

The Devolution of Managed Care Contractor Duties: Analysis and Implications for Public Policy in Managed Behavioral Health Care

Sara Rosenbaum, J.D.
Anne Markus, J.D., Ph.D.
Joel Teitelbaum, J.D., LL.M.

Center for Health Services Research and Policy
School of Public Health and Health Services
The George Washington University

Marcie Zakheim, J.D.
Michael Golde, J.D., M.P.H.

Law Firm of Feldesman, Tucker, Leifer, Fidell & Bank
Washington, DC

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Table of Contents

Acknowledgements	2
Executive Summary.....	3
Part A. Introduction and Overview	7
Part B. Working Hypotheses.....	14
Part C. Study Methodology	15
<i>Selection of Study States</i>	<i>15</i>
<i>Document Collection.....</i>	<i>17</i>
<i>Document Analysis.....</i>	<i>18</i>
Part D. Findings	20
<i>In General/Range of Topics.....</i>	<i>20</i>
N/A	21
N/A	21
<i>Specific Examples of the Cascade Phenomenon/Depth of Topics.....</i>	<i>22</i>
Domain 1. Services	23
Domain 2. Coverage Rules	28
Domain 3. Access Standards.....	32
Domain 4. Provider Payment Terms	37
Domain 5. Case Management and Referral Terms	39
Part E. Study Limitations, Conclusions, and Implications	44
<i>Study Limitations.....</i>	<i>44</i>
<i>Conclusions and Implications.....</i>	<i>45</i>
Appendix—Study Review Instrument.....	48

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Executive Summary

This study, undertaken by the Center for Health Services Research and Policy at the George Washington University (GWU) School of Public Health and Health Services for the United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, analyzes the devolution of the legal duties assumed by managed care organizations (MCOs) in their contracts with group purchasers. Specifically, this study examines the delegation of MCO contractual duties related to member care and services to individual network providers by comparing the language used in master contracts between purchasers and MCOs with the language contained in agreements with network health care providers who serve members covered under the master contract.

This project was prompted by two earlier sets of studies undertaken by GWU for SAMHSA. The first is a series of nationwide point-in-time analyses of the structure and contents of agreements between state Medicaid agencies and managed care organizations. These studies consistently have found that, rather than buying “off-the-shelf” general service and behavioral health care products for beneficiaries, Medicaid agencies seek highly customized products adapted to the often complex needs of Medicaid enrollees. The customization of managed care has been evident particularly in the case of managed behavioral health care, in which high-need beneficiaries and evolving concepts of how health systems should function for persons with serious mental illness and addiction disorders have encouraged many agencies to develop managed care arrangements that extend well beyond the “typical” behavioral health benefit found in a commercial product.

The second series of studies that prompted this project were designed to examine the contractual agreements between managed care organizations and network providers. These studies analyze the structure and content of individual provider agreements between MCOs (or their provider network sub-contractors) and individual providers of mental illness and addiction disorder treatment and prevention services. The principal finding from the provider contract studies was that, unlike master Medicaid agreements, provider contracts are highly generic in nature, regardless of sponsor or geography. The studies concluded that, consistent with the intrinsic needs of market suppliers (managed care or otherwise) to standardize their product offerings to achieve consistency and reliability, the provider contracts used by the managed care industry are designed to achieve the central goal of creating provider networks that can reliably and adequately supply health services to any member, regardless of sponsor or product type. Thus, without reference to individual group contracts (other than attachments dealing with payment rates), provider contracts serve to bind suppliers of the raw goods and services (in this case, health care) to products essential to the construction of a managed care product, much as an auto manufacturer would secure a generic contract with steel suppliers for its cars, regardless of make or model.

The customization of Medicaid master contracts and the more generic nature of provider sub-contracts give rise to a logical question: How do managed care companies deal with the customization issue in the context of their provider networks? After all, while health care is only one of the raw inputs into managed care product, it is the most important. Most of the specifications in a master contract relate to what care will be provided, how that care will be provided and its quality established and measured, and who will decide what care gets provided. When a master contract is highly tailored to meet the needs of a unique sub-population, it would seem that there is a corresponding need to adjust the conduct of suppliers to take this customization

into account. It is customary of course for a managed care company to supply network providers with supplemental explanatory materials regarding its products. However, such supplemental explanatory materials alone would be insufficient when the level of customization being sought changes the basic structure of the product and hence, the nature of the goods and services to be furnished by the suppliers.

Based on our prior reviews of managed care contracts and recognition of the need for standardization, we hypothesized that, in delegating duties to sub-contractors, MCOs would perform unevenly, with the result being significant lapses between the specifications contained in the master contract and the provisions of the supplier agreements pertaining to that master contract. We further hypothesized that these lapses would occur most often in the case of delegations under Medicaid agreements due to the unique nature of these master agreements. We also hypothesized that these lapses would involve duties neither extrinsic nor unrelated to the provider's duties (i.e., they would involve activities and functions that at least in part implicate the way in which the "ground zero" health provider furnishes care to members). We assumed that the lapses would take two basic forms: mis-description or inaccurate description of basic service duties to be customized (e.g., service definitions, access measures); and failure to describe certain service duties altogether that necessitate the involvement of the health providers themselves.

We made these hypotheses not because we believed MCOs intend to circumvent the purchasing specifications of Medicaid agencies or other group purchasers, but because the job of tailoring the conduct of suppliers to the tasks entailed in producing a customized service are so complex that it is easy to overlook fundamental matters or to assume that the customization that is required falls well within the ambit of how the supplier normally acts. In other words, an MCO might assume that because modifications sought by the Medicaid agency were not a significant departure from its standard product, no further effort on its part was necessary. The MCO, also accustomed to selling a standardized product, might overlook critical design differences between what it typically sells and what it is expected to supply to a Medicaid purchaser. This failure to recognize the need for customization would be particularly true in the case of aspects of the contract that, on the surface, resemble those found in any managed care agreement but that differ significantly because of the underlying legal requirements of the Medicaid program itself.

Our hypotheses proved correct: Irrespective of the type of master agreement used as the benchmark (Medicaid general service agreement, Medicaid behavioral health carve-out, or state employee benefit plan), the provider agreements deviate substantially with respect to both the range of topics addressed and the depth to which they are addressed (although comparatively speaking, the deviation is less pronounced among the employee benefit contracts). For example, a comparison of the master contracts to the provider agreements yielded three major general findings concerning the range of topics addressed in the contracts:

First, the provisions of the master agreements cascade down to provider agreements in a manner often refined and narrowed as part of the delegation of duties. The description to a provider of the range of service duties enumerated in the master agreement is typically more limited than the language used in the master agreement. In essence, the provider contracts generally attempt to explain and translate an MCO's duties toward the purchaser, but often fail to disclose the full scope of its duties or how the provider's relationship to the MCO bears on the MCO's ability to execute its duties.

Second, because the state employee contracts are broader, more ambiguous, and less customized in terms of services and health care-related duties than is the case for the Medicaid master contracts, deviation between the master employee benefit plan agreements and the provider agreements is less pronounced.

Third, in the case of both types of master Medicaid contracts, the deviant nature of the cascading effect is more pronounced, with considerable variation between what the master agreement calls for in the case of service delivery and what the provider agreement actually says. This is true even in cases in which the provider's ability to execute its service duties necessarily would be influenced by a complete and accurate description regarding what is expected in the master agreement.

These and other findings presented in this study underscore the enormous challenges faced by managed care organizations, health care providers, group purchasers, and most importantly perhaps, individual members, whenever a group health purchaser attempts to buy a customized managed care product. As with any marketer of complex goods and services, the managed care industry needs to build products that can be sold in mass quantities to group purchasers. The products need to be designed to meet the standardized needs of most consumers in order to ensure a market of adequate size. Some limited customization (i.e., differential cost sharing, supplemental provider networks, a point of service option) can be accommodated with relative ease. However, once a buyer wants a product that is so unique as to fall outside the types of customization requests that reasonably can be anticipated, an industry may experience significant difficulties accommodating the demands. The purchaser in turn ends up with a product that does not function as expected. The intended beneficiaries of the product (in this case the members who are entitled to receive the customized product) might receive care that is significantly different from what is expected. Other intended beneficiaries of customization, such as network providers in this case, might also end up losing the advantages that the master contract attempts to give them.

This study underscores the paradox that confronts all of the parties to the Medicaid managed care purchasing enterprise. On the one hand, Medicaid managed care works only if the standard managed care product is customized to account not only for patient needs but also for federal legal requirements. On the other hand, this study suggests what much of the industry already knows: that customization is very difficult if not impossible to achieve for the reasons discussed above. Whatever pathway is chosen by a state agency to deal with this paradox will not be easy, for this study also suggests that agencies must pay extremely close attention to provider agreements and the devolution effect. The companies with whom an agency works depend entirely on their suppliers to furnish the services the companies contract to provide to the agency and its beneficiaries. If the companies are unable to accurately translate these duties down to the provider level, the agency has little chance of realizing the results of its purchasing expectations.

This study also raises numerous questions for future health services research. This project examined issues of paper devolution that help explain the difficulties in making Medicaid managed care work. Yet no specific study of the devolution of customization ever has been pursued. How do MCOs internalize these types of customized specifications? How do they attempt to translate them to providers and members? How do providers in turn absorb these alterations and respond to them? Do customized expectations in the areas of access, coverage, treatment, and organizational scope actually ever reach the members? These are critical questions that could determine the future of customized managed care products, and they should be pursued. If the paper pathway for

customization looks bad but in fact customization works well in practice, then the problem could be viewed as simply a legal one for MCOs. That is, their failure to capture customization in their provider agreements means that they cannot legally enforce their customization expectations if they do not get what they expected. However, it is doubtful that the reality of customization practice is a good deal better than the paper suggests. In this case, additional health services research becomes essential, because it relates to a basic problem that confronts health care policy makers: how to adapt the new health system to the millions of the most vulnerable children and adults who fall outside of pre-established industry norms.

Part A. Introduction and Overview

This study, undertaken by the Center for Health Services Research and Policy at the George Washington University (GWU) School of Public Health and Health Services for the United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), analyzes the devolution of the legal duties assumed by managed care organizations (MCOs) in their contracts with group purchasers. Specifically, this study examines the delegation of MCO contractual duties related to member care and services to individual network providers by comparing the language used in master contracts between purchasers and MCOs with the language contained in agreements with network health care providers who serve members covered under the master contract.

This study is of importance to group health purchasers, program administrators and policy makers, health care providers, and consumers because it bears directly on the extent to which the complexities of managed care permit companies that sell standardized products – whether general services or behavioral products – to deviate significantly from industry norms when responding to the needs and expectations of particular group purchasers. Thus, the findings may be of special interest to group purchasers such as Medicaid agencies, that buy substantially customized managed care products for program beneficiaries, including large numbers of special needs children and adults whose presence in the Medicaid managed care system has increased substantially in recent years.

This project was prompted by two earlier studies undertaken by GWU for SAMHSA. The first, repeated at regular, periodic intervals since its original version, and adapted to allow analysis of a variety of group purchaser managed care agreements,² is a nationwide point-in-time analysis of the structure and contents of agreements between state Medicaid agencies and managed care organizations.³ This study consistently has found that, rather than buying “off-the-shelf” general service and behavioral health care products for beneficiaries, Medicaid agencies seek highly customized products adapted to the often complex needs of Medicaid enrollees. The customization of managed care has been evident particularly in the case of managed behavioral health care, in which high-need beneficiaries and evolving concepts of how health systems should function for persons with serious mental illness and addiction disorders have encouraged many agencies to develop managed care arrangements that extend well beyond the “typical” behavioral health benefit found in a commercial product.⁴ Because Medicaid's broad financing scheme supports a range of preventive, long-term, and chronic care services that exceed those of standard insurable care, state agencies can work to develop both general and behavioral health products that better meet the needs of members whose very eligibility for medical assistance, in many cases, is based on the existence of complex and multi-dimensional conditions. Medicaid managed care contracts

² For example, GWU is currently analyzing state Children's Health Insurance Program managed care contracts and managed care purchasing arrangements between MCOs and state departments of corrections. *See also* Joel Teitelbaum, D. Richard Mauery, and Sara Rosenbaum, “Sub-State Purchasing of Managed behavioral Health Care: An Analysis of County-Level Managed Care Contracts,” The George Washington University School of Public Health and Health Services, Washington, DC (October 1999). Available at <http://www.samhsa.gov>.

³ Sara Rosenbaum et al., “Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts,” The George Washington University School of Public Health and Health Services, Washington, DC (February 1997; February 1998; June 1999).

⁴ Sara Rosenbaum et al., “Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, Special Report: Mental Illness and Addiction Disorder Treatment and Prevention,” The George Washington University School of Public Health and Health Services, Washington, DC (March 1998; 2000).

themselves typically address coverage, access, treatment, and performance matters that are not a part of typical, employment-based managed care group purchaser agreements. Studies of Medicaid managed care products indicate that customization occurs in the areas of service and coverage definitions and coverage limits, specialized network capabilities and access requirements, and obligations to interact with other agencies and programs furnishing services to the same population (e.g., child welfare agencies, schools, judicial and correctional systems, and social service and employment support programs).⁵

The second study that prompted this project, and which also has been repeated at periodic intervals, was designed to examine the contractual agreements between managed care organizations and network providers. These studies analyze the structure and content of individual provider agreements between MCOs (or their provider network sub-contractors) and individual providers of mental illness and addiction disorder treatment and prevention services.⁶ The contracts examined in these studies contained many agreements emanating from Medicaid master contracts, as well as agreements related to other products purchased by other group sponsors (e.g., state employee benefit plans, plans covering privately employed persons, and other sponsored groups). However, the contracts collected for these provider contract studies were not tied specifically to certain master agreements but instead were collected and analyzed independently for their basic structure.

The principal finding from the provider contract studies was that, unlike master Medicaid agreements, provider contracts are highly generic in nature, regardless of sponsor or geography. The studies concluded that, consistent with the intrinsic needs of market suppliers (managed care or otherwise) to standardize their product offerings to achieve consistency and reliability, the provider contracts used by the managed care industry are designed to achieve the central goal of creating provider networks that can reliably and adequately supply health services to any member, regardless of sponsor or product type. Thus, without reference to individual group contracts (other than attachments dealing with payment rates), provider contracts serve to bind suppliers of the raw goods and services (in this case, health care) to products essential to the construction of a managed care product, much as an auto manufacturer would secure a generic contract with steel suppliers for its cars, regardless of make or model.

This finding from the provider contract studies regarding the generic nature of managed care provider agreements is confirmed by the existence of materials used by various segments of the industry, such as training materials used at legal conferences to train health maintenance organization (HMO) lawyers. These materials are used to train these lawyers in the design of legal instruments that meet their clients' needs, as well as "model" provider contracts that naturally have been structured to favor providers, and thus help them understand the critical issues in contract negotiation in the areas of service, pricing, and payment.⁷

⁵ "Negotiating the New Health System," *supra* note 3.

⁶ Sara Rosenbaum et al., "Principal Findings from an Analysis of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Centers," Center for Health Policy Research, The George Washington University, Washington, DC (June 1996); Sara Rosenbaum et al., "An Evaluation of Agreements between Managed Care Organizations and Community-Based Mental Illness and Addiction Disorder Treatment and Prevention Providers (Issue Brief #9)," Hirsh Health Law and Policy Program, The George Washington University, Washington, D.C. (May 2000).

⁷ American Medical Association, Model Managed Care Contract (Chicago, IL), viewed at <http://www.ama-assn.org/ama/upload/mm/38/mmcmmsa.pdf>. The model contract addresses many of the issues raised in GWU's provider contract study, as well as other matters. Generic agreements developed by managed care companies

The customization of Medicaid master contracts and the more generic nature of provider sub-contracts give rise to a logical question: How do managed care companies deal with the customization issue in the context of their provider networks? After all, while health care is only one of the raw inputs into managed care product, it is the most important. Most of the specifications in a master contract relate to what care will be provided, how that care will be provided and its quality established and measured, and who will decide what care gets provided. When a master contract is highly tailored to meet the needs of a unique sub-population, it would seem that there is a corresponding need to adjust the conduct of suppliers to take this customization into account. It is customary of course for a managed care company to supply network providers with supplemental explanatory materials regarding its products. However, such supplemental explanatory materials alone would be insufficient when the level of customization being sought changes the basic structure of the product and hence, the nature of the goods and services to be furnished by the suppliers.

Thus, for example, in a Medicaid contract, companies frequently are expected to furnish care in accordance with purchasing specifications that depart from those governing their normal business operations (e.g., furnishing translation services as part of health care, furnishing care in accordance with service definitions or timelines that differ from their normal standards, furnishing care in certain atypical settings, providing information and services to agencies and entities other than the sponsor, or furnishing services beyond those that typically are furnished). In these cases, the modifications are so great that one would expect to see modified provider agreements, since the additional obligations, even if not carried out solely by network providers, bear directly on how providers carry out their basic obligation (in this case, to furnish health care).

An MCO, of course, could elect not to buy services from its standard suppliers for its Medicaid products and could write highly tailored subcontracts with either different or supplemental provider networks; many may attempt to do so.⁸ A company also could use its own employees to deliver health care to members of customized product lines. However, this would probably be a rare occurrence in the modern managed care era, in which most companies are virtual—rather than brick and mortar—health systems that depend on independent suppliers rather than employees to create the managed care product.

It also is possible that a company would use its normal provider network, either exclusively or in great part, without attempting to customize its services. This might happen in situations in which either the MCO's employees did not fully appreciate the extent to which a specific contract called for customization, or where they believed that the product actually could be furnished without any customization of raw supplies. The failure to customize, of course, could create problems for the MCO at the point at which its services began to deviate from its contractual obligations since, without a negotiated customization of its sub-agreements, the company would have no legally

are structured to give them maximum control over the service they buy for the lowest price possible. The AMA model agreement is designed to offer physicians and other health professionals alternative specifications that if agreed to by the company, would result in better payment and more control over the product they are selling (i.e., greater control over the health care they furnish).

⁸ For example, in a July 2000 meeting sponsored by the Kaiser Commission on Medicaid and the Uninsured concerning California managed care, the head of southern California operations for Wellpoint's MediCal managed care business indicated that his company uses an entirely separate network of primary care providers in order to accommodate the unique needs of MediCal enrollees.

enforceable expectations regarding its suppliers' conformance to the specifications contained in the master contract. In other words, the MCO would be liable for the customization to which it agreed, but its suppliers, not notified of the differences in the product, presumably would not share in this legal liability.

Similarly, a group purchaser, aware of the problem of securing suppliers for its members, might include customized specifications obligating the MCO to follow certain rules in its dealings with its suppliers. This is particularly a problem for Medicaid programs that historically have faced enormous difficulties finding sufficient providers for beneficiaries. Not only might Medicaid agencies want certain rules included to assist network providers, but the agencies also might be obligated to include such rules (such as payment levels for certain providers) as a matter of federal law.⁹

Finally, of course, the problem of translating customization is most significant for the members themselves. A member who enrolls in a customized product has an expectation of services and benefits that may be decidedly different from those available to other members. Were the MCO to fail to amend its supplier contracts to reflect these modifications, members promised certain unique services upon enrollment might never receive the additional or modified care, since the MCO never instructed its suppliers regarding promised modifications.

Thus, when customized products are bought, an MCO would need to alter its sub-agreements with its suppliers to accommodate the particularized needs of one of its customers. This need by MCOs to customize their supplier agreements to conform to customized products is no different from what would be required in the case of any other type of customized good or service. One would expect to find in provider agreements that relate back to a customized master contract at least nominal reference to those elements of the master contract that represent unique specifications. From a legal standpoint, it would not be enough to simply offer the provider supplemental materials that explain the customized expectations, since the customization obligation itself might be one the provider is incapable of carrying out or even willing to undertake. In other words, without modification of the basic agreement, customization might be a demand for modifications that the seller (i.e., the health provider) is unwilling to accommodate. Without disclosure of modification expectations to the supplier and the supplier's express assent, a modified version of the basic supplier contract would be legally unenforceable.

The Nature of the Master Agreements: Customized vs. Standardized Contracts.¹⁰

Because understanding the fundamental differences between highly customized Medicaid contracts and relatively standardized employee benefit contracts is critical to understanding the findings described below, we discuss briefly the nature of the master agreements analyzed in this study.

⁹ For example, Federal law requires that state agencies pay certain health care providers known as federally qualified health centers and rural health clinics on a reasonable cost basis because of the high volume of uncompensated care they furnish. Medicaid agencies that want their MCO contractors to adhere to these rules might include special payment provisions in the master contract.

¹⁰ Portions of this section were taken from Phyllis Borzi and Sara Rosenbaum, "Behavioral Health Benefits for Public Employees: An Analysis of Contracts Covering State Employees," prepared for SAMHSA by the George Washington University School of Public Health and Health Services, Center for Health Services Research and Policy, Washington, DC (1999).

The Federal Medicaid program creates an entitlement to a defined set of benefits and services as a matter of federal law. States participating in the program must cover certain populations and benefits and, at their option, may cover additional benefits. Irrespective of the scope of benefits they choose to cover, state Medicaid programs also must adhere to federal coverage standards, including reasonable coverage requirements, prohibitions against discrimination in coverage based on the type of condition an individual has, and, in the case of children, a special medical necessity standard.

In contrast, as employers, states have both a choice as to whether to provide health benefits to their employees and nearly unfettered authority to design the plans they choose to offer. In fact, precisely this reason—that state employee benefit contracts far more closely resemble commercial managed care contracts than do Medicaid contracts—we solicited and analyzed the state employee benefit contracts. For example, state employee benefit contracts can establish their own eligibility rules, craft their own benefit coverage rules and limitations, differentiate in benefits or cost between employee and dependent coverage, and define key terms, (e.g., “medically necessary”, “experimental”, or “investigational” treatment). States generally also enjoy greater leverage in the marketplace when they seek coverage for their own employees simply because the population for whom they are purchasing coverage is more desirable to the insurance market. Despite the fact that the average age of the group may be older, state employees are generally healthier, wealthier, and more stable as a group than Medicaid enrollees, whose coverage tends to be short-term and intermittent.

Yet, despite these differences, state employees, of course, share many of the same concerns that Medicaid enrollees have, such as making sure they have access to services in a convenient and timely fashion, an adequate choice of providers, high quality care, continuity of care when providers move in and out of the network, and ready access to emergency room coverage. Thus, in structuring contracts with MCOs, states’ contracting objectives may not be as different for state employees and Medicaid enrollees as one might first think.

However, compared to Medicaid agreements, state employee service agreements provide far greater levels of flexibility to MCOs in virtually every respect; indeed, they address fewer issues than do the Medicaid agreements, and when they do address issues, they contain far fewer specifications. While some, but by no means all, of these differences can be attributed to the unique nature of the Medicaid program, employee benefit contracts simply are broader, vaguer, and less focused on the details of health care delivery and coverage than is the case for Medicaid.

At the same time, the different approaches to contract drafting may be explained by the important differences in the nature of the products offered to Medicaid and state employee populations. To curb costs, Medicaid agencies buy only closed, tightly managed arrangements for their managed care populations, with few out-of-network treatment options other than those mandated by Federal or state law (e.g., emergency care, family planning services). Some Medicaid agencies retain direct responsibility for payment for certain services in order to maintain beneficiary access to certain services (e.g., school health services). But because beneficiaries pay no premiums and have virtually no cost sharing, state Medicaid agencies are responsible for the entire cost of care, leaving agencies with tight plan management as a central means of cost control. In this context, extensive specifications may be exceedingly important, since the products offer beneficiaries no “point-of-service/higher co-payment” alternative in the case of a non-responsive plan or network.

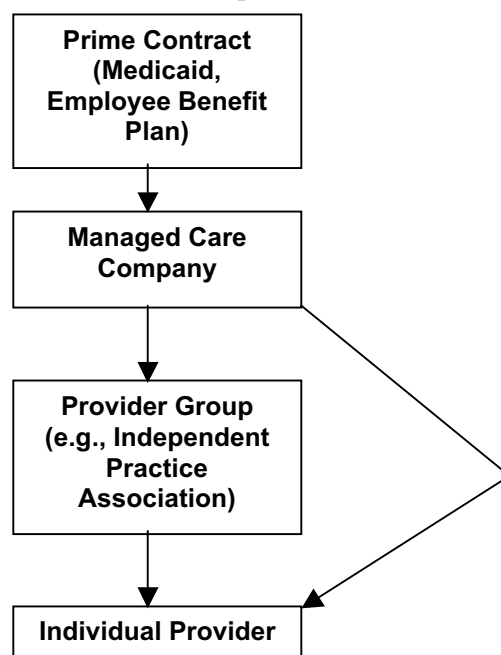
Employee benefit plans, on the other hand, do not face this problem. Plans can offer a wider range of products to their members, including both tightly managed systems (e.g., staff- and group-practice model HMOs), preferred provider organizations, and point-of-service plans. In the view of employee plan purchasers, the choice of more loosely controlled products may lessen the need for the type of stricter purchaser oversight that is associated with Medicaid managed care, since enrollees themselves are perceived as having more control over their health care and greater discretion to compensate for inadequate access to care in the basic network.

The Nature of the Subcontracts: The Relationship Between the Provider and Master Agreements.

Finally, a few additional words about both the contractual relationship that exists between managed care organizations and health care providers with whom they contract to provide covered services, and the nature of the provider agreements themselves.

The contractual process that leads to the drafting of individual provider service agreements takes two forms, as the diagram below indicates. In both instances, the MCO contracts with a group purchaser (the “prime” contract) to cover a set of covered benefits and services. In some cases, an MCO enters into this contract without an established network of providers already in place, waiting to set up its network until the specific terms of the contract are agreed upon. In other cases, the MCO, already having established a provider network and armed with various product lines geared to its network capabilities, sells a relatively “finished” product to the purchaser.

With the prime contract in place, the MCO enters into a sub-agreement with one of two types of providers: a group provider or an individual clinician. Where the MCO contracts with a Individual Practice Association (IPA), for example, the IPA (acting as a middleman and thus creating a bit of turbulence in the cascade of contractual provisions) in turn contracts with its individual members to provide the services detailed in the prime contract. Where the MCO eschews an intermediary and contracts directly with an individual physician (or other health professional), it is relatively easy to trace the cascade of contractual provisions.



In this study, while, for example, we were able to distinguish between Medicaid-only sub-agreements and sub-agreements covering Medicaid and other publicly-paid services, we were not able to directly link the sub-agreements with the master contractor or with a middleman. However, whether the middleman or the master contractor is the source of imperfect devolution is theoretically irrelevant since in the final analysis the master contractor retains the responsibility to properly delegate contractual duties, and thus the duty to assure that the delegations are correct. In the technical sense, however, this distinction does matter, since it suggests that the responsibility for the imperfect devolution may rest entirely with the managed care organization or, at the very least, is shared between the managed care organization and its subcontractor.

At their most fundamental level, contracts serve to memorialize the relationship between the contracting parties by codifying in a written form the service provision and performance requirement expectations of both parties. This contractual relationship is one of the most hidden aspects of the managed care industry, owing mainly to its competitive nature; indeed, most MCOs closely guard the nature and structure of their provider agreements.

However, our initial study of managed care provider network agreements in 1996 revealed several characteristics about the nature of the contracts, foremost, their construction to favor the needs and demands of the managed care industry itself. More specifically, the agreements examined were constructed to shift significant amounts of financial risk onto individual health professionals. Where service duties are vaguely or ambiguously defined, providers (especially those receiving capitated reimbursements) may be exposed to residual liabilities at levels that were clearly unexpected at the time of the drafting of the agreement. They also were constructed to allow the MCOs to retain extensive control over treatment decision-making and resource allocation decisions. The MCOs manage and restrain providers' discretionary choices over the use of health plan benefits and services through the use of powerful financial incentives (such as capitation payments and withhold arrangements) and design the agreements so that treatment coverage decisions hinge on the interpretation of the contractual definitions of terms like "medical necessity" and "emergency". Finally, the provider contracts largely are "at will" documents that permit termination and/or modification by either party under certain notice periods, although there is a clear trend towards the MCOs having more unilateral powers in this regard than is true for providers.

Because agreement to these contracts is a precondition of access to patients and insurance revenues, it is evident that health professionals who wish to continue to run a practice comprised chiefly of insurance payments (as most practices are) have no choice but to sign. There may come a time when the industry as a whole concludes that, regardless of the price concessions from suppliers, the extent to which financial risk can be downstreamed, and the controls over resource consumption that can be maintained, the business of managed care simply is not lucrative enough to justify a major investment of capital. However, until the basic structure for controlling health resources allocation among insured Americans goes through another round of fundamental change, it is probably safe to assume that the contracts between managed care organizations and their provider networks may be modestly altered through negotiation, but that at the same time, their fundamental nature will survive.

Part B. Working Hypotheses

Based on prior reviews of managed care contracts and recognition of the need for standardization, we hypothesized that, in delegating duties to sub-contractors, MCOs would perform unevenly, with the result being significant lapses between the specifications contained in the master contract and the provisions of the supplier agreements pertaining to that master contract. We further hypothesized that these lapses would occur most often in the case of delegations under Medicaid agreements due to the unique nature of these master agreements. We also hypothesized that these lapses would involve duties neither extrinsic nor unrelated to the provider's duties (i.e., they would involve activities and functions that at least in part implicate the way in which the "ground zero" health provider furnishes care to members). We assumed that the lapses would take two basic forms:

- mis-description or inaccurate description of basic service duties to be customized (e.g., service definitions, access measures); and
- failure to describe certain service duties altogether that necessitate the involvement of the health providers themselves.

We made these hypotheses not because we believed MCOs intend to circumvent the purchasing specifications of Medicaid agencies or other group purchasers, but because the job of tailoring the conduct of suppliers to the tasks entailed in producing a customized service are so complex that it is easy to overlook fundamental matters or to assume that the customization that is required falls well within the ambit of how the supplier normally acts. In other words, an MCO might assume that because modifications sought by the Medicaid agency were not a significant departure from its standard product, no further effort on its part was necessary. The MCO, also accustomed to selling a standardized product, might overlook critical design differences between what it typically sells and what it is expected to supply to a Medicaid purchaser.

This failure to recognize the need for customization would be particularly true in the case of aspects of the contract that, on the surface, resemble those found in any managed care agreement but that differ significantly because of the underlying legal requirements of the Medicaid program itself. The legal requirements of Medicaid differ—at times significantly—from those governing other forms of insurance. This is particularly true in the areas of coverage, access, service design, member rights, and health care quality and scope. For example, Medicaid contains numerous Federal service definitions and standards unique in insurance law, particularly in the case of children, where coverage is highly expanded. Federal Medicaid law contains promptness of care requirements, reporting requirements, interagency coordination requirements, and other provisions that may impose higher duties on state agencies and managed care contractors. Unless a managed care company is intimately familiar with Medicaid, there is a distinct possibility that it would not know the degree to which its Medicaid business differs from its other lines of business, particularly where a Medicaid agency's master agreement simply references Federal law without specifying in detail what the company is expected to do. The company remains legally liable up to the federally referenced standard that has been incorporated into the contract, but neither it nor its suppliers may be in conformance.

Part C. Study Methodology

This is a descriptive study of the devolution of managed care contractor duties among three types of master contracts—Medicaid general service agreements, Medicaid behavioral health carve-outs, and state employee benefit agreements—to sub-agreements with behavioral health care providers, with a special emphasis on the devolution’s implications for managed behavioral health care. The study is limited to standard, or model, contract agreements developed by states (to keep the analysis at a manageable level), thereby excluding executed agreements between states and individual MCOs participating in their Medicaid or state employee benefit programs. Because state procurement laws require a significant degree of uniformity, we assumed that the standard agreements would be sufficiently representative of the expectations of state purchasers regarding the content and the structure of the care to be delivered.

Selection of Study States

From a pool of 40 states participating in one or more aspects of GWU’s ongoing nationwide point-in-time analysis of the structure and content of managed care agreements, we selected a total of 27 contracts from nine states for inclusion in this study. States for possible inclusion were preliminarily selected based on criteria that took into account population size, Medicaid enrollment size, the number of state employees covered under an employee benefit plan, location, presence of one or more 1115 or 1915(b) mandatory Medicaid managed care waivers covering behavioral health care services through carve-in and carve-out or integrated physical and behavioral health care arrangements, the degree of managed care penetration within the state, and the use of managed care arrangements that include behavioral health services by State employee benefit systems. We then narrowed down the number of states to nine by matching preliminarily selected states from which we collected state employee benefit contracts and/or Medicaid behavioral health carve-outs with the states from which we collected provider contracts.

Once we selected a state for inclusion in the study, we did not discriminate among the type of contract (i.e., once a state was selected, all of that state’s submitted contracts were included in the study). (See table below for the distribution by type of contract across states.) Since many of the provider contracts contain sanctions for the disclosure of proprietary information (including disclosure of the contracts themselves), we blinded all of the master and provider contracts and assigned a numerical identifier to each document. We do not report our findings by state, name of health care provider, or name of plan. Similarly, we do not identify the contract language quoted in this report.

Distribution by Type of Contract Across States Selected for Analysis

<i>Master Medicaid GSA (total = 9 contracts)</i>	<i>Master Medicaid BH carve-outs (total = 6 contracts)</i>	<i>Master state EBP contracts (total = 3 contracts)</i>	<i>Provider sub-agreements (total = 9 contracts)</i>
State 1			State 1
State 2			State 2
State 3	State 3		State 3
State 4	State 4		State 4
State 5	State 5		State 5
State 6	State 6		State 6
State 7		State 7	State 7
State 8	State 8	State 8	State 8

<i>Master Medicaid GSA (total = 9 contracts)</i>	<i>Master Medicaid BH carve-outs (total = 6 contracts)</i>	<i>Master state EBP contracts (total = 3 contracts)</i>	<i>Provider sub-agreements (total = 9 contracts)</i>
State 9	State 9	State 9	State 9

The selected states' Medicaid master contracts represent two main models of organizing Medicaid managed behavioral health care services: the integrated model that includes a minimum level of coverage for behavioral health care services under the master Medicaid general service agreement; and the carve-out model that separates out some or all behavioral health care services from the Medicaid general service agreement. Both models were analyzed to shed light on potential differences in the ways contract requirements are delegated from Medicaid contractors to sub-contractors. All nine Medicaid general service agreements cover some service duties specific to behavioral health care, from a low of 9 percent to a high of 75 percent of (compared to a low of 36 percent and a high of 85 percent among the six Medicaid behavioral health carve-out agreements). In the six study states with both a Medicaid general service agreement and a Medicaid behavioral health carve-out, providers contract not only for more extensive, carved-out behavioral health services, but also with the managed care organization that delivers services under the general service agreement for the (usually) more limited behavioral services covered under that agreement.

Where available, state employee benefit contracts were added to the set of selected Medicaid contracts for the purpose of testing our hypothesis, according to which the cascade of contractor duties would be more imperfect for Medicaid contracts because of the unique nature of the services to be provided under the master agreements. State employee benefit contracts were used as a comparison group of master contracts with relatively less “tailoring” since, as described above, they are standard employment arrangements. Although we include fewer employee benefit contracts than Medicaid contracts in this study, our previous analyses of managed care employee benefit contracts and provider contracts indicated that little dissonance exists among the language used in the two types of contracts. Thus, the employee benefit contracts are used a relatively small comparison group. All three state employee benefit contracts cover some behavioral health care services.

Overall, the state employee benefit contracts analyzed are less complex than both types of Medicaid master contracts, and the Medicaid behavioral health carve-outs are in turn less complex than the Medicaid general service agreements. Furthermore, on average, the state employee benefit contracts address 23 percent of all of the contractor duties targeted in our analysis, the Medicaid behavioral health carve-outs address 42 percent of all contractor duties reviewed, and the Medicaid general service agreements address 54 percent of the contractor duties. More specifically:

- State employee benefit contracts address fewer issues than do the Medicaid agreements, no matter the domain. There is not a single exception to this finding. Also, state employee benefit contracts are more vague and less focused on the details of health care delivery and coverage than is true for the Medicaid contracts.¹¹

¹¹ While some of these disparities can be attributed to the uniqueness of the Medicaid program, it is worth noting that in certain crucial respects, state employee benefit contracts lack the basic protections that one would find in health plans covered by the Employee Retirement Income Security Act of 1974 (ERISA), from which state employee benefit systems are exempt.

- Medicaid general service agreements are more comprehensive than Medicaid behavioral health carve-outs, i.e., they cover a higher percentage of provisions related to services, coverage rules, network composition, case management and referral, access standards, and payment terms. And in all but one state, Medicaid general service agreements address more service duties than do the carve-outs. Finally, Medicaid general service agreements specify fewer specific mental health and substance abuse services than do the carve-outs, and in two of three states, they address more specific behavioral health services than do the state employee benefit contracts.

The nine provider sub-agreements were either contracts for services covered by Medicaid (three states) or for services covered by Medicaid and other payers, e.g., employers, Medicare, or another prepaid public program (six states). In the case of one of the three states whose provider contract dealt with Medicaid-covered services only, we assumed that the provider contract would reflect similar elements had it also been designed for services covered by the state employee benefit plan.¹² Finally, while the majority of the study states delegate to their managed care organizations the responsibility for developing the sub-agreements, at least one state (State 9) seems to exercise significant control over the content of the sub-agreements.

Document Collection

All documents analyzed in this study were collected by GWU for the 1999 edition of Negotiating the New Health System¹³ or for studies focusing on provider contracts¹⁴ and state employee benefit contracts¹⁵ (both of which were offshoots of Negotiating the New Health System). We analyzed a total of 27 contracts, all but one of which were in effect as of 1998.¹⁶

Both types of master Medicaid contracts (i.e., integrated and carve-out) were originally collected for Negotiating the New Health System by contacting all states that maintain full-risk managed care arrangements for at least some proportion of their populations. A total of 40 states agreed to participate in the 1999 collection effort and submitted a total of 52 contracts. These contracts included 39 general service agreements, which cover a full range of preventive and acute care services, and 13 behavioral health carve-outs.¹⁷

The master state employee benefit contracts were solicited in the fall of 1998 among a pool of approximately 20 states, which varied in the number of state employees covered under the employee benefit plan and the degree of managed care penetration within the state. GWU received contracts

¹² Our assumption is buttressed by the fact that the state at issue requires Medicaid-participating plans to also participate in the state employee benefit plan.

¹³ *Supra*, note 3.

¹⁴ “An Evaluation of Agreements between Managed Care Organizations and Community-Based Mental Illness and Addiction Disorder Treatment and Prevention Providers,” *supra* note 6.

¹⁵ “Behavioral Health Benefits for Public Employees: An Analysis of Contracts Covering State Employees,” *supra* note 10.

¹⁶ An exception is one state employee benefit contract, which covers the 1/1/00-12/31/02 period. For the purpose of this study, we assumed that the contract would not differ in any significant way from its prior iterations. If anything, we assumed that it would expand to include more, rather than fewer, requirements.

¹⁷ “Negotiating the New Health System,” *supra* note 3.

from eight states, all but one of which were in effect in 1998.¹⁸ The employee benefit plan agreements selected for analysis in this study were chosen to achieve a balance between states with Medicaid behavioral health carve-outs and states that include behavioral health care services in their Medicaid general service agreements.

The provider sub-agreements were collected in the fall of 1998. They were solicited directly from mental illness and addiction disorder providers through a letter that explained the purpose and nature of the provider contract study series, as well as the confidentiality measures that would be taken to ensure anonymity. GWU sent this letter to community providers comprised of the following: (1) providers who participated in an identical GWU study in 1995-96; (2) providers identified by the Substance Abuse and Mental Health Services Administration as providers who had taken part in previous SAMHSA studies; and (3) providers chosen at random from the National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs.¹⁹ GWU contacted a total of 505 separate providers in all 50 states over a five-month period and received 112 separate documents from providers in 17 states. Contracts that did not represent agreements with managed care organizations were excluded, leaving a total of 107 contracts. These contracts were assigned a number indicating the order in which they were received and permitting the anonymous referencing of actual contract language. The sub-agreements were in effect at the time they were collected (i.e., in the fall of 1998).²⁰

Document Analysis

In designing this study, we were particularly interested in analyzing the elements of the master agreements that addressed six main domains—services, coverage rules, network composition, case management and referral (e.g., interagency agreements), access standards (e.g., time, geography, language, culture), and provider payment terms. In delineating each type of provision, we followed the grouping methodology established several years ago for Negotiating the New Health System. We used these groupings to categorize our findings and illustrate not only the mis-description or incomplete description of contractor duties, but also the lack of any mention of certain service duties.

We used a pared down version of the review instrument developed for Negotiating the New Health System to analyze and extract the language used in the 27 contracts. The original review instrument for Negotiating the New Health System was developed with the assistance of several advisory groups. These advisory groups included persons with a range of expertise, including state Medicaid agency officials and their representatives, representatives of managed care organizations, community health providers, beneficiary representatives as well as experts in communicable disease, public health, mental health and addiction disorder treatment and prevention. The review instrument is designed to elicit whether a particular document had provisions *relating to* a particular topic, not whether a contract met a certain pre-defined standard of performance (since there are few such standards, such a project could not be done).

¹⁸ “Behavioral Health Benefits for Public Employees,” *supra* note 15.

¹⁹ Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (1996). In using this list, GWU was careful to select from this publication providers who offer both mental health and substance abuse services.

²⁰ “An Evaluation of Agreements between Managed Care Organizations and Community-Based Mental Illness and Addiction Disorder Treatment and Prevention Providers,” *supra* note 6.

The pared-down review instrument was designed to determine whether the contracts addressed the key issues mentioned above, i.e., service duties, coverage rules, network composition, case management and referral, access standards, and payment terms. We pre-tested the instrument on one state's set of contracts. (See table below for a description of the number and type of duties we examined in our reviews, categorized by topic.)

Review Instrument Categories

<i>General area of duties</i>	<i>Number of specific duties (total = 189)</i>	<i>Type of specific duties</i>
I. Services	73	General, mental health and substance abuse, reproductive, EPSDT, communicable disease, urgent and emergency care, treatment plans of other agencies
II. Coverage rules	22	General coverage rule, medical necessity standard, medical necessity standard specific to mental health and substance abuse, utilization review process, prior authorization, drug formularies
III. Network composition	19	Provider network composition, definition of service area, selection of providers
IV. Case management and referral	29	Provider duties, self-referral, relationship to other agencies
V. Access standards	34	Cultural competency requirement, access time standards, geographic access standards, antidiscrimination
VI. Payment terms	12	Network provider and plan relationship, plan payment terms, provider payment terms

Lawyers from the law firm of Feldesman, Tucker, Leifer, Fidell and Bank reviewed all of the documents in accordance with a protocol developed to ensure uniformity in interpretation, using the same review instrument regardless of type of contract. When a contract mentioned an issue at all, it counted as having provisions related to the issue, regardless of how brief the mention was. When vague, the document was interpreted in the light most favorable to the drafter.

Following the lawyers' review, we used our pilot review and the spot checking method to ensure a minimum level of consistency among the lawyers' reviews. We then extracted the specific provisions in the six general areas of duties and inputted those that overlapped among the contracts in each state into a database. Using the report function in the database, we created side-by-side comparison tables by state in order to facilitate the analysis.

We then analyzed the language in the tables and categorized the findings into two sets of findings. The first category consists of general findings about the range of duties addressed by the contracts. The second category consists of specific examples about the depth with which the contracts address the cascading duties. This report presents these findings in the following section.

Part D. Findings

Irrespective of the type of master agreement used as the benchmark (Medicaid general service agreement, Medicaid behavioral health carve-out, or state employee benefit plan), the provider agreements deviate substantially with respect to both the range of topics addressed and the depth to which they are addressed (although comparatively speaking, the deviation is less pronounced among the employee benefit contracts). The first section of this part discusses this deviation in terms of the range of topics; the second section describes the deviation in the depth to which they are addressed by providing several specific examples of contract language to demonstrate the actual cascade phenomenon.

In General/Range of Topics

A comparison of the master contracts to the provider agreements yielded three major general findings concerning the range of topics addressed in the contracts:

First, the provisions of the master agreements cascade down to provider agreements in a manner often refined and narrowed as part of the delegation of duties. The description to a provider of the range of service duties enumerated in the master agreement is typically more limited than the language used in the master agreement. In essence, the provider contracts generally attempt to explain and translate an MCO's duties toward the purchaser, but often fail to disclose the full scope of its duties or how the provider's relationship to the MCO bears on the MCO's ability to execute its duties.

Second, because the state employee contracts are broader, more ambiguous, and less customized in terms of services and health care-related duties than is the case for the Medicaid master contracts, deviation between the master employee benefit plan agreements and the provider agreements is less pronounced.

Third, in the case of both types of master Medicaid contracts, the deviant nature of the cascading effect is more pronounced, with considerable variation between what the master agreement calls for in the case of service delivery and what the provider agreement actually says. This is true even in cases in which the provider's ability to execute its service duties necessarily would be influenced by a complete and accurate description regarding what is expected in the master agreement.

Finally, in at least one instance, the parallel between a master Medicaid contract and a provider agreement from the same state was nearly complete, reflecting the strong oversight exercised by one of the states regarding the structure and elements of the provider agreement. In the case of this state, there was virtually no lapse between its expectations of the MCO and the expectations of the providers.

The following tables demonstrate the deviation that occurs in the range of topics addressed in the four types of contracts analyzed. Table 1 shows the percentage of duties related to services, coverage rules, network composition, case management and referral, access standards, and payment terms addressed by each contract, and table 2 displays the percentage of all service duties addressed

by each contract. Table 3 further refines the data by showing the percentage of service duties that are specific to mental health and/or substance abuse addressed by each contract. Finally, table 4 provides data on the most frequent overlapping duties.

Table 1. Percentage of Duties Related to Services, Coverage Rules, Network Composition, Case Management and Referral, Access Standards, and Payment Terms) Addressed by Each Contract (Total=189)

State	GSA	BHA/MHA	EBP	PROVIDER
1	53%	N/A	N/A	21%
2	48%	N/A	N/A	18%
3	41%	27.5%	N/A	26.5%
4	60%	44%	N/A	18%
5	54%	42%	N/A	13%
6	64.5%	61%	N/A	18%
7	66%	N/A	17.5%	14%
8	49%	35%	21%	21%
9	47%	41%	30%	36.5%

Table 2. Percentage of All Service Duties Addressed by Each Contract (Total=73)

State	GSA	BHA/MHA	EBP	PROVIDER
1	64%	N/A	N/A	29%
2	57.5%	N/A	N/A	18%
3	56%	23%	N/A	29%
4	74%	42.5%	N/A	23%
5	62%	40%	N/A	1%
6	62%	68.5%	N/A	12%
7	86%	N/A	26%	14%
8	67%	36%	41%	18%
9	48%	34%	36%	31.5%

Table 3. Percentage of Service Duties That Are Specific to Mental Health and/or Addiction Disorders Addressed by Each Contract (Total=20)

State	GSA	BHA/MHA	EBP	PROVIDER
1	11%	N/A	N/A	29%
2	28.5%	N/A	N/A	85%
3	27%	76.5%	N/A	48%
4	20%	55%	N/A	65%
5	22%	65.5%	N/A	0%
6	9%	36%	N/A	33%
7	75%	N/A	20%	35%
8	70%	85%	50%	45%
9	25%	70%	40%	65%

Table 4. Most Frequent Overlapping Duties (i.e., Those Duties Addressed by the Majority of Study States)

General area of duties and specific duties	Number of states (total = 9)
I. Services	
<i>General mental health and substance abuse</i>	6
<i>Behavioral health care outpatient treatment</i>	5
<i>Other behavioral health care services</i>	5
<i>Emergency care</i>	6
<i>With a definition specific to behavioral health</i>	5
II. Coverage rules	
<i>General coverage rule</i>	7
<i>With a medical necessity standard</i>	6
<i>Utilization review process</i>	8
III. Network composition	
<i>Mental health and substance abuse providers</i>	6
IV. Case management and referral	3
V. Access standards	
<i>Emergency care services</i>	6
<i>Antidiscrimination</i>	9
VI. Payment terms	
<i>Premium as payment in full</i>	6
<i>Timelines for payment to plan/provider</i>	5

Taken together, these findings suggest that not all duties, whether service-related duties or other duties, cascade down from the master contract to the provider contract. In fact, note that in almost every instance in both tables 1 and 2, the percentage of duties drops as the cascading phenomenon travels from (where they exist) the general service agreements, to the carve-out arrangements, to the employee benefit plan agreements, and finally to the provider contracts. In addition, there is limited overlap between the master contracts and the provider contracts, from a low of eight duties (or 4% of all duties reviewed) in State 7, which had two master contracts, to a high of 33 duties (or 17.5% of all duties reviewed) in State 1, which had one master contract only. Thus, contracts most frequently describe service duties and coverage rules than is true for any other type of duty. Furthermore, within each of the six general areas, duties overlap more often on certain specific duties than others. (See Table 4.) Even when duties overlap, however, their substance is not necessarily the same across contracts, as seen in the next section.

Specific Examples of the Cascade Phenomenon/Depth of Topics

This section demonstrates the cascade phenomenon by describing the deviation between the terms and provisions of the master agreement and the relevant provider agreement by providing specific examples of contract language, since the deviation is best understood by viewing examples from a variety of contract domains. The types of devolution problems illustrated by the excerpts from the master and provider contracts fall into several basic camps.

The first is non-disclosure: Many of the examples illustrate the failure of an MCO to apprise its network of the special rules of the game that apply to Medicaid contracts, even where the rules, as modified significantly, affect a provider's duties to the patient and the MCO as well as the provider's costs. The result is a failure on the part of network providers to understand that the master contract under which they are working is different from their typical sub-contractual work for the MCO. This can injure not only the provider but the patient as well. Take for example the definitions of treatment in table 2 below. Several of the excerpted contractual provisions show that a state Medicaid purchaser typically is careful to apprise an MCO that the service definitions that apply to the product are those applicable to state Medicaid programs under Title XIX of the Social Security Act. Yet, the MCO does not in many cases apprise its providers of this fact, leading providers to believe that services that are not covered under the MCO's standard coverage guidelines for the non-Medicaid products it sells are equally applicable in the Medicaid setting. As a result, providers may fail to pursue expanded care to which the patient is entitled, and the patient may never realize that covered services were not provided.

Another problem illustrated by the excerpts is the direct mis-description of a duty. This can be seen most clearly in the provider payment and third-party liability recovery examples (see table 4 below), where the MCO's standard provider agreement adopts a specification that is utterly at odds with that of the master contract.

A final concern is the ambiguous representation of duties, so that the scope of duties is mis-described or incompletely described. The table containing the translation excerpts (Table 3c) offers examples of this type of ambiguous representation.

The excerpted contract language delineating the cascade phenomenon is portrayed in the following seven tables, arranged by domain. The domains were selected because they tend to involve issues that receive considerable customization attention from state Medicaid agencies. We further divided the tables into numerically labeled "cells," so that in the brief "Highlights" analysis accompanying each table we could more easily direct the reader to specific contract language.

Domain 1. Services

Table 1 provides illustrations of the devolution of service definitions and duties from the master contracts to provider agreements in the area of emergency care, a specific type of service duty.

Highlights:

- Cell 1-1: The compared language offers a good example of the narrowing of the definition from one contemplating all serious conditions to those characterized by "sudden onset," "rapid deterioration," and "time limit[at]ions".
- Cell 1-2: Compare the relatively elaborate definition of targeted case management with the (misnamed) description of the available "administrative" management services in the provider agreement.
- Cell 1-3: This cell excerpts provider agreement language that arguably expands on the master contract's requirements.

- Cell 1-4: As in cell 3-1, the compared provisions offer a good example of devolved language that is actually broader than that found in the master contract.

**Table 1: Services
Emergency Care**

Cell	State	Master Agreement Language	Provider Agreement Language
1-1	8	<p>Carve-Out: Emergency -- shall mean a serious medical condition resulting from injury, sickness, or mental illness which arises suddenly, manifests itself by symptoms of sufficient severity, and requires immediate care and treatment to avoid jeopardy to the life or health of the individual or harm to another person by the individual...</p>	<p>1.15 "Psychiatric Emergency" means, unless otherwise provided in the applicable Health Benefit Program, a clinical condition requiring immediate intervention to prevent death or serious harm to the Member or others, or acute deterioration of the Member's clinical state such that gross impairment of functioning exists and is likely to result in compromise of the Member's safety. A Psychiatric Emergency is characterized by result in compromise of the Member's safety. <i>A Psychiatric Emergency is characterized by sudden onset, rapid deterioration of cognition, judgment or behavior, and is time limited in intensity and duration. Thus, elements of both time and severity are inherent in the definition of Psychiatric Emergency.</i> [italics added]</p>
1-2	4	<p>Carve-Out: 2.2 General Service Requirements</p> <p>A. The prepaid mental health plan contractor will provide a full range of mental health care service categories authorized under the state Medicaid plan and the state mental health program plan, as follows...</p> <p>5. Mental Health Targeted Case Management...</p> <p>6. Mental Health Intensive Case Management...</p> <p>2.3 Medicaid Service Requirements...</p> <p>E. Targeted Case Management</p> <p>The contractor shall adhere to the requirements of the Medicaid Case Management Services Provider Handbook, but will not be required to seek certifications from the [...] District's [mental health office] in regard to clients, agency designation, or mental health care case manager qualifications...</p> <p>F. Intensive Case Management</p> <p>This is a new mandatory service which is intended to provide intensive, team case management to highly recidivistic persons who have severe and persistent mental illness.</p> <p>2.4 Additional Service Requirements...</p> <p>C. Evaluation and Treatment Services for Children...</p> <p>4. Case management of children in the plan is to include involvement of persons, schools, programs, networks and agencies which figure importantly in the child's life. The contractor will make determinations about care based on a comprehensive evaluation, consultation from the above parties, as indicated, and appropriate protocols for admission and retention. [State] will monitor services for adequacy and conformity with agreements.</p>	<p>1.1 "Care Management Product" shall refer to Benefit Plans under which an Affiliate Payor has contracted with [MCO] for a full range of administrative services, that may include, but are not limited to: extensive care management...</p>

Table 1: Services Emergency Care			
Cell	State	Master Agreement Language	Provider Agreement Language
		<p>2.10 – Care Coordination and Management</p> <p>The contractor shall be responsible for the coordination and management of mental health care and continuity of care for all enrolled Medicaid recipients through the following minimum functions:</p> <p>A. Minimizing disruption to the enrollee as a result of any change in service provider or mental health care case manager occurring as a result of the awarding of this contract.</p> <p>B. Providing appropriate referral to the enrollee's [Medicaid] primary care case managers (or other physician, for non-[Medicaid] enrollees) and scheduling of assistance for enrollees needing physical health care and mental health care services.</p> <p>C. Documenting in clinical records all enrollee emergency encounters and appropriate follow-up.</p> <p>D. Documenting all referral services in the enrollees' clinical records.</p> <p>E. Monitoring enrollees with ongoing mental health conditions.</p> <p>F. Providing direct mental health care service providers with copies of the Medicaid Prescribed Drug Report relating to their respective plan enrollees, and coordinating on an as needed basis with other staff, subcontractors, or non-plan providers the provision of psychotropic drugs to plan enrollees.</p> <p>G. Monitoring enrollees admitted to state mental health institutions.</p> <p>H. Coordinating hospital and/or institutional discharge planning for psychiatric admissions that includes appropriate post-discharge care.</p> <p>I. Providing appropriate referral of the enrollee for non-covered services to the appropriate service setting, and requesting referral assistance, as needed, from the Area Medicaid Program Office.</p> <p>J. Entering, prior to commencement of services, into agreements with agencies funded pursuant to [state law], that will not be a part of the plan's provider network, regarding coordination of care and treatment of enrollees jointly or sequentially served...</p> <p>K. Providing court ordered mental health evaluations for its enrollees as required by, and within the time limits specified by, the courts. The contractor shall also provide expert mental health testimony for its enrolled recipients (with the exception of children in specialized therapeutic foster care and residential treatment) as ordered by the courts.</p> <p>L. Providing appropriate screening, assessment, crisis intervention and</p>	

Table 1: Services Emergency Care			
Cell	State	Master Agreement Language	Provider Agreement Language
		<p>support for enrollees who are in the care and custody of the state (including children who are placed in foster homes but not including children placed in specialized therapeutic foster care).</p> <p>M. Providing that, in the event of a disagreement between the agency and the contractor regarding the appropriate treatment of an enrollee who was referred to the contractor's provider by the agency, the decision of the agency shall prevail.</p> <p>The following is a summary list of the services which must be provided under the prepaid mental health plan contract...</p> <p>Mandatory Services...</p> <p>b. Targeted Case Management...</p> <p>k. Intensive Case Management...</p>	
1-3	6	<p>Carve-Out: G. Emergency Behavioral Health Services</p> <p>Services provided after the sudden onset or exacerbation of a behavioral health condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate behavioral health attention could reasonably be expected to result in:</p> <ol style="list-style-type: none"> 1. Serious bodily harm or injury to the enrollee or others; or 2. Serious physical debilitation. 	<p>Definitions...</p> <p>E. Emergency means the sudden onset of a mental and/or nervous or substance abuse condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medical or clinical attention could reasonable be expected to result in seriously jeopardizing or endangering the <i>mental health or physical well-being of the Enrollee</i> or seriously jeopardizing or endangering the physical well-being of a third party. [italics added]</p>
1-4	6	<p>Carve-Out: Urgent -- Any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or emergency situation. Additionally, it includes situations such as when a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.</p>	<p>Definitions...</p> <p>Q. Urgent - means the onset of a mental and/or nervous or substance abuse condition manifesting itself by serious symptoms such that the mental health or physical well-being of the Enrollee will deteriorate unless the Enrollee is treated by a Practitioner immediately.</p>

Domain 2. Coverage Rules

Table 2 provides illustrations of the devolution of coverage rules from the master contracts to provider agreements in the area of medical necessity standards and utilization management rules.

Highlights:

- Cell 2-1: This devolution is problematic for one of the reasons discussed in the opening of this section: non-disclosure of key information to providers. In this case, there is no disclosure to the provider regarding her/his role in the determination of medical necessity.
- Cell 2-2: Again, the issue is one of non-disclosure, in this case the failure of the MCO to apprise its providers of the special rules that apply to Medicaid contracts. Specifically, there is no explanation in the provider contract that Title XIX serves as a coverage floor in the case of Medicaid.
- Cell 2-3: In this cell the medical necessity definition contained in the provider agreement is a far more restrictive definition than that found in the master agreement. Specifically, the provider contract language lacks the preventive or ameliorative language of the master contract.
- Cell 2-4: This cell provides an example of an obligation in the master agreement to adhere to Title XIX standards of medical necessity, while the provider contract indicates that care that is not consistent with the HMO's standards can be denied without clarifying the right to coverage where the HMO's standards are inconsistent with Title XIX.
- Cell 2-5: This is an intriguing example of the devolution phenomenon—the master contract creates a presumption in favor of the practitioner's medical judgment unless the plan rebuts; the provider agreement reverses this presumption.
- Cell 2-6: As with the examples in cell 2-1, the provider agreement language is ambiguous at best because it never explains the potential role of plan practitioners in the determination of medical necessity.
- Cell 2-7: A clear example of devolution that constricts the language included in the master contract. The notions of “maintain” and “achieve” are lost, and providers left to believe that medically necessary services are those only that are used to diagnose or treat “illnesses” and “conditions.”

Table 2: Coverage Rules Medical Necessity and Utilization Management			
Cell	State	Master Agreement Language	Provider Agreement Language
2-1	5	<p>Carve-Out: 3.2.9 Medical Necessity</p> <p>[MCO] agrees that the actual provision of any Covered Service is <i>subject to the professional judgment of [MCO's] providers as to the Medical Necessity of the service as defined in this contract pursuant to []</i>. Disputes between [MCO] and Clients about Medical Necessity can be appealed through [MCO's] grievance system and ultimately to the Department for a determination pursuant to [state law]. [italics added]</p>	<p>Section 2.1 Covered Services to Be Rendered.</p> <p>Facility/Program agrees to provide and ensure that the appropriate Providers provide to be Covered Persons those Covered Services that are within the scope of Facility/Program's and such appropriate Providers' licensed capabilities and that <i>[MCO] determines to be Medically Necessary in accordance with [MCO's] referral, quality assurance, and utilization management procedures...</i> [italics added]</p>
2-2	4	<p>Carve-Out: 2.3 Medicaid Service Requirements... In no instance may the plan's service limitation be more restrictive than those which exist in the [state] Medicaid fee-for-service program, as described below for each service. The plan is encouraged to exceed these service limits.</p>	<p>I. DEFINITIONS...</p> <p>1.11 "Covered Services" means those Medically Necessary mental health and chemical dependency services authorized by an Affiliated Provider and authorized by [MCO] or Affiliate Provider to which Covered Individuals are entitled under the terms of the applicable Benefit Contract and rendered at the Facility; provided that those mental health or chemical dependency services are described in Exhibit 2. For the purpose of this Agreement, chemical dependency services shall include treatment for alcohol dependency and other addictive and abused substances.</p>
2-3	4	<p>Carve-Out: YY. Medically Necessary – The requirement that the goods and services provided or ordered must be:</p> <ol style="list-style-type: none"> 1. <i>Calculated to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition</i> that threatens life, causes pain or suffering, or results in illness or infirmity; 2. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; 3. Necessary and consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; 4. Reflective of the level of service that can be safely provided, and for which no equally effective and more conservative or less costly treatment is available; and 5. Provided in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. [italics added] 	<p>I. DEFINITIONS...</p> <p>1.13 "Medically Necessary" or "Medical Necessity" are those services provided to <i>identify or treat</i> a Covered Individual's mental illness or chemical dependency which are determined by [MCO] or Affiliate Payor to be:</p> <ol style="list-style-type: none"> a) consistent with the symptoms or diagnosis and treatment of the Covered Individual's condition, disease, ailment or injury; b) consistent with standards of appropriate professional practice; c) not solely for the convenience of the Covered Individual, his or her Affiliated Provider, Facility, or other health care provider; and d) the most appropriate level of service which can be safely provided to the Covered Individual. [italics added] e) When specifically applied to a Covered Individual receiving inpatient services, it further means that the Covered Individual's symptoms or condition requires that the diagnosis or treatment cannot be provided to the Covered Individual as an outpatient.

Table 2: Coverage Rules			
Medical Necessity and Utilization Management			
Cell	State	Master Agreement Language	Provider Agreement Language
2-4	7	<p>General Service Agreement: 7.01 The HEALTH PLAN shall provide for an internal quality assurance system consistent with federal requirements under Title XIX of the Social Security Act, Appendix I of this Contract and as required pursuant to [state law]. This system shall provide for review by appropriate health professionals of the process followed in the provision of health services and shall utilize systematic data collection of performance and patient results, provide interpretation of such data to the practitioners and provide for instituting needed change. This system shall include documentation and appropriate review and/or conduct of: ...</p> <p>b) Utilization of service...</p>	<p>IV. RULES AND REGULATIONS...</p> <p>8. [MCO] has the right to review and evaluate the quality and appropriateness of outpatient substance abuse use disorder treatment provided to [MCO] Subscribers. [MCO] may deny payment for services deemed non-efficacious or not medically or therapeutically necessary according to the standards and guidelines in effect at the time the services were actually provided...</p> <p>13. ...Reimbursement for outpatient treatment will be <i>contingent on the provision of quality care which meets [HMO's] Outpatient Substance Use Disorder Criteria.</i> [HMO] or its designated utilization reviewer will complete the review within ten (10) working days concerning the authorization or non-authorization of additional outpatient psychoactive substance use disorder services.... [italics added]</p>
2-5	8	<p>Employee Benefit Plan: SECTION III. DEFINITIONS...</p> <p>21. "Medically Necessary Services" means services for the diagnosis or treatment of an illness or injury or for the prevention thereof which are prescribed by a practitioner within the scope of his/her license, except where the Plan and the Commission determine that the services rendered are not generally viewed by the medical community as an accepted procedure for the diagnosis or treatment of the illness or injury experienced by the patient or for the prevention of illness or injury.</p>	<p>1.08 "Medically Necessary" means, unless otherwise provided in the applicable Health Benefit Program, when applied to Behavioral Health Services, that the service or supply is necessary and appropriate for the diagnosis, care or treatment of the Member's physical or mental condition as determined by [contractor] or the applicable Payor or Sponsor.</p>
2-6	8	<p>Employee Benefit Plan: SECTION VII. CONDITIONS, LIMITATIONS, AND EXCLUSIONS</p> <p>3. Exclusions</p> <p>No coverage shall be provided for...</p> <p>E. Services not considered by a Plan practitioner to be Medically Necessary for treatment or prevention of illness or injury.</p> <p>FY 2000 HMO Rate Renewal Attachment 9: Expanded Mental Health/Substance Abuse</p> <p>I. Benefits limits...</p> <p>All [...] plans will use medical necessity for determining benefit coverage.</p>	<p>ATTACHMENT A</p> <p>COVERED BEHAVIORAL HEALTH SERVICES...</p> <p>Members are eligible only for those Medically Necessary Behavioral Health Services expressly covered by their Health Benefit Programs and which Practitioner is qualified by training, licensure and experience to provide.</p>
2-7	6	<p>Carve-Out: Medical Necessity - Clinical determinations to establish a service or benefit which will, or is reasonably expected to: prevent the onset of an illness, condition, or disability;</p>	<p>J. Medical Necessity or Mental Necessary means that the services provided to <i>diagnose or treat an illness or condition</i> are determined by [MCO] to meet all of the following criteria:</p>

Table 2: Coverage Rules			
Medical Necessity and Utilization Management			
Cell	State	Master Agreement Language	Provider Agreement Language
		<p>reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury, or disability;</p> <p>assist the individual to <i>achieve or maintain maximum functional capacity</i> in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age. [italics added]</p>	<p>1) the service is appropriate for the symptoms, diagnosis and treatment of a particular disease or condition that is defined under ICD-9-CM or DSM-IV, or its replacement;</p> <p>2) the service is provided in accordance with generally accepted standards of mental health/substance abuse professional practice;</p> <p>3) the service is not rendered primarily for the convenience of the patient, the patient's family, Provider or any other health care provider; and</p> <p>4) the service or treatment is of the type, level and length needed to provide safe and adequate care. For inpatient stays, this means that the patient's symptoms or condition require(s) that the Enrollee cannot receive safe and appropriate care as an outpatient or in a less intensive setting.</p> <p>5) [MCO] will authorize payment for all services deemed medically necessary for eligible [MCO] members, including medically necessary services which are rendered under the terms of a court order. In determining Medical Necessity for participants in the [state] Medicaid program, [MCO] Medical Necessity Criteria will be consistent with the standards promulgated by the [state mental health department]. [italics added]</p>

Domain 3. Access Standards

Tables 3a, 3b, and 3c provide illustrations of the devolution of access standards from the master contracts to provider agreements in three areas, respectively: service timelines, cultural competency, and translation services and other supports.

Highlights:

a. Service Timelines

- Cell 3-1: A good example of elaborating on the language in the master contract.
- Cell 3-2: Again, the provider duties to treat actually go beyond the level described in the master agreement.
- Cell 3-3: This cell provides a good example of how an ambiguous master contract provision becomes an ambiguous sub-contract provision.
- Cell 3-4: This is an explicit example of the narrowing of an obligation from the actual provision of care to care simply being available.
- Cell 3-5: The master contract requires a response *to the patient* within 30 minutes; yet the MCO requires providers to respond *to the MCO* within 30 minutes. Bottom line: patients get HMO help, not provider help, in 30 minutes.

b. Cultural Competency

- Cell 3-6: A good example of an effort to translate the cultural competence requirement into a set of expectations for the provider.

c. Translation Services and Other Supports

- Cell 3-7: This is an example of an ambiguous devolution—who pays for these seemingly add-on services?
- Cell 3-8: This is a stunning example of the narrowing of duties that often occurs in the devolution process. (Also note that this example also shows the impact of non-disclosure, since the provider contract never indicates that the provider can obtain interpreter resources as part of the attempt to communicate with a patient.)

Table 3: Access Standards

a. Service Timelines

Cell	State	Master Agreement Language	Provider Agreement Language
3-1	3	Carve-Out: There shall be sufficient professional personnel for the provision of covered behavioral health services, including emergency care on a 24-hour a day, 7-days-a-week basis...	1.3.4 Contractor shall maintain a twenty-four (24) hour per day basis, seven (7) days per week, on-call system that ensures that clinically appropriate and timely response for emergency situations is provided, and that ensures that in every situation emergent services occur within two (2) hours of notification. On-call services shall include provisions for continuous care, crisis intervention, crisis stabilization and emergency case management.
3-2	3	Carve-Out: 7. SCREENING AND EVALUATION, SERVICE PLAN DEVELOPMENT [State] shall ensure that all members who are referred for behavioral health services receive a screening and evaluation, including an assessment for case management needs, within one week of referral. <i>Screenings and evaluation for emergency referrals</i> shall be accepted 24 hours per day, seven days per week and must be performed within 24 hours of referral or request for service. [italics added]	The Contractor will ensure that its intake, urgent and emergent services complement and interface with the community crisis system. The Contractor is responsible for providing crisis stabilization services and maintaining a 24-hour case management on-call system for all assigned Members... On-call services shall include <i>provisions for continuous care, crisis intervention, crisis stabilization and emergency case management...</i> Contractor shall provide to Members a full range of case management services as described in the [state Medicaid plan] which shall include:... c) on call crisis intervention services that include provisions for continuous care and crises intervention twenty-four (24) hours a day, seven (7) days a week. [italics added]
3-3	2	General Service Agreement: 4. Triage Procedures [State law] (see Appendix C) requires HMOs to establish triage procedures that address, within specified timeframes, the scheduling of enrollees that contact their providers with emergency needs, urgent needs, persistent symptoms or with requests for routine care. Respondents must also specifically address how they triage requests for pregnancy determination and prenatal visits. For the purposes of this RFP response, describe how the HMO will monitor its provider panel's compliance with these triage requirements. To meet the mandatory criteria, the response must specifically address both procedures.	15. Subcontractor acknowledges that the provision of services under this Agreement will often be extraordinarily time sensitive, and agrees to make the delivery of services under this Agreement its top priority.
3-4	5	Carve-Out: 3.8 TWENTY-FOUR (24) HOUR COVERAGE. [MCO] shall arrange for the provision of all Emergency Medical Services as defined in this contract 24 hours each day, 7 days a week. [MCO] shall ensure that its Providers have a phone number that Clients or individuals acting on behalf of a Client can call at any time to obtain emergency or urgent care. This number must have access to individuals with authority to	Section 2.3 Availability of Services. Facility/Program/Provider shall be reachable by telephone twenty-four (24) hours a day, seven (7) days per week...

Table 3: Access Standards			
a. Service Timelines			
Cell	State	Master Agreement Language	Provider Agreement Language
		authorize treatment as appropriate. A response to such call must be provided within 30 minutes...	
3-5	5	Carve-Out: 3.8 TWENTY-FOUR (24) HOUR COVERAGE... [MCO] shall ensure that its Providers have a phone number that Clients or individuals acting on behalf of a Client can call at any time to obtain emergency or urgent care. This number must have access to individuals with authority to authorize treatment as appropriate. A response to such call must be provided within 30 minutes...	Section 2.3 Availability of Services. Facility/Program/Provider shall be reachable by telephone twenty-four (24) hours a day, seven (7) days per week, and return calls within thirty (30) minutes of [MCO] calling Facility/Program/Provider's answering service or machine in emergency... Facility/Program/Provider agrees to make its best efforts to be available for appointments with Covered Persons... on the day of a request in the case of an emergency need for treatment...

Table 3: Access Standards			
b. Cultural Competency			
Cell	State	Master Agreement Language	Provider Agreement Language
3-6	2	General Services Agreement: 4. Federally Qualified Health Center (FQHC) Services... If the second option is chosen, the HMO must document its capacity by submitting with its RFP response:... (b) documentation that the HMO will provide a comparable level of services as the FQHC, including ... the availability of culturally sensitive services, such as translators and training for medical and administrative staff.	5.14 Cultural Competency: Provider warrants that it is sensitive to cultural issues, which might arise in the delivery of care under this Agreement. Provider hereby agrees to use its best efforts to assure that its staff, subcontractors and agents are culturally diverse, will successfully participate in cultural competency training, will demonstrate that cultural relevance is inherent and demonstrated in their service/system designs, and will deliver services under this Agreement in a manner that respects cultural differences. Provider must have a written cultural competency plan, which shall include personal care and hygiene in various cultures, and submit a copy of the plan to Children Services within ninety (90) days of the effective date of this Agreement. Cultural diversity includes, but is not limited, to, such differences as race, national and geographic origin, gender, social class, educational level, physical and intellectual abilities and otherwise as necessary to reflect the populations of which Children Services clients are a part.

Table 3: Access Standards			
c. Translation Services and Other Supports			
Cell	State	Master Agreement Language	Provider Agreement Language
3-7	2	General Service Agreement: APPENDIX B BASIC BENEFIT	3.13 Direct Services: Services received by children and their families and

Table 3: Access Standards
c. Translation Services and Other Supports

Cell	State	Master Agreement Language	Provider Agreement Language
		<p>PACKAGE BY SERVICE TYPE</p> <p>The following types of services must be provided to Covered Persons by Participating Health Plan and at least to the extent such services are covered by [state] Medicaid. Additional covered services required under this contract are outlined in the RFP...</p> <p>14. Ambulance and ambulette transportation...</p>	<p>services received by foster parents, including but not limited to : ... arrangement for and transportation to and from school....</p>
3-8	5	<p>Carve-Out: 5. PROVISION OF INTERPRETERS. [MCO] shall use its best efforts to provide reasonable access to interpreter services for Clients as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Furthermore, [MCO] must provide the 24 hour a day, 7 day a week access to interpreters conversant in languages spoken by the population in [MCO's] Enrollment Area including Spanish and American sign language (ASL). Also, upon a Client or Participating Provider request for interpreters services in a specific situation where care is needed. [MCO] shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary care, including urgent and emergency care. Professional interpreters shall be used when needed where technical, medical or treatment information is to be discussed or where use of a family member or friends as interpreter is inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.</p> <p>Measure: Throughout the term of this Contract, [MCO] will maintain a current list of interpreters who are "on call" status to provide interpreter services. Provision of interpreter services must be in compliance with Title VI of the Social Security Act.</p>	<p>Section 2.3 Availability Services. Facility/Program shall be reachable by telephone twenty-four (24) hours a day, seven (7) days per week... Facility/Program/Provider shall make reasonable efforts to communicate with Covered Persons in the language spoken by him or her.</p>

Domain 4. Provider Payment Terms

Table 4 provides illustrations of the devolution of provider payment terms from the master contracts to provider agreements.

Highlights:

- Cell 4-1: Another example of the ambiguous nature of the cascade effect, this time in relation to the reimbursement of clean claims.
- Cell 4-2: To the to the extent that the provider has not agreed to a later payment schedule, the provider language is a direct violation of the master agreement requirement.
- Cell 4-3: The provider agreement is in direct violation of the master contract.
- Cell 4-4: Again, a direct violation of the master contract, since the provider agreement never alerts the provider that she/he will be paid for EPSDT services despite the normal cost avoidance rule.

Table 4: Provider Payment Terms			
Cell	State	Master Agreement Language	Provider Agreement Language
4-1	3	<p>Carve-Out: 37. PROVIDER CLAIMS TIME LIMITS</p> <p>Effective 10/1/97, [health department] and its subcontractors shall not pay claims for covered services that are initially submitted more than six months after the date of service, or six months after the date of eligibility posting, whichever is later. In addition, [health department] and its subcontractors shall not pay clean claims submitted more than 12 months after the date of service.</p>	<p>1.9 The Contractor shall reimburse a subcontracted provider's clean claim within 30 days of the Contractor's or its fiscal agent's receipt of the clean claim and shall distribute an appropriate Explanation of Benefits (EOB) statement with the payment...</p>
4-2	5	<p>Carve-Out: 3.9 FORTY-FIVE (45) DAY PAYMENT REQUIREMENT.</p> <p>Pay at least 95% of Clean Claims from Providers for Covered Medically Necessary Services within 45 days of receipt of the Clean Claim and 100% within 120 days, except to the extent providers have agreed to later payment. [MCO] agrees not to delay payment to subcontractors pending subcontractor collection of Third Party Liability.</p>	<p>Section 3.1 Compensation Amounts and Responsibility. [MCO] shall enter into contractual agreements with Payors obligating Payors to compensate Facility/Program for Covered Services rendered by Facility/Program and Providers to Covered Persons, at the rates specified in Exhibit 3.1 within ninety (90) days of the filing of a Complete Claim pursuant to Section 3 of this Agreement... Where [MCO] is functioning as a Payor, Complete Claims shall be paid within forty-five (45) days of receipt by [MCO]...</p>
4-3	8	<p>Carve-Out: 2.05 Provider Reimbursement</p> <p>The Contractor shall: ...</p> <p>2.05.04 Reimburse all Clean Claims submitted by Providers for all services authorized by the Contractor within thirty days of receipt of the Clean Claim.</p>	<p>ATTACHMENT C</p> <p>COMPENSATION SCHEDULE...</p> <p>2. CLAIMS PAYMENT. [Subcontractor], on behalf of [contractor] shall pay Practitioner for Behavioral Health Services rendered in accordance with Member's Health Benefit Plan within sixty (60) days of receipt of an undisputed claim that provides all information deemed necessary by [subcontractor] to process the claim.</p>
4-4	6	<p>Carve-Out: 8.3 Third Party Liability</p> <p>A. Generally</p> <p>The Contractor shall comply and shall require that [subcontractor] and [subcontractor's] subcontractors comply with the procedures implemented by the Department with regard to Third Party Liability as set forth in Part IV, Section G.3.b. of the RFP. The Contractor will not be held responsible for any TPL errors in the Department's eligibility verification system.</p> <p>B. EPSDT Cost-Avoidance Prohibited</p> <p>In accordance with federal regulation, the Contractor agrees to pay, and to require that [subcontractor] pay, all Clean Claims for EPSDT services to children, and then seek reimbursement from liable third parties. The Contractor specifically recognizes that cost avoidance of these claims is prohibited.</p>	<p>Claims and Payment in General...</p> <p>E. Coordination of Benefits... Provider shall cooperate with [MCO] and each Payer Organization in administering any applicable coordination of benefits and other third party reimbursement provisions. Provider shall use best efforts to determine, through intake questionnaires or other appropriate means, whether other third party reimbursement is available. In the event that [MCO] benefits under an HMO Coverage Agreement are determined to be secondary with respect to Covered Services, Provider shall seek reimbursement pursuant to such other coverage prior to submitting a claim to [MCO].</p>

Domain 5. Case Management and Referral Terms

Finally, table 5 provides illustrations of the devolution of case management and referral terms from the master contracts to provider agreements in the area of interagency relationships.

Highlights:

- Cell 5-1: An example of a good job in the provider agreement of elaborating on the basic duty set out in the master contract.
- Cell 5-2: This devolution results in completely misleading language. There is no explanation of the MCO's affirmative duty to be involved in the development of plans of care, which is a responsibility that clearly would have to be borne at least in part by the personal provider as an added duty.
- Cell 5-3: A great example of a provider contract that elaborates extensively on the master contract.

Table 5: Case Management and Referral Interagency Relationships			
Cell	State	Master Agreement Language	Provider Agreement Language
5-1	3	<p>Carve-Out: [Health department] shall establish written criteria and procedures for subcontractors and providers to promptly handle referrals, including emergency referrals, from [state Medicaid] acute care contractors, courts, tribes, IHS, schools and other referral sources.</p>	<p>1.15 Contractor shall appoint a Corrections Liaison to interact and coordinate with [purchaser] on behavioral health issues regarding Members in jail in accordance with [health department] and [purchaser] policies and procedures regarding this population.</p> <p>1.15.1 The Contractor is responsible for performing intakes and evaluations and coordinating discharge planning with [...] County for all...Members in jail who are assigned to the Contractor.</p> <p>1.15.2 The Contractor shall participate in all jail diversion initiatives coordinated by the [purchaser].</p>
5-2	1	<p>General Service Agreement: 6. Services for Children with Developmental Disabilities</p> <p>c. Provider shall coordinate with [state] agencies, including the Public School system and the [state's] Early Intervention Program that are responsible for services for infants, toddlers, preschool and school age children with developmental disabilities to develop a comprehensive plan of care.</p>	<p>Patient Care Education Services</p> <p>Upon request of the Member, the following educational and referral services will be provided:</p> <p>Referral to adoption agencies;...</p> <p>Referral to other appropriate medical-social services;...</p>
5-3	9	<p>Carve-Out: 13. CROSS SYSTEM WORKING PARTNERSHIPS</p> <p>The Contractor shall work in active partnership with the following allied community providers to ensure that service recipients received a balanced, coordinated and individualized array of quality supports and services;...</p> <p>County jails and Department of Corrections;...</p> <p>This shall be accomplished through demonstration of working partnerships which produce evidence to substantiate at a minimum:</p> <p>Assurance of an overlapping community and institutional network of individualized support for service recipients;</p> <p>Commitment to extended community tenure, and support normalized activities;</p> <p>Participation in development of the respective plans as they pertain to and affect persons with mental illness and children and adolescents with serious emotional disturbance;</p>	<p>8.6 CARE MANAGEMENT</p> <p>8.6.1 The Member Government shall:...</p> <p>8.6.1.25.2 coordinate with non-participating health and social programs including, but not limited to... corrections,...</p> <p>"8.9 PERSONS WITH MENTAL ILLNESS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM</p> <p>8.9.1 The following terms become effective January 15, 1998 unless . . . has submitted a plan, in accordance with the provisions of the [state health department] Contract, for services to persons of all ages who have mental illness and are also involved in the criminal justice system. Upon approval of the plan by the [mental health director] the following terms will be replaced with the provisions of the approved plan.</p> <p>8.9.2 The Member Government shall:</p> <p>8.9.2.1 Implement methodologies, in accordance with . . . regional policies, to assure that persons with mental illness diverted form jails, prisons or juvenile</p>

**Table 5: Case Management and Referral
Interagency Relationships**

Cell	State	Master Agreement Language	Provider Agreement Language
		<p>Exchanging of pertinent data and information; and</p> <p>Collaboration in monitoring and quality assurance activities relative to persons with mental illness, including dementia and children and adolescents with serious emotional disturbance, development and maintenance of an integrated system of care which shall ensure that agencies and care providers work together with service recipients and their caregivers to prevent inappropriate hospitalization and to provide cross-system individualized support, and cost sharing.</p>	<p>detention and rehabilitative facilities are identified and linked to community care.</p> <p>8.9.2.2 Implement methodologies, in accordance with . . . regional policies, to monitor criminal justice diversion for adults and youth, including pre-arrest diversion, court-ordered treatment, sentencing alternatives and post-incarceration treatment planning and implementation.</p> <p>8.9.2.3 Provide access, availability and transportation to emergency mental health response system and/or psychiatric inpatient services for all age groups of mentally ill offenders diverted from jails or prison and/or post prison or detention community transition in order to provide seamless service delivery for release/discharge planning made in conjunction with facility staff, medical personnel and the receiving community.</p> <p>8.9.2.4 Assist local law enforcement in screening and diagnostic activities for all ages upon request for pre-sentence investigations or other diversion processes.</p> <p>8.9.2.5 Assure mentally ill offenders of all ages who are diverted to and/or returning to the community are offered medication monitoring, and linkage with community supports.</p> <p>8.9.2.6 Prominently display brochures and other materials provided by consumer/family advocates regarding issues relating to mentally ill offenders in jails, juvenile detention, prison and juvenile rehabilitation facilities reception areas.</p> <p>8.9.2.7 Maintain interagency collaboration at the local or Member Government level related to people with mental illness who are in the criminal justice system, with [various divisions and agencies] and other agencies and stakeholders that are integrally involved in providing services to enrolled consumers.</p> <p>13. CROSS SYSTEM PARTNERSHIPS</p> <p>13.1 The Member Government shall work in active partnership with the</p>

Table 5: Case Management and Referral Interagency Relationships			
Cell	State	Master Agreement Language	Provider Agreement Language
			<p>following allied community providers at the local or Member Government level to ensure that service recipients receive a balanced, coordinated and individualized array of quality supports and services:...</p> <p>13.1.13 county jails and Department of Corrections;...</p>

Part E. Study Limitations, Conclusions, and Implications

Study Limitations

This study has several limitations, including:

- Our sample of study states was partly a convenience sample and therefore not completely random. We selected this convenience sample based on the contracts available to us through the collection process carried out by GWU for three separate, albeit related, studies (the Negotiating the New Health System series of studies, the study of employee benefit contracts, and the study of behavioral health provider contracts). We chose one-third of our study states from a pool of eight state employee benefit contracts, two-thirds of our study states from 13 Medicaid behavioral health carve-outs, and all nine study states from 39 Medicaid general service agreements. We narrowed down the number of states to nine by matching states from which we collected state employee benefit contracts and/or Medicaid behavioral health carve-outs with the 17 states from which we collected provider contracts. As a result of the selection process, our sample represents states with higher levels of managed care penetration and larger numbers of state employees than most states, and over-represents states with experience in designing managed care arrangements tailored to behavioral health needs. While our findings may not be generalizable to the experience of other particular states, our sample allows us to examine whether and how managed care organizations delegate duties to providers as well as what the implications of that devolution are for managed behavioral health care.
- Because data collection took place in separate phases, we were unable to ascertain if the source of the provider contract was the prime contractor or a middleman (i.e., a network entity). As pointed out above, this inability to distinguish between the two types of arrangements could be problematic, since it suggests that the managed care organizations may be entirely responsible for the imperfect devolution or otherwise share this responsibility with a subcontracting network supplier. However, whether the middleman is the source of the imperfect devolution is irrelevant for purposes of this study, since the prime contractor holds the final responsibility to delegate duties and thus has to make sure that the delegations are correct.
- Applying the comprehensive review instrument developed for Medicaid general service agreements to Medicaid behavioral health carve-outs could be considered “unfair,” since it implies that Medicaid behavioral health agencies have an obligation to address all of the populations of the Medicaid program when, in fact, they deal with a subset of the Medicaid population. While this is a limitation, we nevertheless believe that using the same instrument remains a valid approach for the purpose of comparing each type of master contract with the provider contracts. GWU has tested and used this approach for its review of Medicaid general service agreements and Medicaid behavioral health carve-out agreements for three consecutive years. And while Medicaid behavioral health carve-outs have a narrower population and scope of service focus than do the Medicaid general service agreements, they can nevertheless be expected to address major structural issues related to the delivery of behavioral health services that are of central importance (e.g., coverage rules, care coordination, composition of the provider network). Regardless of whether the populations vary, the contractual domains that must be addressed remain the same in order to achieve a legal contractual standard.

Conclusions and Implications

The findings presented in this study underscore the enormous challenges faced by managed care organizations, health care providers, group purchasers, and most importantly perhaps, individual members, whenever a group health purchaser attempts to buy a customized managed care product. As with any marketer of complex goods and services, the managed care industry needs to build products that can be sold in mass quantities to group purchasers. The products need to be designed to meet the standardized needs of most consumers in order to ensure a market of adequate size. Some limited customization (i.e., differential cost sharing, supplemental provider networks, a point of service option) can be accommodated with relative ease. However, once a buyer wants a product that is so unique as to fall outside the types of customization requests that reasonably can be anticipated, an industry may experience significant difficulties accommodating the demands. The purchaser in turn ends up with a product that does not function as expected. The intended beneficiaries of the product (in this case the members who are entitled to receive the customized product) might receive care that is significantly different from what is expected. Other intended beneficiaries of customization, such as network providers in this case, might also end up losing the advantages that the master contract attempts to give them.

Where a group purchaser is very large and possesses enormous market power and/or where the purchaser can pay very well, it may be more feasible to accommodate this desire for customization. However, this is not the case for Medicaid agencies. Unlike state employee benefit plans (whose need for customization appears to be virtually non-existent, as one would expect, given the nature of their membership), Medicaid agencies need to buy carefully tailored products, and their contracts reflect the magnitude of their effort. Unfortunately, Medicaid agencies represent only a small proportion of all managed care purchasing in a state once public and private employers are factored in. Furthermore, studies suggest that their payments are low in relation to the cost of the products they need to buy.²¹ As a result, the agencies are in a poor position to turn their desires for customization into reality.²² This gap between the need for specialty products and the ability to pay for them probably helps explain the exodus of commercial companies from the Medicaid business.²³

This study underscores the paradox that confronts all of the parties to the Medicaid managed care purchasing enterprise. On the one hand, Medicaid managed care works only if the standard managed care product is customized to account not only for patient needs but also for federal legal requirements. On the other hand, this study suggests what much of the industry already knows: that customization is very difficult if not impossible to achieve for the reasons discussed above.

What are the options? Medicaid agencies might consider working exclusively with managed care organizations that do sufficient Medicaid work to be able to understand how a standard product needs to be customized. This option, which is increasingly a reality for agencies in markets with fewer commercial participants, also means that Medicaid beneficiaries will not have access to large commercial companies. This may or may not be a problem, depending on the quality and stability

²¹ See, e.g., Pamela Lopresti and Gregory Acs, "Profile of Disability Among Families on AFDC," The Urban Institute (August 1996).

²² Sheila Hoag, Judith Wooldrige, and Craig Thornton, "Setting Rates for Medicaid Managed Behavioral Health Care: Lessons Learned," 19 Health Affairs 4:121-133 (July/Aug. 2000).

²³ Robert E. Hurley and Michael J. McCue, "Partnership Pays: Making Medicaid Managed Care Work in a Turbulent Environment," prepared for the Center for Health Care Strategies, Inc. (May, 2000).

of the Medicaid-only plans. Studies suggest that plans that do business only with Medicaid actually furnish care of higher quality, at least in certain respects, than companies that serve a range of sponsors.²⁴ But the notion of Medicaid-only managed care runs counter to the goals of many agencies.

Another option is to abandon full-service managed care and “make,” rather than “buy,” the pared down managed care product. That is, a Medicaid agency could act as its own MCO, building a network, hiring a third-party administrator with the requisite skills to run a Medicaid business, and not contracting out risk services to any MCO, specialized or otherwise. This might be a viable option in some states, where agencies are given extensive staff and resources. In other states, agencies are very limited in the support they receive and could not oversee their own plan.²⁵

A third option for a Medicaid agency would be to buy only standardized managed care products and retain direct responsibility for provision and payment of all Medicaid covered services that exceed the standards of a typical commercial product. In such a situation, an agency’s responsibility would be not for merely a few additional services and benefits but for a broad range of care (both entire classes of benefits as well as benefits that exceed commercial amount, duration, and scope limits). In managed behavioral health care, wrapping around a “standard” product might be infeasible as a practical matter, because the gulf between what is a “standard” product and what Medicaid covers is especially large, given the current tight controls exercised by managed care over consumption of behavioral health resources and plan design.

Whatever pathway chosen by a state agency will not be easy, for this study also suggests that agencies must pay extremely close attention to provider agreements and the devolution effect (as two of our study states appear to do). The companies with whom an agency works depend entirely on their suppliers to furnish the services the companies contract to provide to the agency and its beneficiaries. If the companies are unable to accurately translate these duties down to the provider level, the agency has little chance of realizing the results of its purchasing expectations.

This study should be a strong indication to both providers and consumers regarding the need to pay close attention to provider contracts. Actual living provider agreements, such as the ones reviewed for this study, are generally not available for inspection. However, a state agency could insist on the use of a standard, pre-approved agreement that ensures conformity to the master contract. This is an issue that merits close attention as stakeholders work with agencies on the development of managed care systems. Similarly, providers and consumers alike should insist on the provision of clear and detailed information to providers regarding the ways in which a Medicaid managed care product has been customized, as well as the services and benefits to which both consumers and providers are entitled. Otherwise, the potential for essential benefits to be lost in the translation from master to sub-contract is enormous.

Finally, this study raises numerous questions for future health services research. This project examined issues of paper devolution that help explain the difficulties in making Medicaid managed care work. Yet no specific study of the devolution of customization ever has been pursued. How

²⁴ Arnold M. Epstein, “Medicaid Managed Care and High Quality: Can We Have Both?,” 278 JAMA No. 19, pp. 1617-1621 (November 19, 1997).

²⁵ James W. Fossett et al., “Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers?,” 19 Health Affairs 4:36-49 (July/Aug. 2000).

do MCOs internalize these types of customized specifications? How do they attempt to translate them to providers and members? How do providers in turn absorb these alterations and respond to them? Do customized expectations in the areas of access, coverage, treatment, and organizational scope actually ever reach the members? These are critical questions that could determine the future of customized managed care products, and they should be pursued. If the paper pathway for customization looks bad but in fact customization works well in practice, then the problem could be viewed as simply a legal one for MCOs. That is, their failure to capture customization in their provider agreements means that they cannot legally enforce their customization expectations if they do not get what they expected. However, it is doubtful that the reality of customization practice is a good deal better than the paper suggests. In this case, additional health services research becomes essential, because it relates to a basic problem that confronts health care policy makers: how to adapt the new health system to the millions of the most vulnerable children and adults who fall outside of pre-established industry norms.

Appendix—Study Review Instrument

I. SERVICES

General Services:

- 56. Hospital inpatient services
- 57. Hospital outpatient services
- 58. Laboratory and X-ray
- 59. Physician services
- 60. Nurse midwife services
- 61. FQHC and rural health clinics
- 62. EPSDT
- 63. Home health care
- 64. Nurse practitioners
- 65. Dental care
- 66. Durable medical equipment (DME)
- 67. Mental health and substance abuse
- 68. Prescription drugs
- 69. Case management
- 70. Other
- 70a. Treatment services for individuals with dual diagnosis

2.2 Mental Health and Substance Abuse Duties:

- 71. Care coordination/case management
- 72. Crisis care
- 73. Family therapy
- 74. Individual therapy
- 75. Group therapy
- 76. Hospital detoxification
- 77. Inpatient services for persons under 21
- 78. Long-term residential
- 79. Medication management
- 80. Non-hospital residential detoxification
- 81. Outpatient treatment
- 82. Partial day treatment programs
- 83. Prescribed drugs
- 84. Preventive health services
- 85. Referrals
- 86. Screening, assessment and diagnosis
- 87. Short-term residential (includes hospital)
- 88. Transportation
- 89. Other
- 89a. Service limits and exclusions

2.3 Reproductive Health Services:

- 90. Maternity coverage
- 91. Enhanced prenatal care
- 92. Parenting Education
- 93. Family planning services
- 94. IUD
- 95. Depo provera
- 96. Norplant
- 97. Other contraceptives
- 98. Infertility services
- 99. Other gynecological services

2.4 EPSDT Services:

- 100. General definition
- 101. Immunization
- 102. Developmental/interperiodic screening
- 103. Vision services
- 104. Hearing services
- 105. Dental services
- 106. Other diagnosis and treatment
- 107. Other activities
- 108. Exclusions

2.5 *Communicable Disease Services:*

- 109. Sexually transmitted diseases (STD)
- 110. HIV/AIDS
- 111. Tuberculosis
- 112. Immunizations

2.6 Urgent Care and Emergency Care Services:

Urgent care

113. Coverage

114. Definition

Emergency care

115. Coverage

116. Definition

117. Coverage for urgent and emergency out-of-plan

118. Definition of emergency specific to mental health or substance abuse

Definition of pediatric emergency

119a. Definition of pregnancy-related emergency

2.8 *Services in Treatment Plans of Other Agencies and Court Orders:*

- 126. Individualized Family Service Plan -IFSP (birth to 3 years)
- 127. Individualized Education Plan-IEP (3 to 21 years)
- 128. Children in foster care or out-of-home placement
- 129. Services in court orders or justice system plans
- 130. Mental health agency treatment plan
- 131. Substance abuse agency treatment plan

II. COVERAGE DECISIONS

2.7 *Medical Necessity Standards:*

- 120. General coverage rule
- 121. Medical necessity standard
- 121. Pediatric medical necessity standard
- 123. Mental health or substance abuse related medical necessity standard
- 124. Pregnancy-related medical necessity standard
- 125. TB-related medical necessity standard
- 125a. Dual diagnosis medical necessity standard

3.5 Utilization Review and Prior Authorization:

- 154. Utilization review process
- 155. Prior authorization prohibited for certain procedures
- 156. Reviewers clinically competent
- 157. Time limits for prior authorization
- 158. 24-hour telephone access for prior authorization
- 159. Assessment of under-utilization required
- 160. Required to use review or authorization for mental health and substance abuse
- 160a. Required to use review or authorization for dual diagnosis
- 161. Provision for expedited prior authorization

3.9 *Drug Formularies:*

- 183. Drug formulary permitted
- 184. Time limits for approval of off-formulary drugs
- 185. Prior authorization for drugs on formulary
- 186. Periodic review and update of formulary
- 186a. Substitution of therapeutic equivalence
- 186b. Drug use/utilization review

III. CONDITIONS OF PARTICIPATION IN THE NETWORK

3.1 Provider Network Composition:

- 132. Hospitals and other institutions
- 133. Mental health and substance abuse providers
- 134. Obstetric providers
- 135. Pediatric providers
- 136. Pharmacies
- 137. Primary care providers
- 138. Primary care provider/patient ratios
- 139. Specialty care providers
- 140. Specialty care provider/patient ratios
- 141. Traditional and safety net providers
- 141a. Dual diagnosis providers

3.2 Plan Service Area Standards:

- 142. Service areas defined
- 143. Plan analysis of service area needs

3.3 Selection and Assignment of Primary Care Providers:

- 144. Selection process
- 145. Selection guarantee
- 146. Selection for patients under treatment
- 147. Selection time limit for member
- 148. Assignment of non-selecting members
- 149. Changes in primary care provider selection/assignment

IV. CASE MANAGEMENT AND REFERRAL OBLIGATIONS

3.1.1 Provider Coordination and Standards:

- 132.1 Hospitals and other institutions
- 133.1 Mental health and substance abuse providers
- 134.1 Obstetric providers
- 135.1 Pediatric providers
- 136.1 Pharmacies
- 137.1 Primary care providers
- 139.1 Specialty care providers
- 141.1 Traditional and safety net providers
- 141a.1 Dual diagnosis providers

3.4 Self-referrals to Selected Providers:

- 150. Mental Health
- 151. Substance Abuse
- 152. Obstetrics
- Family planning
- 153a. Other

4.1 Relationships with Other Public Agencies:

200. Adult correction
201. Adult welfare
202. Child welfare
203. Children with special health care needs
204. Early intervention
205. Homeless health
206. Juvenile justice
207. School health clinics
208. Special education
209. State/local public health
210. State/local mental health
211. State/local substance abuse
212. State senior services
- WIC Supplemental Nutrition
- 213a. Head Start

[illegible]

V. *ACCESS DUTIES*

3.6 *Translation Services and Cultural Competence:*

- 162. Multi-lingual providers in network
- 163. Disability-communication capacity required in network
- 164. Materials in other language or in form useful to people with disabilities
- 165. Services for persons whose primary language is not English
- 166. Services for persons with speech, language, hearing, or vision related disabilities

Cultural competence

- 167. Cultural competence requirement
- 168. Cultural competence defined

3.7 Access Time Standards:

- 169. Emergency care
- 170. First appointments for new enrollees
- 171. Medically necessary/acute care adult visits
- 172. Medically necessary/acute care pediatric visits
- 173. Specialty specific services
- 174. Preventive pediatric visits
- 175. Preventive adult visits
- 176. Services for mental illness
- 177. Services for pregnant women
- 178. Services for substance abuse disorders
- 179. Urgent care

3.8 *Geographic Access Standards:*

- 180. For primary care providers
- 181. For specialty or inpatient care providers
- 182. For other benefits or services

3.10 *Anti-discrimination provisions:*

- 187. Age
- 188. Anticipated need for health care
- 189. Disability
- 190. Gender
- 191. Income
- 192. Language
- 193. Medicaid status
- 194. Mental health status
- 195. Pre-existing condition or health status
- 196. Race/ethnicity
- 197. Sexual preference
- 198. Substance abuse status
- 199. Other

VI. PAYMENT TERMS

6.3 Network Provider/Plan Relationship:

Risk adjustment in provider evaluations

Stop loss insurance for providers

259a. Restrictions on physician incentive agreements

7.1 Plan Payment Terms:

- 274. Premium includes all covered services
- 275. Fee-for-service for some or all covered services
- 276. Withholding of payments
- 277. State delegation of third party liability collection
- 277a. Actuarially sound capitation rate

7.2 Provider Payment Terms:

278. Time lines for payment to network providers
279. Special payments for certain classes of providers
280. Payment rules for non-network providers
281. Cost sharing

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. On the left side, there is a vertical margin line, creating a narrow left margin. A small portion of a yellowed piece of paper is visible at the bottom left corner, partially underneath the main sheet.