silent on the issue of timeliness of care. Specific agreements imposed by group purchasers might contain treatment time lines, which, if incorporated into a provider manual, would govern the process of care for members of the group. *(Footnote 19)*

Table 9 displays the range of access standards for treatment in use in the contracts we reviewed. A total of 8 (non-duplicated) contracts contain any treatment time lines. There is no consistent pattern to the range of time lines used. For example, one contract specifies same-day treatment for urgent care, while another requires treatment within 24 hours of the MCO's request for care. Three contracts specify a 72-hour time line for urgent care, three contracts, five working days for routine care, and one agreement, ten working days for a new patient appointment. One contract gives the provider 120 days to respond to certain types of treatment requests.

6. Referrals to, and Relationships with, Other Providers

Table 10 shows that with the exception of four contracts, service agreements either expressly limit referrals to providers within the network or else are silent or unclear on the matter. Where a MH/SA provider seeks to make a referral to a non-network provider, the request is subject to prior authorization by the MCO's medical and utilization review staff.

The issue of referrals of patients from the criminal justice system for treatment is an important one in MH/SA treatment. Standard insurance principles would exclude court-ordered treatment, as well as treatment ordered by public agencies, from coverage, since they are services that had not been determined by the plan to be *medically* necessary under the terms of the insurance plan (i.e., they have not been found necessary by the plan's medical staff or its contractors in instances where such determinations are allowed). Only one contract required acceptance of referrals from the criminal justice system. (Table 11) Furthermore, only a small number of contracts expressly require providers to maintain coordinating arrangements with other agencies

as a basic contract duty, even though, for example, at least some level of coordination is commonly requested by Medicaid agencies (Table 12). This lack of an explicit coordination requirement appears to be consistent with the manner in which MCOs elect to handle relationships between MH/SA providers and other providers generally. That is, the contracts reviewed here do not appear to require that MH/SA agencies will develop independent relationships with either primary care providers or other providers and agencies. Instead MH/SA providers are expected to relate to the MCO with respect to both treatment and referral decisions. Retention of coordination responsibility by the managed care organization may significantly impact continuity of care at the clinical level.

7. Medical Necessity and Emergency Definitions

At the heart of the contract between a provider and an MCO lie the covered services, the service duties the provider undertakes, and the standards and procedures that are used to determine whether any particular service will be covered as medically necessary and appropriate. Table 13 shows that 36 contracts contain clauses expressly linking coverage to a determination of medical necessity by the MCO. (The other contracts imply the need for medical necessity determination in their coverage provisions. Such implied authority has been challenged by others in court, usually unsuccessfully). *(Footnote 20)*

Two contracts specify that their medical necessity standards build on currently recognized placement criteria. Virtually none of the contracts articulate a separate medical necessity standard for children (Table 15), an important issue where the member group includes children covered by Medicaid. *(Footnote 21)* Such standards might be found in separate provider manuals pertaining to Medicaid enrolled children. Table 16 indicates that slightly less than half of the reviewed contracts contain a definition of medical emergency.

Table 14 sets forth the medical necessity and emergency definitions contained in the contracts reviewed. The table shows that there is wide variation in the definition of both medical necessity and emergency. Of particular importance is whether the standard used by the MCO contains references to both conditions as well as illnesses and injuries and whether the MCO must take the patient's overall condition into account in making a medical necessity determination. Also important are the procedural steps which the MCO builds into its medical necessity determinations, whether it reserves discretion to determine medical necessity, and whether the MCO builds certain limitations and exclusions into the basic service agreement. All of these issues go to coverage as well as to the provider's role in the process of coverage determination. (See, e.g., Table 14, contracts 5.01 and 61.01).

Table 17 shows the frequency with which medical necessity determinations are committed to plan discretion. In 29 contracts (58 percent of all contracts), medical necessity determinations were expressly committed to plan discretion and in 17 contracts authority to determine medical necessity was unclear or not addressed. *(Footnote 22)* Three contracts expressly stated that the treating provider's judgement would be taken into account in the plan's determination. *(Footnote 23)* In only one contract was the provider's determination binding (Table 17). This result would be consistent with MCOs' basic duty to the group purchaser to ensure that coverage is in fact

necessary.

8. Enrollee Encounter Data and Eligibility Verification

Despite the demand on the part of purchasers for data on access and utilization, only 8 contracts specify that providers must furnish encounter data to plans (Table 18A). The remaining 92% of contracts are either silent or unclear on the issue.

Because MCOs cannot pay for care unless patients are enrolled at the time services are furnished, it is not uncommon for contracts to specify pre-service eligibility verification requirements. Fifteen of 50 reviewed contracts contained such a requirement while the issue was not addressed or not clearly addressed in 31. (Table 18B). Only four of the 15 specify that the MCO's eligibility verification services will be available on a 24 hour-per-day, 7-day-per-week basis. One eligibility verification requirement reads as follows:

> VERIFICATION OF ELIGIBILITY - Provider may verify the current status of the Covered Person's eligibility for Plan Services by requesting presentation by the Covered Person of his or her identification card or by contacting Plan or designee during normal office hours in accordance with the Plan's Provider Manual. However, if Payor or Sponsor subsequently determines that the individual was not eligible for coverage for the services provided, those services shall not be eligible for payment. Provider may then directly bill the individual for such services. Contract 26.07, Table 18B.

This provision is notable because it not only shifts the financial risk of an incorrect verification to the provider but also instructs the provider to bill a beneficiary whose eligibility was confirmed by the plan and who relied on verification prior to receiving treatment. Such practices may be either prohibited by group purchasers or prohibited under law, leaving providers liable for the entire cost of care furnished to ineligible persons.

9. Quality Management Systems

More than 80 percent of the contracts reviewed explicitly require participation in the contractor's quality management system. Only one contract specifies that the MCO's quality management system will include individuals with expertise in mental illness treatment. One of the contracts reviewed specified that reviewers would have expertise in substance abuse treatment the overwhelming majority of contracts did not address the qualifications of MCOs quality assurance

system personnel.

10. Capitation Agreements

Table 20 shows that only two contracts reviewed in this study contain capitation payment arrangements for one or more covered services. Of these, one includes a withhold arrangement. None includes a shared savings (i.e., "upside risk") clause.

The capitation agreements which do appear in these documents appear to create significant financial risk *(Footnote 24)* to the provider. The following language is taken from one of the agreements:

> **Contract 4.07**
>
> The facility agrees to provide all inpatient psychiatric and acute stabilization services, including both facility and professional services, to Plan Members and Plan's Medicaid Covered Members within the Service Area. In compensation for services rendered, the facility will be paid **$0.77** per member per month (PMPM) for all Covered Services within the Service Area. The Facility will receive **$0.67** PMPM by the 20th of each month. The Company will retain $0.10 PMPM from the Facility's monthly compensation for the establishment of an inpatient fund to pay for inpatient services for enrollees within the Service Area who receive emergency services outside the Facility's delivery system. The Company and Facility agree to mutual best efforts to make all referrals for Covered Members, as outlined in the previous section, into the Facilities delivery system. If all Inpatient Funds have been utilized, the Company will be responsible for costs in excess of the Inpatient Fund. If all Inpatient Funds have not been utilized, the Facility will be reimbursed remaining amount. The Company will make best efforts to conduct a bi-monthly reconciliation for determination of Inpatient Fund. For utilization purposes, the Facility agrees to submit a billing (HCFA 1500) for each patient stay. The billing must be received no later than the 15th working

> day of the subsequent month. **(Emphasis added)**

This agreement as worded potentially creates significant risk in the MH/SA agency for the excess cost of inpatient services, appears to leave the provider with no stop loss protection for its own services, and also contains important ambiguities. First, the member base against which the capitation is estimated is unclear. The agreement calls for a payment of $.77 per member per month. However, the base could be either the company's entire panel of covered lives (in which case the capitation payment amount might be sufficient) or some subset thereof. The ambiguity of the payment provision is compounded by the "best effort to refer" clause which from a purely financial point of view does not belong in a capitation payment system, particularly one in which the membership base on which the capitation is calculated is unclear. Without clarity regarding the patient base against which the sufficiency of the capitation rate is to be measured, the level of financial exposure for the MH/SA agency cannot be measured accurately and may, in fact, be worsened through an active referral effort by the company.

Second, the agreement has the effect of making the MH/SA agency the primary insurer for inpatient care and appears to leave the agency vulnerable to cost overruns for its own "facility" services without a stop loss. Under the agreement, the provider is at risk for all "facility" services, with an amount withheld and applied toward emergency services rendered at other facilities. The Company has agreed to provide a stop-loss, but this stop-loss is worded ambiguously. The Company agrees to be responsible for "costs" beyond the withhold amount, but these costs are not defined. They could include the provider's own excess hospital costs beyond its capitation, or alternatively, they could be limited to the cost of emergency care furnished in other facilities. Under one interpretation the MH/SA agency would have at least some stop loss protection against unanticipated costs in its own facilities. Under the other interpretation the provider effectively would have no stop loss for its own services.

11. Fee-for-Service Agreements

Table 21 shows that 48 contracts provide fee-for-service payments for one or more services. Our sample of contracts clearly shows that, at this point in time, financial arrangements for managed care may imply risk sharing (and potential profit sharing) for the MCOs. But for MH/SA providers, including the community MH/SA agencies in our sample, managed care remains fee-for-service reimbursement. But for MH/SA providers, it sharing these, three contracts include withhold provisions, and two include shared savings arrangements. The withhold arrangement for contract 55.02 is displayed below:

> **Contract 55.02**
>
> WITHHOLD ARRANGEMENT. Plan will reduce, by a minimum of ten percent for inpatient professional services, and twenty percent for outpatient services, the amount payable to Specialist Provider under this arrangement. The total amount of such

> reductions shall be retained in an aggregate Mental Health Services Risk/Incentive Sharing (withhold) Account maintained by the Health Plan. **Plan shall have the right to adjust** on a monthly basis, the percentage of the reduction of the amount otherwise payable to Specialist from a minimum reduction as stated above, to a maximum reduction of twenty percent for inpatient professional services and forty percent for outpatient professional services if such increase in reduction is deemed warranted, **in the judgment of Plan**, to avoid incurring a deficit in Plan's Mental Health Services operations. **Plan's Mental Health Services operation's cost is budgeted to be an amount equal to $2.47 per member per month for all mental health and alcohol and substance abuse professional and institutional fees. The $2.47 per member per month will be evaluated 60 days prior to each anniversary date of this Agreement and potentially adjusted for the subsequent 12 month periods. In no event will the adjustment exceed an increase of ten percent**. This base limit *[left blank]* per member per month fee will not be decreased. **(Emphasis added)**

This agreement vests discretion in the plan to make an upward adjustment in the withhold level at any time. The terms of the contract also place the MCO under no obligation to lower the withhold in the event that the need for an upward adjustment abates, nor is the MCO under an obligation to return any portion of the withhold. The MCO's discretion over payment terms can be thought of as consistent with the expectation of group purchased agreements that the MCO will maintain services within the budget expectations of the purchaser, and with the resulting need on the part of the MCO to maintain control over the flow of funds in order to address possible cost overruns.

11(a). Stop-Loss, Reinsurance, and "Hold harmless" provisions

Regardless of whether an agreement provides for fee-for-service or capitation payments, a provider can find that its financial exposure increases substantially, either because of unanticipated losses resulting from capitation or because fee-for-service withholds brings total revenues below a level needed to be able to cover the cost of agency operations. None of the contracts we examined provides stop-loss coverage for providers' in-office services, nor do the contracts provide for cost settlement in the case of community MH/SA agencies whose fee-for-

service payments result in significant revenue shortfalls which bring their compensation below the cost of services furnished to beneficiaries. The absence of such provisions is consistent with the fundamental theory of managed care as it currently operates, which is built on networks of providers offering substantially discounted services to members. To the extent that providers have other sources of revenues that can absorb such discounting (or that are operating inefficiently) the theoretical base of managed care may result in less expensive care with no loss of quality. To the extent that maximum efficiencies have been realistically achieved and/or other sources of revenues are not available to a provider, the practice of discounting without stop-loss or hold harmless provisions may lead to reductions in care.

12. Coordination of Benefits

Most contracts contain coordination of benefit clauses, which obligate the provider to bill legally liable third parties prior to billing the MCO. In only one contract is the onus of collection placed squarely on the plan. In the remainder, the onus lies with the provider (18) or else is unclear(12) or not addressed(19), despite the potential financial impact of coordination of benefit duties on providers. Coordination of benefits' requirement can slow down payment otherwise due from the MCO while liability from a third party is pursued. In the case of Medicaid managed care, such "cost avoidance" coordination of benefit requirements (under which no payment is made until payments from a legally liable third party have been obtained) would be inconsistent with Federal law in the case of certain pediatric and adult benefits. *(Footnote 25)* The potential impact of a coordination of benefits clause (which is typical of all insuring agreements and therefore is incorporated into managed care-style arrangements as a general rule) can be seen from the excerpted language below:

Contract 13.02

THIRD PARTY LIABILITY - Coordination of Benefits. Provider agrees that his/her office will assist covered persons with the processing of forms required to pursue coordination of benefits with other health care plans or any other permitted methods of third party recovery, including Medicare. Provider further agrees that, where duplicate coverage exists and the health care plan referred to in the applicable Addendum to this Agreement **appears to be** the secondary coverage, **he/she shall so notify Plan and seek payment from the other health care plan, before seeking payment from Plan (in which case the applicable billing schedule described above shall not apply). (emphasis added)**

In this excerpted language the burden falls to the provider to seek out and capture other forms of insurance before billing the MCO. The MCO's fee schedule is no longer in effect, so that if the other payer's compensation should be less, the Plan does not make up the difference. The burden is with the provider to determine who is the primary payer, a piece of information that may not be easily available or available at all to the provider.

13. Term and Termination

The term and termination provisions of contracts are exceedingly important, because they indicate how long the contract remains in effect and the circumstances under which the contractual relationship may be ended. All of the contracts reviewed are "evergreen"; that is, they either are in effect for an indefinite period or else last a term and are renewed automatically unless either side terminates the agreement. *(Footnote 26)*

Table 23 shows that contracts are equally likely to grant both providers and MCOs no-cause termination rights. Plans are somewhat more likely to be able to terminate for cause (Table 24). While no cause termination is a right enjoyed by either party in most of these agreements, as a practical matter such a clause is a far more potent weapon in the case of the MCO. In the event of termination, an MCO retains the group members. A provider that elects to terminate the agreement can leave the relationship but would lose its access to the MCO's patients.

An important issue for both parties is how long it takes to terminate a contract in which a party to the agreement no longer wishes to participate. Table 25 shows that about half of all contracts either require at least three months' notice prior to a no-cause termination or else do not address the matter, leaving the provider subject to whatever later rules are established. In the case of cause-related terminations, plans are more likely than providers to be able to terminate in 30 days or less and frequently are able to terminate upon notice in certain cases (e.g., loss of license by provider). In no case did we find a contract in which the provider was able to terminate immediately on notice for loss of license or accreditation by the plan or loss of a specific contract with a group sponsor.

Beyond the question of termination lies the issue of post-termination treatment obligations. Post-termination treatment obligations are an important safeguard for beneficiaries of the plan so that members can be safely transferred to another care arrangement. A common provider post-termination treatment obligation arises when either party elects to terminate the contract. Another common provider post-termination rule applies when a plan is in bankruptcy or is insolvent (in which case the trustee in bankruptcy negotiates payment arrangements with providers on patients' behalf). A few contracts specify post-termination treatment obligations even when the contract is terminated for non-payment by the plan or the contract is terminated by the Medicaid agency. In slightly more than half of the contracts (52%), the MCO is obligated to pay the provider for post termination services rendered.

In addition to the question of the obligation itself is its duration. Table 26A sets forth language on post termination treatment obligations. In a number of cases the post-termination obligation extends indefinitely, regardless of the cause of the termination or the amount of time needed to

effectuate a patient transfer. Thus, a contract terminated by the provider because of non-payment by the plan may contain a post-termination clause that requires the provider to continue to treat the non-paying plan's patients until the plan can make alternative arrangements. *(Footnote 27)* While post-termination treatment clauses represent important protections for beneficiaries, clauses of indefinite duration can also significantly elevate financial risk to the provider. The following clause illustrates the potential financial exposure created by post-termination treatment obligations:

Contract 13.02.

PLAN FAILURE TO PAY - Care Upon Insufficiency of Funds: Provider agrees to furnish services to Covered Persons through the current term of any in force health care agreements in the event revenues of Plan (or of its contracting parties, if applicable) are insufficient to pay Provider the compensation due; provided, however, that such health care services for such period will be provided only for covered persons whose health care agreements are effective on or before the date funds become insufficient to pay Provider. Provider is not obligated to accept additional covered persons as patients after funds of Plan (or of its contracting parties, if applicable) become insufficient to pay Provider.

The following clause presents another example of how post termination clauses potentially can create unanticipated risks for providers:

Contract 49.01

PAYMENT AFTER TERMINATION - Notwithstanding anything contained herein to the contrary, Plan and Provider agree that upon the termination of this Agreement for any reason, the Plan may continue to withhold all or any part of any compensation payable to Provider, as determined by the Plan, for a reasonable period of time after termination in order to analyze claims and utilization data to determine the exact final amount due Provider. "Reasonable period of time" for purposes of this Agreement shall not exceed one (1) year from the effective date of termination. In the event that Plan terminates this Agreement for cause, then Plan shall have the right to retain all money

due Provider and to offset its expenses related to such termination. Net money due Provider shall be determined by Plan, and such payment by Plan shall be final and binding on Provider.

14. Gag Clauses

Of all the contracts we reviewed, only two contained clauses that could be construed as "gag" clauses (i.e., clauses that appear to prohibit providers from speaking to patients about coverage and treatment determinations made by the plan). The two clauses we found are set forth below:

Gag Clauses	
ID#	**Gag Rule Contractual Language**
15.27	Neither the Company nor the Center shall release any information regarding the terms set forth in this Agreement to any person or entity without the prior written consent of the other, except such information as may be necessary to disclose to agents, third party payers, affiliates, attorneys, accountants, State licensing agencies or Members in order to carry out the terms of this Agreement. Except as otherwise required by applicable law or provisions of this Agreement, Company and Center shall keep confidential, and shall take the usual precautions to prevent the unauthorized disclosure of, any and all records required to be prepared or maintained in accordance with this Agreement. Furthermore, Center and Company shall not disparage the other party or any aspect of Company's behavioral health benefits programs or Center's operations to any Member or other person.
55.02	Specialist agrees to be bound by all of the provisions of this Agreement, which prohibit, among other things, misrepresentations to a Member regarding the policies or program requirements of Plan, including misrepresentation of Plan's benefits and exclusions or presentation to a Member any Specialist Provider Agreement dispute between Specialist Provider and Plan.

We assume that the absence of gag clauses on a widespread basis (which also was true in the case of primary care contracts we have reviewed in the past) indicates that the problem of gag clauses provisions may be less widespread than one would believe given the publicity that the practice has received. *(Footnote 28)*

15. Anti-Delegation Clauses

Numerous contracts reviewed contain provisions that prohibit physicians under contract to the

MCO from delegating any of their duties to any other member of the MH/SA provider. While these clauses technically are meant to deal with the legal and ethical problems arising from unilateral decisions on the part of providers to end their undertaking, the clauses also could be construed as effectively prohibiting the use of a health care team to provide covered services to patients. The following clause is illustrative of a typical anti-delegation provision, which prohibits variation in contractual treatment arrangements unless consent of the MCO's medical director is given:

> **Contract 5.01**
>
> It is agreed and understood that this Agreement involves the personal services of Specialist Physician and it may not be transferred or assigned by Specialist Physician nor may Specialist Physician subcontract or otherwise delegate his duties without QMs written approval. QM may assign this Agreement without the consent of, but with written notice to, Specialist Physician.

16. Indemnification clauses

In our earlier review of contracts between primary care providers and managed care organizations, we found that the contracts consistently include a mutual indemnification clause which requires each party to indemnify the other for suits arising out of the acts and omissions of the parties. Similarly, the contracts reviewed in this study consistently contain such provisions, requiring each party to indemnify the other in the event that lability is established. Mutual indemnification clauses are common in the case of contracts between independent parties. Moreover, in a malpractice action involving the quality of care furnished by a managed care plan, a plaintiff will typically name as defendants both his or her individual providers as well as the managed care organization and any relevant subsidiaries (e.g., a utilization review subcontractor). *(Footnote 29)* In these situations the actual meaning and impact of a mutual indemnification clause is unclear, since all parties may be liable.

Informal Interviews with MH/SA Providers

During 1996 we held informal discussions with 12 MH/SA center directors or their staff regarding their experiences in negotiating managed care provider contracts. Most of the respondents considered that the contracting process had been open to negotiation. Respondents did not feel that the nature of either the company with whom they were negotiating or the ultimate contract sponsor(s) (e.g., Medicaid versus a private sponsor) affected the degree to which the contract was subject to negotiation.

When we asked primary care providers in 1994 about the negotiation process, only about one in ten felt that the process was open. The rate was considerably higher in the present study. This perception of great openness to negotiation may be the result of several different factors. First, in this study we interviewed fewer individuals. Moreover, persons interviewed primarily included several persons who volunteered to share their negotiating experiences with us. In our previous study we had made random calls to providers whose contracts we reviewed. The perceived openness of MCOs to negotiating contracts could derive from community MH/SA providers being sought after by MCOs to form specialty networks.

Finally, in the two years which elapsed since our previous set of interviews, some providers have achieved greater levels of organization and may be more aware of the need to negotiate. Only a minority of our respondents in this study felt that service and payment terms were open to negotiation, suggesting that for most respondents, negotiations focused on the periphery of the contracts rather than their central elements.

With respect to negotiation "preparedness", we found that only half of all interviewees obtained all contract-related information before negotiating the terms of the agreements. In the majority of cases providers that did not review these documents reported that they did not do so because plans would not furnish them during the negotiation process. Because contracts incorporate numerous documents by reference (particularly utilization and quality assurance guidelines, health plan operating procedures and provider membership-related documents), reviewing these items prior to negotiating or executing a contract would appear to be an essential step.

Less than half of all respondents obtained a legal analysis before signing an agreement only one obtained an actuarial analysis. Only half of all respondents indicated that they conducted a business analysis of contracts prior to signing them. The providers that did not obtain either business or legal assistance reported cost as a barrier.

We also sought to explore the issue of concerted bargaining on behalf of MH/SA agencies. We found that while 7 respondents were members of a State or national trade association, in only one case did the association bargain on behalf of its members. Moreover, only one quarter of respondents were members of provider networks that represented their interests on a collective basis.

Footnotes

12 Our methodology for this phase of the study is discussed in greater detail in Appendix A.

13 Presumably the Medicare and Medicaid physician incentive plan regulations issued in 1996 will lead to modification of at least some contracts to provide for risk sharing arrangements in the case of Medicare and Medicaid members that are different from those used by MCOs in the case of other group purchasers.

14 In some contracts MCOs may give network providers the right to refuse to accept certain members (e.g., Medicaid members in the case of private physicians). The legality of such a

practice would be open to question under federal civil rights statutes; as a result, most MCOs probably would use informal arrangements to steer certain members to or away from certain providers (e.g., certain providers would not be listed in member handbooks or would be reported as having full practices). Sara Rosenbaum et.al, ACivil Rights in a Changing Health Care System@ *Health Affairs* 16:1 (Jan./Feb., 1997).

15 This is markedly different from our findings in a companion study of Medicaid managed care contracts, which frequently permit MCOs to request disenrollment of non-compliant patients. This dichotomy suggests that MCOs seek the flexibility to disenroll non-compliant patients while at the same time avoiding giving their network providers similar flexibility, which could disrupt their ability to carry out their obligations were the flexibility to be utilized by many providers.

16 Note that the 90-contract comparison analysis found that 83 out of 90 contracts (92 percent of all contracts reviewed) required prior authorization from the managed care plan for one or more services.

17 This finding is consistent with our earlier study of primary care contracting patterns, in which we determined that primary care providers seldom are given the authority to make medical necessity determinations for services not furnished in their offices. See S. Rosenbaum, R. Serrano, E. Wehr, S. Spernak, ANegotiating the New Health Care System: An Analysis of Contracts between Primary Care Physicians and Managed Care Organizations@ [forthcoming] *JAMA*.

18 Such membership terms are not uncommon. Indeed, the federal Medicare program denies payment to individuals if procedural conditions for coverage (e.g., a three-day hospital stay prior to nursing home admission) are not followed. *Law and the American Health Care System* op.cit., Chapter 4.

19 See *Negotiating the New Health System* op. cit. Volume II, Chapter 3.

20 *Law and the American Health Care System* op.cit., Chapter 3.

21 Under the EPSDT program, services are considered necessary for children if they are needed to ameliorate a condition or promote growth and development. The purpose of EPSDT is preventive, and as a result, coverage determinations must incorporate a preventive standard. Under traditional insurance principles, coverage may be limited to conditions that are the result of illness or injury (which could exclude many childhood developmental disabilities) and will be offered only if a restorative result can be achieved. Se *Negotiating the New Health System* Volume II, Chapter 2.

22 The 90 contract comparison review showed that 73 percent of all contracts explicitly committed medical necessity determinations to plan discretion, a figure significantly higher than in the case of the 50-contract study group. This suggests that if anything, the 50 study contracts established less stringent controls over mental health and substance abuse treatment providers than might typically be the case.

23 The issue here only is whether a plan will contractually promise to consult with a treating physician. A managed care organization probably would face significant legal challenges were it to make coverage determinations with no reference whatsoever to the opinion of the treating physician or the customary standard of practice. See *Law and the American Health Care System*.

24 We consider this risk to be significant because furnishing covered outpatient care to the plan's members might exceed the amount of resources the provider is given under the contract by thousands of dollars depending on the number of patients referred to the provider and their level of need.

25 42 U.S.C.A. '1396a(a)(25).

26 Nearly all of the contracts also give MCOs the right to modify the agreement at any time; for this reason, providers usually are given the express right to terminate the agreement rather than consent to the modification.

27 Indeed, Contract 4.07, which as noted above, provides $,77 per member per month capitation payments also contains a post-termination treatment obligation of indefinite duration ("until discharge"). See Table 26A.

28 What is extremely common, however, is a proprietary clause, which if ambiguously worded could be equated with a "gag clause", as noted supra.

29 *Law and the American Health Care System*, op.cit., Chapter 3.

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An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

Conclusion and Recommendations

This exploratory, point-in-time study of contracts between MCOs and community MH/SA agencies shows that despite a certain degree of difference, provider service agreements are strikingly similar in their structure and content. Just as with any standard set of business agreements, managed care provider contracts are designed to permit managed care companies to meet their buyers' expectations while at the same time realizing a financial gain from their enterprise.

Regardless of their specific provisions, the contracts examined here are designed to establish and maintain control over coverage, practice and costs, the ultimate goal of managed care purchasers. They do this through several basic techniques. First, the contracts establish an at-will relationship between the MCO and the provider, leaving the MCO free to modify or terminate the agreement at any time without cause. While providers typically also have at-will termination rights, they exercise them without the benefit of continued access to members following the end of the agreement with the company. Moreover, because the MCO can influence patient access to specific network providers, particularly in the case of specialist referrals, the company can reinforce its control over the provider's practice style through member referral patterns.

Second, the contracts specify a minimum basic service package that the MCO promises to buy if it considers the services to be medically necessary and appropriate as determined by the MCO. Individual service agreements with particular group purchasers may add to the services that MCOs will buy from certain providers and that providers can agree to sell, but these are add-ons for particular buyers and are not part of the MCO's basic supplier agreement with its providers. These limited-scope basic agreements undoubtedly reflect MCOs' estimate of what its group purchasers will be willing to buy and thus what the market will bear.

Third, the contracts seek to retain control over the movement of funds throughout the health care system created by the MCO. Financial terms can be unilaterally modified. Withhold and risk sharing provisions typically create no legally binding duties on MCOs to return to or pass on to providers a portion of the profits realized from the enterprise, a fact that may be attributable in some cases to the financial risk that the MCO assumes and in other cases to the unwillingness of a self-insured sponsor to allow savings to accrue to providers. Financial risk can be shifted in numerous other ways, from eligibility verification systems that require providers to absorb the risk of erroneous eligibility determinations, payment provisions that do not contain specific time lines, coordination of benefit provisions that place responsibility for recovery of liability with the provider, and other provisions designed to control the flow of funds. These techniques are developed by MCOs in order to ensure that the basic objective of the purchaser -- health care at the price it wants -- can be achieved, while shielding the MCO itself from financial risk (in the

case of risk contracts) and from the loss of the group purchaser's business (in the case of an administrative services contract).

The reason to study managed care contracts is because of their implications for both patients and providers. Behavioral health managed care arrangements have received praise for their ability to improve the overall quality of care while controlling costs. At the same time, the recent problems of TennCare managed behavioral healthcare plan, as evidenced by the loss of health care access and economic damage to community providers serves as a reminder of how market choices can affect not just members and providers, but entire communities as well. *(Footnote 30)*

This study also points to an important issue for managed care group purchasers. Managed care systems operated through a series of interlocking agreements among the various parties in the system. These agreements spell out basic coverage rules and service duties. They can be supplemented for individual group purchasers, but the process of adding on to the basic system and translating these add-ons into provisions that providers can understand and apply is a difficult one. Group purchasers that desire tailored products may find problems in the process of translating their tailored expectations into well functioning modifications of the basic managed care system.

This issue is a particularly pressing one for State Medicaid agencies, which, as noted elsewhere, tend to seek products that are relatively tailored to the needs of their populations. In separate studies we have examined contracts between Medicaid agencies and managed care organizations. These studies suggest that Medicaid agencies are making a substantial effort to purchase managed care arrangements that are tailored to the needs of their clients. In a number of respects the service expectations of Medicaid agencies may differ significantly from the basic coverage and service expectations established by MCOs in their standard provider network agreements. Purchasers such as Medicaid agencies, whose managed care expectations go beyond the level of coverage accorded under a typical managed care plan, need to pay particular attention to how their expectations are translated by MCOs into their contract agreements with providers and how MCOs communicate with providers about these tailored products. In cases in which the group purchaser's managed care expectations are significantly different from those reflected in an MCO's standard agreement with its providers, the purchaser may need to take additional steps to ensure that provider agreements accurately reflect its expectations and that providers are apprised of key differences. Otherwise group purchasers' expectations may be lost in the translation between the master contract and the point at which care is delivered. These added steps might include a requirement that MCOs develop specific contract addenda for a particular product, review and inspection of provider manuals prepared by the MCO, and provider surveys by the purchaser.

In recent years Federal and State governmental agencies, Congress, and State legislatures have evidenced increasing interest in the contracting techniques used by MCOs to carry out the expectations of group purchasers. Group purchasers may expect that an MCO will be able to provide an ever expanding level of benefits at an ever-more-slowly-rising price. But some of the techniques that MCOs develop for meeting what may be unrealistic expectations are ones that ultimately may be unacceptable from a public policy perspective. The Mothers and Newborns Protection Act of 1996 and its State legislative predecessors are examples of legislation aimed at curbing certain MCO practices under which companies override not only the treatment desires of consumers but also the clinical judgement of physicians' and other health providers. Legislation aimed at regulating gag clauses, physician incentive plans, and the use of at-will contracts is

designed to place limitations on the contracting approaches available to companies in their efforts to carry out the desires of their purchasers. While similar efforts at legislative reform will probably continue for some time, a more fundamental question perhaps is whether public and private purchasers will learn to balance their desires for the best health care at the lowest price against the need to limit certain MCO contracting practices that, even if not proved to be related to quality of care problems, nonetheless raise concerns in the minds of the public. To the extent that these practices are triggered by the desires of the purchasers themselves, it is incumbent upon purchasers to recognize their role in the process and adjust accordingly.

The question of provider response to these contracts inevitably arises. In markets with a surplus of products, purchasers and their agents hold the upper hand in contract negotiation. Providers become suppliers of a particular input into the total managed care product, and their interchangeable quality becomes a paramount driver in the process of developing participation agreements. The question is what happens to those providers in such a market who are perceived by public policy makers as offering a unique product -- in this case, community based MH/SA care to all persons regardless of their ability to pay. One answer may lie in better organization and the development of stronger negotiating leverage. Recent rulings of the Justice Department and the Federal Trade Commission may encourage the development of stronger networks.

But even if provider networks are strengthened, MCOs will still have a strong bargaining position. Therefore, group purchasers and policy makers need to make choices. To the extent that a group purchaser values the services that an individual provider or class of providers can offer its members, it needs to specify its expectations regarding these providers in its MCO contract. Moreover, in the case of services that community based MH/SA programs furnish and that group purchasers do not include in their coverage agreements, policy makers need to make deliberate funding decisions and develop an explicit means of paying for these services. The discounted fee-for-service payments that form the basis of most managed care contracts make the continued provision of non-insured services unrealistic in light of the disappearance of cross-subsidy capabilities.

Footnotes

30 "Tennessee pulls plug on mental health carve-out", *State Health Watch* 4:3 (March, 1997) 1. Problems associated with the carve-out included inadequate reimbursement, access problems, the placement of excessive financial risk on individual providers, a lack of control over both admission and discharges, and an underestimation of the cost of the product.

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An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

Appendix A – Methodology

This study was conducted between the fall of 1995 and the spring of 1996. The contracts reviewed in the study are agreements that were signed and in effect at the time they were collected. *(Footnote 31)* These contracts are neither model nor sample contracts. Instead they are living documents. Many of the contracts contain sanctions for disclosure of proprietary information (including the contracts themselves). For this reason we have handled the instruments with complete anonymity. We do not report our findings by State, name of health care provider, or name of plan. Each contract has been assigned a numerical identifier and is otherwise non-identifiable.

Contracts were sought directly from community mental health agencies and substance abuse treatment and prevention centers with the assistance of three national organizations *(Footnote 32)* that either represent or work closely with the centers and agencies whose contracts we studied. The leadership of each organization provided the Center with a letter of introduction encouraging members or agencies to participate in the study. The Center sent this letter to potential participants, along with a cover memorandum which explained the purpose and nature of the study as well as the confidentiality precautions that would be taken to ensure anonymity.

We contacted a total of 508 separate providers in 43 states over a four-month period beginning in 1995. We contacted all States with mandatory Medicaid managed behavioral healthcare systems for some or all beneficiaries. In addition, we identified approximately 20 States, through the literature and in consultation with experts both within and outside SAMHSA, in which significant levels of MC activity on MH/SA issues taking place, arrangements for individuals with mental illness or substance-related disorders. We made additional efforts to solicit study participation in these states. *(Footnote 33)*

We received a total of nearly 380 separate documents (e.g., contracts, provider manuals, provider/facility applications, letters of agreement) from providers in 27 states. Among the documents received were 257 intact contracts. Some providers furnished us with several contracts (in at least one instance, a single provider furnished us with more than 30 separate signed agreements). We eliminated certain contracts from the data base because they involved employee assistance plan agreements, workers' compensation agreements or other provider agreements outside the scope of this study, which was confined to agreements with private managed care organizations. *(Footnote 34)* After eliminating these contracts, we had a potential data base of 194 contracts. From this data base we selected contracts in a manner that would ensure representation from all reporting states, as well as variety in the type of service agreements examined (e.g., HMOs, PPOs, provider networks, and other corporate managed care entities). *(Footnote 35)* We assigned a number to each contract which indicated the State from which it came and the order in which we received it. This numbering system was designed to

permit anonymous referencing of actual contract language displayed on the tables that accompany this report. This system also permits us to store our data and trace it to the original source, if necessary.

A special data collection instrument was developed for this study. The instrument builds on the earlier data collection instrument developed by the Center for use in reviewing contracts between plans and family medicine practices furnishing comprehensive primary health care. Many of the fields in this instrument originated with the first instrument, since many provisions in provider participation agreements are common to all types of agreements regardless of the particular class of contract reviewed. With the assistance of experts in mental illness and addictive disorders prevention and treatment we then modified the basic instrument to add questions designed to evaluate both the special array of services that managed care organizations (MCOs) conceivably might purchase from MH/SA providers, as well as special patient care duties arising from the medical practice specialty in which these providers are engaged. Examples of the questions specially tailored to meet the needs of this study are questions regarding coverage of specific mental health and substance abuse treatment and prevention services, questions related to provider relationships with the penal system, and questions related to provider relationships with State and local agencies serving persons with mental or addictive disorders.

All contracts were logged and prepared for review by the member of the review team with health services research experience. This individual also developed the data input and display system used to create the tables which accompany this report. Two lawyers with extensive experience in provider contract analysis reviewed the documents in accordance with a protocol designed to ensure uniformity in interpretation. The instrument was designed to permit answers of "yes", "no", "unclear", and "not addressed", and attorneys were expected to comment extensively for later resolution and consultation on sections that presented ambiguities. The answer "no" in this form of analysis seldom appears, since a "no" is checked only if the contract states the absolute opposite of the question posed. Where a contract is silent on a particular issue, the answer checked is "not addressed" *(Footnote 36)* which signals silence. Such silence could be construed in various ways by a court. Although the general rule is that ambiguities in a contract are construed against the drafter (in this case, the plan), many of the issues for which "not addressed" was the correct answer are, in our opinion, too important from a provider's point of view to leave ambiguous in the hope of later, favorable resolution. For this reason we sought in our review and analysis to draw readers' attention to these ambiguities. Once the attorneys reviewed each contract and completed the instrument, the data were entered and the attached compilation was prepared.

We reviewed a total of 50 contracts. The membership of all three national organizations participating in the study were proportionally represented in the contracts reviewed. The review process for the 50 contracts occurred in two separate review periods. The first review analyzed 40 contracts. The second review period was a follow-up analysis of 10 contracts reviewed separately to confirm our findings of the first 40 contracts. The results from the two separate reviews were indistinguishable and, therefore, we combined the two groups of contracts to present one unified 50-contract database. In order to additionally verify our findings, we reviewed the prior authorization and medical necessity clauses of an additional 90 contracts to compare their contents against those of the 50 study contracts. The contents of these 90 comparison contracts on selected questions were sufficiently similar to those of the 50 study contracts to lead us to believe that the 50 study contracts are representative of the types of agreements frequently in use with mental health and substance abuse treatment and prevention

centers.

Finally, we conducted a series of informal telephone discussions with 12 providers of mental health and substance abuse treatment and prevention services to learn more about their experiences in negotiating their contracts. The clinics selected for these interviews were chosen in several ways. First, the attorneys who reviewed the contracts selected documents representing a range of service agreements (i.e., HMOs, PPOs, networks, and so forth) so that agreements involving different types of managed care organizations would be included in the interview phase. Second, we interviewed substance abuse treatment and prevention center directors who had previously indicated their interest in describing their contract negotiation process.

Footnotes

31 As noted infra, most of the contracts are Aevergreen@ documents; that is, they are contracts of indefinite duration with no fixed termination point.

32 These organizations are the Legal Action Center, which specializes in substance abuse treatment issues and has a membership of approximately 38 state associations, the National Community Behavioral Healthcare Council, which represents more than 900 community mental health centers nationally and Mental Health Corporations of America, which represents 113 of the nation's largest community mental health centers. Approximately 85 centers are members of both NCBHCC and MHCA; membership lists were matched so that these centers were contacted only once.

33 No providers from one state with significant MH/SA Medicaid managed care activity responded to our request for contracts.

34 For purposes of this study a managed care organization (MCO) is an entity that undertakes to provide one or more covered services on a prepaid basis. An MCO can be an HMO, PPO, integrated service network, physician/hospital network, corporation or provider network.

35 It is important to note that in many instances it was impossible from the contract to identify the precise type of entity whose agreement we were examining. Some documents clearly involved either federally qualified or state-licensed HMOs. Others simply represented that they were being offered by a corporation of some type engaged in managed care activities.

36 For example, if the question is whether a plan must take a provider's medical judgement into question in making a utilization review determination, the correct answer would be "not addressed" if the contract is silent on this matter and "no" if the contract states that the "plan in its absolute and sole discretion will determine if a particular service is needed."

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An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

Appendix B – Tables

General Contract Provisions

- Table 1 Organizational Contractor by Corporate Type
- Table 2 Classes of Service Covered by Contract
- Table 3 Services Purchased Under Fee-for-Service Contracts and Capitation Contracts

Service Duties and Prior Authorization

- Table 4 Prior Authorization by Managed Care Entity
- Table 5 Prior Authorization by Primary Care Provider
- Table 6 Exemption of Emergencies from Prior Authorization Requirements
- Table 7 Prior Authorization Time Lines
- Table 8A Substance-Related Disorders Treatment Time Line
- Table 8B Mental Health Treatment Time Line
- Table 9 Substance-Related Disorders and Mental Health Treatment Time Line Specifications
- Table 10 Referrals to Other Providers
- Table 11 Service to Individuals in the Criminal Justice System
- Table 12 Coordination Arrangements

Medical Necessity

- Table 13 Medical Necessity
- Table 14 Medical Necessity and Medical Emergency Criteria (Contractual Language)
- Table 15 Medical Necessity Standard for Children

- Table 16 Treatment of Emergencies
- Table 17 Determination of Medical Necessity

Enrollee Information and Data

- Table 18A Enrollee Encounter Data
- Table 18B Pre-Service Verification of Coverage

Quality Assurance

- Table 19 Quality Assuarance Participation

Financial Terms and Conditions

- Table 20 Financial Arrangements for Capitated Contracts
- Table 21 Financial Arrangements for Fee-for-Service Contracts
- Table 22 Coordination of Benefits Clause

Term and Termination

- Table 23 No-Cause Termination
- Table 24 Cause Termination
- Table 25 Termination Notice Periods
- Table 26A Post-Termination and Services Obligations

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An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

I. GENERAL CONTRACT PROVISIONS

TABLE 1 - ORGANIZATIONAL CONTRACTOR BY CORPORATE TYPE

The purchaser of the services under this contract is:		
	N=50	Percent (%)
A managed care plan that sells coverage (at risk)	19	38%
Other/Unclear	31	62%

TABLE 2 - CLASSES OF SERVICES COVERED BY CONTRACT

Contracting provider is responsible for the following types of services:		
Contracts may specify > one (1) option (number may add up to > 50).	N=50	Percent (%) Frequency
Mental health services	36	72%
Substance-related disorders services	34	68%
Unclear	6	14%
Other (medical\surgical services=0)	4	08%

Not addressed	1	02%

TABLE 3 - SERVICES PURCHASED UNDER FEE-FOR-SERVICE CONTRACTS AND CAPITATION CONTRACTS

N = 50

Service	**FFS**	**Capitation**
Physician	6	1
Psychiatric physician services *(Footnote 1)*	10	2
Psychologist	8	2
Social worker	7	1
Substance-related disorders counselor	0	0
Nurse practitioner/ physician assistant	1	0
Laboratory	6	0
-includes non-CLIA waivered services	1	0
-excludes non-CLIA waivered services	0	0
-does not address CLIA waivered services	5	0
Screening and diagnosis of mental health disorder	9	0
Screening and diagnosis of substance-related disorders	8	0

Inpatient hospital care for psychiatric conditions:	6	2
-short-term	2	1
-long-term	0	0
-does not distinguish	4	1
Inpatient hospital care for substance-related disorders:	8	3
-short-term	3	1
-long-term	0	0
-does not distinguish	5	2
Outpatient care for psychiatric conditions:	12	2
-short-term	1	1
-long-term	1	0
-does not distinguish	10	1
Outpatient care for substance-related disorders:	12	2
-short-term	2	1
-long-term *(Footnote 2)*	0	0

-does not distinguish	10	1
Outpatient substance-related disorders services for persons with a primary diagnosis of mental illness (dual diagnosis):	4	0
-short-term	1	0
-long-term	1	0
-does not distinguish	3	0
Outpatient mental health services for persons with a primary diagnosis of substance-related disorders (dual diagnosis):	2	0
-short-term	0	0
-long-term	0	0
-does not distinguish	3	0
Partial hospitalization and day treatment programs for persons with mental health disorders:	9	0
-adults	4	0
-children *(Footnote 3)*	4	0
Partial hospitalization and evening treatment for persons with mental health disorders:	4	0
-adults	1	0

-children	2	0
Emergency care: *(Footnote 4)*	8	1
-physician services	1	0
-facility costs	1	0
-does not distinguish	7	1
Evaluation, treatment planning and service coordination	7	0
24-hour crisis services including an 800 number hot-line available to all enrollees	4	0
Community mental health care	0	0
Community substance-related disorders treatment and prevention	1	0
Mental health targeted case management	2	0
Substance-related disorders targeted case management	1	0
Mental health intensive case management	3	0
Substance-related disorders intensive case management	2	0
Methadone therapy	2	1
Residential substance abuse treatment	1	0
Half-way house programs	1	0
Home health care (in-home therapy):	5	0
-short-term	1	0

-long-term *(Footnote 5)*	1	0
-does not distinguish	2	0
Services for individuals identified as having severe and persistent mental illness	1	0
Relapse prevention services	2	0
Community treatment for individuals discharged from state mental hospitals	1	0
Education and prevention services	3	0
Outreach services:	1	0
-IV drug users	0	0
-persons in a close relationship with IV drug user(s)	0	0
Outreach services to homeless persons	1	0
Tuberculosis (TB) services	1	0
HIV/AIDS services: *(Footnote 6)*	1	0
-HIV/AIDS prevention education and outreach	1	0
-HIV testing	1	0
-HIV pre- and post-testing counseling	1	0

Programs for pregnant women with health and/or substance-related disorders	1	0
Teen mother substance-related disorders prevention program	0	0
Programs for substance exposed infants	3	0
Services for women with substance-related disorders and their children	1	0
Violence prevention programs:	1	0
-children identified as having child abuse problems	0	0
-individuals identified as having spousal abuse problems	0	0
Prescription drugs	0	0
Medication management	12	0
Supported living services: *(Footnote 7)*	2	0
-development of community living skills	1	0
-social rehabilitation services	1	0
-development of personal support networks	1	0
-crisis residential services	1	0
-24-hour crisis services	1	0

-supportive counseling	1	0
Health exams	1	0
Transportation	2	0
Culturally appropriate mental health and substance-related disorders services and materials	1	0
Translation or appropriate language services	0	0
Management of certain related conditions	1	0
Other services	15	2

Footnotes

1 Psychotherapy may also be provided by psychiatric social workers and other providers, but not specified here.

2 Only one contract distinguishes between long-term and short-term care and this same contract provides both (1.01).

3 One contract that distinguishes between long-term and short-term care provides both (1.01).

4 The same one contract specifies that it provides physician services and facility costs for emergency care (1.01).

5 Only one contract distinguishes between long-term and short-term care and this same contract provides both (56.05).

6 Contract (1.01).

7 Only one of the two contracts providing supported living services specified the provision of the following services (1.01).

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An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

II. SERVICE DUTIES AND PRIOR AUTHORIZATION

TABLE 4 - PRIOR AUTHORIZATION BY MANAGED CARE ENTITY

Contract requires provider to obtain prior-authorization **from the managed care organization** (e.g., the plan, the MSO or the network) for one or more services.		
	N=50	Percent (%)
Yes	41	82%
No	2	04%
Unclear	3	06%
Not addressed	4	08%

TABLE 5 - PRIOR AUTHORIZATION BY PRIMARY CARE PROVIDER

Contract permits provider to obtain prior authorization **from enrollee's primary care provider** for one or more types of services.		
	N=50	Percent (%)
Yes	5	10%
No	16	32%
Unclear	5	10%
Not addressed	24	48%

TABLE 6 - EXEMPTION OF EMERGENCIES FROM PRIOR AUTHORIZATION REQUIREMENTS

Contract specifically exempts emergency services from otherwise applicable prior authorization requirements.		
	N=50	Percent (%)
Emergency services exempted	25	50%
By CPT code	1	02%
By contractual definition of emergency care	24 *(Footnote 8)*	98%
No	4 *(Footnotes 9, 10, 11, 12)*	08%
Not addressed	21	42%

TABLE 7 - PRIOR AUTHORIZATION TIME LINES

Contract establishes time lines for any prior authorization determinations that are required.		
	N=50	Percent (%)
Yes	5	10%
Not addressed	45	90%
Contract provides that failure to respond within the time line to a prior authorization request with by provider shall be construed as an approval.		
	N=50	Percent (%)
Not addressed	50	100%

TABLE 8A - SUBSTANCE-RELATED DISORDERS TREATMENT TIME LINE

Contract includes time lines for provision of substance-related disorders services.		
	N=50	Percent (%)

Yes	8	16%
Other *(Footnote 13)*	1	02%
Not addressed	41	82%

TABLE 8B - MENTAL HEALTH TREATMENT TIME LINE

Contract includes time lines for provision of mental health services.		
	N=50	Percent (%)
Yes	7	14%
Unclear	1	02%
Not addressed	42	84%

TABLE 9 - SUBSTANCE-RELATED DISORDERS AND MENTAL HEALTH TREATMENT TIME LINE SPECIFICATIONS

Contracts specifying time lines for provision of substance-related disorders and mental health services.			
Contracts may specify > one (1) option (number may add up to > 8).	N=8 Frequency Table		
Specified Time Period	Substance Abuse only	Mental Health only	Both
Immediately in cases of emergency			1
Within 1 hour of presentation at a service delivery site or within 24 hours after telephone contact in urgent cases			1
Same day for urgent care			1
Within 24 hours of Plan's request for care			1
Within 48 hours after reporting the onset of persistent symptoms			1
72 hours for urgent care			3

5 business/working days for routine care			3
10 working days from initial contact for first appointment			1
10 days for non-emergent care			2
14 days from request for admission	1		
120 days from request, if no program has capacity to admit the individual, and, if interim services are offered	1		

TABLE 10 - REFERRALS TO OTHER PROVIDERS

Contract specifically limits provider referrals to other providers within the managed care organization's network.		
	N=50	Percent (%)
Yes	16	32%
No	4	08%
Unclear	3	06%
Not addressed	27	54%

TABLE 11 - SERVICES TO INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM

Provider must accept enrollees who are in the criminal justice system.		
	N=50	Percent (%)
Yes	1	02%
No	1	02%
Not addressed	48	96%

TABLE 12 - COORDINATION ARRANGEMENTS

Document requires provider to have cooperative or coordinating arrangement with:

Contracts may specify > one (1) option (number may add up to > 50).	N=50	Percent (%) Frequency
Child protective services	0	0%
Early intervention/special education programs	0	0%
Educational system	0	0%
Juvenile justice system	1	02%
Criminal justice system (adults)	1	02%
Social services agency	1	02%
Other	2	04%
Not addressed	45	90%

Footnotes

8 One contract states that, "In a Psychiatric Emergency, Provider may provide Covered Services to a Member immediately provided that Provider shall notify Plan of the rendering of emergency services and obtain the required clinical authorization within two (2) hours of rendering such emergency services. If Plan is not available by telephone within that two (2) hour period, Provider must obtain the required authorization within twenty-four (24) hours of rendering any Covered Services.@ (59.01)

9 The language in one contract states that, AIn the event of a life-threatening emergency, Consultant will immediately notify Health Plan=s 24-Hour Special Care Center Emergency Line for instructions.@ (34.04)

10 The language in one contract states that,@ Only Emergency Health Services will be eligible for retroactive authorization at the sole discretion of Plan.@ (37.02)

11 The language in one contract states that,"Provider shall notify and request authorization from Plan by telephone prior to any admission of a Covered Person regardless of time of day or day of week.@ (26.07)

12 The language specified in this contract is that A All Health Services provided to Members by Facility must be authorized by Plan prior to or at the time of rendering services, subject to state regulations.@ (58.03)

13 One contracts states that AProvider agrees to accept such referrals on a daily basis (24 hours per day, 365 days per year) and to schedule initial clinical appointments not more than one hour from the time of referral...@ (68.03)

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III. MEDICAL NECESSITY

TABLE 13 - MEDICAL NECESSITY

Contract contains one or more provisions that limit coverage to medically necessary services:		
	N=50	Percent (%)
Yes	36	72%
Unclear	1	02%
Not addressed	12	24%
Other	1	02%
Contract defines medical necessity standards specifying currently recognized placement criteria:		
	N=50	Percent (%)
Yes	2	04%
Not addressed	48	96%

TABLE 14 - MEDICAL NECESSITY AND MEDICAL EMERGENCY CRITERIA (CONTRACTUAL LANGUAGE)

TABLE 14. CONTRACTUAL DEFINITIONS OF MEDICAL NECESSITY AND EMERGENCY EVENT

ID#	Medical Necessity	Emergency
01.01	"Medically Necessary" means those covered services provided by a qualified service provider within the scope of their practice. Under state law or certification, whichever is applicable, medically necessary services are provided to prevent disease, disability and other adverse health outcomes or their progression, or to prolong life.	"Emergent or Emergent Mental Health Services" means covered inpatient or outpatient services provided after the onset of a mental health or substance abuse condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result in: a) placing the Member's health in serious jeopardy; b) serious impairment to bodily functions; c) serious dysfunction of any body organ or part; or d) serious behavioral dysfunctions to indicate the Member is a danger to self or others.
04.02	No definition	No definition

04.07	"Medical Necessity" (or "Medically Necessary") shall mean services or supplies provided by Facility, or a physician or other health care professional, to identify or treat a condition and which, as determined by Plan are: (1) consistent with the symptoms, diagnosis and treatment of the condition; (2) standards of good medical practice; (3) not solely for the convenience of the patient of the patient's family or health care provider; and (4) furnished in the least intensive type of medical care setting required by the Covered Member's condition. When applied to an inpatient, it further means that the patient's symptoms or condition require(s) that the services or the supplies be safely provided to the patient as an outpatient or in a less intrusive environment.	"Medical Emergency" shall mean a condition or the onset of a condition that requires immediate medical care, as determined by Plan.
08.04	No definition	No definition
26.07	No definition	Emergency: A serious condition that arises suddenly and requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of a Covered Person or to the life of another.
13.02	No definition	Emergency Treatment: "Emergency services" or "emergency treatment" is defined as those medical, psychiatric and/or chemical dependency services required for the alleviation of a disturbance in thoughts, feelings or actions which, if not treated, could result in an attempt to inflict serious bodily harm to self and/or to another, attempted suicide, self mutilation and/or disability within 30 days unless treatment is afforded.
05.01	"Medically Necessary" means any Health Care Service or supply for prevention, diagnosis, or treatment which is not excluded or limited by this Agreement or the Member's Health Plan and which is: (a) consistent with the illness, injury or condition of the Member, and; (b) not primarily for the convenience, appearance or recreation of the Member, and; (c) in accordance with approved and generally accepted medical or surgical practice prevailing in the geographical locality, where and at the time when, the service or supply is ordered, and; (d) neither experimental nor investigative. The determination of the Medical Director regarding "Medically Necessary" will be final, subject only to Articles 8 and 9 *(Footnote 14)* hereof .	"Medical Emergency" means circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the Member's life or health would have been jeopardized had the care been delayed. "Emergency Medical Care" means services rendered in the diagnosis and treatment of a Medical Emergency. The existence and duration of a Medical Emergency shall be determined solely by Plan in the exercise of its reasonable judgment.
04.09	No definition	No definition
52.08	"Medically Necessary" services means those mental health and substance abuse treatment services that (i) are adequate and essential for the evaluation and/or treatment of a disease, condition or illness, as defined by standard diagnostic nomenclatures (ICD9-CM, DSM III-R); (ii) can reasonably be expected to improve an individual's condition or level of functioning; (iii) are in keeping with national standards of mental health professional practice (psychiatry, clinical psychology, psychiatric social work, psychiatric nursing), as defined by standard clinical references, valid empirical experience for efficacy of psychotherapy(ies), and national professional standards referred to in this Agreement and its exhibits, and promulgated by national mental health professional associations and federal agencies utilizing professional consensus development and scientific data; and (iv) are provided at the most cost-effective level of care. Medically Necessary services may also be referred to in materials relating to the Program as "Medically/Psychologically Necessary" services.	No definition

03.01	"Medical Necessity" (or "Medically Necessary") shall mean services or supplies provided by Facility, or a physician or other health care professional, to identify or treat a condition and which, as determined by Plan are: (1) consistent with the symptoms, diagnosis and treatment of the condition; (2) standards of good medical practice; (3) not solely for the convenience of the patient of the patient's family or health care provider; and (4) furnished in the least intensive type of medical care setting required by the Covered Member's condition. When applied to an inpatient, it further means that the patient's symptoms or condition require(s) that the services or the supplies be safely provided to the patient as an outpatient or in a less intrusive environment.	"Medical Emergency" shall mean a condition or the onset of a condition that requires immediate medical care, as determined by Plan.
40.04	Care will be provided in the best interest of patients according to the customary standards of practice in the area. When applicable this includes participation by medical residents who will be subject to the usual supervision by the attending physician as is customary in the residency program and within the customary standards of practice in the community. Provider and Plan agree that it is desirable to deliver services under this Agreement in the most cost-effective manner, while assuring that high standards of medical care are maintained.	No definition
55.01	No definition	No definition
54.02	"Medical Necessity" or "Medically Necessary" means that the services provided to diagnose or treat an illness or condition that meet, in the opinion of the Plan, or its designee, all of the following criteria: a. the service is appropriate for the symptoms, diagnosis and treatment of a particular disease of condition that is defined under ICD-9-CM, DSM-IV, or its replacement; b. the service is provided in accordance with generally accepted standards of mental health/substance abuse professional practice; c. the service is provided for the diagnosis or direct care and treatment of a disease or condition that is defined under ICD-9-CM, DSM-IV, or its replacement; d. the service is not rendered primarily for the convenience of the Member, the Member's family, Provider, or any other health care provider; and, e. the type, level and length of treatment services are needed to provide safe and adequate care. For inpatient stays, this means that the Member's symptoms or condition require(s) that the Member cannot receive safe and adequate care as an outpatient or in another less intensive setting.	"Emergency" means the sudden onset of a mental and/or serious or substance abuse condition manifesting itself by acute symptoms of sufficient severity, such that the absences of immediate medical or clinical attention could reasonably be expected to result in seriously jeopardizing or endangering the mental health or physical well-being of the patient or seriously jeopardizing or endangering the physical well-being of a third party.
56.06	No definition	No definition
61.01	Medically Necessary. Covered Services which, as determined by Plan through utilization review or claims adjudication processes, meet the following criteria: A. Are appropriate and necessary for the symptoms, diagnosis, or treatment of the mental health and/or chemical dependency condition; B. Are provided for the diagnosis, care and treatment of the mental health and/or chemical dependency condition; C. Are within standards of good medical practice within the medical community; D. Are not primarily for the convenience of the Member, Member's family, provider, or another health care provider; E. Are the most efficient and economical source or level of service which can be safely provided. For inpatient care, this means the care is necessary due to the severity of the Member's condition and safe and adequate care cannot be provided in a less intensive setting, such as outpatient; F. Services will not be considered Medically Necessary simply because they are rendered, prescribed, or ordered by the Member's Plan provider. Subject to appeal as described in Article VIII, Plan shall have the sole discretion to determine whether the	No definition

	services provided are Medically Necessary.	
62.01	Medically Necessary means, unless defined otherwise in the Member's Contract, the use of services or supplies as provided by a hospital, skilled nursing facility, Primary care Physician or other provider required to identify or treat a Member's illness or injury and which, as determined by the Medical Director of the applicable review committee designated by the Plan, are: (1) consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Member, his.her physician, hospital, or other health care provider; and (4) the most appropriate supply of level of service which can be safely provided to the Member. When specifically applied to an inpatient Member, it further means that the Member's medical symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the Member as an outpatient.	No definition
63.01	No definition	No definition
67.01	No definition	Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (I) placing the health of a Covered Individual in serious jeopardy; or (ii) serious dysfunction to bodily functions; or (iii) serious dysfunction of any bodily organ or part. For claims payment purposes only, determinations regarding the existence of a Medical Emergency shall be made by Plan.
67.06	No definition	No definition
59.01	Medically Necessary are those Covered Services required to identify or treat a Member's mental illness or chemical dependency and which, as determined by Plan, under its utilization review and quality assurance standards (subject to any required review and approval of the Client) are: (1) consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment, or injury; (2) consistent with standards of appropriate professional practice; (3) sot solely for the convenience of the Member, the Plan provider, or other health care provider, and (4) the most appropriate level of service which can be safely provided to the Member. When specifically applied to a Member receiving inpatient services, it further means that the Member's symptoms or condition requires that the diagnosis or treatment cannot be provided to the Member as an outpatient, consistent with the Plan's utilization review and quality assurance standards set forth in Plan's Procedures, as amended from time to time, appropriate professional standards and the Member's best interest.	Psychiatric Emergency means an immediate and unscheduled admission of a Member evidencing a DSM-III-R or DSM-IV diagnosis with symptoms of such severity that the impairment of functioning presents an immediate danger to self or others. Plan shall determine, in its reasonable discretion, whether a particular set of facts constitutes a Psychiatric Emergency; provided, however, that Client may have ultimate authority to review and approve any findings of a Psychiatric Emergency.
60.02	No definition	Emergency Services: Health care services required to maintain the life or health of a Member on an urgent basis.
34.04	No definition	No definition
08.02	No definition	No definition

45.01	No definition	"Emergency" means, unless defined differently in a specific Program Attachment, an illness or accident in which the onset of symptoms is both sudden and so severe as to require immediate medical or surgical treatment. This includes accidental injuries or medical emergencies of a life-threatening nature of which serious impairment of bodily functions would result if treatment were not rendered immediately.
34.01	"Medical Necessity" (or "Medically Necessary") shall mean services or supplies provided by Provider, or a physician or other health care professional, to identify or treat a condition and which, as determined by Plan are: (1) consistent with the symptoms, diagnosis and treatment of the condition; (2) standards of good medical practice; (3) not solely for the convenience of the patient of the patient's family or health care provider; and (4) furnished in the least intensive type of medical care setting required by the Covered Member's condition. When applied to an inpatient, it further means that the patient's symptoms or condition require(s) that the services or the supplies be safely provided to the patient as an outpatient or in a less intrusive environment.	"Medical Emergency" shall mean a condition or the onset of a condition that requires immediate medical care, as determined by Plan.
49.01	No definition	EMERGENCY means a situation which could result in an Enrollee's death or serious physical impairment if not treated immediately.
67.07	No definition	A valid emergency admission involves an unforseen psychiatric condition which, if not immediately treated, could lead to disability or place the patient or others in imminent danger of death. These conditions are characterized by violence, total disorientation and/or non-responsiveness, or the attempt to seriously harm self or others.
63.03	MEDICALLY NECESSARY means technologies, services, and supplies furnished to a Member/Subscriber that Plan determines are: medically appropriate for the symptoms, diagnosis, and treatment of the Member/Subscriber's condition, illness, or injury; in accordance with standards of good medical practice; not primarily for the Member/Subscriber's convenience or the convenience of his or her family or a provider, and the most appropriate level of service or supply that can safely be provided to the Member/Subscriber. When applied to hospitalization, this further means that the Member/Subscriber requires acute care as an inpatient due to the nature of the services rendered or the Member/Subscriber's condition, and the Member/Subscriber cannot receive safe or adequate care as an outpatient. The fact that a physician or health care professional may prescribe, order, recommend, or approve a service, supply, or technology does not, in itself, make the service, supply, or technology medically necessary. Services, supplies, and technologies that are not medically necessary include, but are not limited to, the following: services provided over a longer period of time than is necessary for effective diagnosis and treatment of the Member/Subscriber's illness or injury; and services provided, if the Member/Subscriber fails to comply fully with the medical regime established by a physician or other provider of services.	No definition
56.05	No definition	No definition
13.03	No definition	No definition

48.01	MEDICALLY NECESSARY SERVICES- are Medical Services which are required by Member as determined by Plan and in accordance with accepted medical and surgical practices and standards in the community and the professional standards recommended by Plan's Quality Assurance and Utilization Management Committees.	EMERGENCY SERVICES- are Medically Necessary inpatient or outpatient Medical or Hospital Services within or outside the Service Area which may not be delayed without possible serious effects on the health of the Member and which appear to be needed immediately to prevent the death of the enrollee or the serious impairment of the Member's health. Plan shall make all decisions regarding the duration of Member's care at an Outside Provider's facility and transfer of Member to Hospital or an alternate care facility. CRISIS INTERVENTION- shall mean any problem-solving activity rendered under the guidance of a psychiatrist, psychologist or other licensed counselor to correct or prevent the continuation of a crisis.
37.02	No definition	Emergency: A critical condition arising which requires immediate treatment to preserve or stabilize the Covered Person's life or health.
46.05	No definition	Emergency: A critical condition arising which requires immediate treatment to preserve or stabilize the Covered Person's life or health.
15.27	"Clinically Necessary" means Medically Necessary services, supplies, or accommodations required to identify, assess or treat a Member's condition.	"Emergency" means an unforseen Behavioral Disorder, Chemical Dependency or Psychological Injury which requires clinical attention within twenty-four (24) hours after its onset, in the absence of which services the Member could reasonably be expected to suffer serious physical or psychological impairment or death, or be a danger to self or others.
02.01	"Medical Necessity" (or "Medically Necessary") shall mean services or supplies provided by Provider, or a physician or other health care professional, to identify or treat a condition and which, as determined by Plan are: (1) consistent with the symptoms, diagnosis and treatment of the condition; (2) standards of good medical practice; (3) not solely for the convenience of the patient of the patient's family or health care provider; and (4) furnished in the least intensive type of medical care setting required by the Covered Member's condition. When applied to an inpatient, it further means that the patient's symptoms or condition require(s) that the services or the supplies be safely provided to the patient as an outpatient or in a less intrusive environment.	"Medical Emergency" shall mean a condition or the onset of a condition that requires immediate medical care, as determined by Plan.
10.01	No definition	No definition
40.01	No definition	No definition
25.01	"Medical Necessity" or "Medically Necessary" means that the services provided to diagnose or treat an illness or condition that meet, in the opinion of the Plan, or its designee, all of the following criteria: 1) the service is appropriate for the symptoms, diagnosis and treatment of a particular disease of condition that is defined under ICD-9-CM, DSM-IV, or its replacement; 2) the service is provided in accordance with generally accepted standards of mental health/substance abuse professional practice; 3) the service is not rendered primarily for the convenience of the Member, the Member's family, Provider, or any other health care provider; and, 4) the type, level and length of treatment services are needed to provide safe and adequate care. For inpatient stays, this means that the Member's symptoms or condition require(s) that the Member cannot receive safe and adequate care as an outpatient or in another less intensive setting.	"Emergency" means the sudden onset of a mental and/or serious or substance abuse condition manifesting itself by acute symptoms of sufficient severity, such that the absences of immediate medical or clinical attention could reasonably be expected to result in seriously jeopardizing or endangering the mental health or physical well-being of the patient or seriously jeopardizing or endangering the physical well-being of a third party.

16.01	"Medically Necessary" with reference to a Covered Services, shall Mean: (a) generally accepted by qualified professionals as necessary for the proper and efficient diagnosis and treatment of a Covered Person's mental health or substance condition, (b) not primarily for the convenience or preference of a Covered Person, the Covered Person's family or physician , clinician, or any other individual or institutional provider of Covered Services, (c) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency, and (d) no more intense a level of service than can safely be provided.	No definition.
55.02	No definition.	No definition.
50.06	"Medically Necessary" means that a health service (1) is appropriate and consistent with the diagnosis, and is consistent with accepted medical standards; (2) is Skilled Care; (3) as to institutional care, cannot be provided in any other setting, such as a physician's office or the outpatient department of a Network Provider, without adversely affecting the Covered Person's condition; (4) is required for the treatment of illness, injury, diseased condition, or impairment; (5) is not provided as a convenience to the covered person or Network Provider; (6) is not experimental, investigational, or unproven; and (7) is not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment to the Covered Person.	No definition.
58.03	Medically Necessary Health Services: Health Services, including professional services and supplies rendered by a provider to identify or treat an illness that has been diagnosed or is suspected, and which are (a) consistent with (i) the efficient diagnosis and treatment of a condition; and (ii) standards of good medical practice; (b) required for other than convenience; (c) the most appropriate supply or level of service; (d) unable to be provided in a more cost-effective and efficient manner; and (e) unable to be provided at a facility providing a less intensive level of care. When applied to inpatient care, the term means: The needed care cannot be safely given on other than an impatient basis.	Emergency: The sudden and unexpected onset of a medical condition or severe symptoms of sufficient severity that the absence of immediate medical attention within twenty-four (24) hours could reasonably be expected to cause physical harm to the life and safety of the Member and/or others.
28.05	"Medically Necessary or Medical Necessity" means the services or supplies furnished by a Provider that are required to identify or treat the Member's condition, illness, or injury and which the Plan determines are: a. consistent with the symptoms or diagnosis and treatment of the Member's condition, diseases, ailment, or injury; b. appropriate with regard to standards of good medical practice within the community; c. the most appropriate supply or level of service which can be safely provide to the Member. When applied tot he care of an inpatient, it means the most appropriate type of facility or level of care where the Member's condition or medical symptoms can be safely treated. It further means that the Member's medical symptoms or conditions require that the services cannot be safely provided to him/her as an outpatient.	"Emergency" means unforeseen circumstances requiring Medically Necessary care for the treatment of an accidental injury or a medical emergency. Accidental injury means a traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to result in serious physical impairment or loss of life. Medical emergency means a serious health-threatening or disabling condition manifested by severe symptoms occurring suddenly and unexpectedly which could result in serious physical impairment or loss of life if not treated immediately. Psychiatric emergency means the immediate and unscheduled admission of a Member to a behavioral healthcare facility because the Member is experiencing a severe level of symptoms according to a DSM III-R diagnosis which may be reasonably expected to cause impairment in his or her functioning to the extent that he or she may present an immediate danger of harm to self or others.
40.07	"Medically Necessary" health care services or supplies are those that are: (i) consistent with the symptoms, diagnosis and treatment of a Member's condition or disease; (ii) appropriate given the standards of medical practice prevailing in the applicable professional community at the time of treatment; and (iii) provided in accordance with the requirements of the Provider Manual.	No definition.

68.03	No definition.	No definition.
70.02	"Medically Necessary" shall mean Covered Services which a *XXXX* (*Footnote 15)* Member requires in the judgement of a *XXXX* Physician, in accordance with generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment and in conformity with the professional and technical standards adopted by the *XXXX* Quality Assurance and Medical Management Programs. The final decision of whether treatment is Medically Necessary shall be made by the *XXXX* Medical Director, subject to the applicable *XXXX* Dispute Resolution and *XXXX* Grievance Procedures.	"Emergency" shall mean the sudden and unexpected onset of a symptom, illness, or injury which, in the judgement of a Physician, requires immediate diagnosis and/or treatment in order to alleviate or attempt to prevent severe pain, permanent disability, serious medical complications or loss of life. The final determination of whether an emergency existed shall be made by the *XXXX* Medical Director, subject to the applicable *XXXX* Dispute Resolution and *XXXX* Grievance Procedures.
50.14	Medically Necessary shall mean MH/SA care which a CL (covered life) requires, as determined by Plan and in conformity with the professional and technical quality and utilization management standards adopted by the Plan.	Emergency MH/SA Services shall mean those services defined as chemical dependency or psychiatric conditions characterized by the sudden onset of acute symptoms of such severity that the absence of immediate medical or psychiatric attention may result in acute danger to the CL, harm to others or which places the CL at acute risk of disability.
30.02	"Service Necessity" means that the services or supplies provided by Facility, or a physician or other health care professional to diagnose or treat an illness or condition meet, in the opinion of Plan, or its designee, pursuant to the guidelines set for in the ICPC (Iowa Client/Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorder or the Iowa Juvenile Placement Criteria for the Treatment of Psychoactive Substance Use Disorder) , all of the following criteria: 1) appropriate and necessary to the symptom, diagnosis or treatment of a substance abuse disorder; 2) provided for the diagnosis or direct care and treatment of a substance abuse disorder; 3) provided within standards of good practice for the substance abuse service area; 4) not primarily for the convenience of a Medicaid Enrollee or a Provider; and 5) the most appropriate level or supply of service which can safely be provided.	"Emergency" means a substance abuse condition manifesting itself by acute symptoms of sufficient severity, such that the absence of treatment could reasonably be expected to result in death, injury or lasting harm to the patient or a third party.
71.01	"Medically Necessary" shall mean medical, surgical or other treatment which a Plan patient requires as determined by one or more of the Contractors' Participating Physicians, or by Plan in accordance with generally accepted medical practice standards in effect at the time of treatment and in conformity with the professional and technical standards adopted by the Plan's Risk Management/Quality Improvement Program.	No definition.
71.02	"Medical Necessity" or "Medically Necessary" means that the services provided to diagnose or treat an illness or condition that meet, in the opinion of the Plan, or its designee, all of the following criteria: 1) the service is appropriate for the symptoms, diagnosis and treatment of a particular disease of condition that is defined under ICD-9-CM, DSM-IV, or its replacement; 2) the service is provided in accordance with generally accepted standards of mental health/substance abuse professional practice; 3) the service is not rendered primarily for the convenience of the Member, the Member's family, Provider, or any other health care provider; and, 4) the type, level and length of treatment services are needed to provide safe and adequate care. For inpatient stays, this means that the Member's symptoms or condition require(s) that the Member cannot receive safe and adequate care as an outpatient or in another less intensive setting.	"Emergency" means the sudden onset of a mental and/or nervous or substance abuse condition manifesting itself by acute symptoms of sufficient severity, such that the absences of immediate medical or clinical attention could reasonably be expected to result in seriously jeopardizing or endangering the mental health or physical well-being of the patient or seriously jeopardizing or endangering the physical well-being of a third party.

TABLE 15 - MEDICAL NECESSITY STANDARD FOR CHILDREN

Provision includes a separate medical necessity standard for children.		
	N=50	Percent (%)
Unclear	1	02%
Not addressed	47	94%
Not applicable (children's services contract)	2	04%

TABLE 16 - TREATMENT OF EMERGENCIES

Contract includes definition of medical emergency:		
	N=50	Percent (%)
Yes	24	45%
No	1	02%
Not addressed	25	50%
Contract exempts emergency services from network provider requirements.		
	N=50	Percent (%)
Yes	16	32%
No	4	08%
Unclear	3	06%
Not addressed	27	54%
Emergency exemption only if the enrollee's emergency occurs *outside* the managed care organization's service area.		
	N=50	Percent (%)
No	2	04%
Unclear	1	02%
Not addressed	46	92%
Other	1	02%

TABLE 17 - DETERMINATION OF MEDICAL NECESSITY

Contract commits medical necessity determinations to plan discretion:		
	N=50	Percent (%)
Yes	29	58%

No	1	02%
Unclear/Not addressed	17	38%
Other	1 *(Footnote 16)*	02%
Contract provides that provider's judgment *determine*s whether services or service settings/providers are medically necessary:		
	N=50	Percent (%)
Yes	1	02%
No	25	50%
Unclear/Not addressed	24	48%
Contract provides that provider's judgment will be *taken into account* in medical necessity determinations:		
	N=50	Percent (%)
Yes	3	06%
No	13	26%
Unclear/Not addressed	34	68%

Footnotes

14 Articles 8 and 9 respectively refer to the Plan=s Grievance and Arbitration procedures.

15 *XXXX* = blinded plan/provider designations.

16 One contract (1.01) is Ano@ to services not requiring prior authorization and Ayes@ to services requiring prior authorization.

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An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

VI. ENROLLEE INFORMATION AND DATA

TABLE 18A - ENROLLEE ENCOUNTER DATA

Provider must provide, or make available, enrollee encounter data to plan:		
	N=50	Percent (%)
Yes	8	16%
Unclear	4	08%
Not addressed	38	76%

TABLE 18B- PRE-SERVICE VERIFICATION OF COVERAGE

Provider must verify member enrollment *before* furnishing care to member:		
	N=50	Percent (%)
Yes	15	30%
No	2	04%
Unclear	7	14%
Not addressed	24	48%
Other	2 *(Footnotes 17, 18)*	04%
For contracts that include a pre-service verification provision, managed care organization must make verification information available to provider:		

	N=50	Percent (%)
On a 24-hour-per-day, 7-day-per-week basis	4	08%
During normal business hours (indicate below)	1	02%
Other	4	08%
Not addressed	39	78%
Unclear	2	04%

Footnotes

17 The Plan duty is to supply verification on a specified form, but timing is not addressed. (62.01).

18 The verification requirement is not addressed, although there is a Plan duty to maintain a Asystem@ by which Provider can verify eligibility. (40.04)

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VII. QUALITY ASSURANCE

TABLE 19 - QUALITY ASSURANCE PARTICIPATION

Contract requires provider to participate in the managed care organization=s quality assurance system:		
	N=50	Percent (%)
Yes	42	84%
Unclear	2	04%
Not addressed	6	12%
Contract requires that the quality assurance system include individuals with relevant substance abuse treatment experience, training, or credentials?		
	N=50	Percent (%)
Unclear	2	04%
Not addressed	48	96%
Contract requires that the quality assurance system include individuals with relevant mental illness treatment experience, training, or credentials?		
	N=50	Percent (%)
Yes	1	02%
Unclear	1	02%
Not addressed	48	96%

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VI. FINANCIAL TERMS AND CONDITIONS

TABLE 20 - FINANCIAL ARRANGEMENTS FOR CAPITATED CONTRACTS

Capitation contracts with withhold arrangements:		
	N=2	Percent (%)
Yes	1	50%
No	1	50%
Of the **2** capitation contracts, those that have incentive or shared savings arrangements:		
	N=2	Percent (%)
Yes	0	0%
No	1	100%

TABLE 21 - FINANCIAL ARRANGEMENTS FOR FEE-FOR-SERVICE CONTRACTS

Fee-for-service contracts with withhold arrangements:		
	N=48	Percent (%)
Yes	4	09%
No	44	91%
Of the **48** fee-for-service contracts, those that have incentive or shared savings arrangements:		

	N=48	Percent (%)
Yes	2	04%
No	46	96%

TABLE 22 - COORDINATION OF BENEFITS CLAUSE

Contract contains a coordination of benefits clause:		
	N=50	Percent (%)
Yes	37	74%
Not addressed	12	24%
Other	1	02%
Party responsible for collection of third party payments is:		
	N=50	Percent (%)
Provider	18	36%
Plan	1	02%
Unclear	12	24%
Not addressed	19	38%

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An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies

IX. TERM AND TERMINATION

TABLE 23 - NO-CAUSE TERMINATION

Contract permits *provide*r to terminate the contract without cause:		
	N=50	Percent (%)
Yes	46	92%
Unclear	2	04%
Not addressed	2	04%
Contract permits *managed care organization* to terminate contract without cause:		
	N=50	Percent (%)
Yes	46	92%
Unclear	2	04%
Not addressed	2	`04%

TABLE 24 - CAUSE TERMINATION

Contract allows *provide*r to terminate with cause:		
	N=50	Percent (%)
Yes	41	82%
No	1	02%
Not addressed	8	16%
Contract allows *managed care organization* to terminate with cause:		

	N=50	Percent (%)
Yes	47	94%
Not addressed	3	06%

TABLE 25 - TERMINATION NOTICE PERIODS

Without-cause termination by provider:		
	N=50	Percent (%)
≤ 30 days	6 *(Footnote 19)*	12%
45 - 60 days	16	32%
≥ 90 days	24 *(Footnote 20)*	48%
Not addressed	2	04%
Unclear	2	04%
Without-cause termination by plan (managed care organization):		
	N=50	Percent (%)
≤ 30 days	6 *(Footnote 21)*	12%
45 - 60 days	16	32%
≥ 90 days	24	48%
Not addressed	2	04%
Unclear	2	04%

With cause termination by provider upon notice:		
	N=50	Percent (%)
≤ 30 days	31 *(Footnotes 22, 23)*	62%
45 - 60 days	8	16%
90 days	1	02%
Not addressed	10	20%

With cause termination by plan (managed care organization) upon notice:		
	N=50	Percent (%)
≤ 30 days *(Footnote 24)*	38 *(Footnotes 25,26,27,28)*	76%
45 - 60 days	8 *(Footnote 29)*	16%
90 days	1	02%

TABLE 26A - POST-TERMINATION AND SERVICES OBLIGATIONS

Provider is obligated to continue to serve plan members if:		
Contracts may specify > one (1) option (number may add up to > 50).	N=50	Percent (%) Frequency
Member elects to disenroll from plan	1	02%
Member changes primary care providers	0	0%
Plan elects to terminate contract	23	46%
Provider elects to terminate contract	21	42%
Plan files for bankruptcy or becomes insolvent	5	10%
Plans fails to pay	3	06%
Medicaid agency terminates plan contract	1	02%
Other	8	16%
Unclear	7	14%
Not addressed	12	24%
Managed care organization is obligated to pay provider for services provided under the continuation requirement(s).		
	N=50	Percent (%)
Yes	26	52%
No	2	04%
Unclear	6	02%
Not addressed	16	32%

Footnotes

19 One of the contracts included in this category stipulates that termination is "By mutual agreement between the Plan and the Participating Provider." (62.01)

20 One contract states that, "This Agreement may be terminated by either party by written notice give at least ninety (90) days in advance of such termination. Notwithstanding the above during the first (12) months of this Agreement, Specialist Provider may only terminate this Agreement for reason of breach by Health Plan." (55.02)

21 One of the contracts included in this category stipulates that termination is "By mutual agreement between the Plan and the Participating Provider." (62.01)

22 "Upon written notice by certified mail by one party to the other party of its intention to terminate this Agreement by reason of the other party's material breach of this Agreement." (62.01)

23 Contract 68.03 specifies termination upon notice and fourteen (14) days if breach; Contracts 71.02, 50.14, and 70.02 specify upon notice and thirty (30) days if breach.

24 Several plans, such as in contracts 48.01, 37.02, 15.27, 40.07, and 71.01 list 30+ day notification periods but also specify immediate termination for grounds such as loss of medical license, suspension from the Medicare or Medicaid program, and/or loss of insurance coverage.

25 One of the contracts included in this category stipulates that termination is "By mutual agreement between the Plan and the Participating Provider." (62.01)

26 In one contract, several grounds for termination are specified and, in addition, A...Termination under this subsection shall not be effective, and no withdrawal or non-renewal shall be deemed to have taken place for purposes of this subsection until all available rights of appeal have been exhausted; provided, however, the withdrawal non-renewal shall be deemed to have taken place at such time prior to the exhaustion of all appeals as Facility or Plan is required to cease or suspend its activities.

27 One contract states that, "...Any determination under this section may be appealed by Specialist Physician to the governing body of Plan, whose decision shall be final. An appeal will not stay the effective date of termination pursuant to this subsection." (5.01)

28 Contract 68.03 specifies termination upon notice and fourteen (14) days if breach; Contracts 71.02, 50.14, and 70.02 specify upon notice and thirty (30) days if breach.

29 Contract 37.02 specifies that AFailure to satisfy any such authorization or notification requirements may result in loss of reimbursement and/or termination of this Agreement."

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SAMHSA Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA)