

***NEGOTIATING THE NEW HEALTH SYSTEM:
A NATIONWIDE STUDY OF MEDICAID MANAGED
CARE CONTRACTS***

Third Edition

**SPECIAL REPORT:
MENTAL ILLNESS AND ADDICTION DISORDERS AND
MEDICAID MANAGED CARE**

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Executive Summary

This Special Report on mental illness and addiction disorders is part of *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, now in its third edition.¹ *Negotiating the New Health System* is a nationwide point-in-time study of agreements between state Medicaid agencies and managed care organizations (MCOs) offering general or specialized managed behavioral health care products. Each individual edition of *Negotiating the New Health System* is a point-in-time study or “snapshot” of these agreements for a particular year. However, the current series of editions, taken together, are beginning to form a longitudinal basis for reviewing the evolution of the agreements, for evaluating progress, and for identifying areas needing further work or scrutiny.

The manner in which contracts between state Medicaid agencies and comprehensive service managed care organizations address issues related to the management of mental illness and addiction disorders has been a particular focus of *Negotiating the New Health System* since the project began in 1995. This Special Report examines the evolution of Medicaid managed care for persons with mental illness and addiction disorders over a three-year time period, using the full contract database for the 1996-1998 time period.

This Special Report focuses on two separate matters. First, this edition examines the evolution of purchasing agreements in several contexts, including assessment of their provisions in earlier editions of this study, the Balanced Budget Act of 1997, and the Consumer Bill of Rights and Responsibilities (hereinafter referred to as the CBRR).

Second, this edition once again focuses on the issue of coverage under Medicaid managed care agreements. The question of how Medicaid managed care agreements address the issue of coverage is perhaps the most complex of all aspects of Medicaid managed care contracting and one that has been central to *Negotiating the New Health System* since its initial publication in 1997. This special focus on coverage stems from the key differences between the Medicaid entitlement on the one hand and the type of coverage typically found in managed care products on the market today. These differences have enormous implications for Medicaid beneficiaries generally, and for beneficiaries with special physical and mental health care needs in particular.

Generally speaking, states have made considerable progress in expanding the extent to which their contracts provide detailed descriptions of service specifications, including definitions of coverage and exclusions. Compared to the findings from the first and second years of this study, both the scope and the specificity of contract terms have increased. Contracts are also more likely to describe the manner in which such services should be furnished. At the same time, contractors retain much discretion over decisions regarding the medical necessity of care, as well as broad discretion over the range and capabilities of their provider networks. The following observations summarize the current findings on the overall evolution of state’s Medicaid managed behavioral health contracting practices:

¹ The third edition, along with the general overview (which this year focuses on pediatric care) can be obtained from the Center for Health Services Research and Policy at <http://www.gwhealthpolicy.org>.

a. Contract provisions relating to the classes and scope of covered services are becoming clearer. Consistent with the merger of coverage and care under managed care, contract provisions are more specific regarding how coverage should be achieved.

b. Some contracts show a greater interest in defining coverage in a manner that is culturally competent.

c. Coverage terms and definitions are becoming clearer.

d. States are making greater efforts to close the “coverage gap” between services that are covered under their contracts and services that are exempt or “carved out” and covered through separate contracts.

e. Medical necessity clauses continue to remain ambiguous or narrower than the standards that apply to Medicaid. Furthermore, important issues related to the resolution of potential coverage conflicts among competing health care entities remain unresolved, but states are showing progress.

In regards specific contract findings, we found that:

1. Network and Access Standards

- a. Network Composition:** Generally speaking, and consistent with the prior studies, the majority of contracts contain specifications relating to at least one class of provider, with the overwhelming class mentioned being primary care providers. Of the states that require primary care providers, most contain specifications related to primary care provider-to-patient ratios. Slightly less than half of the states continue to include the stipulation that specialty care providers be included in a plan’s network. Similarly, approximately half the contracts contain specifications regarding specialty care provider-patient ratios. Almost three-quarters of the states address the issue of including certain classes of “safety net” providers in their MCO network (e.g., local mental health agencies). Only a handful of states include a requirement that dual diagnosis providers be included in the network.
- b. Self-Referral to Mental Illness and Addiction Disorder Providers:** Our findings indicate that while most contracts still do not include any language which addresses the issue of self-referral for enrollees, the number that do address this issue has almost doubled this year. Specifically with regard to behavioral health services, however, the numbers are far less dramatic. Last year, 15 general service agreements and 7 behavioral health carve-out contracts addressed the issue of self-referral to providers of MI/AD services; this year, 14 general service contracts and 10 carve-out contracts address the issue. In addition, consistent with the earlier study, fewer states permit self-referral for substance abuse services (16 this year) than for mental health services (all 24).
- c. Cultural Competency:** Slightly more than half of all contracts in the 1997 database addressed cultural competency issues; this percentage has increased to nearly two-thirds in the current study. In the 1998 database, 32 out of 52 contracts (62%) address the issue of cultural competency, up from 29 out of 54 contracts (54%) in the prior year. Of

the 13 managed behavioral health contracts in 1998, 10 (77%) address this issue, an increase of 1 contract over the prior year. Consistent with our findings in the 2nd edition, contracts less frequently include a specific definition of cultural competency; of the 13 behavioral health contracts, only 4 of them do so, and only 4 of the remaining 39 general contracts make such a reference. Translation services and accessibility of materials by vision-, hearing-, and/or physically-impaired persons are almost universally addressed. Forty-five out of 52 contracts address requirements to make available materials in other languages or in forms useful to people with disabilities.

- d. Access to Emergency Services: Overall, states do a relatively good job of including in their Medicaid managed care general service agreements provisions that require access to emergency services, but are less likely to include similar language in their carve-out contracts. For example, in the 1998 database, 42 out of 52 contracts, but only 6 carve-out agreements, contain provisions requiring health plans to educate members about the availability, location, and appropriate use of services, and about cost-sharing and availability of care, outside the emergency room. In the first-year database, these numbers stood at 35 and 4, respectively. In addition, in 1998, 40 contracts—an increase of 3 over time—included a prohibition against billing for emergency care by non-network providers. However, only 7 carve-out agreements contained such a provision.

2. Relationships Between Managed Care Organizations and the Rest of the Health System

Notably, and not unlike the findings from the second edition, one of the areas most commonly addressed by contract provisions related to public agency relationships concerns generalized coordination requirements with state and local mental health and substance abuse programs. The database for the current edition of the study contains 52 separate contracts and RFPs (including 13 carve-out arrangements) in use at the beginning of 1998, as submitted by 39 states and the District of Columbia. Among the general service agreements, 29 of 52 specify relationships between managed care organizations and mental health agencies, and 22 address the relationships with substance abuse agencies. Further, 11 of the 13 managed behavioral health carve-out contracts address MCO relationships with either mental health or alcohol and substance abuse agencies (or both). Compared to last year, the only significant change—either positive or negative—is the decrease from 36 to 29 in the number of general service agreements that contain provisions specifying relationships between MCOs and mental health agencies.

3. Quality Improvement, Performance Measurement, and Data Reporting

The number of contracts containing provisions describing or referring to specific elements of a quality assurance system remains relatively unchanged from our prior year findings. Consistent with general service contracts, almost all (12 out of 13) behavioral health contracts include specifications for development of internal quality assurance and performance measurement systems by contractors. A larger proportion of behavioral health contracts require external review of a plan's performance than the general contracts (10 out of 13 vs. 28 out of 39); behavioral health contracts also more frequently cite the need for clinical studies and the use of clinical guidelines in quality assurance systems. Almost all contracts, whether general or behavioral health, require corrective action plans.

4. Patient Confidentiality

The federal Medicaid statute prohibits the disclosure of information about applicants and recipients other than for purposes directly related to the administration of a state's Medicaid plan. This provision would apply to all Medicaid managed care contracts regardless of the language included in the contract, since contractors act as agents of the state for purposes of medical assistance administration.² Thus, the Medicaid statute has for years addressed at least in part the issue of privacy raised by the current debate. In addition, regulations implementing federal programs prohibit recipients of federal funds from disclosing information or releasing client records.³

5. Respect and Nondiscrimination

In general, the agreements both in the original and 1998 database contain broad prohibitions against discrimination. A significantly smaller number of documents both in the first and third databases specifically apply these provisions to their subcontractors and network providers. Agreements are more likely to address discrimination on the basis of race, national origin, age, religion, sex and gender, disability, and anticipated need for health care and are less likely to address the specific issues of sexual orientation and mental disability.

6. Complaints and Appeals

Over the three-year time period covered by the database the extent to which the contracts address internal complaint and grievance systems has been consistently high. In the first year of the database, all but one of the 45 contracts, including all 8 carve-out agreements, specified that contractors maintain internal complaint and grievance procedures. In the current study, all 52 contracts, including the 13 carve-out contracts, contain provisions requiring contractors to maintain internal grievance procedures.

In conclusion, this analysis underscores a series of trends in Medicaid managed care contracting. The trends viewed in the contracts are consistent with other developments in Medicaid managed care. State Medicaid managed care contracts for both general and behavioral health services have become more detailed and specific regarding both coverage and contractors' service duties. This development appears to have coincided with a reduced interest in managed care contracting on the part of companies that also engage in a significant commercial business especially in relatively mature Medicaid managed care

² See *J.K. v Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993).

³ 42 C.F.R. §2.11. A separate question is whether contractors are independently held obligated to report data that are considered notifiable data under state public health or safety laws (e.g., communicable diseases, attempted suicides, crimes such as domestic abuse). At least one state, Vermont, requires its managed care contractors to assume responsibility for reporting cases of communicable diseases to the state health department (Vermont Contract, page 40). Most states, however, have not yet begun to treat MCOs as "providers" for purposes of notification and require only the individual clinicians and hospitals within its networks to report this information. See Rosenbaum et al, *An Overview of Data Submission Requirements Applicable to Managed Care Organizations Under State Medicaid Managed Care Contracts*. The Center for Health Policy Research, The George Washington University Medical Center. July 1998.

markets.⁴ These companies may view this greater level of specificity on the part of agencies as incompatible with the looser approach to contracting that appears to be taken under many employer-sponsored agreements, which leave far greater discretion to the industry.

The complexity of the service provisions in many Medicaid contracts also raises questions about whether most managed care companies that deal primarily with a commercial market are in fact equipped, particularly in the case of enrollees with disabilities, to design and administer an adequate product. At the same time, this analysis suggests that state agencies appear increasingly willing to use gap-closing clauses that allow them retain the power to decide whether a particular coverage determination is contrary to the contract or inconsistent with state and federal law.

Even as the contracts grow more complex in terms of coverage and service duties, it would be a mistake to view Medicaid managed care contracts as foreclosing contractor discretion. The data in this study suggest that states remain willing to allow their suppliers significant latitude in selecting their networks and establishing their own access rules for enrollees. States also appear willing to allow their contractors to rely exclusively on their own networks for the provision of care, regardless of whether the network proves sufficient to the task.

Furthermore, evidence from the database suggests that states continue to place only limited emphasis on the full disclosure of information to enrollees, most notably, information regarding network composition and membership. Given the close association between consumer satisfaction and the ability to maintain a relationship with a regular source of care, this relative lack of attention to network sufficiency, network disclosure, and remedial efforts by contractors in the event that networks prove inadequate bear closer scrutiny. As persons with mental and physical disabilities increasingly enroll in managed care organizations, the issues of coverage, access, and network sufficiency and network disclosure provisions may take on added meaning.

As in prior years, contracts continue to show relatively few specific performance measurements that purchasers will use to determine contractor compliance with the terms and conditions of the agreements. This area also merits ongoing attention, since the contracts are now so comprehensive that their enforceability has grown even more difficult. Without clear performance measures and specification of the data that contractors will be expected to submit to document compliance, the agreements are far less easy to administer, and critical data will be lacking in the event of a dispute.

Finally, because of the descriptive nature of this study, it is not possible to know how the variations in coverage and service provisions affect access and quality. Much work remains to be done on the issue of whether certain purchasing specifications are associated with certain outcomes. For example, where a state agency retains discretion to review contractor coverage determinations and reverse where necessary, does the retention of such authority change the outcome of decision-making in certain ways? Do very specific access

⁴ Suzanne Felt-Lisk, "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation." The Kaiser Commission on Medicaid and the Uninsured. May 1999. Available at <http://www.kff.org/content/1999/2141/KFFChangingMedicaid.pdf>.

and network standards yield different outcomes in terms of network composition and access timelines? Does a comprehensive grievance and complaint system reduce beneficiary reliance on fair hearings? These and other questions are important health services research topics that bear closer scrutiny.

Introduction

This Special Report on mental illness and addiction disorders is part of *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, now in its third edition.⁵ *Negotiating the New Health System* is a nationwide point-in-time study of agreements between state Medicaid agencies and managed care organizations (MCOs) offering general or specialized managed behavioral health care products. Each individual edition of *Negotiating the New Health System* is a point-in-time study or “snapshot” of these agreements for a particular year. However, the current series of editions, taken together, are beginning to form a longitudinal basis for reviewing the evolution of the agreements, for evaluating progress, and for identifying areas needing further work or scrutiny.

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As with its predecessors, this Special Report is not limited to states’ managed behavioral health care “carve-out” agreements; instead, it surveys the entire Medicaid MCO contract “landscape” (both general and behavioral health) for its implications for persons with mental illness and addiction disorders. This study is expansive for several reasons. First, limiting the survey to managed behavioral health care contracts would leave out much of the mental illness and addiction disorder treatment and prevention services that state Medicaid agencies purchase from managed care organizations. As of the most recent data collection year captured in this Special Report, 12 states maintained 13 managed behavioral health care “carve-out” contracts for some or all mental illness and addiction disorder treatment and prevention services covered under their state Medicaid plans. However, the majority of states (including those with specialty contracts) also purchased at least some level of mental illness and addiction disorder treatment and prevention services through their general agreements. It is impossible to evaluate how comprehensive Medicaid managed care service agreements address mental illness and addiction disorders without considering the entire database assembled for *Negotiating the New Health System*.

Second, understanding how managed care addresses the needs of persons with mental illness and addiction disorders means examining both the physical and mental health aspects of contracts. Managed care has become a predominant means by which Medicaid beneficiaries obtain health care generally. Because this project is designed to focus on *persons* rather than *services per se*, it is important to understand the issues and challenges that arise in the managed care contracting process as a whole, not merely those matters that deal specifically with managed behavioral health care services.

⁵ The third edition, along with the general overview (which this year focuses on pediatric care) can be obtained from the Center for Health Services Research and Policy at <http://www.gwhealthpolicy.org>.

Third, a significant proportion of all Medicaid managed care enrollees may have a mental illness or addiction disorder.⁶ As with any group of individuals with disabilities, persons with mental illness and addiction disorders merit special consideration in the design and implementation of general systems of care, since their underlying conditions may make all health services more complex to deliver. How states recognize and respond to this issue is a matter of ongoing concern. The relevance of managed care to the care of persons with serious physical and mental disabilities is underscored by trends at the state and community levels over the last several years, as agencies have increasingly turned to managed care systems for the care of persons with serious illnesses and disabilities.⁷

Finally, the barriers to health care faced by Medicaid beneficiaries, including those with mental illness and addiction disorders, compel attention to the entire spectrum of managed care contracts. Since Medicaid's inception, beneficiaries have struggled to find appropriate sources of health care because of Medicaid's low acceptance rate of Medicaid coverage among health care providers.⁸ While Medicaid has the potential to remove access barriers through its contractual guarantee of care, biased attitudes do not disappear simply because a contract guarantees care.

As noted in earlier editions of *Negotiating the New Health System*,⁹ how state Medicaid agencies approach these historic barriers is of central importance to the study of managed care. Unlike managed care services purchased for privately insured persons, Medicaid managed care is highly structured and highly managed, a model that bears little resemblance to the system that has evolved for privately insured persons.¹⁰ Plans offered by MCOs to privately insured persons tend to use large networks and less gate-keeping and also tend to permit enrollees to obtain out of plan care for higher co-payments. Medicaid agencies on the other hand are more restricted in their spending and have an obligation to cover persons who are deeply impoverished and without the ability to supplement their basic coverage with greater levels of cost sharing.

⁶ The greater presence of persons with mental illness and addiction disorders among the Medicaid managed care population probably is the result of several factors. First, unlike private health insurance, Medicaid is designed to cover persons with serious disabilities and thus is integral to the financing of services for the treatment and prevention of mental illness and addiction disorders among both children and adults. Congressional Research Service, *Medicaid Source Book: Background Data and Analysis* (Washington, D.C. 1993). As states increasingly enroll persons with serious disabilities into managed care arrangements, the proportion of enrollees with these conditions will grow correspondingly. Second, studies suggest that individuals who receive welfare benefits (and who are far more likely than other low-income persons to receive Medicaid) suffer from higher rates of mental illness and addiction disorders. See, e.g., Pamela Loprest and Gregory Acs, "Profile of Disability Among Families on AFDC," The Urban Institute (August, 1996). As welfare reform has removed from welfare rolls individuals who are able to work, it is likely that among the remaining population, the proportion with mental or physical disabilities may be increasing.

⁷ See, e.g., Marsha Regenstein and Christy Schroer, "Medicaid Managed Care for Persons with Disabilities: State Profiles," Prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, DC (December, 1998).

⁸ Robert and Rosemary Stevens, *Welfare Medicine in America* (The Free Press, 1974); Congressional Research Service, *Medicaid Source Book: Background Data and Analysis* (Washington, D.C. 1993); Diane Rowland et al., *Medicaid at the Crossroads* (Kaiser Family Foundation, Washington, D.C. 1992).

⁹ S. Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, The George Washington University Medical Center, Washington, DC (February 1997 & 1998).

¹⁰ Ibid.

Given these limitations, Medicaid plans, even when offered by companies that serve both public and private markets, may bear little resemblance to plans for the privately insured in terms of either coverage or access. Their networks may be more limited and may rely to a much greater degree on traditional providers of services to recipients such as clinics and public hospitals. Companies and network providers may maintain tighter controls over both access and utilization. Medicaid-sponsored managed care products are not likely to contain any “point of service” flexibility other than that required under federal law for family planning services,¹¹ care for emergency medical conditions,¹² and services that are exempted from states’ managed care contracts entirely and thus subject to federal freedom-of-choice requirements.¹³ In light of the historic discrimination in health care access faced by Medicaid beneficiaries as a group,¹⁴ the question of health care access and quality under highly structured, compulsory managed care arrangements is central to the study of Medicaid managed care.

How states use managed care to attempt to ameliorate these longstanding problems faced by persons with mental illness or addiction disorders has perhaps assumed even greater importance as a result of the United State Supreme Court’s decision in *L.C. v Olmstead*.¹⁵ The *Olmstead* case, decided during the Court’s 1999 term, held that the unnecessary segregation of persons with mental illness within residential institutions constitutes discrimination under the Americans with Disabilities Act (ADA).¹⁶ The case also held that the ADA requires states to provide community-based care to persons with disabilities to the extent that this can be accomplished through reasonable accommodations and without fundamental alterations in publicly financed health service systems.

In today’s world, managed care is the dominant mode of health care delivery. The availability of managed health care systems with the experience and skill needed to appropriately care and support persons with mental illness and addiction disorders is highly relevant to the course of appropriate de-institutionalization of persons with mental and

¹¹ Section 1902(a)(23) of the Social Security Act, 42 U.S.C. §1396a(a)(23), requires that state agencies allow beneficiaries to obtain family planning services and supplies from the provider of their choice, regardless of their enrollment status in a managed care plan. For a discussion of the family planning freedom of choice guarantee, see S. Rosenbaum et al., 22 *Jour. Health Pol. Pol & Law* 5 (October, 1997), at 1191-1215.

¹² Section 1932(b)(2) of the Social Security Act, 42 U.S.C. §1396u-2(b)(2), requires that states that mandate managed care enrollment as a state option ensure that beneficiaries have access to care for emergency medical conditions as well as post-stabilization care without regard to the source of the care. The law also prohibits state agencies and plans from conditioning the receipt of care on prior authorization for most services. An “emergency medical condition” is defined as “...a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.” Section 1932(b)(2)(C) of the Social Security Act, 42 U.S.C. §1396u-2(b)(2)(C).

¹³ Many states continue to directly cover some or all services related to the treatment of mental illness and addiction disorders; however, as will be discussed below, the case management provisions of state MCO contracts frequently assume that the contractor will at least manage care that is paid directly by the state, even if the contractor is not directly responsible for provision and payment of the care.

¹⁴ Congressional Research Service, *Medicaid Source Book: Background Data and Analysis* (Washington, D.C. 1993); Diane Rowland et al., *Medicaid at the Crossroads* (Kaiser Family Foundation, Washington, D.C. 1992).

¹⁵ 119 S. Ct. 2176 (1999).

¹⁶ 42 U.S.C. §12101 et seq.

physical disabilities. As a result, examining the entire landscape of MCO-style managed care, as captured in the contracts reviewed here, is an essential step in this analysis. As the core means by which health services are delivered and financed today, managed care increasingly may be expected to adapt itself to the needs of persons with disabilities in order to further the goal of appropriate community care.

* * * *

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The Medicaid entitlement is far broader than that found in traditional health insurance, including managed care plans. Managed care agreements typically provide somewhat more generous coverage than conventional indemnity insurance for certain preventive health services. At its core, however, managed care is a special form of insurance and is governed in large part by traditional insurance principles regarding coverage and exclusions as well as insurance-based notions of medical necessity. Medicaid, in contrast, is a third-party financing program that can best be thought of as the mirror image of insurance, covering *classes* of services not customarily found in insurance agreements as well as a *scope and depth of coverage* that far exceed that found in insurance.

Medicaid's core benefit structure is designed to assist persons (such as low-income working age adults with disabilities, elderly persons, and indigent, non-working families with children) whose status or greater health care needs place them beyond the reach of private health insurance. Unlike many forms of private coverage, Medicaid contains no pre-existing condition exclusions or waiting periods for newly enrolled persons with chronic illnesses and disabilities. In contrast to insurance, Medicaid does not permit states to exclude medically necessary services of covered benefits solely because of the settings in which they may be furnished or the nature of the person or entity that initially may identify the need for care (such as a program operated under the jurisdiction of a state health agency, school psychologist, a child welfare agency, or court). Indeed, in its very structure, the Medicaid statute contemplates that its coverage scheme will interact in multiple ways with services and

programs operated by numerous programs and agencies furnishing or overseeing health and health-related services to beneficiaries.¹⁷

Medicaid contains special coverage standards. Federal regulations require that coverage levels be sufficient in amount, duration, and scope to reasonably achieve the purpose of the treatment.¹⁸ Federal standards prohibit arbitrary denials or reductions in coverage solely based on diagnosis or condition.¹⁹ In the case of children, the Medicaid program defines what is medically necessary to extend beyond immediate need and reach treatment that prevents long-term disability. Most fundamentally perhaps for purposes of this study, unlike many conventional insurance policies,²⁰ Medicaid does not permit limits that restrict care to persons who can “return to normal functioning” as a result of receipt of covered care. In sum, from its inception Medicaid was designed to act not only as a source of coverage for customarily insured primary, preventive and acute care but also as a source of coverage for persons with complex, and chronic illnesses and conditions who may be under the care of multiple programs and agencies.

Given the multi-faceted nature of Medicaid and its uniqueness as a source of third-party financing, it is likely that all but the most specialized managed care contracts will cover less than the full range of services to which beneficiaries are entitled under law. It is hard to overstate the importance of understanding, in the case of access to care by persons with chronic illnesses and conditions, the evolution of the intersection between the full Medicaid entitlement on the one hand, and the managed care agreement (or agreements in the case of states that purchase both basic products and specialized products for certain enrollees, such as managed behavioral carve-out plans) on the other.

For example, many Medicaid managed care agreements cover a limited level and array of mental health coverage akin to traditional insurance plans (e.g., 10 visits annually to a mental health professional; 10 days per year of inpatient crisis hospitalization). However, a Medicaid-eligible child enrolled in managed care remains entitled to the full array of Medicaid-covered services that may be necessary to prevent, treat, or ameliorate a mental health condition, regardless of whether they are included in the agreement with the contractor. How the state agency articulates the specifications in its contracts--and clarifies the relationship between the managed care agreement and the child’s traditional Medicaid coverage to the contractor, the network, the family, and other agencies and programs involved in the care and support of the child--may be central to the child’s continued access to all necessary services.

¹⁷ See Section 1902(a)(11) of the Social Security Act, 42 U.S.C. §1396a(a)(11) (relating to collaboration with habilitation agencies and Title V grantees); Section 1902(a)(21) of the Social Security Act, 42 U.S.C. §1396a(a)(21) (community-based mental health programs); Section 1902(a)(22) of the Social Security Act, 42 U.S.C. §1396a(a)(22) (cooperation agreements with state health and rehabilitation agencies regarding institutional services and standards); and Section 1902(a)(24) of the Social Security Act, 42 U.S.C. §1396a(a)(24) (consultative services by health and other agencies).

¹⁸ 42 C.F.R. 440.230(b).

¹⁹ 42 C.F.R. 440.230(c).

²⁰ Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System*, (Foundation press, Old Westbury, NY, 1997; 1999-2000 Supplement) at Ch. 4.

Similarly, the Medicaid program permits only certain types of limits on coverage of prescribed drugs.²¹ As a result, drug coverage under the traditional Medicaid program may result in a scope and depth of benefits that extend beyond that found in most insurers' drug formularies. Beneficiaries remain entitled to the full array of drugs under the state Medicaid plan regardless of the discretion given to managed care contractors to offer a more limited formulary similar to that provided to privately insured enrollees. Thus, how a state agency specifies the contractor's duties and discretion with respect to drug coverage, as well as the manner in which the agency communicates the availability of additional coverage under the traditional Medicaid program, are matters of critical importance.

In sum, in developing comprehensive managed care agreements today, state Medicaid agencies face a difficult situation. On the one hand, for a significant number of beneficiaries, state agencies need to buy a managed care product that simply put does not resemble the typical managed care product, either in the enrollees served or in the services offered. On the other hand, agencies in many parts of the country are struggling with what appears to be a growing movement on the part of mainstream managed care companies to bypass or exit the Medicaid market because of its complexity and low payment rates.²² Part of this complexity stems from Medicaid's unique coverage requirements; other dimensions of the Medicaid challenge relate to the unique access barriers and utilization patterns that are the hallmark of Medicaid.

How state agencies use the promise of managed care to improve access to covered services whenever possible, without pushing the model beyond where it is ready to go or triggering a further exodus by companies who are either unwilling or unable to create and manage such uniquely tailored products for the level of compensation offered, is key to the study of Medicaid managed care. Furthermore, the task of fashioning workable managed care systems has been made more complicated by the fact that the entire managed care industry is evolving and in flux, as traditional forms of managed care decline in popularity and importance and new, more diversified systems emerge.²³ A central characteristic of these newly emerging systems is a more far-flung service network of subcontractors that bears a greater, "down-streamed" proportion of the prime contractor's legal duties and financial risk.²⁴ This cascading of legal and financial risk into hundreds of sub-arrangements makes developing and overseeing a master agreement particularly challenging.

²¹ Section 1927d of the Social Security Act, 42 U.S.C. §1396r-8(d).

²² Suzanne Felt-Lisk, "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation." The Kaiser Commission on Medicaid and the Uninsured. (May, 1999). Available at <http://www.kff.org/content/1999/2141/KFFChangingMedicaid.pdf>.

²³ James C. Robinson, "The Future of Managed Care Organizations," *Health Affairs*, Vol. 18, No. 2 (March/April 1999).

²⁴ *Id.*

1. Study Overview: A Framework for Measuring the Evolution of State Contracts and Key Challenges in Managed Care

Measuring the evolution of documents as complex as Medicaid contracts requires a study framework. The central objective in this project has been to provide a tool for state Medicaid agencies and other purchasers to use as they build and strengthen their programs. The first edition of this study identified six key issues that appeared to arise in the development and management of Medicaid service agreements for persons with mental illness and addiction disorders:

1. The lack of enrollment and disenrollment protections for beneficiaries who are receiving ongoing, active treatment for care and persons with mental illness and addiction disorders;
2. Ambiguity in coverage specifications that increased the potential for the simultaneous denial of Medicaid services by both MCOs and state Medicaid agencies, a problem that intensified for persons enrolled in multiple managed care arrangements for both general and specialized health care needs;
3. The tendency on the part of service agreements to use contractual service definitions and standards of coverage (including standards for the determination of medical necessity) that depart from federal Medicaid standards, particularly in the case of coverage for children, and the absence of a medical necessity standard that require consideration of individual patients' condition and relevant and reliable evidence;
4. Access and service delivery measures that may fail to focus sufficient attention on barriers or ensure the inclusion of health professionals and providers with the necessary skill and experience in the management of persons with certain conditions and health problems;
5. The lack of provisions for ensuring coordination in both coverage and care at numerous levels: between general and managed behavioral health care MCOs; between MCOs and the state Medicaid agency in the case of residual services that remain covered under the traditional Medicaid fee-for-service program; and between MCOs and other agencies and entities involved in the care and support of persons with mental illness and addiction disorders, such as special education agencies, child welfare agencies, the juvenile justice and court systems, and mental health and substance abuse agencies; and
6. The lack of specific performance measures to determine contractors' ongoing compliance with key provisions in the contracts.

In the intervening years since this study was first published, numerous initiatives have been undertaken at the state and federal levels to improve the overall quality of managed health care purchasing. SAMHSA's Office of Managed Care has, through its *Managed Care Initiative*, published numerous reports that focus on critical issues for both public and private sector purchasing of managed behavioral health services. These reports include a series of Issue Briefs on topics such as county-level managed care contracting, an

evaluation of state Medicaid managed care contracts, carve-out contracts, and an evaluation of MCO contracts with providers of community-based mental health and addiction disorder services. Special topics include an analysis of cultural competence in Medicaid managed care purchasing, an overview of Medicaid managed care litigation, and an analysis of the Americans with Disabilities Act as it applies to persons with mental illness and/or addiction disorder diagnoses. SAMHSA's website contains downloadable electronic copies of these and other reports and is located at: <http://www.samhsa.gov/mc/mancare.htm>.

Other examples of these types of quality improvement in contracting initiatives are the Quality Improvement Systems for Managed Care (QISMC) from the Health Care Financing Administration, and the development of federal/state partnerships around specific performance measures such as childhood immunizations. The Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services published a summary of various performance measurement schema for people with disabilities, including people with mental illness or substance abuse diagnoses, "Meeting the Challenge of Serving People With Disabilities: A Resource Guide for Assessing the Performance of Managed Care Organizations" in July 1998. Various measurement systems, such as HEDIS and the Performance Measures for Managed Behavioral Healthcare Programs (PERMS), are described and evaluated for their ability to adequately gauge performance indicators in terms of structure, process, and outcomes.²⁵

In addition, two important policy developments can be expected over time to have a significant impact on many of the issues raised by his study. The first was the enactment of the Balanced Budget Act of 1997 (BBA).²⁶ The second has been the growing managed care consumer rights movement.

The BBA, whose provisions by and large became effective on October 1, 1997, restructured Medicaid's statutory requirements in several important respects that bear directly on the issues identified by this study. The Act granted states broader flexibility to establish mandatory managed care systems for most beneficiaries²⁷ and define their supplier markets.²⁸ At the same time, it also established new protections in the areas of enrollment

²⁵ The resource guide is available on ASPE's website. Available at <http://aspe.os.dhhs.gov/daltcp/complete.htm#GWU1>.

²⁶ P.L. 105-33; §§4701-4710.

²⁷ Section 1932 of the Social Security Act; 42 U.S.C. §1396u-2. At their option states may mandate enrollment into managed care without use of either §1915 or §1115 arrangements in the case of all beneficiaries other than children with "special health care needs," persons dually eligible for Medicare and Medicaid, and Indians. Section 1932(a)(2) of the Social Security Act; 42 U.S.C. §1396u-2. Adults with disabilities who are neither Indians nor Medicare beneficiaries (e.g., disabled Medicaid beneficiaries ages 18 and older) can be covered by an enrollment mandate without a waiver.

²⁸ The BBA permits states to contract with all-Medicaid MCOs. Section 1903(m) of the Social Security Act; 42 U.S.C. §1396b(m). Under prior law, with limited exceptions states could purchase comprehensive managed care services only from companies that maintained an enrollment base no more than 75% of which were Medicare and Medicaid beneficiaries. State Medicaid §1115 managed care demonstrations waived this enrollment composition requirement, but the provision could not be waived under the more prevalent §1915 demonstration authority. Sara Rosenbaum and Julie Darnell, *An Analysis of State Medicaid Managed Care Demonstrations Under Section 1115 of the Social Security Act: Implications for Federal Policy* (Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. 1997).

and disenrollment, information and disclosure, coverage, access, and quality.²⁹ The database for the third edition consists of contracts that were in effect as of the beginning of 1998; while they can be expected to evolve, these contracts provide an early indication of how state contracts reflect the provisions of the BBA.

The consumer rights movement has led to managed care reform legislation of one type or another in most states,³⁰ as well as legislation at the federal level.³¹ Many of the elements in this consumer protection movement are reflected in the Balanced Budget Act as well as other, more long-standing provisions of the Medicaid statute. The major themes in managed care reform are reflected in the Consumer Bill of Rights and Responsibilities (CBRR), which was released in November, 1997 by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.³² In February of 1998, President Clinton issued an Executive Order instructing all federal agencies, including the Health Care Financing Agency (HCFA), which oversees Medicaid, to implement the CBRR because "[a]lthough the Federal government is taking a leading role to assure consumer protections are in place, . . . it has the authority to do more. The . . . Executive Memorandum [will] ensure that Federal programs come into substantial compliance with the Consumer Bill of Rights by no later than next year."³³

The CBRR addresses issues related to both health care access and quality. Because a number of the CBRR provisions relating to enrollee-initiated access to health services presume a more loosely structured managed care structure than that available to most Medicaid beneficiaries, some of the provisions of the CBRR may not be specifically applicable. At the same time, as Table 1 (below) indicates, the major themes reflected in the CBRR are those that run through the BBA's Medicaid managed care provisions. As a result, the CBRR is of relevance to the study of Medicaid managed care, and an important question becomes the extent to which states on their own have developed agreements that move toward issues addressed in the Consumer Bill of Rights and Responsibilities.

Medicaid managed care service agreements remain integral to any study of Medicaid managed care. General quality improvement efforts have extraordinary value; when done right, they raise the level of performance across the board. However, the actual agreements are the key, since it is these documents that define the enforceable terms of the agreement between the buyer and seller and that act as an ultimate protection for enrollees. Ambiguities and vague provisions in the agreements not only threaten access to appropriate care of good quality but also can result in residual obligations for state Medicaid agencies in the area of coverage beyond that which was anticipated. Thus, this study assesses the changing nature

²⁹ Section 1932 of the Social Security Act; 42 U.S.C. §1396u-2. Final HCFA regulations implementing the BBA are expected to address the question of the extent to which BBA access, coverage, enrollment, and quality standards also apply to managed care demonstrations carried out under §§1915 and 1115 of the Social Security Act.

³⁰ See Molly Stauffer, "1999 State by State Guide to Managed Care Law," Panel Publishers, Fredrick, MD (1999).

³¹ As of January 2000, measures have been passed in both houses of Congress. However, no meeting has been scheduled to consider the two bills in joint House/Senate conference committee.

³² The full text of the report is available at <http://www.hcqualitycommission.gov>.

³³ President Clinton press release, available at <http://www.hcqualitycommission.gov>.

of these documents in the increasingly complex framework of overall quality improvement initiatives and federal statutory changes themselves.

Table 1.
A Comparison of Key Managed Care Consumer Protections:
The Consumer Bill of Rights and Responsibilities and Medicaid Managed Care Provisions in the
Balanced Budget Act of 1997

Issue	Consumer Bill of Rights and Responsibilities	Medicaid Managed Care Provisions of the Balanced Budget Act
Information and disclosure	<ul style="list-style-type: none"> ➤ Consumers have the right to accurate, easily understood information on covered benefits, cost sharing, procedures for resolving complaints, provider networks, procedures governing access to specialists and emergency services, and care management information. ➤ No similar provision. 	<ul style="list-style-type: none"> ➤ States and MCOs must provide information in easily understood form on coverage, cost sharing, providers, grievance and appeal pro-cedures, and enrollee rights and responsibilities, as well as annual comparative information on benefits and cost sharing, service area and quality and performance. ➤ States and MCOs must inform enrollees regarding services that are covered under the MCO contract and those that are available under the state plan as fee-for-service.
Choice of providers and plans	<ul style="list-style-type: none"> ➤ Consumers have a right to a choice of health care providers sufficient to ensure access to high quality, appropriate care. 	<ul style="list-style-type: none"> ➤ States must allow a choice among at least two managed care entities and in the case of rural residents and certain county-operated plans, a choice among at least two primary care providers.
Access to health care including emergency care, and continuity of care	<ul style="list-style-type: none"> ➤ Plans should have a network that is sufficient to ensure access to services without unreasonable delay, including access to 24/7 emergency services. ➤ Plans with an insufficient network to provide covered benefits with the appropriate degree of specialization should ensure access to care from non-network providers at the same price. ➤ No similar provision.³⁴ 	<ul style="list-style-type: none"> ➤ State contracts must include access standards so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity. ➤ MCOs must be able to demonstrate to the state and Secretary adequate capacity and services, including an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in the service area and a sufficient number, mix, and geographic distribution of providers. ➤ MCOs must comply with the Newborns and Mothers Protection Act and Mental Health Parity laws.

³⁴ As a matter of federal law, all employee health plans and insurance issuers must comply with the Newborns' and Mothers' Health Care Protection Act of 1996 and the Mental Health Parity Act. See Pub. L. No. 104-204, 110 Stat. 2935 (1996), and Pub. L. No. 104-204, Title VII, 110 Stat. 2944 (1996), respectively.

Issue	Consumer Bill of Rights and Responsibilities	Medicaid Managed Care Provisions of the Balanced Budget Act
	<ul style="list-style-type: none"> ➤ Coverage of emergency care should be in accordance with a “prudent layperson” standard. Coverage should be without regard to the network status of the provider, and services should be furnished without prior authorization. ➤ Women should be able to choose a qualified provider offered by a health plan for routine and preventive women’s services. ➤ Consumers with complex and serious medical conditions who require frequent specialty care should have direct access to a network specialist and authorizations should be for an adequate number of direct access services under an approved treatment plan. ➤ Consumers undergoing a course of treatment or who are in the 3rd trimester of pregnancy at the time they involuntarily change plan or a provider is terminated from a plan should be covered for a 90-day transition period. 	<ul style="list-style-type: none"> ➤ States and MCOs must cover emergency care in accordance with a “prudent layperson” standard. Coverage must be without regard to the network status of the provider, and services must be furnished without prior authorization. ➤ No similar statutory provision. ➤ No similar statutory provision. ➤ No similar statutory provision.
Participation in treatment decisions	<ul style="list-style-type: none"> ➤ Consumers have the right to full participation in all decisions related to their health care. Consumers who are unable to fully participate may be represented by others. Consumers have the right to refuse treatment. ➤ Plans and providers must provide patients with easily understood information and the right to decide 	<ul style="list-style-type: none"> ➤ No similar express statutory provision; however, statute contains a general requirement that medical assistance be furnished in the best interest of applicants and recipients. In addition, common law and state statutory concepts of informed consent would apply to health care providers participating in managed care networks. ➤ No similar express statutory provision; however, the statute contains a general requirement that medical assistance be furnished in the best interest of applicants and recipients. Common law and state statutory principles of

Issue	Consumer Bill of Rights and Responsibilities	Medicaid Managed Care Provisions of the Balanced Budget Act
	<p>among treatment options consistent with informed consent.</p> <ul style="list-style-type: none"> ➤ Plans must discuss advanced directives and abide by patients' decisions. 	<p>informed consent would apply to network providers in Medicaid managed care plans.</p> <ul style="list-style-type: none"> ➤ Medicaid participating MCOs must abide by federal advance directive requirements.
Quality of care	<ul style="list-style-type: none"> ➤ No similar provisions. ➤ No similar statutory provision. 	<ul style="list-style-type: none"> ➤ Plans must maintain internal quality assessment and improvement strategies that include standards, measures, and procedures for monitoring the care and appropriateness of services that reflect the full spectrum of populations enrolled under the state's plan. ➤ States must have external review systems that provide for an annual external review by qualified personnel using appropriate protocols.
Grievances and appeals	<ul style="list-style-type: none"> ➤ Consumers have the right to a fair and efficient process for resolving differences with health plans, health care providers, and the institutions that serve them, including a rigorous internal review and an independent system of external review. ➤ Internal appeals systems should include: timely, written notice of decisions to deny, reduce, or terminate services or deny payment, along with an explanation of the reasons and notification of appeals rights; timely resolution of appeals (including expedited timeframes for decisions involving emergency or urgent care); claims reviews by appropriate professionals; written notice; and a reasonable process for resolving complaints that affect the quality of care but do not involve coverage and treatment decisions (e.g., waiting times, demeanor). ➤ External systems should: be 	<ul style="list-style-type: none"> ➤ MCOs must establish a grievance procedure. In addition, federal Medicaid fair hearing requirements applicable to state Medicaid agencies also apply to adverse contractor decisions relating to coverage.³⁵ ➤ No similar statutory provision.

³⁵ Several courts have deemed coverage decisions by managed care organizations to constitute “state action” for purposes of the Constitutional due process requirements embodied in the fair hearing statute. *See, e.g., Catanzano v Dowling*, 60 F.3d 113 (2d Cir.1995); *J.K. v Dillenberg*, 836 F. Supp. 694 (D.Ariz.1993); and *Grijalva v Shalala*, 152 F.3d 1115 (9th Cir.1998).

Issue	Consumer Bill of Rights and Responsibilities	Medicaid Managed Care Provisions of the Balanced Budget Act
	<p>available following exhaustion of internal system; applicable to decisions that involve either medical necessity or experimental care and that exceed a significant threshold or jeopardize the patient's life or health; be conducted by appropriate professionals not involved in the initial decision; follow a standard of review that promotes evidence-based decision-making and relies on objective evidence; and resolve disputes in a timely manner, including expedited review for urgent and emergency care.</p>	<ul style="list-style-type: none"> ➤ No similar requirement; federal fair hearing requirements apply to any adverse health plan decision regarding coverage.
Respect & non-discrimination	<ul style="list-style-type: none"> ➤ Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. ➤ Plans may not discriminate in delivery or coverage in their policy or as required by law, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. ➤ Plans must not discriminate in marketing and enrollment based on race, ethnicity, national origin, religion, sex, mental or physical disability, sexual orientation, genetic information, or source of payment. 	<ul style="list-style-type: none"> ➤ No similar express statutory provision; however, the law contains statutory provisions related to managed care quality and administration of the plan in the best interests of applicants and recipients. ➤ All Medicaid-participating managed care plans are covered by federal civil rights laws prohibiting discrimination on the basis of race, national origin, disability, and age. ➤ Plans covered by federal civil rights laws prohibiting discrimination on the basis of race, national origin, disability, and age.
Confidentiality	<ul style="list-style-type: none"> ➤ Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers have the right to review and copy their own medical records and request amendments to their records. 	<ul style="list-style-type: none"> ➤ The Medicaid statutory provision prohibiting state agencies from disclosing information about applicants and recipients except for purposes directly related to administration of the plan would apply to managed care contractors. Federal Medicaid law does not address access by enrollees to medical records, but state laws as well as common law principles would apply.

2. The Evolution of Coverage and Enrollment Provisions in Medicaid Managed Care Contracts

~ Findings ~

Generally speaking, states have made considerable progress in expanding the extent to which their contracts provide detailed descriptions of service specifications, including definitions of coverage and exclusions. Compared to the findings from the first and second years of this study, both the scope and the specificity of contract terms have increased. Contracts are also more likely to describe the manner in which such services should be furnished. At the same time, contractors retain much discretion over decisions regarding the medical necessity of care, as well as broad discretion over the range and capabilities of their provider networks.

a. Contract provisions relating to the classes and scope of covered services are becoming clearer. Consistent with the merger of coverage and care under managed care, contract provisions are more specific regarding how coverage should be achieved.

A comparison of the three-year database shows definite improvements in the coverage provisions of state contracts. In general, state documents are becoming clearer with respect to both the *classes* of benefits included in the agreement, as well as the *scope* of benefits covered. Terms and definitions are more explicitly stated, and permissible limitations on classes of covered benefits are more explicitly addressed.

Most interestingly perhaps, and consistent with the merging of health care and health coverage that is the hallmark of tightly structured Medicaid managed care systems, states are not only becoming clearer and more detailed with respect to what is covered, but also, how they expect that coverage will be effectuated. In other words, the contracts show a definite evolution among Medicaid agencies toward the purchase of *care*, not merely the purchase of *coverage*. This evolution should not be surprising. As the full impact of managed care on the health system has become more apparent, purchasers have come to better understand that it is virtually impossible to distinguish between *coverage* and the *manner in which coverage will be effectuated and achieved*. In the case of Medicaid, the purchase of coverage, with the details regarding how coverage actually will be furnished left to contractors, is giving way to more specific purchase of care.

These trends over time toward greater specificity in coverage and a more detailed approach to the coverage that is furnished can be seen in a number of state contracts over time. Several examples are provided below.

In the first year of the study database, the Arizona general service contract contained the following description of behavioral health services under the AHCCCS system:

“Covered services are *** behavioral health services.”

Arizona RFP, *Negotiating the New Health System, 1997* (Table 2.1)

In contrast, the Arizona general agreement contained in the database for the third edition describes behavioral health services as follows:

Behavioral Health

The Contractor shall provide behavioral health services * * * . For non-categorical members *** behavioral health services are limited to up to the first 72 hours per episode of emergency crisis/stabilization, not to exceed 12 days per contract year. ***

The contractor is responsible for the provision of Title XIX covered behavioral health services to members as described below:

Under Age 18, Age 21 and over, SMI: On and after the effective date of enrollment, the contractor is responsible for up to 72 hours of emergency behavioral health services ***. The contractor is also responsible for referring categorically eligible members under the age of 18 and age 21 and older and SMI members of many age to the Regional Behavioral Health Authorities (RHBAs) for the provision of Title XIX covered behavioral health services. *** The contractor is responsible for ensuring that a medical record is established by the PCO when information is received about an assigned member, even if the PCP has not yet seen the assigned member. The contractor shall also communicate information pertaining to ADHS enrolled members to the ADHS RHBAs including but not limited to current diagnosis, medication, pertinent laboratory results, last PCP visit, and last hospitalization. For prior period coverage the contractor is responsible for payment of all claims for medically necessary covered behavioral services to eligible persons not enrolled with ADHS.

Non-SMI, age 18, 19 and 20: The contractor is responsible for providing Title XIX covered services to categorically eligible non-SMI members age 18, 19 and 20 in accordance with [the AHCCS regulations and Behavioral Health Policy Manual]. Covered services include: inpatient hospital, inpatient psychiatric facility for individuals under the age of 21, individual therapy and counseling, group and /or family therapy and counseling, psychotropic medication adjustment and monitoring, partial care, emergency crisis services, behavior management, psychotropic medications, and medically necessary transportation.

Referrals: Categorically eligible members age 18, 19 and 20 may be referred directly for the provision of behavioral health services by the PCP, family members, self referrals, schools, other service providers, and members of the community and State agencies as well as contractor's staff. The same referral procedures which are applicable to other health care services shall apply to behavioral health services.

Case management, case coordination: The contractor is responsible for providing case management services when medically necessary. Case management services may vary in scope and frequency, depending on the eligible person's intensity of need. Case management services consist of a set of services and activities through which appropriate and cost-effective. Title XIX services are identified, planned coordinated, obtained, monitored, and continuously evaluated. ***

Arizona RFP, *Negotiating the New Health System*, 1999 (Table 2.1)

The evolution of the Arizona agreement is notable in several respects. First, and most obviously, the document details general contractors' basic service duties in the case of behavioral health services. Second, the document is relatively specific regarding the interaction between general contractors' coverage responsibilities and those of the state's Regional Behavioral Health Authorities (RBHAs). Third, the contract sets forth specific duties for its general contractors with respect to how they will deliver covered benefits,

manage members' cases, and interact with RBHAs in the case of members receiving services from both entities.

One of the most remarkable evolutions in the treatment of coverage for behavioral health needs can be found in the Florida contracts. In 1997, the Florida contract contained the following language relating to coverage of behavioral health services:

“The prepaid mental health contractor will provide a full range of mental health services categories.”

Florida Contract, *Negotiating the New Health System*, 1997 (Table 2.1)

In contrast, the state's documents in the current database contain the following language, which, like Arizona, shows a trend toward not only greater specificity in coverage but also in how coverage will be achieved.

Services to be provided

The plan shall insure the provision of the following covered services: ***

Substance abuse: the plan shall have primary care physicians screen enrollees for signs of substance abuse as part of prevention evaluation. Targeted enrollees shall be asked to attend community or plan sponsored substance abuse workshops. ***

In addition the plan shall provide inpatient hospital treatment for severe withdrawal cases exhibiting medical complications which meet the severity of illness criteria under the alcohol/substance abuse system specific set which generally requires treatment on a medial unit where complex equipment is available. ***

Physician services. The plan shall furnish psychiatrist services as medically necessary for Medicaid recipients, which may be rendered in the physician's office or in an outpatient or inpatient setting.

Community mental health services. Community based rehabilitative services which are psychiatric in nature, rendered or recommended by a psychiatrist or physician. Such services must be provided to plan members *** in accordance with the policy and service provisions specified *** in this contract.

Behavioral Health Care

*** The plan shall provide medically necessary behavioral health care services *** once it has demonstrated its ability to provide such services. The plan shall demonstrate its ability by the following: submittal of a behavioral health services implementation plan that shall be submitted to the agency and through an agency conducted onsite survey. ***

The plan, in addition to the provisions set forth in this contract and elsewhere in this attachment, shall provide a full range of behavioral health care service categories authorized under the state Medicaid plan and the state mental health program ***.

Florida's most current contract also shows the addition of a comprehensive new benefit that is integral to coverage for behavioral health services and effectuates the coverage/care interaction. In the document contained in the first edition database, Florida's contract specified a simple “case management” requirement. The contract contained in the third edition database shows an enormous evolution, not only in the scope of the duty but in

the application of case management techniques to individuals with or at risk for mental illness or addiction disorders:

Case management

1. The plan shall contact each new member at least two times, if necessary, within 90 days of enrollment, to urge scheduling of an initial appointment with the primary care provider for the purpose of a health risk assessment so that the primary care provider shall provide services indicated by such assessment ***.
2. The plan shall contact each new member within 30 days of enrollment to request the member to authorize release of his or her medical records to the plan or its health services subcontractors from practitioners who treated the member prior to plan enrollment. The plan shall then request the medical records from the previous practitioners.
3. The plan must use the health risk assessment and the released medical records to identify members who have not received EPSDT screenings in the past according to the agency approved periodicity schedule.
4. The plan must contact, up to 2 times if necessary, any members who are more than two months behind in the periodicity screening schedule to urge those members or their legal representatives to make an appointment for a screening visit.
5. Enrollees known or suspected to be pregnant shall be screened within 30 days of enrollment and, if pregnant, referred for appropriate prenatal care ***.
6. The plan must assign a pediatrician or other appropriate primary care physician to all pregnant enrollees for the care of their newborn babies no later than the beginning of the last trimester of gestation.
7. The plan shall for enrolled members comply with [Florida state law] which requires that all children taken into protective custody, emergency shelter or into the foster care program by the Department of Children and Families be physically screened within 72 hours or immediately if required. ***

Additional Medicaid Behavioral Care Services Requirements

Targeted case management: The plan shall adhere to the mental health requirements of the Medicaid case management services coverage and limitations handbook ***.

Treatment planning and comprehensive services plan: the Plan shall establish a treatment plan for all enrollees assessed to need mental health services ***. For persons meeting the following criteria, the plan shall establish a written comprehensive services plan in accordance with the plan's internal policy. This plan shall contain a long-term view, supports and resources; clearly establish goals and responsibilities, and incorporate consumer choice:

- a. Children who are diagnosed to be seriously emotionally disturbed
- b. Adults pending, certified or who have been certified within 5 years by the Social Security Administration or the Veteran's Administration as disabled due to a psychiatric disability or people on SSSA who develop a psychiatric disability; adults with 2 or more admissions to crisis stabilization units or short term residential treatment centers within the past year or discharged from a treatment facility; or adults over the age of 61 with a primary psychiatric diagnosis or major mental illness, dementia, or delirium.

Care coordination and management: the plan shall be responsible for the coordination and management of behavioral health care and continuity of care for all enrolled Medicaid recipients through the following minimum functions:

1. Contacting each new member to authorize the release of their clinical records within 30 days of enrollment and for current members within 5 days after their first behavioral health service provision.
2. Minimizing disruption to the enrollee as a result of any change in service provider or behavioral health care case manager occurring as a result of this contract ***;
3. Documenting in behavioral clinical records all enrollee emergency behavioral encounters and appropriate follow-up, and where medical in nature, in the primary care physician's medical record;
4. Documenting all referral services in the enrollees' behavioral clinical records;
5. Monitoring enrollees with ongoing behavioral health conditions;
6. Monitoring enrollees admitted to state mental institutions as follows: the plan shall participate in discharge planning and community placement of enrollees who are being discharged within 60 days of losing their plan enrollment due to state institutionalization ***;
7. Coordinating hospital and /or institutional discharge planning for psychiatric admissions and substance abuse detoxification that includes appropriate post-discharge care;
8. Providing appropriate referral of the enrollee for non-covered services to the appropriate service setting and requesting referral assistance ***.

Florida contract, *Negotiating the New Health System*, 1999 (Table 2.1)

b. Some contracts show a greater interest in defining coverage in a manner that is culturally competent.

The Arizona contract also illustrates the greater attention paid by states to questions of coverage and service delivery for enrolled populations for whom coverage alone may be relatively without meaning unless it is specifically tailored to their unique cultural needs. For example, in the first year of our study, the Arizona contract contained no explicit coverage specifications related to Native Americans. In the 1998 database, the contract documents contain the following provision:

Covered Services for Native Americans

ADHS shall ensure that covered services are available to all Title XIX-eligible Native Americans whether they live on or off reservation. ADHS shall ensure that an effective and comprehensive behavioral health service delivery system is in place for each Native American tribe in Arizona. ADHS shall develop and enter into an intergovernmental agreement with each Native American tribe that expresses an interest in such an arrangement. In the absence of an IGA, ADHS shall nonetheless ensure that all covered services are available to all eligible Native Americans and may use the Indian Health Service (IHS), tribal providers, private providers, and RHBAs to provide these services. RHBAs may serve eligible Native Americans on reservation with agreement of the tribe.

Arizona Behavioral Health RFP, *Negotiating the New Health System*, 1999 (Table 2.1)

c. Coverage terms and definitions are becoming clearer.

Among the key findings in the first edition of *Negotiating the New Health System* were the ambiguities in coverage terms, the lack of clear definitions of services, and potential inconsistencies between state definitions and federal definitions. Analysis of the third

edition database suggests that states are paying considerably more attention to how they use terms and definitions and the amount of discretion they give their contractors to self-define the scope of their duties through purchaser silence.

In the first edition of the study, Colorado was silent on how disparities between its drug formulary and those used by its contractors would be resolved. The latest database demonstrates how the state has altered this earlier language. The first contract document specified:

[...] drugs and medicines published as covered drugs which have been approved for use in the United States by the Food and Drug Administration *** and only to the extent they are used to treat a condition which the FDA has determined that the drug or medicine is medically appropriate ***.

Colorado Contract, *Negotiating the New Health System*, 1997 (Table 2.1)

This language left to contractor discretion the scope of its formulary and meant that the state would be directly liable for drugs covered under the Medicaid plan but not under its contractors' formularies. The third edition contract shows how the state has altered this provision to limit the potential for uncovered pharmaceuticals under its contracts:

Outpatient prescribed drugs

[new and additional] *** The contractor may establish a drug formulary. If an authorized prescriber indicates that there is a medical necessity which is unmet by a contractor formulary product but is covered by the Colorado Medicaid program *** the contractor shall provide said product.

Colorado Contract, *Negotiating the New Health System*, 1999 (Table 2.1)

Similarly, Missouri's contract from the third edition database shows significantly greater clarity with respect to the coverage of prescribed drugs.

Pharmacy: Under the *** Missouri Medicaid program, nearly all products of manufacturers participating in the national rebate programs are reimbursable, including many over-the-counter preparations. *** Some products have been excluded from coverage ***. Everything that is covered under the Medicaid *** program either without restriction or through prior authorization, must be covered by the plans ***. However, it is not essential that plans cover pharmaceutical products without restriction to the same extent that the fee-for-service program does. Plans may have a more extensive list of products requiring prior authorization, but plans may not exclude from coverage any products not excluded under the current Medicaid *** program. *** Any drug prior authorization program implemented by a plan must meet the following criteria:

Plans must provide response by telephone *** within 24 hours of a request ***;
Plans must provide for the dispensing of at least a 72-hour supply of a drug product that requires prior authorization in an emergency situation.

Approvals must be granted for any medically accepted use. Medically accepted use is defined as any use for a drug product which is [FDA] approved ***, which appears in peer reviewed literature, or which is accepted by one or more [professional drug] compendia. *** In addition, plans must have a mechanism whereby drugs can be prior-authorized if a member is out of the plans' service area ***.

Missouri Contract, *Negotiating the New Health System, 1999* (Table 2.1)

The evolution of definitions is illustrated with this pair of excerpts from Kentucky's contracts. Kentucky's contracts from the first year database provided no definition for the term "outpatient service." By the third year, the state had adopted a comprehensive definition that left contractors with relatively little discretion regarding the scope of coverage. The first contract simply specified:

"outpatient and emergency services."

Kentucky Contract, *Negotiating the New Health System, 1997* (Table 2.1)

The contract from the third edition database provides the following explanation of outpatient coverage:

Currently covered outpatient services include the following:

- Diagnostic services;
- Emergency room services for emergency conditions. Medically necessary emergency care, including unlimited diagnostic, therapeutic and emergency department services, will be provided; however, partnerships may establish a system of prior authorization for emergency department services;³⁶
- Clinic evaluation and management services;
- Drugs and biologicals administered in the outpatient department;
- Emergency department services;
- Laboratory services;
- Minor surgical and radiological services;
- Outpatient dental services for high risk recipients (individuals with heart disease, mental retardation, high blood pressure, etc.);
- Observation and holding beds;
- Physical therapy prescribed and directed by a physician and provided by a licensed; physical therapist or registered physiotherapist;
- Renal dialysis services;
- Radiological services;
- Speech therapy when prescribed and directed by a physician [facility must have a licensed speech therapist on staff]; and
- Therapeutic services.

Excluded from hospital outpatient coverage are:

- Drugs, biologicals and injectables dispensed to recipients;
- Items and services which are not reasonable and necessary and related to the diagnosis or treatment of illness or injury, impairment, or maternity care;
- Occupational therapy; and
- Routine physical examinations.

Kentucky Contract, *Negotiating the New Health System, 1999* (Table 2.1)

Maine's contract provisions applicable to school-based health services shows how one state has attempted to clarify what is a contract service, what is a residual covered service under the state's Medicaid plan, and how it expects its contractors to relate to

³⁶ Note that this type of prior authorization is now disallowed under the Balanced Budget Act of 1997.

providers of key non- contract services relevant to the provision of care to children with mental and emotional disorders.

Services available on Fee-for-Service Basis

Enrollees in the managed care initiative are also entitled to Medicaid services which are not included in the capitated benefit package. These services include ***

- b. non-emergency transportation services
- c. school based clinic services ***
- h. organ transplants

HMOs are not responsible for furnishing these services. They are responsible for informing the enrollee of the availability of these services and providing coordination in the overall delivery of care to the enrollee ***.

*** School based clinics. School based clinics provide physical and mental health services to student populations at the school site. Currently there are two school based clinics that receive Medicaid reimbursement in Maine. Given [their] infancy and the variety of their organizational models and the services they provide, HMOs will not be required to have formal contracts with them at this time. However, an HMO should develop arrangements with these clinics, including protocols for communication and referral to ensure coordination of care. An HMO may choose to contract with the clinics for payment and referral arrangements. ***

Maine contract, *Negotiating the New Health System*, 1999 (Table 2.1)

d. States are making greater efforts to close the “coverage gap” between services that are covered under their contracts and services that are exempt or “carved out” and covered through separate contracts.

The Balanced Budget Act requires states to clarify for enrollees which state plan services are available through the contract and which continue to be covered directly under the plan. This clarification is difficult, since distinguishing between contract services and state plan services involves more than simply identifying which classes of benefits are in the contract (e.g., prescribed drugs, physician services) or the express limits on contract services versus state plan services (e.g., 15 outpatient mental health visits covered under the contract, remaining medically necessary visits covered directly). Coverage is a product not only of express terms and limits but also of the application of medical necessity definitions as well as the use of exclusions and limitations that are common in the insurance industry but not found in Medicaid (e.g., preexisting condition exclusions, exclusions of “educational” services, “social” services, “free” services, exclusions of “non-rehabilitative” services, or “maintenance” services.).

Even were Medicaid agencies to be more explicit about the concepts of medical necessity and coverage exclusions, gaps would inevitably appear between the contractor’s understanding of its coverage duties and those of the state agency. These gaps might be revealed through the grievance and fair hearing process, as beneficiaries’ appeal denials of previously covered services; they might also become evident through provider complaints or external audits of contractor coverage determination systems.

As noted in the overview volume to the Third Edition of *Negotiating the New Health System*, states are making more widespread use of a general “gap closing” provision in their agreements. This provision provides a state with broad discretion to overturn contractor coverage decisions in the case of contract services that run counter to the agency’s expectations regarding what will be covered. Studies of the coverage process suggest that Medicaid agencies are more liberal than commercial insurers in their interpretation of coverage provisions, perhaps in part because the program is oriented to the care of persons with significant illnesses and disabilities.³⁷ The use of such “gap closing” language allows an agency to maintain this more liberal approach to coverage. The Maryland contract excerpt presented below illustrates such language:

Departmental Order to Provide Services

A. If the Department determines, either through the complaint resolution process *** or otherwise, that an MCO is not providing a [required] benefit or service, the Department is authorized to order the MCO to provide the service. **** The Department’s order *** is not subject to a stay during the pendency of an appeal.

Maryland Contract, *Negotiating the New Health System*, 1999 (Table 2.1)

The Maryland provision not only gives the state the authority to overturn a coverage decision reached by its contractor but also allows the state to order provision of the service, vests the state with the discretion to determine that a service is indeed “covered,” and prohibits the contractor from seeking a stay of the state’s decision pending appeal. This final aspect of the state’s requirement is consistent with the Constitutionally grounded prohibition under Medicaid against reducing or terminating coverage prior to a fair hearing, if such a hearing is requested in a timely fashion.

e. Medical necessity clauses continue to remain ambiguous or narrower than the standards that apply to Medicaid. Furthermore, important issues related to the resolution of potential coverage conflicts among competing health care entities remain unresolved, but states are showing progress.

While states are achieving greater clarity in coverage and making more frequent use of gap-closing language, the contracts continue to show relatively limited progress in adapting medical necessity language that parallels the basic elements of the Medicaid statute, particularly the preventive aspects of coverage for children. The Missouri contract in the third edition database demonstrates this continued trend:

In Plan Services

Description of Comprehensive Benefit Package. The health plan must agree to assume the responsibility for all covered medical conditions of each [member]. Services must be provided according to the medical needs of the individual. Limitations on specific services may be established as long as the health plan provides alternative services that are medically appropriate. The health plan must have a process for allowing exceptions to these limitations. Health plans may develop criteria by which the health plan will review future

³⁷ Finkelstein BS, Silvers JB, Marrero U, Neuhauser D, and Cuttler L. “Insurance Coverage, Physician Recommendations, and Access to Emerging Treatments: Growth Hormone Therapy for Childhood Short Stature,” *JAMA* 1998; 279:663-668.

treatment options for the plan's administration of medical care benefits. It is the responsibility of the health plan to determine whether or not a service furnished or proposed to be furnished is *reasonable and medically necessary for the diagnosis or treatment of illness or injury, to improve the function of a malformed body member, or to minimize the progression of disability, in accordance with accepted standards of medical practice in the medical community of the area in which the health services are rendered; and the service could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered; and the service is furnished in the most appropriate setting.*

Missouri Contract, *Negotiating the New Health System*, 1999 (Table 2.1) [emphasis added]

The Missouri definition, italicized for emphasis in the above excerpt, allows a plan to deny coverage for care that is not medically necessary for the “treatment of illness or injury.” In several respects, this definition is inconsistent with federal Medicaid coverage principles and could create significant service gaps. First is the state’s use of the term “illness or injury.” Unlike insurance, Medicaid coverage is not limited to treatment for “illness and injury.” State agencies are prohibited under federal law from discriminating in coverage on the basis of an individual’s *condition*.³⁸ In the case of children and adults with developmental disabilities and delays or other health problems that are not considered either “illnesses” or “injuries,” an insurer operating under standard insurance principles would be free to deny coverage for the treatment of the “condition;” a Medicaid agency would not be permitted to do so.

A second discrepancy between the state’s definition and that found in federal law is the failure to define the concept of “treat.” For private insurers, the concept of treatment can mean “restore to normal functioning;” that is, if a treatment in question cannot restore an individual to “normal functioning,” then an insurer may deny treatment as not “medically necessary” since the problem cannot be cured.³⁹ Medicaid has no curative provisions; indeed, a significant proportion of the Medicaid population has chronic physical and mental illnesses and conditions and cannot be restored to “normalcy.”

A third issue in the state’s definition is its failure to capture the preventive standard of coverage that applies to children under the Medicaid EPSDT program, an issue that is discussed more fully in the Overview volume. Under EPSDT, services are medically necessary if they are needed to treat or ameliorate a condition in a child or the ensuing complications, developmental delays, and disabilities that may flow from a child’s condition. The Missouri definition appears to authorize a contractor to withhold care unless it is necessary to avoid deterioration or minimize a condition, a stricter coverage standard than the affirmative and preventive standards that apply to children.⁴⁰

While the type of “gap closing” language noted previously would permit the state to step in where specific instances of coverage limitations arise, the absence of a medical necessity clause that is consistent with the requirements of the statute may encourage contractors to make many more narrow coverage determinations than might be the case were they under a broader coverage standard.

³⁸ 42 C.F.R. §440.230(c).

³⁹ See *Bedrick v Travelers Insurance*, 93 F.3d 149 (4th Cir.1996) and *McGraw v Prudential Insurance*, 137 F.3d 1253 (10th Cir.1998).

⁴⁰ See *Bond v Stanton*, 655 F.2d 766 (7th Cir.1981).

At the same time that states appear to continue to permit contractors to use more limited definitions of medical necessity, states are attempting to address the issue of coordination of coverage and treatment requirements among health care systems. In the first edition of our study, we noted that contracts were ambiguous with respect to how differing opinions regarding the medical need for care would be resolved in the case of enrollees under the simultaneous care of a managed care organization and the child welfare system, the special education system, or the judicial system. We also noted a lack of clarity regarding the relationship between general and behavioral health carve-out contractors.

A review of the third edition database indicates that while much of this ambiguity remains, states are making a greater effort to provide advance guidance regarding the resolution of these coverage matters. The excerpt from Kentucky's documents in the 1999 database shows how states are beginning to approach these matters:

Referrals

Referral between the Physical and Behavioral Health Plans. Office visits for mental health services are currently covered by Medicaid and will continue to be covered for primary care providers under the Partnership program. Under the fee-for-service system, mental health services by non-psychiatrist physicians were limited to four per year. After four visits, the fee-for-service system assumed that the recipient needed continuing care through Medicaid's community mental health program. No such limitation exists in the managed care system. Contractors should set standards that permit continuing mental health services by primary care providers and for referrals to the [behavioral health plan] when the primary care physician concludes that referral *** is needed.

When a primary care provider identifies a member's need for behavioral health services through [the behavioral plan] the provider will contact the 'primary care liaison' for the [behavioral plan] who will arrange access to appropriate behavioral health services. [The general plan] shall inform providers of the method established in the Memorandum of Agreement [between the two plans] for contacting the MBHO's Primary Care Liaison. Similarly Partnerships will be required to provide a "Behavioral Health Liaison" function to facilitate access to physical health services. MBHOs shall inform behavioral health care providers of the method established in the Memorandum of Agreement for contracting the Partnership's Behavioral Health Liaison. Persons responsible for liaison between a Partnership and a MBHO shall meet at least monthly.

The Department for Medicaid Services will monitor referral patterns between physical and behavioral plans to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications will also be closely monitored. The findings from these evaluations shall be provided to the Contractors.

Kentucky Contract, *Negotiating the New Health System*, 1999 (Table 2.1)

This provision indicates that the state anticipates that its general MCOs will provide significant amounts of care for mental illness and addiction disorders as part of their primary care duties and that they will develop referral protocols with managed behavioral health organizations with whom they share overlapping service responsibilities. While the contract does not suggest where one set of responsibilities ceases and the other emerges, it does outline a required system for resolving matters.

Maine's contract offers an example of how a state approaches the issue of permissible exclusions by its contractors in order to limit denials of items and services

enumerated in the contract based on an exclusion that is not permissible under Medicaid (such as an “educational” exclusion):

Services Not Covered by Medicaid

a. Academic services: any program, services, or components of services which are academic in nature are not reimbursable by Medicaid. Academic services are those traditional subjects such as: science, history, literature, foreign languages and mathematics.

b. Vocational services: any programs, services, or components of services provided to recipients of which the basic nature is to provide a vocational program are not reimbursable by Medicaid. Vocational services relate to organized programs directly related to the preparation of individuals for paid or unpaid employment, such as vocational skills training or sheltered employment.

c. Socialization or recreational services: Any programs services or components of services of which the basic nature is to provide opportunities for socialization, or those activities which are recreational in nature are not reimbursable under this section. These noncovered services include but are not limited to: picnics, dances, ball games, parties, field trips, and social clubs.

d. Other services

Any other services not specifically included as a covered service in the Managed care Initiative and the Maine Medical Assistance Manual is not reimbursable by Medicaid.

Maine Contract, Negotiating the New Health System, 1999 (Table 2.1)

Mississippi’s agreement in the third edition database offers an additional example of attempting to elaborate on the relationship between a managed care provider and other agencies and services that enrollees need and use:

The Contractor shall be responsible for the management and continuity of medical care for all Members through the following minimum functions:

- a. each member will be allowed to choose his or her primary care health professionals to the extent reasonable and appropriate ***.
- b. appropriate referral and scheduling assistance for members needing specialty health services, including those identified through EPSDT.
- c. documentation of referral services ***.
- d. monitoring and treatment of members with ongoing medical conditions according to appropriate standards of medical practice.
- e. documentation in each medical record of all urgent care and emergency encounters ***.
- f. coordination of hospital and institutional admissions and discharges including ***.
- g. determination of the need for non-covered services and referral *** to appropriate services ***.
- h. coordination with other health and social programs such as Individuals with Disabilities Education Act *** WIC *** school health services, and other programs for children with special health care needs.
- i. ensuring that Members are entitled to the full range of their health care providers’ opinions and counsel about the availability of medically necessary services under the provisions of this contract. Any contractual provisions, including gag clauses or rules, that restrict a health care provider’s ability to advise patients about medically necessary treatment options violate federal laws and regulations. ***
- j. ensuring that Medicaid providers are not limited in the scope of practice, as defined by federal and state law in providing services to Medicaid recipients.

Mississippi Contract, *Negotiating the New Health System, 1999* (Table 2.1)

Finally, both Washington State's and South Carolina's contracts from the third edition database also shows a significant effort to broaden and deepen service duties in order to better ensure the emergence of relationships between managed care organizations and other parts of the health care system. The Washington State example addresses the duties of managed behavioral health providers, while South Carolina focuses on high-risk teenage pregnancies and other populations whose illnesses and disabilities may also affect their mental health:

Individualized Plan: A plan developed by the provider in collaboration with the service recipient and others providing supports to the service recipient. The individualized plan: (a) is developed with the service recipient and the people who know the service recipient best; (b) focuses on and enhances service recipient's strengths as defined by the service recipient; (c) is flexible and responsive to the service recipient's changing needs; and (d) focuses on meeting those basic needs that persons of similar age, gender, and culture have. ***

The provider shall implement the *** plan with the service recipient within 30 days of initiating community support services. The provider shall: (a) for adults, develop the plan with the service recipient and include people who provide active support to the service recipient *** at the service recipient's request. (b) for children, develop the plan with the child, family, and other who provide active support to the child. For children under 3, the plan shall be integrated with the IFSP when applicable; (c) focus on normalization and address needs identified by the service recipient; (d) be responsive to the service recipient's age, culture and disability ***

The contractor shall:

1. Ensure accessibility, engagement and utilization of mental health services for individuals who are high need, resistant to treatment, or home-bound due to medical or psychiatric conditions, providing crisis intervention and case management and treatment services on an outreach basis. Locate high need, resistant to services or home bound individuals by developing active and passive case-finding efforts.
2. Assure that all *** recipients *** are referred to a physician for a health screening, if they have not had one in the past year. For persons over the age of 60, if a physical examination has not occurred in the past 90 days, these persons should be referred ***.
3. Ensure that *** recipients receive a face-to-face assessment within 30 days of seeking treatment. The contractor will insure a method to track EPSDT assessments, referral to health providers, and mental health services ***.
4. Facilitate transition for service recipients back to their community from long term psychiatric care.
5. On execution of this agreement, put into operation a discharge planning process for all recipients of the geriatric wards of the two state hospitals.
6. Provide assistance to older adults with mental illness to maintain or restore their ability to function independently at the highest level that their mental condition permits.
7. Coordinate the necessary services for sight and hearing impaired *** recipients who may need special disability services in order to utilize mental health treatment.

8. Provide residential services emphasizing the least restrictive, stable living situations appropriate to age, cultural, linguistic and residential needs of each service recipient.
9. Ensure after a comprehensive assessment, Medicaid personal care services options are considered to maintain service recipients in their own homes before final determination of placement. If residential placement is necessary the contractor shall consider Medicaid personal care services options to maintain the service recipient in the least restrictive placement while assisting the service recipient in daily activity.
10. Ensure that services are available to *** recipients *** within 30 days of receiving a PASARR evaluation from the [mental health department] which indicates a need for mental health services, when a state-run referral system is established.
11. Maintain separation whenever possible between providers of housing and providers of mental health services.
12. Participate in continuum of care planning that provides for housing and supportive services leading to permanent housing with the highest level of self sufficiency in independent or interdependent living services recipients may achieve.
13. Provide or obtain services which will enable service recipients to become employed. These services may include assistance in obtaining a GED or other supported education and training options.
14. Provide service recipients information about employment and SSDI/SSI incentives and/or disincentives.
15. Provide or obtain active involvement which includes the participant's input into job, career or training plans, education or volunteer work, and supported employment options ***.
16. Provide resources and/or technical assistance to support consumer operated businesses, peer support, and consumer involvement.
17. Assure that mental health care is coordinated ***. Coordination may be delegated to the service recipient's PCP; however the contractor is ultimately responsible ***. The contractor shall (a) coordinate services to meet the recipient's mental health needs ***; (b) coordinate with participating health and social service programs; (c) ensure appropriate referrals for community health and social services ***; (d) ensure the existence of an advisory committee for children, older persons, and ethnic minorities ***.

Washington Mental Health Contract, *Negotiating the New Health System*, 1999 (Table 2.2)

* * *

The contractor must possess the expertise and resources to ensure the delivery of quality health care services *** in accordance with the Medicaid program standards and the prevailing medical community standards ***. Services must be furnished up to the limits as specified in the minimum service requirements *** and no medical service limitations can be more restrictive than those that currently exist under the *** State Medicaid plan. *** The [state] shall make final interpretation of any disputes about the medical necessity and continuation of core benefits.***

Medical services for special populations: Individuals with sickle cell disease, physically handicapped children, and pregnant women determined to be at high medical risk *** and all infants of high-risk mothers are defined as special populations ***. The special populations are identified as individuals which may require additional health care services which should

be incorporated into a health management plan which guarantees the most appropriate level of care ***.

Diabetes Education

Purpose: The primary objective of diabetes education is to help the recipient adapt to the chronic diagnosis of Diabetes, learn self-management skills, educate the recipient and families as to the nature of diabetes, and make important behavioral changes in their lifestyle ***. The ambulatory Diabetes Education Program is one that (a) provides medically necessary comprehensive diabetes education and counseling services ***. The fifteen content areas are as follows: general facts, psychosocial adjustment, family involvement, nutrition, exercise, *** illness guidelines, complications *** benefit/responsibilities of care, use of health care, and community resources.

Pregnancy Prevention Services – Targeted Populations

The Medicaid program provides reimbursement for pregnancy prevention services for targeted populations through community providers. The Medicaid program will reimburse fee-for-service directly to enrolled Medicaid providers for these services. The HMO should ensure that *** members continue to have access to these programs, which include but are not limited to:

Teen companion program *** providing education and counseling to prevent and/or delay teenage pregnancy among at-risk youth ***

Socialization, Education and Parenting

The Department of Disabilities and Special Needs operates regional programs that are for people with developmental disabilities ***. Services provided under this program are needs assessment, intervention plan development, *** and pregnancy prevention counseling. The program reinforces the principle role of health and human services providers.

South Carolina Contract, *Negotiating the New Health System*, 1999 (Table 2.1)

3. The Evolution of Managed Behavioral Health Care Contracts Generally: Trends and Findings

A. Trends in Contracts

There are overarching considerations in evaluating the responsiveness of managed care to the needs of consumers that transcend any particular right. Some of these considerations, particularly those relevant to coverage and access, were articulated in our original study and remain relevant today.

In light of the unique nature of state Medicaid managed care contracts and the local conditions to which they must necessarily respond, it is difficult to make findings regarding overall trends. At the same time several developments are evident.

1. The growing complexity of contract service requirements

As noted elsewhere,⁴¹ state contracts are growing more comprehensive and complex and appear to be more likely to address in detail issues related to access and quality. This growing complexity can be seen in the specification of service obligations relating to the treatment and support of mental illness and addiction disorders. By 1998 states clearly had come to understand that buying managed care involves more than buying traditional insurance coverage. In the first year of our study, we found that states were likely to provide their contractors with extraordinary discretion to define service terms and scope and design service delivery system. This degree of discretion appears to be waning, replaced by significantly greater specificity regarding delivery itself. This growth in the detail and complexity of the documents is consistent with the increasingly complex nature of Medicaid managed care enrollees. It also shows an enormous shift in the nature of Medicaid agencies themselves, which previously were relatively unconcerned with health care delivery and focused their efforts on coverage, financing and payment.

It is clear that contracts are becoming more complex in their structure and requirements related to access, information, and quality, (the central issues addressed in the consumer protection movement), regardless of whether they are “general” service agreements or specialized managed behavioral health care documents. The carve-out agreements, like their general counterparts, are more complex documents. But because the general agreements cover thousands of persons with mental illness and addiction disorders and cover a broad range of services for the treatment of these conditions, it would be surprising to see greater evolution of complexity in the relatively small number of carve-out arrangements than in the general agreements.

2. The continuing lack of medical necessity standards that ensure proper consideration of individual patient needs

⁴¹ S. Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, The George Washington University Medical Center, Washington, DC (June, 1999), Overview Volume.

As noted elsewhere in the case of pediatric care,⁴² state contracts generally do not show movement toward a medical necessity standard that requires evaluation of an individual's need for care in light of his or her medical condition and taking into account only reliable and valid evidence. This lack of a "consumer-responsive" medical necessity standard, which has become a central issue in the consumer rights debate, has particular implications for persons with complex medical conditions and represents an important counterweight to our finding of greater specificity in the area of service delivery.

First, with respect to coverage for *mental illness and addiction disorder treatment and prevention services*, the absence of a consumer-oriented medical necessity standard might lead to the application to individual Medicaid beneficiaries of behavioral health practice guidelines developed by the managed care industry for less complex cases. Industry guidelines are not necessarily scientific and may be more actuarial in their basis. Moreover, in light of the individual facts surrounding a particular patient, even the most well developed guidelines may not be relevant to or appropriate in an individual patient's case. In the area of employee benefits, questions about the clinical appropriateness of generalized behavioral health practice guidelines for specific patients have begun to appear with greater frequency in litigation challenging the sufficiency of care.⁴³ In the case of Medicaid beneficiaries, industry guidelines may be even less appropriate, because of the comparable degree of severity of their illnesses and the fact that their health outcomes have not been the focus of the industry guideline development movement.

The second problem with the use of generalized guidelines can be seen in the management of the physical health needs of persons with underlying mental illness and addiction disorders. As with any disability, the presence of an underlying health problem might influence clinical judgement regarding how to structure a course of treatment for a physical health care need. At the same time, a medical necessity standard that does not require consideration of a particular patient's underlying medical condition in determining the sufficiency of care could result in inadequate care, or care of poor quality.

3. The continuing lack of reasonable accommodation requirements for the delivery of care to persons with mental disabilities

Even as contracts become more complex in how they articulate service duties, they lack provisions requiring contractors to make certain reasonable modifications in their normal policies and practices to accommodate the needs of persons with disabilities. As noted, the importance of this issue is growing in the wake of the *Olmstead* decision. For example, states do not require their general contractors to reasonably alter their policies relating to provider networks, physician incentive arrangements, or adherence to certain practice guidelines to reasonably accommodate the care of persons with underlying disabilities. While nearly all states include in their documents general provisions prohibiting discrimination on the basis of disability, contracts generally do not set forth specifications

⁴² *Id.*

⁴³ See, e.g., *Jones v The Kodak Medical Assistance Plan*, 169 F.3d 1287 (10th Cir., 1999), *Andrews-Clarke v Travelers Insurance Co.*, 984 F. Supp. 49 (D. Mass. 1997), and *McEvoy v Group Health Cooperative of Eau Claire*, 570 N.W.2d 397 (Wis. 1997).

regarding reasonable alterations that contractors will be expected to take in administering their plans.⁴⁴

4. The Consumer Bill of Rights and Responsibilities

In examining how contracts between MCOs and state Medicaid agencies are evolving in the areas covered by the CBRR and its parallel BBA provisions, it is important to bear in mind the limitations inherent in such comparisons. Contracts evolve slowly, and laws that alter the terms of contracts can take effect only on a prospective basis,⁴⁵ managed care agreements are so complex to develop that most typically are drafted to be in effect for multiple years. Consequently, the policy changes that took place over the 1997-1998 time period would not be immediately visible in these agreements. The most recent documents in this study base were in effect as of the winter of 1998, only two months after the CBRR first was articulated and any of the BBA provisions first became effective.

It is important also to bear in mind that even if a contract does not address a particular issue, this does not necessarily mean that a state has not addressed the issue. Thus, an examination of contracts alone to determine if state-regulated providers have certain duties has inherent limitations. A state might elect to establish a standard of conduct for its Medicaid managed care plans as part of a state law of general applicability to the entire managed care industry (such as state HMO regulatory statutes). Alternatively, a state might establish a standard as a special condition of participation under the state Medicaid plan and applicable to all Medicaid-participating managed care entities.⁴⁶ As of the summer of 1999, only a few state Medicaid agencies had developed comprehensive regulations establishing conditions of participation for Medicaid managed care entities; the vast majority have maintained standards for Medicaid contractors as part of their contract documents. Similarly, while numerous states have enacted across-the board reforms in certain selected areas of managed care quality regulation (e.g., gag clause legislation), only a relative handful have attempted comprehensive reforms, in light of the preemptive effects of the Employee Retirement Income Security Act (ERISA) on state managed care reform efforts aimed at the industry generally.⁴⁷

At the same time, however, the themes of the BBA and the CBRR can be expected to echo with increasing strength in these agreements for several reasons. First, many of the relevant BBA provisions relating to access and quality were either identical, or highly similar, to conditions of approval that the Health Care Financing Administration already imposed on

⁴⁴ Sara Rosenbaum, Joel Teitelbaum, and Robert Silverstein, *The Americans with Disabilities Act: Implications for Managed Care for Persons with Mental Illness and Addiction Disorders*, The Managed Behavioral Health Care Issue Brief Series (Nos. 5/6). Available at: <http://www.samhsa.gov/mc/mancare.htm>. Click on "Managed Care Contracting." Accessed January 7, 2000.

⁴⁵ The contract clause of the United States Constitution prohibits Congress from enacting laws that impair contracts. This clause has been interpreted to prohibit the retroactive application of laws that alter contracts.

⁴⁶ Beginning in the fall of 1999, the Center for Health Services Research and Policy expanded its database to include state regulatory conditions of participation for Medicaid managed care entities. This addition permits this study to examine both state contracts and state Medicaid regulations.

⁴⁷ *Law and the American Health Care System*, *supra* note 5, at Ch. 2(C).

Medicaid managed care systems under its §§1115 and 1915 demonstration authority.⁴⁸ Second, the BBA and CBRR are hallmarks of the evolutionary nature of federal policy, particularly policy that is designed to regulate large and complex industries. Such policy developments tend to follow rather than precede state-driven developments. Earlier analyses of certain provisions of the BBA suggest that a number of its provisions, particularly those related to quality, already were embodied in state documents at the time of the law’s enactment.⁴⁹

Finally, while contracts that were in effect in 1998 might show only preliminary evidence of evolution in the areas addressed by the BBA and CBRR, it is important to examine these changes as they unfold. The BBA and CBRR establish important but very broad baselines of conduct for the managed care industry. States have considerable flexibility to implement both the BBA and CBRR standards, and much can be learned from the approaches that different states take in their contract documents to the task of converting a broad standard into workable and enforceable policy.

B. Specific Contract Findings

1. Network and Access Standards

a. Network Composition

Generally speaking, and consistent with the prior studies, the majority of contracts contain specifications relating to at least one class of provider, with the overwhelming class mentioned being primary care providers. Of the states that require primary care providers, most contain specifications related to primary care provider-to-patient ratios. Slightly less than half of the states continue to include the stipulation that specialty care providers be included in a plan’s network. Similarly, approximately half the contracts contain specifications regarding specialty care provider-patient ratios. Almost three-quarters of the states address the issue of including certain classes of “safety net” providers in their MCO network (e.g., local mental health agencies). Only a handful of states include a requirement that dual diagnosis providers be included in the network.

One method states use to assure access for Medicaid enrollees is the inclusion in their managed care contracts of specifications related to the composition and technical capabilities of health plans’ provider networks. For example, some states require the plan to describe or define the types of providers that will be part of the networks, while other states actually specify the structure and composition of the provider network. Others may—and, in fact, many do—leave the composition of the provider network largely to plan discretion.

⁴⁸ Rosenbaum and Darnell, *An Analysis of State Medicaid Managed Care Demonstrations Under Section 1115 of the Social Security Act*, *supra* note 22.

⁴⁹ Rosenbaum S. “Recent and Pending Federal Reforms Related to Managed Care Quality: Implications for State Medicaid Programs.” National Academy for State Health Policy. (Summer, 1998). Available at <http://www.nashp.org>.

As with our prior studies, we focused this year on whether states specifically referenced inclusion in the plan’s network of types of providers ranging from those generally regarded as basic elements of a comprehensive network, such as primary care, obstetrical, and pediatric providers, to those traditionally associated with treating the Medicaid population, such as safety-net providers.

Findings specific to behavioral health services indicate that 28 contracts, including 10 of the 13 managed behavioral health care contracts, contain some level of detail regarding the characteristics and competence of MI/AD-related network providers. Overall, this represents an increase of just one carve-out contract from last year’s analysis. As a general matter—and particularly so in the case of the behavioral health care carve-out agreements—the contracts grant broad authority to contractors to set competency and skill levels of the professionals, agencies, and institutions that will furnish care under the contracts. Presumably, this choice on the part of state agencies is a result of their belief that network design and development represent an area in which managed care organizations are uniquely qualified due to the nature of the business. Whether or not this expectation is correct in the case of more severely and chronically ill low-income populations is perhaps open to question, since these are not the populations whom managed care organizations traditionally have served.

State approaches to the issue of provider network specifications vary tremendously. For example, Hawaii’s behavioral health contract specifies as follows:

* * * All providers of service shall meet applicable state and federal regulations, licensing, certification and recertification requirements * * *. [Required network components include] Outpatient behavioral health services * * * Mental health rehabilitation services * * * [and] Behavioral health specialists such as psychiatrists who have admission and treatment privileges in a general acute care hospital or psychiatric facility. . .

Hawaii Behavioral Health RFP, pp. 16-17

Read as broadly as possible, the Hawaii contract would permit a company to assemble a network consisting of psychiatrists and hospital-based rehabilitation programs. Iowa’s mental health contract specifies simply that:

The Contractor shall provide at least as much access to Medically Necessary Covered Services as currently exists within Iowa’s Medicaid Fee-For-Service delivery system. This shall be measured against current Medicaid provider enrollment. . .

Iowa Mental Health Contract, p. 17

Florida takes a significantly different approach in its specialized mental health care agreement, setting forth relatively extensive specifications regarding provider composition:

5. The contractor shall have access to no less than one fully accredited psychiatric community hospital bed per 2,000 prepaid members, as appropriate for both children and adults.

1. The contractor's staff shall include at least one board certified adult psychiatrist, or one who meets all education and training criteria for board certification * * * [to be available within thirty minutes typical travel time of all enrolled recipients].

2. The contractor's staff shall include at least one board certified child psychiatrist, or one who meets all education and training criteria for board certification * * * [to be available within thirty minutes typical travel time of all enrolled recipients]. * * * The contractor's array of direct service mental health care providers for adults and children must include providers that are licensed or eligible for licensure, and demonstrate two years of clinical experience in the following specialty areas: (1) adoption, (2) separation and loss, (3) victims and perpetrators of sexual abuse, (4) victims and perpetrators of physical abuse, (5) court ordered evaluations, and (6) expert witness testimony. * * * The contractor shall provide staff appropriately trained and experienced to provide psychological testing. The contractor shall provide staff appropriately trained and experienced to provide rehabilitation and support services to persons with severe and persistent mental illness.

* * * To demonstrate the plan will have the staffing resources necessary for the provision of services, complete and attach * * * PMHP Service Provider Staffing Table, denoting, for each county in the service area, the number of actual and proposed FTE psychiatrists; child psychiatrists; mental health care case managers; psychologists; psychiatric nurses; licensed certified social workers; other licensed mental health care professionals * * *.

Florida Mental Health RFP, pp. 28-9, 38, 85

Beyond the issue of network membership and capabilities is the issue of patient access to the network. Nineteen contracts address access-time standards in the area of MI/AD services (no change from last year's study). In many instances, the state delegates to the contractor relatively broad authority to establish access standards for routine, urgent, and emergency care for certain MI/AD services; in other circumstances the standards are specified, as exemplified by the following provision:

The MCO provider network must provide face-to-face intervention within one hour for emergencies * * * [and] within seven days for routine appointments [and] specialty referrals.

Pennsylvania Behavioral Health RFP, p. 69

Also beyond the issue of network composition is the issue of whether state contracts define standards for the roles of various network providers. This issue is noteworthy because inherent in the managed care system is the concept that the primary care provider acts as a gatekeeper to the network of various professionals or entities that render care. The PCP is responsible for facilitating enrollees' access to most specialty care providers and various kinds of services. While the standards may not provide an exhaustive list of the providers' responsibilities, by establishing coordination standards in the contracts, states can clarify their expectation that the MCOs maintain a systematic approach to a standard of care for their patients.

Notably, almost half of the reviewed contracts include provisions for coordination of care between PCPs and mental health and substance abuse providers. This may be a reflection of the fact that many states are incorporating their behavior health services into their general service agreements. This may also reflect the fact that states acknowledge the need for communication between a PCP who may be rendering service under a general

service agreement and a behavioral health specialist who may be providing care under a carve-out agreement. For example, Oregon’s mental health contract requires that mental health providers must coordinate and communicate with the patient’s physical health care providers, “[A]s medically appropriate and within laws governing confidentiality. . .” The Pennsylvania and Utah contracts contain similar provisions.

b. Self-Referral to Mental Illness and Addiction Disorder Providers

Our findings indicate that while most contracts still do not include any language which addresses the issue of self-referral for enrollees, the number that do address this issue has almost doubled this year. Specifically with regard to behavioral health services, however, the numbers are far less dramatic. Last year, 15 general service agreements and 7 behavioral health carve-out contracts addressed the issue of self-referral to providers of MI/AD services; this year, 14 general service contracts and 10 carve-out contracts address the issue. And consistent with the earlier study, fewer states permit self-referral for substance abuse services (16 this year) than for mental health services (all 24).

Self-referral to certain providers is an issue that continues to receive attention in the public policy debate concerning managed care patient protection. Even in managed care systems in which a gatekeeper plays a central role in assuring continuity of care for patients and preventing the unnecessary use of specialty services, there may be certain services of particular importance to the Medicaid population that states may want to encourage by permitting direct access through patient self-referral. Because these services typically involve obstetric and family planning visits or mental health and substance abuse treatments, we focused on these indicators in this year’s study to determine the extent to which states operated to expand or restrict choice within the managed care system. Moreover, it is possible for states to require plans to permit self-referral for these services only to network providers, while others require self-referral both in and out of the network.

Also consistent with earlier findings, in a number of instances self-referral is limited to emergency care. In other instances enrollees are permitted a specified number of self-referrals, typically for assessment and counseling purposes. The Nebraska mental health contract provides as follows:

A. ACCESS TO COVERED SERVICES.

1. CLIENT ASSISTANCE PROGRAM. Through the Client Assistance Program . . . provide direct access to [MI/AD] Providers by self-referral as well as PCP referral, state agency referral, and referral by school health personnel for up to five (5) visits per Client on an annual basis. . .

Nebraska Mental Health Contract, Addendum A

The New York and Oklahoma contracts each permit one annual self-referral for mental health assessment and one annual self-referral for substance abuse assessment.

c. Cultural Competency

Slightly more than half of all contracts in the 1997 database addressed cultural competency issues; this percentage has increased to nearly two-thirds in the current study. In the 1998 database, 32 out of 52 contracts (62%) address the issue of cultural competency, up from 29 out of 54 contracts (54%) in the prior year. Of the 13 managed behavioral health contracts in 1998, 10 (77%) address this issue, an increase of 1 contract over the prior year. Consistent with our findings in the 2nd edition, contracts less frequently include a specific definition of cultural competency; of the 13 behavioral health contracts, only 4 of them do so, and only 4 of the remaining 39 general contracts make such a reference. Translation services and accessibility of materials by vision-, hearing-, and/or physically-impaired persons are almost universally addressed. Forty-five out of 52 contracts address requirements to make available materials in other languages or in forms useful to people with disabilities.

In their September 29, 1998 Proposed Rules for the Medicaid program, HCFA officials addressed the importance of providing culturally appropriate and competent health services to Medicaid beneficiaries in the following manner:

In Sec. 438.306(e)(4), we are proposing that the State agency ensure that each MCO provide services in a culturally competent manner, including at least satisfying the language requirements in Sec. 438.10(b). This requirement is proposed here because of our recognition that more than half of Medicaid program beneficiaries are members of a racial or ethnic minority group. We know that managed care organizations and advocates have made great strides in developing culturally competent approaches and would expect a State agency to work with them and others in setting its standards. Accordingly, State agencies should ensure that MCOs identify significant sub-populations within their enrolled population that may experience special barriers in accessing health services such as the homeless or enrollees who are part of a culture with norms and practices that may affect their interaction with the mainstream health care system. State agencies should ensure that MCOs make continued efforts to improve accessibility of both clinical and member services for these specific groups.

Cultural competency requires awareness of the culture of the population being served. Therefore, in order to ensure services are provided in a culturally competent manner, State agencies should require MCOs to give racial and ethnic minority concerns full attention beginning with their first contact with an enrollee, continuing throughout the care process, and extending afterwards when care is evaluated. Translation services must be made available when language barriers exist, including the use of sign interpreters for persons with hearing impairments and the use of Braille for persons with impaired vision. Further, for each racial or ethnic minority group, the MCO's network should include an adequate number of providers, commensurate with the population enrolled, who are aware of the values, beliefs, traditions, customs, and parenting styles of the community. This awareness includes, but is not limited to, a provider being cognizant, among other things, of the importance of non-verbal communication, the recognition of specific dietary customs unique to certain populations, and the existence of folk medications or healing rituals that may be used by an enrollee. In addition, cultural competence requires network providers to have knowledge of medical risks enhanced in, or peculiar to, the racial, ethnic, and socioeconomic factors of the populations being served. Accordingly, MCOs

*should have accurate epidemiological data from which to form appropriate education, screening, and treatment programs.*⁵⁰

The nature and scope of how cultural competency is defined and implemented continue to vary widely across contracts.⁵¹ The following contract excerpts from the 1998 database illustrate some of the more detailed examples. Note that the first two examples from Pennsylvania comprise both a definition of cultural competency and its application in the delivery of behavioral health services. The third example, from Iowa, enumerates a list of cultural, ethnic, and gender groups that constitute a diverse treatment population.

Cultural Competency – The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and deliver; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Pennsylvania Behavioral Health RFP, page ii.

CULTURAL CONSIDERATIONS

A specialized program that includes the following goals and resources: ...

- A. A program philosophy that acknowledges that individuals and families make different choice based on culture.
- B. Treatment that includes the discussion of cultural pain and racism, and other culturally specific clinical issues.
- C. Use of culturally appropriate diagnostic tools and treatment methodologies.
- D. Consideration of the individuals' primary language with corresponding understanding of verbal cues, facial expressions and non-verbal styles of specific culture.
- E. Decor, literature, and program material that represent the art style, lifestyle and culture of the group being served.
- F. Outreach services that decrease cultural barriers to program access.
- G. Coordination of services that connect clients to community resources and supports that are part of the culture.
- H. Integration of appropriate culturally based health beliefs and practices into the treatment approach.
- I. Ongoing plans for training of staff and program plans.

Pennsylvania Behavioral Health RFP, Appendix T, Part C, page 122.

⁵⁰ *Federal Register*: September 29, 1998 (Vol. 63, No. 188). Proposed Rules, 42 CFR Part 438, Department of Health and Human Services, Health Care Financing Administration. Available at <http://www.hcfa.gov/medicaid/bbamcreg.htm>. Accessed January 3, 2000.

⁵¹ For a detailed analysis of cultural competence in Medicaid managed care purchasing, see Sara Rosenbaum and Joel Teitelbaum, "Cultural Competence in Medicaid Managed Care Purchasing: General and Behavioral Health Services for Persons With Mental and Addiction-Related Illnesses and Disorders," Issue Brief #4 in the Managed Behavioral Health Care Issue Brief Series. June 1999. Hirsh Health Law and Policy Program, GW Center for Health Services Research and Policy, Washington DC. Available at: <http://www.samhsa.gov/mc/Managed%20Care%20Contracting/issubr4/TOC.htm>. See also, Center for Mental Health Services, "Cultural Competence Standards in Managed Care: Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups," November 1998, DHHS/SAMHSA. Available at: <http://www.mentalhealth.org/publications/allpubs/MC99-78/>.

8. Cultural/Ethnic Competency, Handicapped and Special Populations – Residents of the State of Iowa bring a diversity of cultural, racial and ethnic backgrounds. Bidders must discuss how they will ensure access to treatment services for all cultural, ethnic, and gender groups, to include but not be limited to, African American, Native American, Hispanic, Asian, gay and lesbian populations, handicapped (e.g., deaf, visually impaired, physically impaired, etc.) and dually diagnosed. Bidders should discuss how they will work with the treatment program network to maintain cultural and language sensitive services, accommodate the special needs of handicapped clients and otherwise provide appropriate treatment services for these individuals.

Iowa Substance Abuse RFP, page 30-17.

d. Access to Emergency Services

Overall, states do a relatively good job of including in their Medicaid managed care general service agreements provisions that require access to emergency services, but are less likely to include similar language in their carve-out contracts. For example, in the 1998 database, 42 out of 52 contracts, but only 6 carve-out agreements, contain provisions requiring health plans to educate members about the availability, location, and appropriate use of services, and about cost-sharing and availability of care, outside the emergency room. In the first-year database, these numbers stood at 35 and 4, respectively. In addition, in 1998, 40 contracts—an increase of 3 over time—included a prohibition against billing for emergency care by non-network providers. However, only 7 carve-out agreements contained such a provision.

The contracts show significant movement toward the adoption of a prudent layperson standard. Forty-eight contracts in the 1998 database, including eleven carve-outs, contain a prudent layperson standard, up from 35 contracts and only 3 carve-out contracts in the first study year. States have not only expanded their use of a prudent layperson standard but also specify prohibitions against the use of prior authorization or restriction of emergency care to in-network providers. In 1995 only 25 contracts, including 4 carve-outs, incorporated this information; by 1998, the number stood at 43 and 8, respectively.

The state of Nebraska provides an illustration of a particularly comprehensive emergency care provision in its general contract, while New York offers an example of a comprehensive definition in its carve-out agreement.

Emergency Care: Definition

1.12 The term "emergency medical services" means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions; (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child as determined by the attending physician.

Coverage for urgent and emergency services out-of-plan

3.3 Emergency Care...

3.3.1 HMOs obligation to pay for Emergency Medical Services that are received from Providers other than HMO or its subcontractors is limited to the Emergency Medical Services obtained in circumstances beyond the Client's control, or Emergency Medical Services required before the Client can, without medically harmful consequences, be transferred to HMOs source of health care for further treatment. HMO is responsible for medically appropriate transportation to transfer the Client to HMO's care when it can be done without medically harmful consequences.

3.3.2 Emergency Medical Services include unexpected premature delivery, but do not include normal delivery unless HMO determines, subject to the Client's appeal rights, that the Client was outside HMOs Designated Geographic AREA because of circumstances beyond the Client's control.

3.3.3 HMO has no obligation to pay for Emergency Medical Services unless the Provider of such services submits a bill to HMO within ninety (90) days of the date services were provided.

Nebraska RFP, pages 2, 6.

Definition of emergency specific to mental health or substance abuse

13) "Emergency" means a situation which requires services that are medically necessary and required to be provided to a enrollee as a result of an unexpected onset of serious psychiatric symptoms having the potential of causing disability or harm, (to self or others) or requiring immediate alleviation.

Section 7.0: COVERED SERVICES

E. Emergency Services ...

1) "Emergency Services" shall mean services, within or outside of the plan's service area, which are medically necessary and required to be provided to an enrollee as a result of the unexpected onset of severe psychiatric symptoms having the potential of causing disability or harm...

New York Mental Health Contract, Appendix A, Sections 2.0, 7.0.

In the case of emergency care, in the original database, all 36 general contracts, and 6 out of 9 managed behavioral health contracts, required such disclosure (see Table 1.3 from the first edition). In this year's study, 45 out of 52 general contracts, and 9 out of 13 managed behavioral health care agreements required disclosure of the conditions under which emergency care would be covered (see Table 1.5 from the third edition). While some states have enacted legislation establishing a prudent layperson standard for emergency care, thereby obviating the need for separate contractual language to establish the obligation, prudent layperson laws generally do not address the issue of disclosure.

2. Relationships Between Managed Care Organizations and the Rest of the Health System

A critical issue in the treatment of persons with mental illness and addiction disorders is the extent to which MCOs are required to interact with other programs and agencies which are involved in the treatment and management of such individuals. Some of

these agencies, such as local mental health agencies, may be responsible for the provision of health and related services to individuals with MI/AD-related conditions and thus are likely to bear directly on the care enrollees receive from their managed care plans. In addition, courts, or agencies within the juvenile justice or adult corrections systems, may be charged with the oversight of enrollees on both non-health and health-related matters. Finally, other agencies, including state substance abuse treatment and prevention agencies, may have a direct concern in the structure, content, and quality of care furnished by managed care organizations to members of the populations for which they are responsible as a matter of state policy.

Because state and local public agencies have so many facets and programmatic personalities, working through these types of relationships has always been difficult (failure to coordinate among numerous programs serving the same population was a constant complaint in the fee-for-service system as well). The question of coordination is made more complicated in a managed care context by the fact that many public agencies have limited budgets and depend heavily on Medicaid funds to pay for covered services which their clients need. Where these services are furnished directly by local health agencies, the shift to managed care may also be costing the agency needed revenues, thereby increasing the problem. The remainder of this section is devoted to tracking the issue of MCO interaction with agencies also involved in the treatment and management of individuals with MI/AD-related conditions, from the first edition of this study to the present.

a. First Edition

In the first edition of this study we concluded that states face major challenges in attempting to establish and define the relationships between MCOs and various public agencies. The most notable finding was that of those states that included in their Medicaid managed care contracts provisions regarding relationships with public agencies, most gave MCOs considerable discretion to determine the extent and components of those relationships. Forty-five contracts, including 9 behavioral health carve-out contracts (representing a total of 37 states), that were “live” during the 1995 calendar year were collected for the first edition. Of those, 17 (including 1 carve-out) contained provisions related to relationships between managed care plans and mental health agencies, while 14 (including 3 specialized behavioral health contracts) contained provisions defining relationships with state or local substance abuse agencies.

b. Second Edition

Whereas the first edition of the study involved contracts and RFPs that were effective through December 31, 1995, the second edition involved contract documents in use by states as of the beginning of 1997. In the intervening period, significant changes developed in the number of states that included in their contracts provisions related to relationships between MCOs and public agencies, even taking into account the increase in the number of contracts submitted for inclusion in the study. Forty-one states and the District of Columbia submitted 54 contracts and RFPs (including 12 behavioral health carve-outs) for the second edition of this study. Of those, 36 (including 10 carve-out)

contained provisions related to relationships between managed care plans and mental health agencies, while 24 (including 8 specialized behavioral health contracts) contained provisions defining relationships with state or local substance abuse agencies. Beyond these statistical advancements and the tweaking by some states of their contract language, however, no significant systematic changes occurred in the specificity or scope of MCOs' duties to engage in meaningful relationships with state or local public agencies.

c. Current Findings

Notably, and not unlike the findings from the second edition, one of the areas most commonly addressed by contract provisions related to public agency relationships concerns generalized coordination requirements with state and local mental health and substance abuse programs. The database for the current edition of the study contains 52 separate contracts and RFPs (including 13 carve-out arrangements) in use at the beginning of 1998, as submitted by 39 states and the District of Columbia. Among the general service agreements, 29 of 52 specify relationships between managed care organizations and mental health agencies, and 22 address the relationships with substance abuse agencies. Further, 11 of the 13 managed behavioral health carve-out contracts address MCO relationships with either mental health or alcohol and substance abuse agencies (or both). Compared to last year, the only significant change—either positive or negative—is the decrease from 36 to 29 in the number of general service agreements that contain provisions specifying relationships between MCOs and mental health agencies.

As we found in both our previous studies, while there are numerous examples of state efforts to specify some level of relationship, in fact most states give plans considerable discretion to determine the extent and components of their agency relationships. Additionally, contracts often define the relationships in terms of recommendations rather than requirements.

As noted previously, however, the nature and extent of those relationships that are addressed in state Medicaid significant state care c o i specifications range from broad directives (Iowa's substance abuse contract requires plans to "establish a close working relationship" with the Division of Substance Abuse and its special substance abuse carve-out plan) to mere implicit recommendations (Missouri specifies in its general service RFP that it wishes to preserve its county mental health delivery system and that it implicitly expects that the plans will contract with the providers). Hawaii requires that plans contract with community mental health centers but leaves the scope of involvement to plan discretion.

The following examples illustrate the wide variation in states' approaches to the issue of MCO relationships with state or local mental health or substance abuse agencies:

2.06.07 Agreements with State Agencies

The Contractor shall: ...

b. Develop and submit to the Division for prior review and approval within the first six months of the Contract, a plan to ensure that its Network Management staff communicate on an ongoing basis, and no less than monthly, with DSS designated staff, DPH/BSAS designated staff, DMH area directors and other appropriate state agencies' designated staff to address Enrollees' service planning, admissions, discharge plans, utilization, and coordination of DMH Continuing Care Services.

Massachusetts MH/SAP Contract, Appendix B, page 22.

The HEALTH PLAN must work cooperatively with a collaborative to assure the integration of physical and mental health services to enrollees of the collaborative.

Minnesota Contract, page 37.

336 Service Authorization and Coordination...

336.12 Linkage to Substance Abuse Treatment

The Service Coordination Plan must include an explicit strategy for recognizing substance abuse or chemical dependency problems among MHAP members and providing or referring them for appropriate evaluation and treatment. It must also include a specific strategy for the identification of eligible or potentially eligible individuals needing mental health services who are receiving treatment for substance abuse. The State will prefer proposals that commit to the development of written memoranda of agreement with substance abuse treatment programs and providers that explicitly establish linkage mechanisms, delineate joint and separate responsibilities, and define mutual expectations.

Montana Mental Health RFP, pages 200-24, 200-28.

The Department strongly advocates the development of collaborative relationships among HMOs, Local Health Departments and other community health organizations to achieve improved services in priority areas.

RR. SUBCONTRACTS WITH LOCAL HEALTH DEPARTMENTS----The Department encourages the HMO to contract with local health departments for the provision of care to Medicaid recipients in order to assure continuity and culturally appropriate care and services. Local health departments can provide HealthCheck outreach and screening, immunizations, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases (e.g., tuberculosis, HIV/AIDS, sexually transmitted diseases, hepatitis and others).

SS. SUBCONTRACTS WITH COMMUNITY-BASED HEALTH ORGANIZATIONS----The Department encourages the HMO to contract with community-based health organizations for the provision of care to Medicaid recipients in order to assure continuity and culturally appropriate care and services. Community-based organizations can provide HealthCheck outreach and screening, immunizations, family-planning services, and other types of services.

1. The HMO must designate at least one individual to serve as a contact person for case Management providers...
2. The HMO may make referrals to case management agencies when they identify a recipient from an eligible target population who they believe could benefit from case management services.
3. If the recipient or case manager requests the HMO to conduct an assessment, the HMO will determine whether there are signs and symptoms indicating the need for an assessment...

5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required.

1. The case management agency is responsible for initiating contact with the HMO to coordinate services to recipient(s) they have in common and provide the HMO with the name and phone number of the case Manager(s).

2. If the HMO refers a recipient to the case management agency, the case management agency must conduct an initial screening based on their usual procedures and policies. The case management agency must determine whether or not they will provide case management services and notify the HMO of this decision...

5. The case manager must identify whether the recipient has additional service or treatment needs. As a part of this process, the case manager and the recipient may seek additional assessment of conditions which the HMO may be expected to treat under the terms of its contract, if the HMO determines there are specific signs and symptoms indicating the need for an assessment.

6. The case management agency may not determine the need for specific medical care covered under the HMO Contract, nor may the case management agency make referrals directly to specific providers of medical care covered through the HMO...

7. EMERGENCY CARE COVERAGE---The HMO shall be liable for the cost of all mental health... treatment, including involuntary commitment or stipulated voluntary commitment and the new crisis intervention benefit, provided by non-HMO providers to HMO enrollees where the time required to obtain such treatment at the HMO's facilities, or the facilities of a provider with which the HMO has arrangements, would have risked permanent damage to the enrollee's health or safety, or the health or safety of others...

8. COURT-RELATED COMMITMENT COVERAGE---The HMO shall be financially liable for the enrollee's court-related diagnosis or treatment where an HMO enrollee is defending him/herself or a member of his/her Medicaid case against a mental disability... commitment.

9. INSTITUTIONALIZED CHILDREN, COVERAGE

REQUIRED---The HMO shall be financially liable for inpatient and institutional care for all children enrolled under this Contract (by being members of a case in the medical status codes covered by the Contract) for the entire period for which capitation is paid no matter what the child's medical status code becomes, even if the child's relationship to the original AFDC case changes. The HMO is financially liable for inpatient and institutional care for all children enrolled under the Contract for the entire period for which capitation is paid. If the medical status code changes, the HMO will continue to be liable if a capitation is paid.

12. CRITERIA FOR EXEMPTION---The HMO shall not be liable, at the point in time commencing with the month for which the recipient's voluntary exemption becomes effective, except as provided in 9 above, for providing contract services to Medicaid cases in which there is an HMO enrollee who meets one or more of the following criteria as provided in requirement 11 of this addendum:

a. a person with recurrent or persistent psychosis and/or a major disruption in mood, cognition or perception...

6. COURT-RELATED AODA SERVICES---The HMO shall be liable for the cost of providing all medically necessary AODA treatment, as long as the treatment occurs in an HMO-approved facility or by an HMO-approved provider prescribed in the subject's Driver Safety Plan, pursuant to Chapter 343, Wis. Stats., and HSS 62 of the Wis. Administrative Code. The medical necessity of services specified in this plan is assumed to be established, and the HMO shall provide those services unless the assessment agency agrees to amend the enrollee's Driver Safety Plan. This is not meant to require HMO coverage of AODA educational programs. Necessary HMO referrals or treatment authorizations by providers

must be furnished promptly. It is expected that no more than five days will elapse between receipt of a written request by an HMO and the issuance of a referral or authorization for treatment. Such referral or authorization, once determined to be medically necessary, will be retroactive to the date of the request. After the 5th day an assumption will exist that an authorization has been made until such time as the HMO responds in writing.

7. EMERGENCY CARE COVERAGE----The HMO shall be liable for the cost of all... AODA treatment, including involuntary commitment or stipulated voluntary commitment and the new crisis intervention benefit, provided by non-HMO providers to HMO enrollees where the time required to obtain such treatment at the HMO's facilities, or the facilities of a provider with which the HMO has arrangements, would have risked permanent damage to the enrollee's health or safety, or the health or safety of others...

8. COURT-RELATED COMMITMENT COVERAGE----The HMO shall be financially liable for the enrollee's court-related diagnosis or treatment where an HMO enrollee is defending him/herself or a member of his/her Medicaid case against a... AODA commitment.

12. CRITERIA FOR EXEMPTION----The HMO shall not be liable, at the point in time commencing with the month for which the recipient's voluntary exemption becomes effective, except as provided in 9 above, for providing contract services to Medicaid cases in which there is an HMO enrollee who meets one or more of the following criteria as provided in requirement 11 of this addendum: ...

c. a person participating, or who has been determined to need participation in a methadone treatment program...

Wisconsin Contract, various pages.

In conclusion, our trend analyses indicate that one of the most difficult issues in designing managed care systems is the question of how managed care organizations should relate to public agencies at the state and local level. This area continues to be one that commands the attention of program administrators and policymakers.

3. Quality Improvement, Performance Measurement, and Data Reporting

The number of contracts containing provisions describing or referring to specific elements of a quality assurance system remains relatively unchanged from our prior year findings. Consistent with general service contracts, almost all (12 out of 13) behavioral health contracts include specifications for development of internal quality assurance and performance measurement systems by contractors. A larger proportion of behavioral health contracts require external review of a plan's performance than the general contracts (10 out of 13 vs. 28 out of 39); behavioral health contracts also more frequently cite the need for clinical studies and the use of clinical guidelines in quality assurance systems. Almost all contracts, whether general or behavioral health, require corrective action plans.

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The most striking difference between the behavioral health and general contracts is that 11 out of 13 behavioral health contracts (85%) include profiling of provider performance vs. 25 out of 39 general contracts (64%). One of the primary goals of a quality assurance system is to measure and verify the extent to which health services are utilized appropriately in a cost-effective manner leading to optimal outcomes. Provider profiling, whereby the length and intensity of the treatment services ordered by a provider are retrospectively reviewed to compare them to clinical and treatment practice guidelines and/or against a provider's peers, can be interpreted as a less formal way of gauging the appropriateness of service utilization. In the case of mental health and addiction disorder treatment, where clinical indicators of outcome efficacy are perceived by some as less "scientific" or "reproducible" than in physical medical care, provider profiling may be viewed as a tool to validate quality assurance functions.⁵²

Several of the contracts cite HCFA's statutory basis for the use of provider profiling in quality assurance activities. 42 CFR 434.34 states:

Sec. 434.34 Quality assurance system.

The contract must provide for an internal quality assurance system that:

- (a) Is consistent with the utilization control requirement of part 456 of this chapter;
- (b) Provides for review by appropriate health professionals of the process followed in providing health services;
- (c) Provides for systematic data collection of performance and patient results;
- (d) Provides for interpretation of this data to the practitioners; and
- (e) Provides for making needed changes.⁵³

In addition to serving as a quality assurance mechanism, provider profiling is also used in capitated reimbursement systems for determining a provider's compensation, especially in regards to participation in shared savings arrangements and returns of withholds. It is also a factor considered in the renewal or cancellation of a provider's contract with the MCO. Ideally, such profiles should be adjusted for patient mix, severity of illness, and measured with specific reference to standards of care established by professional health associations and/or generally accepted community practice patterns. Note in the

⁵² As an example of such a perception, consider the decision by United Behavioral Health (UBH) on November 12, 1999 to continue requiring prior authorization for mental health services, unlike its parent organization, UnitedHealth Group. Saul Feldman, chief executive of UBH stated, "There is in medical care much more evidence-based practice, while in mental health you have a wide variety of treatment philosophies and methods, the great majority of which have not been evaluated in terms of efficacy. While we've made a lot of progress in determining which mental health practices are best, we're still far behind medical care and we have a lot of catching up to do." Hilzenrath, David S. "HMO Doctors' Choice Has Limits." *The Washington Post*. November 12, 1999.

⁵³ Code of Federal Regulations, Title 42, Volume 3, Part 434, Section 34. Available at: http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr434_99.html. Accessed January 5, 2000.

following examples that both the Iowa and Kentucky contracts cite the need for incorporating risk adjustment in provider profiling activities.

12.4 Provider Profiling

The MCO must have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to HCFA's "A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States." The MCO also must have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with the MCO's medical management standards.

Delaware RFP, page II.65.

The Contractor shall establish and maintain a peer review program approved by the Department to review the quality of care being offered by the Contractor, employees and sub-contractors. This program shall provide, at a minimum, the following:

- A. A peer review committee comprised of physicians licensed to practice medicine in all branches, and proceed with the required reviews for both the health professionals of the Contractor's staff and any contracted Providers which include:
 - i. A regular schedule for review; and
 - ii. A system to evaluate the process and methods by which care is given.

Provider reviews – The written description shall document how physicians licensed to practice medicine in all its branches and other health professionals will be involved in reviewing the provisions of health services and how feedback to health professionals and Contractor staff regarding performance and patient results will be provided.

Illinois Contract, Exhibit A, page 2.

8. Coordination with the Departments...

Any Network Provider profiling systems our outcomes pertaining to treatment effectiveness must be risk adjusted based upon the population(s) served by the Network Providers.

Iowa Substance Abuse Contract, page 11.

7.4.1.7 Utilization/Quality Improvement Subsystem

[...] This system profiles providers and compares them to experience and norms for comparable individuals.

Kentucky Contract RFA, pages 31-32.

G. Provider Performance Measurement and Process

1. PROVIDER PROFILING ACTIVITIES. OPTIONS will conduct physician Provider and other profiling activities defined as multi-dimensional assessments of an individual physician or Provider performance, and utilize such measures in the evaluation and management of those physicians. The evaluation management approach will address, but not be limited to:

- a. Resource utilization of MHS AS services, including specialty and ancillary services.
- b. Clinical performance measures on structure, process, and outcomes of care.
- c. Client experience and perceptions of service delivery.

d. Access.

Measure: Participate on a semi-annual basis in the first Contract Year in NMMCP Quality Assurance/Utilization Management activities to maximize the use of Provider profiling data in the management and evaluation of MHS AS Providers.

Nebraska Mental Health Contract, Addendum A.

For this Edition, we analyzed for the first time the extent to which contracts require that there be a linkage between service duties and performance measures intended to demonstrate that such duties have been fulfilled in a timely and satisfactory manner. Nine of the behavioral health contracts (75%) and 18 of the general contracts (46%) contain such provisions. The Massachusetts Behavioral Health Contract provides a linkage between performance measures and service duties by structuring monetary incentives and penalties with targeted performance threshold indicators. The performance measurement domains are quite extensive, ranging from timeliness and prior approval rates for inpatient and outpatient services, medication management, aftercare planning, readmission rates, continuing care, crisis intervention, and administrative efficiency, among others. Of particular note is that the contract specifies that the imposition of penalties is discretionary, e.g., “the Division *may* elect to ...”, whereas the award of incentive payments in the event of superior contractor performance is mandatory, e.g., “the Division *shall* ...” The following examples illustrate Massachusetts’ performance linkage process:

Section 5: REIMBURSEMENT:...

C. Risk Sharing...

5. Performance Incentives and Sanctions...

d. Performance Standard for Timeliness of Inpatient Admission: The Contractor shall ensure that inpatient hospital disposition occur within two hours of receiving clinical assessment information from a credentialed Provider or ESP ...

- 1) If the annual compliance rate for timeliness of inpatient admissions is less than 90% and greater than or equal to 80%, the Division *may* elect to impose a penalty of up to \$100,000.
- 2) If the annual compliance rate for timeliness of inpatient admissions is less than 80% but greater the 70%, the Division *may* elect to impose a penalty of up to \$200,000.
- 3) If the annual compliance rate for timeliness of inpatient admissions is equal to or greater than 90%, the Division *shall* pay the contractor \$333,333.

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. .

5) Continuing Care: Medication Monitoring: The Contractor shall measure the percentage of members across all rating and age categories discharged from inpatient psychiatric treatment who attend within 21 days of discharge: an outpatient medication evaluation; a medication monitoring appointment; an initial evaluation by a physician or a Clinical Nurse Specialist; or a medication group appointment...

- a) If the actual measure is less than the compliance target, the Division *may* impose a penalty of up to \$500,000.
- b) If the actual measure is greater than or equal to the compliance target but less than a 25% increase above the first contract year performance level, the Contractor *shall* receive a bonus of \$500,000; or
- c) If the actual measure is greater than or equal to a 25% increase above the first contract year performance level, the Contractor *shall* receive a bonus of \$700,000.

.
.

6) Performance Improvement Bonuses

a. General Provisions

[...] (2) If the Contractor meets or exceeds each of the performance improvement standards listed in subsections 5.1.C.6.b. and 5.1.c.6.c., as determined by the Division, the Division *shall* pay the Contractor a \$500,000 performance improvement bonus for each performance improvement.

Massachusetts MH/SAP Contract, Amendment, pages 6-7; Appendix A, pages 36-41, 44-45. [*emphasis added*]

Iowa's mental health contract also specifies thresholds for performance measurement, however they are not tied to monetary incentives or penalties.⁵⁴ The contract covers performance indicators that refer to behavioral health services access, appropriateness, quality of life, consumer involvement, and coordination of services. As seen in the following excerpt, the contract drafters note that performance indicators and targets are not rigidly defined standards from which no deviation is permitted; rather, they are guidelines to achieving overall population-based goals that must be considered in light of individual client needs.

Services provided through the Mental Health Access Plan [MHAP] will be appropriate to the needs of the enrollees for clinical, rehabilitative, or supportive mental health care.

7. MCBI will conduct an ongoing clinical outcome study using a clinical assessment scale with a sample of MHAP recipients by eligibility group. The study results shall be shared with the providers who administer the clinical assessment scale to improve clinical care and MCCI will use the results to guide quality improvement efforts. The overall results shall show improvement in overall functioning as a result of mental health treatment provided through MHAP.

8. Based on patient satisfaction surveys, 85% of respondents will indicate some degree of satisfaction with the services provided through the Mental Health Access Plan.

9. The average length of stay for inpatient shall not exceed 12 days which was the ALOS under fee-for-service.

10. For MHAP enrollees who are admitted to inpatient, the readmission rate from the date of discharge shall not exceed 28% in 60 days. *This performance indicator is a target versus a standard since admissions are based on the needs of the client – readmission is not necessarily a bad outcome for some patients.*

Iowa Mental Health Contract, Amendment, unnumbered pages. [*emphasis added*]

Eleven of the 13 behavioral health contracts include provisions relating to reporting MH/AD treatment data to the state wherein care process and outcome data are linked. Only 3 contracts, however, require submission of discharge or hospitalization data for addictive disorders, while 8 contracts require hospitalization data for mental illness. The Massachusetts Behavioral Health Contract requires quarterly submission of the following specific service access and outcome measures:

⁵⁴ Beginning in January 1999, the year following the Iowa contract included in this report, the state began linking performance measurement with both monetary incentives and penalties. (Iowa Plan for Behavioral Health, Contract Between State of Iowa Department of Human Services and State of Iowa Department of Public Health and [***]). The 1999 contract will be included in the upcoming 4th edition of *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (forthcoming 2000).

F. Service Access and Outcome Measures:

The Contractor shall report the following:

1. readmission rate within 7, 30, 60, and 90 days of discharge by type of service and Enrollee;
2. number and percentage of face-to-face evaluations performed within sixty minutes of referral and presentation to an ESP or DEP;
3. number and percentage of times that a psychiatrist responds by telephone or in person within fifteen minutes of receiving a request from an ESP to a DEP to perform a psychiatric consult on an Enrollee;
4. number of Enrollees diverted from inpatient hospitalization who are hospitalized within 7, 30, 60, and 90 days by type of service and Enrollee;
5. number of admissions stratified by type of service;
6. number of patient days stratified by type of service;
7. number of admissions per 1000 Enrollees stratified by type of service;
8. number of patient days per 1000 Enrollees stratified by type of service;
9. number of admissions outside of the Provider Network stratified by type of service;
10. average length of stay stratified by type of service, Region, Provider, mental health, substance abuse, including a separate breakout of ICM Enrollees;
11. number of Enrollees discharged from an inpatient facility who receive Outpatient Services within three days of discharge from the inpatient facility;
12. number of Enrollees receiving mental health or substance abuse services, or both, ninety days following discharge from an inpatient facility;
13. number of episodes in which Enrollees were restrained during a stay in an inpatient facility; and
14. number of episodes in which Enrollees were placed in seclusion during a stay in an inpatient facility.

Massachusetts MH/SAP Contract, Appendix B, pages 54, 57-59.

4. Patient Confidentiality

As noted previously, the federal Medicaid statute prohibits the disclosure of information about applicants and recipients other than for purposes directly related to the administration of a state's Medicaid plan. This provision would apply to all Medicaid managed care contracts regardless of the language included in the contract, since contractors act as agents of the state for purposes of medical assistance administration.⁵⁵ Thus, the Medicaid statute has for years addressed at least in part the issue of privacy raised by the current debate.

In addition, regulations implementing federal programs prohibit recipients of federal funds from disclosing information or releasing client records.⁵⁶

⁵⁵ See *J.K. v Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993).

⁵⁶ 42 C.F.R. §2.11. A separate question is whether contractors are independently held obligated to report data that are considered notifiable data under state public health or safety laws (e.g., communicable diseases, attempted suicides, crimes such as domestic abuse). At least one state, Vermont, requires its managed care contractors to assume responsibility for reporting cases of communicable diseases to the state health department (Vermont Contract, page 40). Most states, however, have not yet begun to treat MCOs as "providers" for purposes of notification and require only the individual clinicians and hospitals within its networks to report this information. See Rosenbaum et al, *An Overview of Data Submission Requirements Applicable to Managed Care Organizations Under State Medicaid Managed Care Contracts*. The Center for Health Policy Research, The George Washington University Medical Center. July 1998.

5. Respect and Nondiscrimination

In general, the agreements both in the original and 1998 database contain broad prohibitions against discrimination. A significantly smaller number of documents both in the first and third databases specifically apply these provisions to their subcontractors and network providers. Agreements are more likely to address discrimination on the basis of race, national origin, age, religion, sex and gender, disability, and anticipated need for health care and are less likely to address the specific issues of sexual orientation and mental disability.

Only 3 contracts in the 1998 database--only one of them a carve-out agreement--proscribe discrimination against individuals who have a current or past addiction disorder. In the original database, no contract contained such a prohibition.

6. Complaints and Appeals

Over the three-year time period covered by the database the extent to which the contracts address internal complaint and grievance systems has been consistently high. In the first year of the database, all but one of the 45 contracts, including all 8 carve-out agreements, specified that contractors maintain internal complaint and grievance procedures. In the current study, all 52 contracts, including the 13 carve-out contracts, contain provisions requiring contractors to maintain internal grievance procedures.

Analyzing the application of the grievance and appeal provisions of the CBRR to Medicaid managed care is complex. Because MCOs carry out a state Medicaid agency's duties under contract, their decisions regarding coverage are subject to the same Constitutional due process requirements regarding access to fair hearings and the structure of these hearings as those that would apply to Medicaid decisions by a state Medicaid agency.⁵⁷ Consequently, a decision by an MCO (or the MCO's own provider subcontractor)

⁵⁷ *J.K. v Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993); *Daniels v Wadley*, 926 F. Supp. 1305 (M.D. Tenn. 1996). This concept may also apply to Medicare. See *Grijalva v Shalala*, 152 F.3d 1115 (9th Cir., 1998), *vacated and remanded* 119 S. Ct. 1573 (1999), a closely-watched case affirming a district court decision that HMO denials of medical services to Medicare beneficiaries constitute state action. Note, however, that the *Grijalva* decision was vacated on May 3, 1999 by the U.S. Supreme Court and remanded to the Ninth Circuit in light of three things: relevant provisions of the Balanced Budget Act of 1997; regulations of the Secretary of the Department of Health and Human Services implementing those provisions; and *American Manufacturers Mutual v Sullivan*, 119 S. Ct. 977 (1999), a Supreme Court case that raised state action questions involving insurer decisions made during the course of administering Pennsylvania's Worker's Compensation program. The Court in *Sullivan* determined that a state amendment to the worker's compensation program authorizing private insurers to withhold payments to health care providers if an insurer disputed the necessity of provided treatment did not constitute

to deny, reduce or terminate benefits would amount to an agency decision and would be appealable through the Medicaid fair hearing process and would be covered by all of the protections that apply to Medicaid fair hearings.⁵⁸ Furthermore, to the extent that the request for an appeal of a reduced or terminated benefit is filed in a timely fashion, the benefit would be continued pending the outcome of the fair hearing in accordance with federal regulations.⁵⁹

Thus, because MCO decisions are covered by federal fair hearing requirements, the grievance and complaint provisions in the contracts could be viewed as supplementing these basic due process rights. These supplemental rights are important, since complaint and grievance procedures may be speedier than a fair hearing and also may deal with matters such as consumer satisfaction and the quality of care that are not related to coverage and thus fall outside of the fair hearing regulations.

The Balanced Budget Act requires that state contracts provide for grievance systems for managed care enrollees.⁶⁰ The documents show considerable variation in the approaches that agencies take in fashioning their grievance and appeals provisions. Some states specify that their contractors offer relatively comprehensive internal grievance systems that are subject to minimum requirements. A number of states provide for external review of contractor decisions systems in addition to maintaining a fair hearing process. Other states provide minimal specifications regarding internal grievance systems and thus leave contractors with considerable discretion to design their grievance procedures.

The first year of the study did not address requirements for a separate external review system for contractors' grievance decisions. This topic was addressed in the second year as well as in the current year. In the second year of the study, 44 out of 54 contracts, including 11 out of 12 carve-out agreements, provided for an independent external review of some or all internal grievance decisions in addition to the already existing fair hearing to which all beneficiaries are entitled. Currently, the number of contracts that provided for a separate external review of internal grievance decisions stood at 45 out of 52 total, with review provided under 12 of the 13 carve-out agreements.

The states of Florida and Arizona offer a contrast in their approach to grievance specifications. In the case of Florida, the specifications for contractors are detailed and address numerous issues in the structure of the grievance system. In the case of Arizona, contractors are given a broad directive to establish a grievance system and retain discretion over the nature of the system.

Internal grievance process

2.17 Grievance System Requirements

state action. Further note that on September 1, 1999, the Ninth Circuit Court of Appeals remanded the *Grijalva* case back to the U.S. District Court for the District of Arizona for reconsideration in light of *Sullivan*.

⁵⁸ *J.K. v Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993); *Daniels v Wadley*, 926 F. Supp. 1305 (M.D. Tenn. 1996).

⁵⁹ 42 C.F.R. §431.230.

⁶⁰ Section 1932(b)(4) of the Social Security Act, 42 U.S.C. §1396u-2(b)(4).

The contractor shall develop and implement grievance (formal complaint) procedures that are binding upon the contractor and all its subcontractors, subject to agency approval, prior to implementation...

A. The contractor shall have a grievance aide at each clinic or facility service site to provide information and instructions regarding filing a grievance. Providers in solo or group practice shall provide such information to patients seen their private offices.

B. Grievance information, filing instructions, and responses shall be communicated in a language spoken by the enrollee.

C. The names, telephone numbers and addresses of the grievance coordinator and the area Medicaid personnel responsible for client advocacy shall be posted at all service sites.

D. There shall be sufficient support staff (clerical and professional) available to process grievances.

E. Staff shall be educated concerning the importance of the grievance procedure and the rights of the enrollee.

F. Someone with problem solving authority shall be part of the grievance procedure.

G. The contractor shall have a grievance coordinator responsible for the overall grievance process.

H. Procedural steps shall be clearly specified in the member handbook, including name, address, telephone number and office hours of the grievance coordinator and of the area Medicaid personnel responsible for client advocacy.

I. Grievance forms, in English and Spanish shall be available at each site.

J. Upon request, the member shall be provided with a grievance form(s).

K. Upon receipt of the grievance, the contractor shall acknowledge to the enrollee, in writing, that the complaint has been received, and shall also indicate the expected time frame for processing.

L. All grievants shall have the right to assistance during the grievance process.

M. Grievances shall be resolved within sixty days from initial filing by the enrollee, unless information must be collected from providers located outside the authorized service area or from non-contract providers. In such exceptions, an additional thirty-day extension is authorized.

N. The contractor shall inform the enrollee in writing of the grievance resolution.

O. The contractor shall maintain a log of all grievances filed by enrollees in the plan.

P. The contractor shall not permit the filing of a grievance by an enrollee to adversely affect the quantity or quality of medically necessary services provided to that enrollee.

Q. The contractor shall inform the agency on a monthly basis, or as requested by the agency, of each grievance that it has received and its status.

R. The contractor shall maintain a record of informal complaints received which are not grievances. This record shall include the date, the enrollee's name, and the nature of the complaint and its disposition.

Florida Mental Health RFP, pages 40-42.

Internal grievance process

42. GRIEVANCE SYSTEM

ADHS shall adopt, implement and maintain a grievance system which provides for an administrative resolution of disputes for members, subcontractors, providers, or non-contracting providers arising from this contract in accordance with the AHCCS *Behavioral Health Policy Manual*, applicable AHCCS Rules, status and federal regulations. Said system shall be approved in writing by AHCCS prior to the execution of this contract and shall be in compliance with AHCCS grievance standards, as well as requirement resulting from the decision in *Perry v. Kelly*.

In addition to maintaining a grievance system, ADHS shall have a method for promptly resolving problems or issues raised by members or providers in the form of at least one staff person who acts as an ombudsperson. This staff person shall contact appropriate parties on behalf of the member or provider to achieve resolution of problems relating to services, claims payment, behavioral health eligibility or other areas related this contract...

ADHS shall develop and establish an appeal process for use by its subcontractors and by providers and individuals who have exhausted the subcontractor's grievance and appeal process. This process shall include required notice to aggrieved parties, notification of final decisions, complaint processes and internal appeal mechanisms. ADHS shall require all its subcontractors to develop and establish a grievance and appeal process for use by service providers, individuals requesting services and members receiving services.

Arizona Behavioral Health RFP, page 26.

4. Conclusions

This analysis underscores a series of trends in Medicaid managed care contracting. The trends viewed in the contracts are consistent with other developments in Medicaid managed care. State Medicaid managed care contracts for both general and behavioral health services have become more detailed and specific regarding both coverage and contractors' service duties. This development appears to have coincided with a reduced interest in managed care contracting on the part of companies that also engage in a significant commercial business especially in relatively mature Medicaid managed care markets.⁶¹ These companies may view this greater level of specificity on the part of agencies as incompatible with the looser approach to contracting that appears to be taken under many employer-sponsored agreements, which leave far greater discretion to the industry.

The growing complexity of Medicaid managed care contracts is obvious on its face. It is also a necessity. Medicaid agencies purchase services for a far more complex population, and their purchasing must be consistent with federal benefit and administration requirements as well as the provisions of their state plans and applicable state laws. Medicaid contracts, like Medicare agreements, must necessarily be broader and more complex than the relatively unregulated employee benefit market.

The complexity of the service provisions in many Medicaid contracts also raises questions about whether most managed care companies that deal primarily with a commercial market are in fact equipped, particularly in the case of enrollees with disabilities, to design and administer an adequate product. Whether group or staff model or network in structure, managed care companies are vertically integrated entities that rely on administrative, practice and coverage norms for their existence, as would any large company producing an integrated product. State Medicaid agencies attempt to defer to this operational imperative in the area of medical necessity determinations; rather than specifying individualized determinations that rely on guidelines only to the extent that they are relevant and reliable, agencies delegate broad authority to plans to apply norms and standards. At the same time, this analysis suggests that state agencies appear increasingly willing to use gap-closing clauses that allow them retain the power to decide whether a particular coverage determination is contrary to the contract or inconsistent with state and federal law.

This power to overturn a contractor's decision is akin to the fiduciary powers that employers retain under ERISA, and it is an important check on unfettered discretion to decide the medical necessity of care. However, evidence suggests that there are few appeals involving the denial and reduction of care by managed care plans. As a result, even this agency check on discretion may not prevent an overall decline in coverage, as Medicaid agency decision-making, which has become calibrated over the years to the needs of a complex population, is replaced by and large with industry norms. Whether normative coverage standards used by a commercially oriented industry are legally sufficient to meet the due process requirements of the Medicaid statute remains to be seen. Cases to date have

⁶¹ Suzanne Felt-Lisk, "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation." The Kaiser Commission on Medicaid and the Uninsured. May 1999. Available at <http://www.kff.org/content/1999/2141/KFFChangingMedicaid.pdf>.

raised procedural issues with managed care decision-making but have not directly challenged the application of coverage norms that are unrelated to the needs of individual cases. As enrollees with disabilities grow in number, this type of challenge can be expected in Medicaid, just as it is occurring within the employee health care system.

Even as the contracts grow more complex in terms of coverage and service duties, it would be a mistake to view Medicaid managed care contracts as foreclosing contractor discretion. The data in this study suggest that states remain willing to allow their suppliers significant latitude in selecting their networks and establishing their own access rules for enrollees. States also appear willing to allow their contractors to rely exclusively on their own networks for the provision of care, regardless of whether the network proves sufficient to the task.

Furthermore, evidence from the database suggests that states continue to place only limited emphasis on the full disclosure of information to enrollees, most notably, information regarding network composition and membership. Given the close association between consumer satisfaction and the ability to maintain a relationship with a regular source of care, this relative lack of attention to network sufficiency, network disclosure, and remedial efforts by contractors in the event that networks prove inadequate bear closer scrutiny. As persons with mental and physical disabilities increasingly enroll in managed care organizations, the issues of coverage, access, and network sufficiency and network disclosure provisions may take on added meaning.

As in prior years, contracts continue to show relatively few specific performance measurements that purchasers will use to determine contractor compliance with the terms and conditions of the agreements. This area also merits ongoing attention, since the contracts are now so comprehensive that their enforceability has grown even more difficult. Without clear performance measures and specification of the data that contractors will be expected to submit to document compliance, the agreements are far less easy to administer, and critical data will be lacking in the event of a dispute.

Finally, because of the descriptive nature of this study, it is not possible to know how the variations in coverage and service provisions affect access and quality. Much work remains to be done on the issue of whether certain purchasing specifications are associated with certain outcomes. For example, where a state agency retains discretion to review contractor coverage determinations and reverse where necessary, does the retention of such authority change the outcome of decision-making in certain ways? Do very specific access and network standards yield different outcomes in terms of network composition and access timelines? Does a comprehensive grievance and complaint system reduce beneficiary reliance on fair hearings? These and other questions are important health services research topics that bear closer scrutiny.

5. Appendix

Methods

As with previous editions of the study, the third edition of *Negotiating the New Health System* represents a nationwide, point-in-time study of contracts between state Medicaid agencies and managed care organizations (future editions will also include findings on the managed care contracts used in freestanding State Children’s Health Insurance Programs). A total of 52 separate contract documents from 39 states and the District of Columbia are included in the latest database, which represents contracts that were in effect as of January 1, 1998. The database includes 13 managed behavioral health care “carve-out” agreements from 12 states (Iowa has separate carve-out contracts for mental health and substance abuse).

Most, but not all, of the agreements in the 1998 database represent new documents or else documents that states modified in one or more respects from previous years. Several of the documents are the same ones that were included in the 1997 database, since the states indicated that there was no change.

As we have noted, building managed care contracts is a slow and evolutionary process. While our study does note important new directions in the contracts, the process of change can be expected to take years, as states adapt their programs to changes in federal and state law as well as the structural shifts within the managed care service industry itself. It is unlikely that in the space of three years one would witness dramatic changes, although several of our findings regarding the evolution of the documents are highly important to future federal health policy, including the implementation of the Balanced Budget Act.

Because of the complex structure of the contracts, the variability in state programs, and the fact that no two states use exactly the same language when building their agreements, it is not feasible to compare all elements of all state contracts over time. Nonetheless, it is possible to report on general trends and to provide illustrative examples of key changes in contracting that are of particular interest to managed care policies for persons with mental illness and addiction disorders.

The comparative analysis carried out for this Special Report as well as the Overview volume focusing on pediatrics was undertaken by a group of attorneys who have worked on this study and have analyzed its database since the inception of the project. The attorneys use a common analytic instrument to analyze contract terms as well as a common analytic protocol.

In constructing these comparisons, we attempted to identify trends in the number of states whose documents address certain issues as well as how they address them. We also examined the evolution *within a single* state of its approach to developing key terms and provisions in contract documents.

State Medicaid Managed Care Contracts Included in *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Edition, 1999*

Medicaid Managed Care Contracts and RFPs

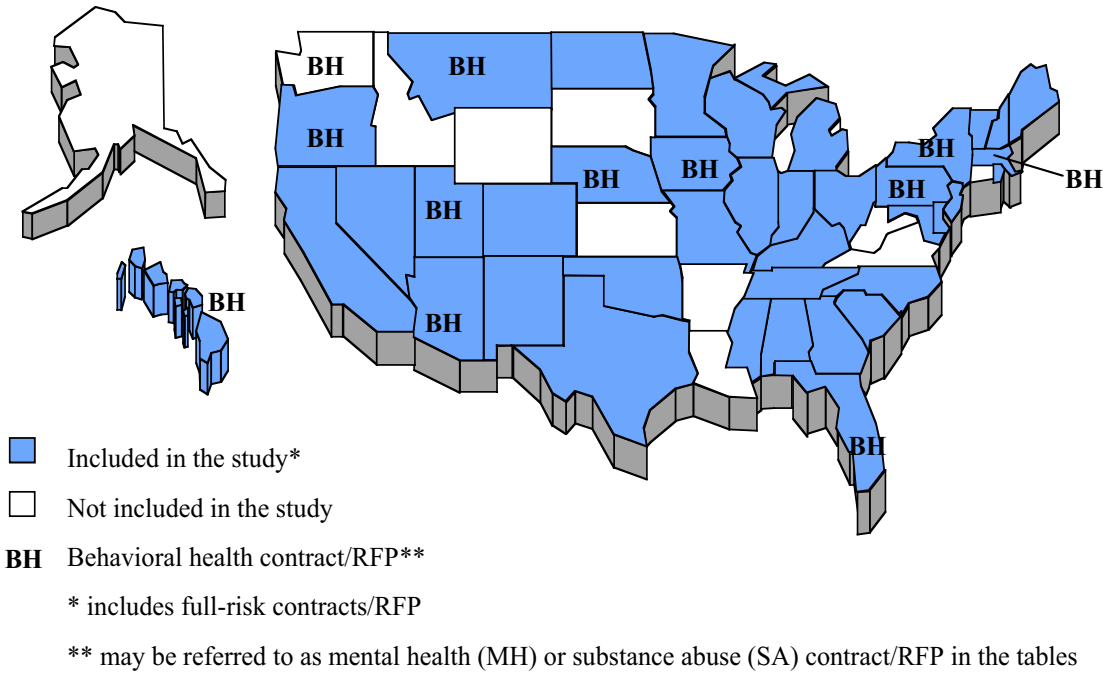


Figure 1. Mental Health and Substance Abuse Services

	AZ BH	FL MH	HI BH	IA		MA BH	MT MH	NE MH	NY MH	OR MH	PA BH	UT MH	WA MH
				MH	SA								
Care coordination/case management	•	•	•	•	•	•	•	•	•	•	•	•	•
Crisis care	•	•	•	•	•	•	•	•	•	•	•	•	•
Family therapy	•	•	•			•	•	•		•	•		•
Individual therapy	•	•	•	•		•	•	•	•	•	•	•	•
Group therapy	•	•	•	•		•	•	•	•	•	•	•	•
Hospital detoxification					•	•	•				•	•	
Inpatient services for persons under 21	•	•	•	•	•	•	•	•	•	•	•	•	•
Long-term residential		•		•	•	•	•	•	•	•	•		•
Medication management	•	•	•	•	•	•	•			•	•	•	•
Non-hospital residential detoxification						•	•				•		
Outpatient treatment		•	•	•	•	•	•	•	•		•	•	•
Partial day treatment programs	•	•	•	•		•	•	•		•	•		•
Prescribed drugs	•	•	•	•	•	•	•			•	•		
Preventive health services		•					•	•		•	•	•	
Referrals		•	•			•		•	•		•	•	•
Screening, assessment and diagnosis	•	•	•	•	•	•	•	•		•	•	•	•
Short-term residential (includes hospital)	•	•	•	•	•	•	•	•	•	•	•	•	•
Transportation	•	•	•	•	•		•	•	•	•	•	•	
Other	•	•	•	•	•	•	•	•	•	•	•	•	•

• means that an issue was addressed in the contract or RFP.

Figure 2. Quality Assurance, General and MI/AD-specific Data Reporting, and Grievance Procedures

	AZ BH	FL MH	HI BH	IA		MA BH	MT MH	NE MH	NY MH	OR MH	PA BH	UT MH	WA MH
				MH	SA								
Table 5.1 Quality Assurance ‡													
Internal QA system	•	•	•	•	•		•	•	•	•	•	•	•
External review of plan's performance	•	•	•				•	•	•	•	•	•	•
Clinical studies		•	•	•			•	•					•
Clinical guidelines		•	•	•	•		•	•	•	•	•		
Profiling provider performance	•		•	•	•	•	•	•	•		•	•	•
Evaluation of grievances and complaints		•						•	•	•	•	•	•
Corrective action plan	•	•		•	•	•	•	•	•	•	•	•	•
Linkage between performance measures and services duties	•		•	•		•	•	•	•	•			•
Table 5.2 General Data Reporting ‡													
Access data	•	•	•			•	•	•	•	•	•		
Complaints and grievances	•	•	•	•	•	•	•	•	•	•	•	•	
Encounter data	•		•	•	•		•	•	•	•	•	•	
Financial data	•	•	•	•	•	•	•	•	•	•	•	•	•
General authorization		•	•	•	•		•		•	•	•	•	•
Outcomes data							•	•			•	•	•
Performance data	•		•					•	•	•	•		
Utilization data	•	•	•			•	•		•	•	•		•
Other	•	•		•		•	•	•	•	•	•	•	•

• means that an issue was addressed in the contract or RFP.

‡ Table numbers correspond to equivalent tables in *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Edition*, CHSRP, 1999.

Figure 2. Quality Assurance, General and MI/AD-specific Data Reporting, and Grievance Procedures (continued)

	AZ BH	FL MH	HI BH	IA		MA BH	MT MH	NE MH	NY MH	OR MH	PA BH	UT MH	WA MH
				MH	SA								
Table 5.3 Mental Health and Substance Abuse Data Reporting ‡													
Care process and outcome data for mental health and substance abuse treatment		•	•	•	•	•	•	•	•	•	•	•	
Discharge data for addictive disorder			•			•					•		
Hospitalization for addictive disorder			•			•					•		
Hospitalization for mental illness		•	•	•		•				•	•	•	•
Identified substance abuse				•		•							
Identified domestic abuse		•											
QA/Utilization measures for mental health/substance abuse treatment		•	•	•	•	•	•	•	•	•	•	•	•
Other		•		•		•		•	•	•			•
Table 6.2 Beneficiary Grievance Procedures ‡													
Internal grievance process	•	•	•	•	•	•	•	•	•	•	•	•	•
Time lines for grievance response		•	•	•	•	•	•	•	•	•	•	•	•
Expedited grievance process								•		•	•		
External appeal to state		•	•	•	•	•	•	•	•	•	•	•	•

• means that an issue was addressed in the contract or RFP.

‡ Table numbers correspond to equivalent tables in *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Edition*, CHSRP, 1999.

List of Reviewed Documents

- **Arizona RFP** - AHCCCSA Contract Amendment, Contract No. YH8- 0001 [10/1/97-9/30/98]
- **Arizona Mental Health Contract** - Contract No. YH8-002 [10/1/97-9/30/98]
- **California Contract** - “Boilerplate” Contract [effective through 3/31/02]
- **Colorado Contract** - Medicaid Contract [7/1/96-6/30/98]
- **Delaware Contract** - Agreement for Managed Care Services, Diamond State Health Plan between the Delaware Department of Health and Human Services and (Contracting MCO) [1/1/96]
- **Delaware RFP** - State of Delaware Department of Health and Human Services Request for Proposal for Managed Care Organizations [11/95]
- **District of Columbia Contract** - Medicaid Managed Care Contract for Goods and/or Services [7/11/97-7/11/99]
- **Florida Contract** - Medicaid Prepaid Health Plan Model Contract [7/97]
- **Florida Mental Health RFP** - Prepaid Mental Health Plan, Request for Proposal; RFP #Med9501 [3/96-2/99]
- **Georgia Contract** - Medicaid Health Maintenance Organization Contract between the State of Georgia, Department of Medical Assistance and _____ A Health Maintenance Organization [12/31/97]
- **Hawaii RFP** - Med-Quest Division, Medical Request for Proposal [7/97]
- **Hawaii Behavioral Health RFP** - Hawaii Health Quest Division Request to provide Behavioral Health Services [no date]
- **Hawaii Behavioral Health RFP** [9/1/97-6/30/98]
- **Illinois Contract** - Contract for Furnishing Health Services by a HMO [12/1/97-11/30/98]
- **Indiana RFP**- Medicaid Managed Care RFP # F-1-6-642 [7/10/96]
- **Iowa Contract** - Contract For Services Between the Iowa Department of Human Services and _____, [7/1/96-6/30/97]; Waiver Program [7/1/97-6/30/98]
- **Iowa Mental Health Contract** - Contract Between State of Iowa, Department of Human Services and MEDCO Behavioral Care Corporation of Iowa for the Iowa

Medicaid Managed Mental Health Care Plan; [7/1/97 - 2/28/99]; Amendment 5/8/96; MHAP Performance Indicators [no date]

- **Iowa Substance Abuse Contract** - Iowa Managed Substance Abuse Care Plan (IMSACP) Contract; [9/01/95 - 6/30/97]; IMSACP Contract Amendments 1/1/96
- **Kentucky Contract [RFA]**- Medicaid Health Partnership Standard Contract for Personal Services [9/97-6/30/98]
- **Maine RFP** - Medicaid Managed Care Initiative Contract for Special Services [3/1/97-3/1/98]
- **Maryland Contract** - MCO Provider Agreement for Participation in the Maryland Healthchoice Program [6/2/97-6/30/98]; Maryland Department of Health and Mental Hygiene Medical Care programs [7/1/97-12/31/97]
- **Massachusetts Contract** - Division of Medical Assistance Standard Contract [terminates 1996]
- **Massachusetts MH/SAP Contract** - Standard Contract Between the Division of Medical Assistance and the Massachusetts Behavioral Health Partnership [no date]; First Amendment [7/1/96]; Second Amendment [6/30/97]
- **Michigan RFP** - RFP For Comprehensive Health Care Program for Medicaid Eligible Persons [Contracts negotiated ending 12/31/98]; Questions and Answers: Comprehensive Health Care Program
- **Minnesota Contract** - Minnesota Department of Human Services Contract, Prepaid Medical Assistance Program Services, Model PMAP Contract [12/06/95 to take effect 1/1/96]
- **Mississippi Contract** - Medicaid Health Maintenance Organizational Contract Between the State of Mississippi Division of Medicaid, Office of the Governor and _____ A Health Maintenance Organization [1/25/96]; Amendments 1-3 [7/1/97-6/30/98]
- **Missouri RFP** - Medicaid Managed Care RFP # B600437 [11/1/96]
- **Montana Contract** - Contract Between Montana State Department of Public Health and Human Services and _____ for Managed Care Services [7/1/97 - 6/30/99]
- **Montana Mental Health Contract** - Montana Mental Health Access Plan RFP 9709-K [12/15/96]
- **Nebraska Contract** - Contract for Services Between Nebraska Department of Social Services and Exclusive HealthCare, Inc. [7/1/95 - 6/30/97]

- **Nebraska Mental Health Contract** - Managed Mental Health Services Contract [6/27/95]; 1997 Amendments [no date]
- **Nevada Contract** - State of Nevada Welfare Division Voluntary Managed Care Program, Request for Contract Health Maintenance Organization [4/1/97-12/31/98]
- **New Hampshire Contract** - Agreement Between New Hampshire Department of Health and Human Services and Health Maintenance Organization/Prepaid Health Plan Provider [no date]; 1997 Amendments [no date]
- **New Jersey Contract** - Contract between State of New Jersey Department of Human Services, Division of Medical Assistance and Health and Services and _____, HMO Contractor [9/1/95-7/3/99]
- **New Mexico RFP** - State of New Mexico Human Services Department, Medicaid Managed Care Services Agreement [7/1/97-6/30/99]
- **New York RFP** - Prepaid Mental Health Plan Memorandum Agreement Between Department of Social Services and Office of Mental Health [2/13/96]; Medicaid Model Contract for Fully Capitated Managed Care Providers Under the Partnership Plan [4/1/97-3/31/98]
- **New York Mental Health Contract** - Prepaid Mental Health Plan Memorandum Agreement Between Department of Health Office of Temporary and Disability Assistance and Office of Mental Health [4/1/96-3/31/00]
- **North Carolina Contract** - Medicaid Managed Care Risk Contract Between the State of North Carolina Division of Medical Assistance and _____ [7/01/96]
- **North Dakota Contract** - Contract between North Dakota Department of Human Services and Northern Plans Health Plan for Managed Care Services [9/1/97-6/30/98]
- **Ohio RFP** - Request for Proposal for Health Maintenance Organizations to Provide Medicaid-Covered Services to the Aid to Dependent Children and Healthy Start Eligible Population in Ohio, State of Ohio Department of Human Services [12/11/95]
- **Oklahoma Contract** - State of Oklahoma, Oklahoma Health Care Authority, SoonerCare Health Plan Contract [7/1/96]
- **Oregon Contract** - Oregon Health Plan: Fully Capitated Health Plan Agreement [10/1/97-6/30/98]
- **Oregon Mental Health RFP** - Oregon Health Plan Mental Health Services Model Mental Health Organization Agreement [10/1/97-9/30/98]
- **Pennsylvania RFP** - Commonwealth of Pennsylvania Request For Proposals for HealthChoices Behavioral Services; RFP No. 3-96 [5/24/96]

- **Pennsylvania Behavioral Health RFP** - HealthChoices Behavioral Health Services for Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. RFP No. 3-96.
- **Pennsylvania Behavioral Health Contract** - HealthChoices Behavioral Health Agreement Between Commonwealth of Pennsylvania and County of Philadelphia [2/97-11/99]
- **Rhode Island** - Contract between State of Rhode Island and Providence Plantations Department of Human Services and Contractor for the Provision of Health Plan Services [4/1/96]
- **South Carolina Contract** - Contract between South Carolina Department of Health and Human Services and _____ For the Purchase and Provisions of Medical Services Under the South Carolina Medicaid HMO Program [11/97]
- **Tennessee Contract** - A Contractor Risk Agreement Between The State of Tennessee, d.b.a. TennCare _____, [9/11/95]; Amendments 1-4 [no date]
- **Texas Contract** - 1996 Contract for Services Between The Texas Department of Health and HMO [9/01/96]
- **Utah Contract** - Utah Medicaid HMO Model Contract [11/97-6/30/99]
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- **Vermont Contract** - State of Vermont Department of Social Welfare, Vermont Health Access Plan Contract [10/01/96]
- **Vermont RFP** - Vermont Health Access Plan Request For Proposals For Managed Care Services [12/18/95]
- **Washington State Mental Health Contract** - Integrated Services Contract, Interagency Agreement Between State of Washington Department of Social and Health Services/Mental Health Division and _____ [10/1/97-6/30/99]
- **Wisconsin Contract** - Contract for Medicaid HMO Services Between HMO and Wisconsin Department of Health and Family Services [July 1996 - December 1997]

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