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WORKING PAPER

Negotiating the New Health System: Findings from a Nationwide Study of Medicaid Primary Care Case Management Contracts

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IN BRIEF

These findings are the results from a study of 27 primary care case management (PCCM) contracts between state Medicaid agencies and primary care providers that were effective in the Fall of 1999:

Overall Findings Regarding Business Terms in PCCM Contracts

- PCCMs condition receipt of benefits through a provider network.
- PCCMs are unlikely to be structured as a contract at-will.
- PCCMs are unlikely to use compensation as a means of inducing care.
- PCCMs are likely to delegate broad decision-making powers regarding individualized treatment decisions to a network.
- The extent that PCCMs use grievance, appeal, and fair hearings is unknown from the contract.

Findings Regarding Beneficiary Access in PCCM Contracts

- PCCM contracts are specific to the Medicaid business and contain extensive provisions clarifying the obligations of contractors to conduct their operations in conformity with the general requirements of Medicaid.
- PCCM providers must administer primary care as well as manage coverage decision-making relating to numerous classes of specialty services affecting both acute and long-term physical and mental health conditions.
- PCCM contracts can be unclear about the scope of a provider's obligations regarding coverage, particularly in the area of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.
- All PCCM providers are required to serve all Medicaid sub-populations.

Executive Summary

This study was prepared by The George Washington University, Center for Health Services Research and Policy with support from the following organizations: the Center for Health Care Strategies, Inc; The David and Lucile Packard Foundation; the Substance Abuse and Mental Health Services Administration; and the Centers for Disease Control and Prevention. The review presents findings from the first nationwide study of Medicaid primary care case management contracts.

More than half of all Medicaid beneficiaries are enrolled in some form of managed care. In 2000, 28 state Medicaid agencies used primary care case management for some or all of their Medicaid population. Under PCCM systems, "primary care" means all health and laboratory services customarily provided by a physician in accordance with state law. "Primary care case management services" means related activities such as locating, coordinating, and monitoring health care services. State Medicaid agencies act as managed care organizations (MCO), contracting with a network of primary care case managers to perform both sets of duties. PCCMs vary in size from small office-based practices to large medical groups.

The contract reviews produced the following principal findings:

- PCCM contracts are specific to the Medicaid business and contain extensive provisions clarifying the obligations of contractors to conduct all phases of their operations in conformity with the general requirements of Medicaid.

- Although there may be variation in the operational scope of state PCCM programs, the contracts are highly similar in the broad scope of both clinical and administrative duties assigned to PCCMs in the areas of patient care, coverage determinations, and the management of patient use of resources for specialty care.

- While all contracts exclude one or more classes of benefits from either provision of care or case management responsibilities, many contracts contain important ambiguities regarding what is "in" and what is "out," particularly in the area of Early and Periodic Screening, Diagnosis and Treatment services.

- The contracts require service to all sub-populations. PCCMs must assume both clinical primary care responsibilities as well as varying degrees of responsibilities for the management of clinically complex cases, including oversight of specialty coverage and use of resources by specialists. Some of the contracts enumerate certain specific additional duties for patients who are members of key sub-populations.

- PCCM providers may face significant levels of professional liability for the quality of care patients receive. With limited exceptions, the contracts do not set forth standards for care or case management. Providers may not be familiar with the full scope of their duties at the time they sign the agreement.

- The contracts have significant implications for persons with special health care needs and disabilities. The advanced care management duties and capabilities that may be required for such beneficiaries are not spelled out in these agreements, and thus may not be enforceable.

The findings from this analysis suggest the need for further study to determine:

- Whether policies should be developed regarding the appropriate role of a primary care case manager.
- Whether providers with generalized knowledge can manage the specialized care needs of some populations, or whether specialized agreements would ensure better health care.
- Whether PCCM contracts should be required to demonstrate an ongoing arrangement with certain related providers and programs.
- Whether PCCM contracts should require performance standards in the areas of physical and mental health, with safeguards instituted for performance monitoring.
- Whether standards should be developed to measure the competencies of PCCM providers who are vested with treatment decision-making powers.
- Whether detailed specifications for PCCM arrangements defining coverage determinations should be developed.
- Whether the case management fee levels are sufficient given the range of responsibilities undertaken.
- Whether further study is needed to determine if PCCMs yield better outcomes (particularly for higher need patients), more satisfied patients, or more stable and satisfied providers than other managed care systems.
- Whether contractors should be required to notify beneficiaries of their fair hearing rights, provide internal systems for review of grievances and appeals, establish systems to include expedited procedures for urgent cases, and develop external review systems.

Introduction

This study was prepared by The George Washington University, Center for Health Services Research and Policy with support from the following organizations: the Center for Health Care Strategies, Inc; The David and Lucile Packard Foundation; the Substance Abuse and Mental Health Services Administration; and the Centers for Disease Control and Prevention. This Working Paper presents findings from the first nationwide study of Medicaid primary care case management contracts. The report examines standard agreements between state Medicaid agencies and providers of primary care case management services (hereinafter referred to as PCCM contracts). Given the renewed interest in this type of managed care arrangement, as well as the enactment of the Balanced Budget Act of 1997 expanding state authority to use both PCCM and MCO options, we concluded that such a study would be useful.

Analytic Methods

This analysis provides a nationwide study of contracts between state Medicaid agencies and primary care providers. Twenty-eight state agencies were identified that maintain PCCM systems[1] as of Fall 1999. The standard PCCM network contracts were solicited from those agencies. The process produced 27 PCCM agreements.[2]

The contract review instrument that was developed was a modified version of the provider contract review instrument developed for previous provider network studies.[3] The analysis focused on the core issues that directly relate to the essential elements of a managed care organization's relationships: 1) the basic nature of the relationship; 2) the degree of delegation and autonomy over treatment decisions delegated to the network; 3) compensation; 4) quality improvement and measurement; 5) the level of specificity and detail; 6) the assignment of health care and administrative duties; and 7) the degree of coverage required for the Medicaid sub-populations.[4]

Both the documents and discussions with state agencies indicated that PCCM contracts typically operate as a supplement to the standard Medicaid provider participation agreement. As a result, the provisions of these basic standard provider participation agreements remain in full force and effect, except to the extent that they are superseded by the specific terms of the PCCM contracts.

Background and Overview

More than 90 percent of privately insured Americans and more than half of all Medicaid beneficiaries are enrolled in some form of managed care. Most Medicaid beneficiaries are members of comprehensive service managed care organizations;[5] at the same time, a number of states use primary care case management systems in Medicaid, particularly in sparsely populated areas, or where the MCO market is not sufficiently developed or strong. PCCM style managed care also may be used for populations whose special health needs place them beyond the capabilities of the existing MCO market.[6] Still other states continue to use PCCM arrangements to promote a more competitive environment in cases where there is little or no MCO competition for Medicaid business. Finally, a state may use a PCCM system as a means of ensuring

that if the MCO market shifts or shrinks, it will not be left without managed care capabilities. Table 1 shows the managed care contracting arrangements used by state agencies as of 2000.

Table 1. Managed Care Arrangements under State Medicaid Programs*

State	PCCM Arrangement**	One or More MCO Arrangements***
Alabama	√	
Alaska †		
Arizona		√
Arkansas	√	
California	√	√
Colorado	√ ****	√
Connecticut		√
Delaware		√
District of Columbia		√
Florida	√	√
Georgia	√	√
Hawaii		√
Idaho	√	
Illinois		√
Indiana	√	√
Iowa	√	√
Kansas	√	√
Kentucky	√	√
Louisiana	√	
Maine	√	
Maryland		√
Massachusetts	√	√
Michigan		√
Minnesota		√
Mississippi	√	
Missouri		√
Montana	√	√
Nebraska	√	√
Nevada		√
New Hampshire		√
New Jersey		√
New Mexico		√
New York	√	√
North Carolina	√	√
North Dakota	√	√
Ohio		√
Oklahoma	√	√
Oregon		√
Pennsylvania	√	√
Rhode Island		√
South Carolina		√
South Dakota	√	
Tennessee		√
Texas	√	√
Utah		√
Vermont	√	
Virginia	√	√
Washington	√	√
West Virginia	√	√
Wisconsin		√
Wyoming †		
Total	28	41

* As of Summer 2000.
** Primary care case management arrangements as defined under §1905(t) of the Social Security Act, 42 U.S.C. §1396d(t).
*** MCO arrangement as defined under §1903(m) of the Social Security Act, 42 U.S.C. §1396b(m). A state may have more than one class of MCO arrangements (e.g., general and behavioral health and other specialty contracts).
† No managed care in 2000.
**** State does not utilize a contract, but uses a Letter of Agreement, which was not collected.

During the 1999-2000 time period when this study occurred, a total of 40 states and the District of Columbia reported that they utilized one or more types of managed care arrangements. Of the 28 states that maintained PCCM arrangements, eight states (AL, AR, ID, LA, ME, MS, SD, VT) reported that they maintained only PCCM arrangements and had no full-risk MCO contracts in effect.

General Findings Regarding Terms in PCCM Contracts

1. The level of specificity and detail. PCCM contracts are specific to the Medicaid business and contain extensive provisions clarifying the obligations of contractors to conduct all phases of their operations in conformity with the general requirements of Medicaid. More than agreements between MCOs and state Medicaid programs, the PCCM contracts range in their complexity and in the level of detail they contain regarding the contractor's obligations in the areas of primary care, all phases of case management, quality improvement and performance measurement, and data and reporting. Unlike the provider agreements developed by MCOs, Medicaid PCCM contracts are for a fixed, specific term rather than "evergreen" (i.e., without an end date).

2. Assignment of significant health care and administrative duties to PCCM providers. Although there may be variation in the operational scope of state PCCM programs, the contracts are highly similar in the scope of both clinical and administrative duties assigned to PCCMs in the areas of patient care, coverage determinations, and the management of patient use of resources for specialty care. PCCM providers are responsible not only for providing primary care but for managing coverage decision-making relating to numerous classes of specialty services affecting both acute and long-term physical and mental health conditions. Providers who sign these agreements are under an obligation to oversee a broad range of preventive, treatment, and long-term care services, render coverage determinations, and make decisions that can affect access to most covered services under a Medicaid plan. The contracts are less comprehensive than those used with MCOs, but from a patient and health care quality perspective, the duties appear to be no less significant.

The care and case management functions assigned to PCCM contractors are at least as complex as those assigned to MCOs, even though the typical PCCM may lack the type of corporate structure necessary to permit the entity to engage in coverage decision-making, care of complex cases, and oversight of specialty practices. The same complex interaction between managed care and Medicaid requirements that arise with respect to MCO contracts are also present in the case of the PCCM agreements.

3. Providers' liability. PCCM providers may face significant levels of professional liability for the quality of care patients received, because their authority extends not only to the services they directly provide or arrange for, but also the quality and timeliness of specialty care. Despite the reach of the contracts, none provides for added threshold qualifications relating to the classes of patients assigned to a practice, and there are relatively few diagnosis-specific conditions of participation in the area of case management. With limited exceptions, the contracts do not include standards regarding coverage determinations and notice to patients, provider relationships with specialists, or access standards in the areas of specialty and referral services, language or cultural access, disability access, or standards for the timely provision of health services. Provider manuals may offer greater specificity in these areas. Yet, although most contracts indicated that

providers must comply with the manuals, in only a few cases did the PCCM standard package include the manual attachments as part of the initial agreement. This means that providers may have little familiarity with the full scope of their duties at the time they sign the agreements.

4. Application of the contracts to all Medicaid sub-populations. We found that the contracts are structured to require service to all sub-populations by contractors meeting the basic PCCM participation rules (i.e., status as a primary care specialist, state licensure, and agreement to comply with the terms of the agreement). The contracts stipulate that PCCMs will assume both clinical primary care responsibilities as well as varying degrees of responsibilities for the management of clinically complex cases, including oversight of specialty coverage and use of resources by specialists. A few of the contracts enumerate certain additional duties for patients who are members of key sub-populations. As a general rule, the working assumption inherent in the agreements is that while the agreement is tailored to the Medicaid program, the duties of a primary care case manager are sufficiently common regardless of age, health status, or diagnosis, so that a primary care specialist is capable of carrying out case management duties.[7]

One notable exception to this contractual obligation to accept all patients into a practice can be found in the Mississippi contract. The state's agreement contains a unique provision that permits a PCCM provider to request an exclusion from the state's program on behalf of certain enrollees with complex conditions if, in the provider's judgment the condition requires a level of management expertise that extends beyond the provider's capabilities, as long as the provider agrees to continue to furnish primary care. The contract provides as follows:

> Please confirm that the individual named below has a medical condition which you have been treating and exclusion from the HealthMACS managed care program is needed for you to continue management of this condition. Exclusion *** can be allowed only if you agree to:

(1) Confirm the medical condition and advise that you will continue to treat and manage the health care for this person because of it.

(2) Continue to treat and manage the condition.

(3) Provide primary health care to this person and refer him/her for any specialty services needed.

> This condition should be one that cannot be managed by a primary care physician. You will need to provide sufficient information for review by Division of Medicaid medical personnel to confirm that this person should be approved for exclusion from participation in *** HealthMACS ***.
> ***Mississippi contract, Attachment E***.

The Mississippi contract permits a primary care specialist to elect not to assume case management responsibilities for a patient who lies outside of the specialist's area of clinical competence, as long as the practitioner does not refuse to provide primary care to the patient. This provision would require the state to locate an alternative contractor to perform case management and specialty service functions.

The findings from this review carry significant implications for persons with special health care needs and disabilities. Recent studies suggest that PCCM arrangements are increasingly used in the case of persons with disabilities. Because PCCM contracts are drafted to apply to all enrollee sub-populations, the advanced care management duties and capabilities that would be required in the case of PCCM arrangements for such beneficiaries are not spelled out as an enforceable agreement.

5. Ambiguity regarding where the contract ends and direct access to health care begins. While all contracts exclude one or more classes of benefits from either provision of care or case management responsibilities, many contracts contain important ambiguities regarding what is "in" and what is "out," particularly in the area of EPSDT services. This ambiguity in the scope of a contractor's obligations is discussed at greater length in Part 2.

Part One: Business Requirements between the Contracting Parties in State Medicaid PCCM Contracts

We studied the essential elements of managed care arrangements with both the state Medicaid agency and the beneficiaries they serve. The results of our research are shown in a table format, and we provide examples of actual contract language to illustrate the different methods that state Medicaid agencies employ to address these elements.

The elements essential to Medicaid PCCM arrangements are:

- *The basic nature of the relationship*. Private MCO contracts are a special type of contract termed an at-will contract.[8] The question here was whether Medicaid PCCM contracts would specify a term or operate on a similar at-will basis.

- *The degree of delegation and autonomy over treatment decisions delegated to the network*. Private MCO/network contracts control treatment decision-making by their networks by expressly retaining legal authority to determine the necessity of care. At the same time, contracts may extend to networks a large degree of responsibility for treatment decisions (increasingly this delegated authority is tied to practice guidelines and incentive payment structures). The issue here was whether Medicaid PCCM contracts would follow this dual structure of extensive delegation coupled with retention of final decision-making powers.

- *Compensation*. Private agreements use base payments coupled with incentives and withholds. We sought to determine the extent to which Medicaid agencies use similar payment structures with PCCMs.

- *Quality improvement and measurement*. Private MCO agreements typically contain provisions allowing external review of the quality of care. We sought to determine whether Medicaid agencies exercise similar authority over health care quality measurement with PCCMs.

Our findings are summarized in Table 2.

Table 2.
Selected Business Requirements between the Contracting Parties in State PCCM Contracts

State	Contracts At-Will	Treatment Decisions/ Utilization Management by PCCM	Prior Authorization from Agency	Performance Incentives	Provider Withholds	External Review of Contractor Performance
AL	√	√				√
AR		√				
CA		√		√		√
CO *						
FL	√	√				√
GA		√				√
IA		√			√	
ID		√				√
IN		√			√	√
KS	√	√			√	
KY	√	√			√	
LA		√				√
ME		√				
MA		√		√		√
MS		√				
MT		√				
NE		√	√			√
NY		√				√
NC		√				√
ND		√				
OK		√		√	√	√
PA		√				√
SD		√				
TX		√		√		√
VT		√				
VA	√	√				
WA	√	√				
WV		√				
Total	6	27	1	4	5	14

* Colorado does not use a contract, so information from that state was not reviewed.

1. The Use of At-Will Contracts. An at-will contract permits either party to terminate its relationship at any time for any reason. Privately operated MCOs often employ such contracts to maximize control over the providers. However, our research reveals that at-will contracts are extremely rare in Medicaid, presumably because of the difficulties obtaining provider participation in the program. Only six states include an at-will termination clause; most states specify a term, for a typical duration of two years.

Alabama provides an example of at-will language. Alabama is the only state that reserves the right to terminate a provider without a specified notification period:

Section Four: PMP Participation…
B. PMP Termination. . .
4. Medicaid may terminate the Patient 1st agreement with or without cause upon written notice to the PMP. ***Alabama PMP, p. 8.***

Florida, Kentucky, Virginia, and Washington require 30 days notice before termination for any reason. The following example illustrates typical language found in these contracts:

1. Termination (General). . .
b) Either party may terminate this agreement without cause upon 30 days written notice. ***Florida Agreement, p. 12.***

Kansas permits termination of its contract by either party with 60 days notice:

G. Procedures for Termination of Contract
This contract may be cancelled by either party at any time without cause upon giving the other party written notice at least 60 days in advance of the effective date of such cancellation. ***Kansas Contract, p. 5.***

2. Contractor Authority to Carry out Treatment Decisions and Utilization Management and Agency Discretion to Pre-Authorize Specified Treatments. Medicaid PCCM contracts delegate to their networks broad authority to carry out the utilization management and treatment decision-making functions that all Medicaid agencies must perform as a matter of federal law. Contracts with PCCMs vest broad authority in their networks, typically as part of their case management responsibilities. Furthermore, the contracts do not condition this delegation of authority on specific demonstrated competencies in the area of case management.

The contracts vary in how they describe their contracting provider's treatment decision-making functions. The following examples provide a sense of the range of state approaches to utilization management and treatment decision-making functions as part of case management.

California provides an example of a broad, general definition of the PCP's case management duties:

Article II… J. Case Management means responsibility for referral, consultation, ordering of therapy, admission to hospitals, follow-up care, and prepayment approval of referred services. It includes responsibility for locating, coordinating, and monitoring all medical care on behalf of a member.

Article V – DUTIES OF THE CONTRACTOR
In discharging its obligations under this contract, the Contractor will:
A. Provision of Services
Provide or arrange for the provision of all covered services and provide case management to a voluntarily enrolled population of eligible beneficiaries. ***California Contract, pp. 3, 17.***

Indiana requires that all services conform to "universally accepted standards," while Mississippi requires that services be "appropriate":

1. Role of the Primary Medical Provider…
[T]he PMP will provide, or will arrange for the provision of, routine comprehensive preventive services, medically necessary primary care treatment and urgent care services, in keeping with the universally accepted standards as defined by Article II, Paragraph 1, of this Addendum. ***Indiana Contract, p. 1.***

* * *

> 4.07 Functions and Duties of the Primary Care Provider
> Responsibilities of the PCPs include the following: . . .
> 6. Determine the medical necessity for and approve/authorize, when appropriate, non-emergency care covered under HealthMACS.
> 7. Make referrals when appropriate. Referrals may include services covered under HealthMACS or Medicaid services not covered under HealthMACS but covered generally under the Mississippi Medicaid program. . . .
> 8. Approve/authorize, any follow-up consultations and/or treatment, subsequent to making a referral to a specialist for consultation and/or treatment of a specific condition, of the duration of the illness. This includes services rendered by the specialist and referrals for related service made by the specialist.
> 9. Approve/authorize, when appropriate, treatment for urgent or emergency care in accordance with HealthMACS provisions relating to those services. ***Mississippi Manual, pp. 76-77.***

The New York contract uniquely addresses special populations when describing the PCP's case management duties:

> 10.15(a) Adults with Chronic Illnesses and Physical or Developmental Disabilities
> The PCPCP and the PCP/Contractor agrees to implement all of the following to meet the needs of their adult Enrollees with chronic illnesses and physical or developmental disabilities: . . . (iii) Satisfactory case management systems to ensure all required services are furnished on a timely basis…
>
> 10.15(b) Children with Special Health Care Needs . . .
> The PCPCP and PCP/contractor will be responsible for performing all the same activities for this population as for adults. . . .
>
> 10.15(c) Member Needs Relating to HIV . . .
> To adequately address the HIV prevention needs of uninfected Enrollees, as well as the special needs of HIV positive (+) individuals who do enroll in managed care, the PCPCP and the (PCP/Contractor) shall have in place all of the following: . . . (iv) Satisfactory case management systems to ensure that all necessary services are furnished on a timely basis. Special attention should be paid to establishing linkages with traditional HIV providers, such as Aids Designated Treatment Centers (ADTCs), community provider, and clinical education programs as a means of obtaining the most current treatment guidelines and standards. ***New York Contract, pp. 29-32.***

Additionally, New York has broadened the case management responsibility to include a more inclusive program for some populations:

> Comprehensive Medicaid Case Management (CMCM): A program which provides 'social work' case management referral services to a targeted population (e.g., pregnant teens, mentally ill). A CMCM case manager will assist a client in accessing necessary services in accordance with goals contained in a written case management plan. . . . Some of these services are medical, social, psycho-social, education, employment, financial, and mental health. CMCM referral to community service agencies and/or medical providers requires the case manager to work out a mutually agreeable case coordination approach with the agency/medical provider. Consequently, if an Enrollee of the Contractor is participating in a CMCM program, the Contractor should work collaboratively with the CMCM case manager to coordinate the provision of services covered by the Contractor. ***New York Contract, Appendix L, pp. 5, 6.***

While agencies typically delegate broad decision-making powers to their contractors, they seldom expressly retain control over final decisions regarding the need for treatment. Nebraska's contract provides the only example of an agreement that specifies that a PCP must obtain the prior approval of the state agency before providing or arranging for one or more services. As the excerpt

below illustrates, even in this case, the need for prior authorization is limited to narrowly restricted procedures:

> 7.38.2 Services Requiring Prior Authorization by the Department: The PCP/Contractor shall provide or approve all services in the Basic Benefits Package. In addition to the PCP/Contractor provision/approval, the following services shall be prior authorized by the Department:
> (a) HEALTH CHECK (EPSDT) treatment services not covered by the State Plan pursuant to 471 NAC;
> (b) Abortions pursuant to 471 NAC;
> (c) Transplants pursuant to this contract; and
> (d) Sterilization Exceptions pursuant to 471 NAC. ***Nebraska Contract, p. 78.***

3. Provider Compensation (Incentives and Withholds). *Incentive payments:* Private agreements routinely use provider incentive payments and withholds as a method of cost containment. We found that such compensation methods were infrequent in the context of Medicaid PCCM agreements. Medicaid agencies often operate in an environment that includes special populations with exceptional health care requirements, coupled with a dearth of health care providers. As a result, only a few of the PCCM contracts use incentive payments or withholds as a method of cost containment.

Four contracts (California, Massachusetts, Oklahoma, and Texas), provide for "upside risk" (i.e., bonus style incentive payments) under certain conditions as a means of inducing care. California and Oklahoma offer special payments for providers who furnish services to particular categories of patients. California pays a premium for providers who treat AIDS patients. Oklahoma offers additional fees to providers for treating minors or patients who are aged, blind, or disabled.

The following example illustrates California's AIDS incentive payment system that provides not only for higher rates, but also for prompt payment:

> K. Payment of AIDS Beneficiary Rates
> Payment of the AIDS beneficiary rate to the contract will be contingent upon the following:
> 1. The Contractor will be entitled to claim and be reimbursed at the AIDS beneficiary rate. The AIDS rate will be made in lieu of any other capitation payment made for an AIDS beneficiary in any month. * * *
> 2. The Department will process the AIDS rate invoices, calculate payments and submit the necessary paper work to the Department's accounting section within 25 days of receipt of the invoice. * * * ***California Contract, pp. 53, 54.***

Oklahoma's contract provides for additional case management fees tied to treatment of certain children as well as patients who are aged, blind, or disabled. Oklahoma also provides for additional stop-loss coverage in the case of services to aged, blind, and disabled enrollees:

> 2.6 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)...
> B. For these activities, the Authority shall pay an enhanced case management fee of $3.00 per member, per month as provided in Section 3.4(C)...
>
> ARTICLE 4
> REIMBURSEMENT - PAYMENT OF CAPITATED RATE

4.3 Enhanced Case Management Fee for TANF Members Under Two Years of Age
For those Temporary Assistance to Needy Families (TANF) recipients enrolled with the Contractor who are under the age of two, the Authority shall pay an additional $3.00 per member, per month in addition to payment as provided in subsections 4.1 and 4.2...

4.4 Enhanced Case Management Fee for ABD Members
For those recipients enrolled with the Contractor who are Aged, Blind, or Disabled, the Authority shall pay an additional $3.00 per member per month in addition to payment as provided in subsections 4.1 and 4.2.

4.14 ABD Members Bridge Payment
For SoonerCare Choice members categorized as ABD, the authority will pay on a quarterly basis the difference the provision's adjusted capitation revenue and the fee-for-service equivalent value of capitated services as defied by the benefit portion of the contract for their SoonerCare Choice ABD panel. Adjusted capitation revenue is defined as capitation revenue less case management revenue. The fee-for-service equivalent value will be determined based on clean encounter claims submitted by the last day of the month following the date on which service are rendered. On the last day of the month following the end or each quarter, beginning with the quarter January - March 2000, the Authority will: Compare each provider's adjusted capitation revenue and the fee-for-service equivalent value of their to-date submitted clean encounter claims. If the value of the encounter claims is less than the adjusted capitation revenue, no additional payment will be made. If the value of the encounter claims exceeds the adjusted capitation revenue, the Authority will make an additional payment of ninety percent (90%) of the cumulative difference (Offset by any previous quarter payments) at the end of each of the first three (3) quarters. A final bridge payment will be made following the end of each contract year, based on previous or current capitation revenue. All clean encounter claims submitted by August 31 will be considered in the final contract year bridge payment. ***Oklahoma Agreement, pp. 8-9, 12-16***.

California, Massachusetts, Oklahoma, and Texas also use incentive plans for providers who meet various cost containment and/or patient care goals:

SECTION 5. ADDITIONAL INITIATIVES
The Division reserves the right to implement, through this Contract, additional initiatives related to MassHealth Managed Care, and expansions of MassHealth coverage and initiatives related to utilization management of drugs and other services, including risk sharing reimbursement. The parties shall negotiate in good faith to implement any such initiatives proposed by the Division. The Contractor's responsibilities, including staffing requirements, are subject to change due to implementation of such initiatives. The Division reserves the right to increase the budget and reimbursement due to implementation of such initiatives.
Massachusetts Behavioral Health PCCM Contract, p. 38.

* * *

2.6 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) * * *
A. The Contractor shall comply with the Authority requirements regarding periodicity of EPSDT screens and services, and shall make EPSDT a priority in his/her health care for recipients under the age of twenty-one (21). The Contractor shall: 1) Schedule the following EPSDT appointments for all recipients under the age of 21; a) Six (6) visits during the first year of life; b) Two (2) visits in the second year of life; c) One (1) visit yearly for ages two through five; d) One (1) visit every other year for ages six through twenty. 2) Conduct and document follow up with all members under the age of 21 who have missed appointments; 3) Conduct and document EPSDT outreach to ensure that members under the age of twenty-one (21) are current with respect to the periodicity schedule in 2.6(A)(1); 4) Educate families who have members under the age of twenty-one (21) about the EPSDT Program and its importance to the health of children and adolescents...

C. In addition, for the services rendered in 2.6(A) above, the Authority shall pay an annual EPSDT bonus payment, as described in Section 3.4., when the Contractor achieves a seventy percent (70%) or higher annual compliance rate with the appointments described in Section

2.6(A)(1) for contract Year IV, seventy-five percent (75%) for contract Year V and eighty percent (80%) for contract Year VI...

4.5 EPSDT Bonus Payment
In addition to payments described in Subsections A, B, and C of this section, the Authority shall make an additional payment to the Contractor only if the Contractor: A. Has achieved a seventy percent (70%) for Year IV, seventy-five percent (75%) for Year V, and eighty percent (80%) for Year VI or better compliance level for EPSDT screens for twelve (12) months during the term of this contract as reflected by the periodicity schedule in 2.6(A)(1) as verified by an on-site chart audit after review of encounter data submitted to the Authority by the Contractor. B. Provides notice under Section 5.6 no later than sixty (60) days after the end of the contract year; that he/she believes that the appropriate compliance rate for the current year or better compliance rate has been achieved. Such notice must be received at the address noted in Section 5.6; D. Demonstrates that all EPSDT screens have been performed and documented appropriately and that all standards for completeness have been met; E. Demonstrates that medically necessary follow-up services were provided or appropriate referrals for follow-up were made; and F. Demonstrates that he/she has outreach mechanisms in place to encourage patients to obtain appropriate screens. G. The Authority shall make this additional payment in a lump sum payment within one hundred fifty (150) days after the end of the contract year. Payment shall be made at the rate of one dollar ($1.00) for each EPSDT-eligible recipient in the Contractor's panel during the year when the Contractor achieves an appropriate compliance rate as specified above. For each percentage point of compliance above the contractually specified compliance rate, the rate shall be multiplied by the difference between the specified compliance rat and the provider's above compliance rate not to exceed 100%. The provider's actual compliance rate will be based upon encounter data submitted to the Authority no later than August 1 of each year. An annual EPSDT bonus payment will not exceed 20% of the provider's annual capitation payment for SoonerCare Choice... ***Oklahoma Contract, pp. 8-9***

Texas uses an incentive arrangement that is tied to global savings:

C.1 OVERVIEW OF PRICING STRUCTURE Payment for the contractual services described in this RFP will be based on one of several pricing structures. The methods by which the Contractor will be paid for services under this contract include: ... b. Performance Incentive: The Contractor will be subject to a performance incentive related to the risk that beneficiary medical care costs vary from a prospectively established amount. The gains or losses to the Contractor under this arrangement will not exceed 0.0013 of medical claims costs for STAR enrollees during a Contract period... d. Global Incentive Payments: Contractor will be eligible to receive a global incentive payment in the event that specific State Agency objectives are achieved in each State Fiscal Year. The global incentive payment, to be shared by all TMAS contractors, will not exceed $2 Million...

C.3 PERFORMANCE INCENTIVE PAYMENTS AND PENALTIES

C.3.1 Medical Care Cost Containment Incentive
To provide the Contractor with incentives to manage the medical care utilization and medical benefits costs of STAR Network enrollees, the Contractor will be subject to a performance standard that is tied to the medical benefit costs of STAR Network enrollees. The performance standard will operate as follows: In the event that medical benefit costs for STAR Network enrollees during a contract period are lower than expected medical benefits costs (as projected by the State Agency at the beginning of the Contract period) the Contractor will receive a payment equal to a percentage of a bonus/penalty payment amount specified by the State Agency (described below). In the event that medical benefit costs for STAR Network enrollees during a contract period are greater than expected medical benefits costs (as projected by the State Agency at the beginning of the contract period) the Contractor will be assessed a penalty equal to a percentage of the bonus/penalty payment amount specified by the State Agency. Medical benefit costs used in the computation of the payment/penalty will only be those associated with core Title XIX services. The incentive payment/penalty does not apply to benefit costs associated with the following: **[identifies medical transportation, family planning, kidney health care and certain services for patients with long term and chronic health care needs as exempt from the computation] * * ***

C.3.1.1 Incentive Payment and Penalty Structure
For a Contract period, the incurred claims costs for STAR Network enrollees will be measured and compared to the expected claims cost amount projected by the State Agency prior to the beginning of the Contract period. There will be two measurement dates following a Contract period - one occurring 30 calendar days after receipt of actuarial printouts six (6) months past the close of the contract period in question, and another occurring 30 calendar days after receipt of actuarial printouts 12 months past the close of the contract period in question. The former measurement date represents an interim measurement while the latter represents a final measurement. If a measurement shows that incurred claims costs for STAR Network enrollees exceed the expected value, the Contractor will be assessed a penalty... If a measurement shows that incurred claims costs are below the expected value for STAR Network enrollees, the Contractor will be paid a bonus...

The incentive payment/penalty formula will be as set out below for the contract period…In no event, however, will the sum of bonus payments made to the STAR Network Administration Contractor and the Claims Administration Contractor (which is subject to a similar performance incentive) exceed $5 Million. In the case where the above formulas result in bonus payments exceeding $5 Million to the two Contractors, each Contractor's payment will be reduced proportionally until the sum of the payments equals $5 Million...

C.5 GLOBAL INCENTIVE PAYMENTS
To provide all TMAS contractors with positive incentives to contribute to the achievement of State Agency objectives for the total system, the Contractor will be eligible to receive a global incentive payment in the event that specific State Agency objectives are achieved in each State Fiscal Year. In the event that the annual target objective is attained, each eligible TMAS contractor will receive a percentage of a Two Million Dollar Global Incentive Payment. The share of the $2 Million Global Incentive Payment received by each contractor will correspond to each Contractor's share of total system administrative costs. I The Global Incentive Payment will be paid in the event that total Medicaid benefit costs for a given Fiscal Year are less than or equal to * * * $20 Million ***Texas RFP, pp. 53-60.***

Withholds: A withhold is a percentage of the capitation that is retained by the state and used to pay for cost overruns in referral or institutional services. Indiana, Iowa, Kansas, Kentucky, and Oklahoma permit the withholding of payments. However, these withhold provisions all relate to sanctions for conduct that contravene the terms of the agreement rather than to the issue of financial inducements. In these contracts, payments may be withheld for failure to comply with the contract terms, the provision of unnecessary care, or as a prophylactic means of avoiding the provision of duplicative services to an individual enrolled with another PCCM. As a result, it appears that while several states create incentives for their network through additional payments, none use “downside risk” (i.e., the withholding of funds otherwise due) as a means of fostering certain types of practices or conduct.

Arguably, the withhold provision contained in the Indiana contract and related to the provision of unnecessary care may work like a downside risk, discouraging certain care as a means of avoiding sanctions. However, because the impact of this withhold is after the fact (i.e., after a provider is determined to have furnished unnecessary care), its actual impact is difficult to assess from the face of the contract. Similarly of interest is Oklahoma’s withhold in the case of duplicative screens furnished by safety-net clinics. To the extent that the state tracks individual children to determine duplicate preventive health exams and has a mechanism for identifying “duplication,” a withhold of up to one month in capitation payments may be imposed.

The following excerpts illustrate state use of withholds:

F. Failure by the patient manager to adhere to terms of this agreement, including but not limited to failure to notify the Department properly of changes in status and failure to maintain proper records and documentation, shall subject the patient manager to recovery of patient management fees paid for the specific patients and/or time period during which the agreement was not adhered to**.**

Iowa Agreement, p. 6.

* * *

5. Sanctions
During a given calendar year, any PMP who provides or authorizes services which 1) are not medically necessary, appropriate, and cost-effective; and/or 2) do not conform with Hoosier Healthwise policies and procedures for inpatient hospital, outpatient hospital, physician/laboratory and radiology, by separate category or for all Medicaid services, may be sanctioned at the option of the OMPP and after appropriate review.

These sanctions will include . . . case management fee withdrawal . . . . ***Indiana Addendum, p. 6***.

* * *

J. Withholding of payments by SRS
The case manager agrees that SRS may withhold case management payments otherwise due the case manager in full or in part if: SRS has determined that the case manager has been overpaid for case management services; SRS has reliable evidence, although additional evidence may be needed for a determination, that an overpayment exists or that the payment to be made may be incorrect; Case manager fails to make acceptable coverage arrangements prior to temporarily vacating his/her practice. . . .

Financial remedies: Withholding amounts for overpayments for case management services shall be equal to the amount of the overpayment; Withholding amounts for failure to make acceptable case management coverage arrangements shall equal the portion of the month left uncovered by the case manager; No later than the effective date of a withholding action, SRS shall send written notification of the withholding action and the reasons for such action to the affected case manager. A withholding action shall become effective with the date indicated in the letter of notification.; A withholding action shall remain in effect until:; Overpayment is recouped from amounts withheld or is otherwise recovered; SRS enters into an agreement with the case manager for recovery of the overpayment; SRS determines that there is no overpayment; SRS is notified by Health and Human Services (HHS) that the withholding action is not pursuant to federal instructions. No payment for the withheld federal share shall be made to any case manager unless SRS receives notification from HHS to do otherwise**. *Kansas Contract, pp. 7-8.***

* * *

4.9 Family Planning
Under Federal law, adolescents under the age of 18 may seek any provider for family planning services. The Contractor shall recognize the adolescents' right to freedom of choice regarding family planning services and shall not discourage the exercise of this choice. Because the State is prohibited from paying twice for the same services, should an adolescent recipient in the Contractor's panel seek family planning services covered under this contract from the Contractor's capitation payment in a subsequent month. The deduction amount shall be based on the Medicaid fee-for-service schedule, but shall not exceed one month's capitation payment attributable to the adolescent.

4.10 Safety Net EPSDT
The capitation rates shown in Attachment C reflect the established EPSDT screening requirements, as found in Section 2.6 (A)(1). The cost of EPSDT services covered under this contract provided by a school-based clinic or local health department clinic, pursuant to the provisions of Section 2.7(B), will be deducted form the Contractor's capitation payment based on the Oklahoma Medicaid fee schedule rate. In no case will the deduction exceed an amount equal

to one month's capitation for that recipient. This deduction provision shall be in effect form the time of execution of this contract. ***Oklahoma Agreement, p. 14.***

4. External Review of Contractor Performance. External review of PCCM performance is conducted to ensure that medical care and service meet clinical standards of quality. Fourteen contracts, approximately half of all contracts, address the external review of contractor performance. These external reviews concentrate on the beneficiary's access to care, quality of care, and provider utilization patterns. The excerpts below are frequently extensive and applicable to a broad range of service categories and management activities that are covered in the provider contract.

One of the aspects of an external review is the standard of performance measurement a contractor is expected to use. We were unable to identify any contract that sets forth specific contractual performance measures in the area of patient management in the case of enrollees with special health needs.

Nebraska and Georgia offer illustrations of relatively detailed approaches to external quality review of participating providers. Of particular interest is Nebraska's extensive quality improvement committee process, which is a contractual obligation of PCCMs:

9.12 Review Process: Any potential quality of care concern reported to the Department, shall be forwarded to the Department's QA/QI Manager with a copy provided to the Contractor's QA/QI Department. Additional information will be gathered by the Department and/or the Contractor, as appropriate. The concern shall be shared with the Department's and/or the Contractor's QAC. If necessary, a physician of like specialty shall be asked to review the case and submit any comments or recommendations in writing. The QACs of the Department and Contractor shall review the concern and make any final recommendations.

9.13 Levels of Concern: Quality of care or service concerns identified through the Department's and/or Contractor's QA/QI process will be categorized for assessment, intervention and resolution as follows:

(a) Serious: The problem resulted in, or contributed to, the death of a patient or seriously jeopardized the health of a patient (though the eventual outcome may have been satisfactory). Immediate intervention by the Medical Director of the Contractor and the Department is required at the provider and the entity level.

(b) Substantial: The problem involved a significant deviation from the Community/National standards of care with respect to diagnosis, treatment, or expected outcome; direct intervention by the Medical Director of the Contractor and the Department at the provider and entity level is required

(c) Minor: The problem had a minimal or inconsequential effect on the health status of the member; intervention not required, continue to monitor to identify trends; direct intervention at the provider level not required.

(d) Service: The problem involves the health care delivery system and did not directly impact the medical intervention not required for health of the client but did impact the client's satisfaction. Ongoing monitoring to identify trends required.

9.14 Corrective Action: When the QAC of the Department determines that inappropriate care or substandard services have been provided, or services which should have been furnished have not been provided, the Department's QAC shall be responsible for communicating concerns identified and outlining the corrective action necessary. * * *

9.15 Quality Improvement Subcommittees: As a means of measuring quality, and in conjunction with Preventative Health, the Department shall develop and maintain subcommittees, and assist the Department to the Contractor's participation in these subcommittees shall pursue continuous quality improvement in the following areas: (a) Pediatric asthma; (b) Diabetes; (c) Prenatal care; (d) Health Check/EPSDT/Immunizations; (e) Persons with disabilities.

The Department and the Contractor may pursue additional subcommittees if mutually agreed in writing. Those subcommittees may include: (f) Breast and cervical screenings; (g) STDs, including Chlamydia; (h) HIV/AIDS; (i) Elevated lead blood levels; (j) Tuberculosis; (k) Others as may be identified by HCFA or the parties.

9.15.1 Subcommittees: The Department utilizes participation from the Department, the Contractor, providers, clients, and other entities with expertise in the above areas to form subcommittees of the Department's QAC to develop standards for evaluating quality improvement and quality of care in the NHC. The Contractor's participation in subcommittees shall be limited to no more than 20 hours per month.

9.15.2 Quality Improvement Process: As a means of measuring quality, the Department shall generate the following HEDIS like measures for the Contractor. Upon receipt of the HEDIS like measure reports and any supplemental agreed upon reports, the Contractor will be required to conduct QA/QI activities within these areas: Access and Availability, Children's Access to Care; Adult's Access to Care; Utilization, C-section Rates, Well child visits (all age groups), Selected procedures; Quality, Childhood and Adolescent Immunizations, Breast Cancer Screening, Cervical Cancer Screening, Eye Exams for Diabetics, Care for People with Asthma. The Contractor's HEDIS like results will be compared to the rest of the NHC's fee for service population when setting quality improvement goals.

9.16 Contractor Review: The Department is responsible for monitoring the QA/QI . activities of the Contractor, and monitor that corrective actions have been taken by the Contractor. The Department shall monitor the Contractor's QA/QI program through the following mechanisms: (a) External Quality Review: The Department is required to monitor the quality of care provided by the Contractor/provider through an annual, independent, external review. The Department Contracts with the Iowa Foundation of Medical Care, which is the Peer Review Organization (PRO); (b) Periodic Medical Audits: The Department is responsible for and conducting; periodic medical audits to ensure that each Contractor furnishes quality and accessible health care to enrolled clients. These audits are conducted at least annually and must identify and collect management data; and (c) Onsite monitoring or participation as necessary.

9.17 Review Activities: Through the use of external and internal review activities, the Department shall monitor the following areas:

(a) Medical Record Review, to include but not limited to: (1) Organization of Medical Records; (2) Patient Information; (3) Content of Medical Records; (4) Continuity of Care; and (5) Health Promotion;

(b) Quality Management and Improvement, to include but not limited to: (1) Program Structure; (2) Program Operation; (3) Health Services Contracting; (4) Continuous Quality Improvement; (5) Member Satisfaction; (6) Health Management Systems; (7) Clinical Practice Guidelines; (8) Quality Management/Quality Improvement Studies/Assessments; (9) Effectiveness of the Quality Improvement Program; and (10) Delegation of Quality Improvement Activity.

(c) Utilization Management, to include but not limited to: (1) Policies and Procedures; (2) Utilization Management Procedures; and (3) Utilization Management Documentation.

(d) Credentialling and Recredentialling, to include but not limited to: (1) Policies and Procedures; (2) Credentialling Documents; and (3) Recredentialling Documents.

(e) Member Rights and Responsibilities, to include but not limited to: (1) Policies and Procedures; (2) Member Responsibilities; (3) Contractor Responsibilities; and (4) Confidentiality.

(f) Disease Prevention and Health Promotion Services, to include but not limited to: (1) Disease Prevention and Health Promotion Services; (2) Participation with Public Health Agency initiatives, disease reporting requirements, and preventative health programs.

9.18 Accreditation: The Contractor shall inform the Department of all external accreditation activities and shall provide the Department with access to final reports of external accreditation as applicable to the execution of this Contract. * * * The Department shall utilize contract deliverables to document the Contractor's compliance and compare to national standards.

Reporting: Through the use of claims data, the Department shall focus on the following reporting areas: Expenditures/Usage; Eligibility; Utilization; Provider Access; Provider Expenditures; and

Performance Measures: In addition to developing and implementing the NHC program according to policy and procedures, the Contractor shall follow QA/QI methodologies, adhere to all specified reporting requirements, assist the Department in validating that services provided were authorized, and comply with all elements pursuant to this contract. ***Nebraska Contract, pp. 107-111.***

* * *

909. Access to Care, Quality of Service, and Utilization Review Activities. GBHC will monitor members' access to care and their level of satisfaction with services. In addition, utilization patterns will be monitored as specified below.

1. Access to Care and Quality of Service
GBHC members' access to care will be monitored by the plan * * * a. A toll fee number will be maintained which handles any type of inquiry, complaint, or problem. The member may call this number, 404-982-3535 or 1-800-246-2757 Monday through Friday between the hours of 8 a.m. to 7 p.m. b. Periodic member surveys will be mailed to a random sample of members which questions members' access to and level of satisfaction with all services covered under the plan. c. PCPs' 24-hour accessibility will be monitored through random calls to PCPs during and after regular office hours. d. The same grievance procedure which is in effect under the regular Medicaid program is effective under the GBHC plan. A formal appeal process under 42 CFR Part 431, Subpart E, is available to members. e. The total number of each PCP's members will be monitored to assure that enrollment levels do not exceed the limit authorized by the plan and assure that enrollment levels are appropriate for each full time equivalent provider. f. GBHC will review the following indicators to identify access and/or service problems -1) Long waiting periods to obtain services from a PCP. --2) Member concerns regarding availability of referrals to specialists, and referral for second opinions. -3) Member confusion about how to obtain services not requiring authorization. 4) After Hours Telephone Coverage. 5) Visits to emergency rooms, specialists, etc., for medical care. 6) Lack of access to family planning services. 7) Frequent member requests to change a specific PCP. 8) PCP's knowledge of case management roles and responsibilities and the referral authorization process. 9) Abuse and inappropriate use of GBHC authorization numbers.

2. Utilization Review. To assure quality of medical services, GBHC will review payment files to identify member over- or under- utilization of services and PCP practice patterns.

a. System Overview. The GBHC Utilization Review System monitors services received by GBHC members and provides feedback to PCPs pertaining to the overall utilization patterns of their caseloads. Reports which allow participating providers to compare their caseload experiences are distributed on a periodic basis. These reports provide a basis for evaluation of the performance of individual PCPs and of the Georgia Better Health Care plan. The system will stratify the data according to the major practice specialties of the PCPs. Data will be expressed in terms of utilization rates per 100 members for each variable, as described below.

These rates will be developed for each participating provider, for each participating specialty group, and for all PCPs combined.

Providers with individual rates for any variables which fall more than ± 2 standard deviations from the statewide rate in two consecutive report periods (derived from all participating providers) will be provided with detailed utilization data pertaining to services received by each of their GBHC members. These detailed utilization reports are used by program staff in conjunction with other available data to determine acceptable practice patterns and to take appropriate corrective action when necessary.

b. Detailed System Description
The system will generate measures of utilization based on dates of service. These measures are recorded quarterly and converted to rates based upon each PCP's assigned caseload during the study quarter. * * *

Following are the nine measures which will be used in the system: a) Emergency room visits.; b) Physician specialist referrals. c) Hospital outpatient visits. d) Inpatient Hospital admissions. -e) Health Check (EPSDT) participation by members. f) Number of independent laboratory and x-ray procedures. g) Number of prescriptions filled for a PCP's members. h) Office visits billed by each PCP for his or her members. i) Family Planning Services. j) X-ray services. k) All other services. l) Total Medicaid expenditures for services.

In addition, the average quarterly enrollment and average quarterly cost per member will be specified in each PCP's utilization report.

--2) Provider Groupings. For each of these measures a utilization rate will be computed for each PCP, for the specialty group in which these providers practice, and for the Georgia Better Health Care provider population. Specialty groups to be considered are defined by the population of patients served: Adults and Children, Adults Only, Children Only, Women Only, 3. Feedback Reporting. All participating PCPs will be given quarterly reports which indicate their individual rates for the nine utilization measures in comparison to the corresponding rates for the provider groupings and the statewide rates.

Providers with utilization rates which fall outside ±2 standard deviations from the statewide rate in two consecutive report periods for any variable will be identified by the system. The statewide rate is expressed in terms of a rate per 100 members per year. Those having rates outside ±2 standard deviations from the statewide rate in two consecutive reports will be provided with detailed reports which list the recipients, billing providers, and dates of service used to compute rates outside ±2 standard deviations. In addition, each PCP will be given a periodic report listing all the providers who have used his or her GBHC referral authorization number for billing claims to Medicaid. This report will include the names of the recipients for whom such referrals are billed.

c. Monitoring and Analysis
The Georgia Better Health Care staff will review all quarterly and periodic utilization reports to determine individual, specialty group, and statewide patterns in two consecutive reports for any variable. The GBHC detail reports in conjunction with available Medicaid Management Information System historical claims file date, GBHC correspondence files, GBHC records, and on-site medical record audits, when warranted, will be used to determine the specific causes of unusually high or low rates. In addition, each provider will be notified when his or her rate(s) fall outside the ± 2 standard deviations in any given quarter and will be given an opportunity to discuss the date. ***Georgia Agreement, pp. IX-8-IX-11.***

Part Two: Beneficiary Access

We examined the contract terms that control the beneficiary's access to medical care. We provide our findings in table format, and then we provide examples of contract language to show how state Medicaid agencies address these terms.

We reviewed the following contract elements that govern access to medical care:

- *The definition and scope of basic contract terms*. We attempted to ascertain how Medicaid agencies defined primary care and primary care case management and the minimum contractual qualifications for PCCM providers with respect to both care and case management functions.

- *Duties assigned to the PCCM providers*. We reviewed providers' duties in the areas of provision of information, enrollment and disenrollment, coverage determinations and notice, access standards, and referral affiliations.

- *Duties related to quality and information*. We looked at quality measurement and improvement and the submission of data and other information to the state Medicaid agency and other entities.

- *Other relationships*. We queried whether the PCCM provider was required to maintain associations with other entities and agencies serving the provider's patients, particularly public health agencies, mental health and substance abuse prevention and treatment agencies, schools, and child welfare agencies.

Our findings are summarized in Table 3.

Table 3. Elements of State PCCM Contracts Regarding Access for Beneficiaries

State	Primary Care and Case Management Services Defined	Network Capabilities and Relationships with Specialists	Access to Services	Information to Members	Quality Assurance	Enrollment and Disenrollment Protections	Provision of Data and Information
AL	√	√	√	√	√	√	√
AR							
CA	√	√	√	√	√	√	√
CO*							
FL	√	√	√		√	√	√
GA	√	√	√	√		√	
IA	√	√				√	√
ID	√				√		
IN	√						
KS	√		√	√		√	√
KY					√		
LA	√			√	√	√	√
ME							
MA					√		√
MS	√	√		√		√	√
MT	√					√	
NE	√	√	√	√	√	√	√
NY	√	√	√	√	√	√	√
NC	√		√			√	√
ND							√
OK	√		√		√	√	√
PA				√	√	√	√
SD						√	√
TX	√			√	√		√
VT	√		√		√		√
VA	√					√	√
WA			√	√		√	√
WV	√					√	√
Total	19	8	11	11	13	18	20

* Colorado does not use a contract, so information from that state was not reviewed.

1. Primary Care and Case Management Services Defined. Federal law provides a global definition of primary care that is tied to the capabilities of the primary care specialties themselves (i.e., those services customarily furnished by a primary care specialist).[9] On the other hand, the Medicaid statute describes covered services in terms of specific, defined services and benefits which, depending on the needs of the patient and the service in question may or may not constitute primary care.[10] For example, certain items and services covered under the EPSDT benefit would fall into a primary medical care category (e.g., periodic and interperiodic health exams and laboratory tests performed as part of such an exam), while other services, such as specialized care for persons with physical and mental disabilities, lie beyond the capabilities of a primary care practitioner.

With significant variation, 70 percent of the PCCM contracts describe certain "care" and "case management" duties that are expected of PCCMs. The contracts differ with respect to the scope of Medicaid-covered services that are subject to case management responsibilities but are relatively consistent with respect to those services that PCCMs are expected to be able to furnish or arrange as a matter of primary health care. Most notably for purposes of this review, the

contracts show considerable ambiguity with respect to EPSDT, which invariably is enumerated in its entirety as a contract duty, even as specific diagnostic and treatment services are excluded from the agreement. This suggests that in the case of children, the entire scope of Medicaid benefits may be subject to PCCM case management gatekeeping activities, even as the same services, when furnished to adults, may be carved out. This interpretation of the agreement is further suggested by the fact that some of the contracts appear to explicitly exclude certain pediatric benefits, thereby implying that all other pediatric coverage is included in the agreement. The following excerpts illustrate the complexity of this "inside-and-outside-the-contract" issue:

Referrals and Authorization Process

1. Referrals For all Medicaid covered services which PCPs do not provide directly or which are not exempted ***, PCPs must refer to another Medicaid participating provider. This includes referrals for members to be seen by specialists, hospitals, or other Medicaid enrolled providers. If the PCP determines that a referral is necessary based on the member's diagnosis and medical condition, the PCP must authorize the services *** [A] GBHC primary care provider is not required for services provided in hospital emergency departments. Hospitals will be reimbursed for medical screening, examination, and stabilization services. ***

Services Exempt from Authorization

The following services do not require authorization by the Primary Care Physician:
Emergency services: Emergency services are defined as covered inpatient and outpatient services that are needed to evaluate or stabilize and emergency conditions. ***
Services delivered by providers enrolled in the following Medicaid programs:

Anesthesiology
Community Care services
Dental services
Dialysis services
Early intervention case management
Family planning
Health department services – diagnostic, screening and preventive services
Hospice services
Independent care
Independent laboratory services
Non-emergency, transportation and ambulance services
Nursing home, ICF/MR, swing bed services
Optometry services (including eyeglasses)
Pathology (interpretation and report)
Pharmacy services
Pregnancy-related services
Psychology and other mental health services
Targeted case management
Therapeutic residential intervention services
Waivered home care ***

Individual Education Program (IEP) Services

*Federal law requires that state Departments of education, through local school systems, provide school age children with special health care needs certain medical or therapeutic services in order for the child to meet his or her educational requirements. Such children must have a written plan called an ***IEP [which] is the care plan documented by the school to reflect the need for certain medical services, primarily physical therapy, occupational therapy and speech therapy, and for monitoring the child's progress. Medicaid enrolled schools may provide these services without authorization from the child's PCP. This policy affects only those children who have a need for medical services which are documented in an IEP. ****

Case Management Responsibilities

In addition to providing primary health and medical care services, PCPs must provide the following case management services to *** members ***:

1. Refer members for specialty care, hospital care, and other services only when medically necessary.
2. Authorize services provided by referred providers to members if it is determined by the PCP that those services are medically necessary.
3. Ensure GBHC members are provided access to primary care in a timely manner ***
4. Ensure GBHC members are provided *timely access to needed [EPSDT} services either by directly providing the services or referring the services to a qualified *** provider*.
5. Coordinate the provision of other essential services such as dental services, immunizations, family planning and maternity care to ensure that such services are received by members as appropriate.

Authorization of Health Check Services

*** GBHC PCPs are required to authorize referrals for the delivery of Health Check [EPSDT] services to their GBHC members. *However, immunizations continue to be exempted from the authorization requirements*. ***Georgia Contract, VIII-1 – VIII-2, IX-7 - IX-8***. *[Emphasis added]*

* * *

Services to be Managed
General services. It is agreed that the MediPass provider will provide patient management for the following services for each patient:

- Advanced registered nurse practitioner services
- Ambulatory surgical center services
- Birth center services
- County health department services
- Chiropractic services
- Durable medical equipment services
- Child health check up services (formerly EPSDT)
- Federally qualified health center services
- Home health services
- Hospital inpatient services
- Laboratory services
- Licensed midwife services
- Physician services
- Physician assistant services
- Podiatric services
- Prescribed drug services
- Rural health clinic services
- Therapy services
- X ray services

Florida Contract, p. 4. *(Emphasis added)*

The Georgia and Florida contracts vary in the scope of the case management expectation. For example, Georgia exempts pharmacy and laboratory services, services of hospital emergency rooms, pregnancy-related care, and the services listed in Individualized Educational Plan (IEPs). The Florida contract covers all of these services, suggesting a more far-reaching and ambitious program of primary care case management, with far greater controls over specialty care resource consumption assigned to the PCCM contractor. Both contracts appear to assign nearly complete case management duties to PCCM contractors with respect to EPSDT; a straightforward reading of each contract would seemingly support an interpretation that regardless of other exclusions, all primary and specialty services for children are covered by the agreement. This interpretation is

underscored by the exclusion of certain pediatric services (IEP and immunization services in the case of the Georgia contract). Thus, for example, while mental illness and addiction disorder treatment and prevention services are wholly or partially exempt for adults, they would be covered by the global EPSDT case management duty.

Certain states attempt to identify minimum services that providers are expected to furnish, as opposed to "arrange." For example, the Mississippi contract requires a PCCM provider to carry out a range of specified activities considered to fall within the framework of "primary care." Under the contract the provider must perform as follows:

> 12. refer enrollees under the age of 21 to the local health department or other EPSDT provider for EPSDT screening, EPSDT case management, or other EPSDT high risk case management services if these services are not provided by the HealthMACS provider. (Note: EPSDT continuing care, if needed, must be provided by the PCP and not referred to another physician unless the PCP cannot provide the needed care.)
> 13. Refer the appropriate enrollees for perinatal high risk management services to the *** designated provider in the area (if available) when the PCP is not a participant in the [perinatal] program.
> 14. Refer the appropriate enrollees to community resources that provide family planning services if these services are not provided by the PCP." ***Mississippi Contract, Ch. 4.***

In addition to the federal definition of primary care, certain states attempt to amplify on the definition that speaks to the range of services they anticipate will be available to their enrollees. For example, the Florida MediPass agreement limits its description of primary care duties to a restatement of the legal definition of primary care, as follows:

> Primary care – the ongoing responsibility for medical care, provided at the patient's first point of contact with the health care system. Primary care includes treatment of illness and injury, health promotion, identification of individuals at special risk, early detection of serious disease and referral to specialists when appropriate. ***Florida Contract, p. 3.***

2. Basic PCCM Qualifications and Sub-Population-Specific Conditions of Participation. As noted above, the contracts appear to assume that individuals who meet the basic capability requirements of a PCCM are competent to provide primary care and case management services within the scope of the agreement to any sub-population covered by the state's program. Rather than establishing threshold provider qualifications for different sub-populations, the agreements appear to set generic standards for participation as a PCCM. At the same time, some of the agreements also establish specific conditions of participation for certain sub-populations. For example, none of the contracts contain threshold requirements that restrict who can be a PCCM for children with special health needs (e.g., physicians who either have board certification in the relevant sub-specialty or else who maintain a pre-existing formal affiliation with a relevant sub-specialist). On the other hand, certain agreements require participating PCCMs as a condition of participation to maintain a formal list of referral specialists. Thus, the agreements allow a PCCM who meets certain basic requirements to case manage any patient.

As noted, the Mississippi contract offers a unique example of a state's effort to allow physicians to exercise medical judgment regarding their competence to case manage certain patients, while at the same time building in safeguards to ensure that physicians do not use such discretion to screen complex patients out of their primary care practices.

3. Enrollment and Disenrollment Protections. Typically, state Medicaid agencies require their Medicaid beneficiaries to participate in the PCCM program. Through various means, beneficiaries are informed about their choices of providers, and the beneficiaries then make their selection. The contracts vary in their approach to enrollment. For example, the Georgia agreement specifically allows providers to indicate the extent of their willingness to participate in the PCCM program, as follows:

> Check accepting new patients if you wish to accept new patients through the Medicaid Management Information System auto assignment or by patients selecting you as their primary care provider.
>
> Check established patients only if you wish to case manage only those patients already established with your practice. If you check this option, FBHC will not assign patients to your practice.
>
> Check historical patients only if you wish to case manage only those patients who have a history with your practice or new patients that you wish to case manage. If you check this option, patients may be assigned to you if there is a paid claims history on file for the practice location you are filing.
> ***Georgia Contract, Instructions for Completing the GBHC Application.***

Conversely, the California contract does not give discretion over the degree of enrollment:

> Contractor Duties
> Beneficiary Enrollment
>
> Accept for enrollment eligible beneficiaries from the state's health care options enrollment system as well as those obtained through the contractor's own enrollment efforts.
> ***California Contract, p. 17.***

With respect to disenrollment of specific patients from a practice, the contracts appear to extend at least some discretion to participating providers to disenroll certain patients from their practices. In addition to the Mississippi example noted previously, other states attempt to address the problem of unworkable provider/patient relationships:

> The Contractor will have the right to recommend to the Department the disenrollment of any member in the event of a breakdown in the doctor-patient relationship which makes it impossible for the contractor or its subcontractors to render services adequately to a member or in the event any member has abrogated the enrollment agreement by habitually seeking and receiving covered services, other than emergency care, from a provider other than the Contractor or subcontractors. The decision to allow disenrollment of any member will be solely that of the Department.
> ***California Contract, p. 49.***

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> MediPass providers may secure the disenrollment of a patient by notifying the Medicaid patient by certified mail and sending a copy of the letter to the MediPass unit in the area Medicaid office. Patients may be disenrolled only if the provider/patient relationship is not satisfactory or if the primary care provider feels a specialist can better serve the recipient's medical needs. The provider must continue to provide MediPass managed services to patients until the patient disenrollment process is complete and the recipient is enrolled with another provider, which may take from two to six weeks. ***Florida Contract, p. 20.***

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> The Clinic may request the Department to disenroll a Clinic enrollee. This request must be in writing and sent to the Healthy Options program representative at the Department. The

Department shall approve or deny the request within thirty (30) days of receipt. Disenrollment requests will not be approved based solely on an adverse change in the enrollee's health."
Washington State, Healthy Options, p. 3.

Unlike the Mississippi contract that permits physicians to avoid initial service completely by identifying a prospective patient as too complex for their case management capabilities, all of these examples assume an initial relationship that subsequently does not prove clinically satisfactory. These examples also show the variation in disenrollment discretion given to PCCM contractors. Florida allows a provider to seek disenrollment if the "provider/patient arrangement is not satisfactory."[11] Washington State allows its clinics to request the disenrollment of any enrollee, but specifically prohibits adverse changes in health status alone as a basis for disenrollment. California offers the most circumscribed example in this series. The agreement appears to require a provider to demonstrate a "breakdown in the doctor-patient relationship, which makes it impossible for the contractor or its subcontractors to render services adequately to a member." Alternative bases for a disenrollment request are that a "member has abrogated the enrollment agreement by habitually seeking and receiving covered services, other than emergency care, from a provider other than the Contractor or subcontractors." The more circumscribed nature of California's contract is consistent with the fact that the state's contract covers medical groups, which presumably have the discretion to transfer a complicated patient to another provider in the group rather than seek outright disenrollment.

4. Information to Members, Notice of Grievance and Appeal, and Fair Hearing Rights. The contracts vary in the information duties assigned to PCCM providers. For example, the California contract sets forth extensive requirements related to information to prospective members, notification to members about covered services, notification to members about changes in covered services, and member notification of denial, deferral, or modification of requests for prior authorization:

Information to Prospective Members

Inform each Medi-Cal beneficiary signing an enrollment form of the following

1. There is a 15-45-day processing period between the date the designation form is received by the PCCM plan and the date the PCCM plan receives written notice from the Department that the beneficiary has been enrolled.
2. Enrollment is not effective until processing is completed.
3. The beneficiary may obtain health care services under Medi-Cal fee-for-service during the processing period ***
4. A member may disenroll upon request without having to provide a reason ***
5. The beneficiary is entitled to receive the full scope of Medi-Cal benefits. If a member requires a service which the contractor is not required to provide or authorize but which is a Medi-Cal benefit, the contractor will assist the member in disenrolling to allow coverage under the fee-for-service Medi-Cal program, if disenrollment is required to obtain the service.

Notification to Members About Covered Services

Within seven days after the effective date of enrollment, notify the member or the member's family in writing, concerning the type, scope and duration of covered services to which they are entitled. The format of the notifications must be approved by the Department and will include:
1. The effective date of enrollment.
2. The term of enrollment.
3. A description of all covered services provided by the contractor and exclusions or limitations thereof.

4. An explanation of the procedure for obtaining covered services.
5. The name, telephone numbers and service site address of the primary care physician chosen or otherwise made available to the member.
6. The name, telephone numbers and procedures for obtaining health services in the event of an emergency.
7. Explanation of and the procedure for obtaining health services rendered in emergency circumstances occurring outside the contractor's service area.
8. The causes for which a member will lose entitlement to receive services under this contract.
9. The grievance procedure, including the title, address and telephone number of a person responsible for resolving grievances or initiating the grievance procedure.
10. Disenrollment procedures .***
11. An explanation of appropriate use of health care services and the contributions the member can make toward maintenance of the member's own health.
12. An explanation of the member's potential liability for the cost of services if services, other than emergency or those specifically excluded, such as dental, are obtained without the contractor's prior approval.
13. Information concerning the availability and value of scheduling an initial health assessment appointment.

Notification to Members about Changes in Covered Services

Notify members in writing of changes in the availability or location of covered services being provided by the contractor at least 30 days prior to the effective date of the changes or within 14 days of the change in cases of unforeseeable circumstances.

Member Notification of Denial, Deferral, or Modification of Requests for Prior Authorization

1. The contractor will comply with the final judgement and order issued by the United States District Court in ***Jackson v Rank***by providing written notification to members and if known their authorized representatives at the time of denial, deferral or modification of a request for prior approval to provide a health care service. This notice must be provided as specified in the court order, which is incorporated herein, consisting of 10 pages *** when the following conditions exist:

a. the request is made by a provider of services who has an arrangement with the contractor to provide services.
b. the request is made by the provider through the formal prior authorization procedures operated by the contractor.
c. the service for which prior authorization is requested is a medi-cal covered service for which prior authorization is required.
d. the prior authorization decision is being made at the ultimate level of responsibility within the contractor's organization for approving, denying, deferring or modifying the service requested. The member may not be required to initiate the contractor's grievance procedure before such notice is sent.

2. The written notification will be given the contractor to the member *** on a standardized form*** and will inform the member of the following:

a. the member's right to and method for obtaining a fair hearing to contest the denial, deferral or modification action;
b. the member's right to represent himself *** at the fair hearing ***,
c. the action taken by the contractor on the request ***and the reason for that action***;
d. the name, address, and telephone number of the contractor and the state toll-free telephone number for obtaining information on legal service organizations for representation. The notice *** may inform the member that the member may file a grievance concerning the contractor's action *** prior to or concurrent with the initiation of the fair hearing process.

This lengthy excerpt underscores the broad range of administrative duties assigned to PCCM entities in California, including a specific assignment to the contractor of duties related to the determination of the entitlement to coverage itself and the obligation to explain the due process

procedures available to beneficiaries whenever medical assistance is denied, reduced, or terminated.

The California contract is thorough, probably in light of the nature of PCCM arrangements in the state (i.e., large complex group practices). Other states include limited informing duties in their contracts, as illustrated by the following excerpts:

> The Clinic agrees to . . . [i]nform enrollees about the appropriate use of primary care services including, but not limited to, explaining the use of a PCP at the Clinic, the process for obtaining referrals when necessary to other providers, and appropriate use of emergency department services. ***Washington State, Healthy Options, p. 1.***
>
> The HealthMACS enrollee must be given information regarding the usual days and hours the physician is available and schedules appointments. If a certified nurse practitioner is the PCP for an enrollee, the enrollee must know the HealthMACS physician responsible for supervision and performance of functions not covered in the protocol.
> ***Mississippi Contract, p. 73.***
>
> Provide enrollees with information about the Department's fair hearing process whenever the Clinic denies authorization of a service. ***Washington State Healthy Options, p. 2.***

This variation in informing duties is notable since, regardless of the state program considered, PCCM duties invariably appear to cover essentially the same mix of health care and administration functions, including an obligation to make coverage determinations and manage the use of health resources. Thus, the question arises in any state regarding how beneficiaries are informed regarding their appeals rights when decisions affecting their entitlement to covered services are made by their PCCM providers. For example, the Mississippi HealthMACS contract specifies broad care management duties for participating PCCM contractors that could significantly affect access to covered benefits:

5. Provide primary care and case management services to each enrollee *** and render necessary services;
6. Determine the medical necessity for and approve/authorize, when appropriate, non-emergency care covered under HealthMACS.
7. Make referrals when appropriate ***.
8. Approve/authorize as appropriate, any follow-up consultations and/or treatment, subsequent to making a referral to a specialist for consultation and/or treatment of a specific condition, for the duration of the illness. This includes services rendered by the specialist and referrals for service made by the specialist.
9. Approve/authorize, when appropriate, treatment for urgent or emergency care ***.

Despite the broad nature of these obligations (including continuing case management of every service and procedure furnished or ordered by a sub-specialist), the contract does not address the issue of notice. It may be that Mississippi and most other states use separate circulars or the issuance of the policy to lay out the obligations of PCCM providers regarding notice to members.

Only four states – California, Nebraska, New York, and Pennsylvania – use the contract itself to apprise providers of their duties at the point of program entry and in a legally binding fashion:

> 5.3 Enrollment Activities
> The EBS shall complete the following enrollment activities for mandatory clients: ***
> 14) An explanation of the complaint/grievance/appeal/process; and ***

5.3.2 Client Requested Materials: The EBS shall also coordinate the following with the Contractor if the following or similar, information is requested by the mandatory client or potential mandatory client: … (c) Complaint, grievance and appeal procedures ***

7.33 Client Rights: The Contractor shall provide written notice to the client of any adverse reaction (i.e., denial or reduction) regarding the provision of services that complies with all federal and state requirements. The contractor shall also allow clients to challenge decisions to deny, limit or terminate coverage of services. Clients shall be allowed to file complaints, grievances and appeals pursuant to this contract.
Nebraska Contract, pp. 50-51, 74.

***

11.0 Contractor Responsibilities Rights and Responsibilities

11.1 Introduction: The Contractor shall ensure that the client is fully informed, through use of a handbook, and verbally when appropriate of his/her rights and responsibilities as well as avenues for pursuing complaints and grievances. ***Nebraska Contract, p. 115***.

5. Coverage and Treatment Decision-Making. As the excerpts related to primary care case management duties illustrate, the contracts uniformly assign to PCCM providers an obligation to make coverage and treatment decisions, not only with respect to primary care, but also with respect to specialized treatment. In the case of several contracts, the case management duties continue past the point at which the initial referral is made to the specialist and explicitly require the PCCM provider to exercise oversight responsibilities of the specialist's consumption of primary care services.

The contracts are silent with respect to the procedures that PCCM contractors are required to follow in making treatment decisions for case management services. Factors not addressed include any timeframes for determinations, the level and extent of the evidence that must be considered in making the determination, consultation with the treating physicians as well as experts in complex cases, and the standards of medical necessity that apply (in particular the special pediatric standard of necessity that applies to children). These duties may be addressed in separate provider manuals.

6. Network Capabilities and Relationships with Specialists. PCCM providers typically do not form their own sub-networks. However, we assumed that a state would expect the provider to be able to demonstrate that it is capable of, and does in fact make referrals for covered services over which it has case management duties to participating area specialists.

The contracts varied greatly in this regard. California requires that contractors must:

> Provide accessibility [sic] to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral.
> ***California Contract, p. 18.***

Florida's MediPass contract specifies that one area of performance evaluation should concern access to the full range of services for which a contractor assumes either primary care or case management responsibilities:

> Utilization. In the MediPass model, primary care providers are expected to monitor the costs and medical appropriateness of care provided to recipients. MediPass is committed to increasing the quality of care that recipients need while reducing the use of unnecessary services. MediPass has adopted the goal that all recipients will receive appropriate authorized care for the medically

necessary covered services. The MediPass primary care provider will review and assess patient utilization and cost reports provided by the Medicaid program and report any noted errors, omissions or discrepancies ***. ***Florida Contract, p. 17.***

Similarly, the Georgia contract specifies that:

GBHC will review the following indicators to identify access/or service problems: *** Member concerns regarding availability of referrals to specialists and referrals for second opinions. ***Georgia Contract, pp. IX-9.***

None of the contracts we reviewed specifically requires a contractor to demonstrate capabilities in the area of specialist referrals or the ability to identify cases in which a referral might be medically warranted. The contracts generally do not appear to address the issue of how PCCM providers are expected to use specialists in their practices or the circumstances under which providers will be expected to involve specialists in treatment. There are certain exceptions, although these situations may be limited to pre-existing specialty treatment programs. For example, the Mississippi contract obligates PCCM providers to pursue special services for pregnant patients:

Refer the appropriate enrollees for perinatal high risk management services to the local health department, community health center, or other designated provider in the area (if available) when the PCP is not a participant in the PHRM program. ***Mississippi Contract, p. 77.***

Nebraska and New York require PCCM providers to use established specialists for children with special health care needs:

10.15(b) Children with Special Health Care Needs
Children with special health care needs are those who have or are suspected of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. The PCPCP and PCP/contractor will be responsible for performing all of the same activities for this population as for adults. In addition, the PCPCP and the PCP/Contractor will implement the following for these children:

(i) Satisfactory methods for interacting with school districts, preschool services, child protective service agencies, early intervention officials, behavioral health, and developmental disabilities service organizations for the purpose of coordinating and assuring appropriate service delivery.

(ii) Assure access to an adequate supply of pediatric providers and sub-specialists, including pediatric HIV practitioners and tertiary institutions, to meet their medical needs.

(iii) Satisfactory methods for assuring that children with serious, chronic, and rare disorders receive appropriate diagnostic work-ups on a timely basis.

(iv) Satisfactory arrangements for assuring access to specialty centers in and out of New York State for diagnosis and treatment of rare disorders.

(v) A satisfactory approach for assuring access to allied health professionals (Physical Therapists, Occupational Therapists, Speech Therapists, and Audiologists) experienced in dealing with children and families. ***New York Contract, pp. 30-31.***

Only the New York contract requires the use of specialists in mental illness or addiction disorders (e.g., community mental health centers), and then only for emergency purposes:

10.7 Emergency Services ***
10.7(b) The (PCPCP/LDSS/PCP/Contractor) shall ensure and demonstrate that it maintains relationships with hospital emergency facilities, including comprehensive psychiatric emergency

programs (where available) within and around its Service Area to provide Emergency Services.
New York Contract, p. 27.

7. Relationship with Other Programs and Agencies Furnishing Care to Enrollees. In some cases, contracts specify certain relationships that providers are expected to maintain with other organizations and agencies furnishing care to the enrolled population. For example, Florida, Mississippi, Nebraska, and New York specifically require providers to promote access to WIC benefits.

The most extensive contract with respect to relations with other agencies is the Florida contract, which enumerates numerous relationships with other programs as well as public health agencies:

Services to be Managed

* * *

Obstetrical services. It is agreed that the MediPass provider will: *** offer healthy start prenatal risk screening to each pregnant woman upon entry to care. The healthy start risk screening instrument may be obtained through the local health department in each county. Completed screening instruments must be forwarded to the local health department and documented in the patient's medical record.
***It is agreed that the MediPass provider who makes a diagnosis of tuberculosis or provides medical services to a person with suspected or confirmed tuberculosis shall report that diagnosis by telephone or in writing within 72 hours to the county health department having jurisdiction for the area where the reporting provider's office or the patient's residence is located. Subsequent status reports on the patient's treatment or progress shall be submitted by the provider to the county health department at least every three months until the case is closed and follow-up is completed.
*** Provide post authorization to public providers for the provision the following services: 1. The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and HIV; 2. The provision of immunizations; 3. School health services listed as 1 and 2 above;[12] 4. Services rendered on an urgent basis. Services rendered on an urgent basis are those health services needed to immediately relive pain or distress for medical problems such as injuries, nausea, and fever, and services needed to treat infectious diseases or other conditions. Public providers are not required to obtain prior authorization from a Medi-pass provider if providing services 1,2, 3 or 4, listed above.
Provide post-authorization to county health departments for the provision of emergency shelter medical screenings provided to clients of the Department of Children and Family [sic].
Florida Contract, pp. 3-7.

While the Florida contract is more extensive than other agreements with respect to certain service relationships, these relationships in fact appear to be bounded by the discretion given the PCCM provider regarding coverage. For example, the PCCM is responsible for covering, treating, and reporting tuberculosis cases, but is not obligated to consult with the health department with respect to specific treatment decisions. A local health department might refuse to declare a case closed as a means of securing additional treatment under the contract, but treatment decisions do not appear to be directly subject to review. Similarly, while the PCCM must post-authorize certain services, it appears that these services nonetheless remain subject to PCCM determinations regarding medical necessity. In other words, there is nothing in the contract that would require the PCCM to post-authorize the treatment in accordance with the determination of the need for service by the public agency. Thus, while a PCCM provider cannot deny payment on the ground that prior authorization was not obtained, it conceivably could deny coverage on the ground that the furnished service was not medically necessary.

8. Access to Services. The contracts contain numerous provisions related to access to care. We examined various access measures, including access to providers, cultural and linguistic access, and access for persons with disabilities. The standards vary considerably.

a. *Practice size*. Most of the contracts contain specifications regarding practice size. Typically the practice size is expressed in terms of the number of Medicaid patients per FTE-equivalent physician, but do not place overall limits on practice size (e.g., 150-2,000 enrollees/PCP in the case of Indiana; one PCP per 1,200 enrollees in the case of Georgia; 1,500 enrollees per PCP, plus 500 additional enrollees for each nurse practitioner in the case of Mississippi). Only Florida's contract expresses its limits in terms of overall patients (e.g., 1,500 patients per FTE and no more than 3,000 active patients per MD).

b. *Offices and office hours*. All of the contracts require the PCCM to maintain an office and to maintain office hours. All contracts require coverage 24 hours per day, seven days per week, but only some require access to a live person during hours when the office is closed. For example, the California and Florida contracts show contrasting approaches to the 24/7 coverage:

> Hours of operation and provision for after-hours services will be reasonable; emergency services will be available and accessible in the service area 24 hours a day, seven days a week.
> ***California Contract, p. 18.***
>
> ***
>
> It is agreed that the MediPass provider will provide or arrange for coverage for services, consultation, or approval for referrals 24 hours per day, seven days per week. This coverage must consist of an answering service, call forwarding, provide call coverage, or other customary means approved by the agency. The chosen method of 24 hour coverage must connect the caller to someone who can render a clinical decision or reach the MediPass Provider for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number.
> ***Florida Contract, p. 7.***

The provisions are notably different. California's contract provides no standards for what is a "reasonable" set of office hours and conceivably permits the provider to use a hospital emergency room to provide full-time coverage (assuming of course that the provider is willing to pay for such expensive care). The contract does not address the accessibility of other contract services, most notably consultation and approval services, even though PCCMs have ongoing obligations in both areas. The Florida contract, on the other hand, provides more detailed specifications regarding the operation of the practice and covers all aspects of the care and case management duties undertaken by PCCM providers.

c. *Travel time and appointment waiting time*. The contracts vary in the extent to which they address travel times and services waiting times. Furthermore, although the contracts require PCCM contractors to manage specialty services (in some cases explicitly requiring ongoing management after the initial referral and when the patient is under the care of the specialist) the contracts do not address the issue of accessibility of specialty care. Furthermore, the Florida and California contracts specifically permit PCCM contractors to self-monitor the accessibility of both primary and case managed services by comparing its performance against agency-supplied data. California's contract does not set access standards but instead allows the contractor to benchmark itself:

> Contractor will provide information regarding accessibility of service in accordance with the needs of members for such information [sic] in accordance with Sections O and P of this Article and

through other appropriate means. The Contractor will obtain departmental approval prior to making any substantial change in the availability of location for provision of covered services under this contract except in the case of unforeseeable circumstances. ***California Contract, p. 18.***

d. *Cultural competence and language access*. Only the Nebraska contract addresses the requirement for cultural competence:

7.13 Adequate Mix of Providers: The Contractor shall arrange for an appropriate range of PCP services and access to preventive and primary care services in the designated coverage areas, and maintain a sufficient number, mix, and geographic distribution of providers that are skilled in areas such as cultural diversity and sensitivity, *** ***Nebraska Contract, p. 71.***

"ARTICLE IV
4.O GOALS/MEASURES CLIENT PARTICIPATION AND ENROLLMENT PROCESSES
4.1 Goal: Ensure that the PCP/Contractor is culturally diverse and sensitive to the cultural needs of the NHC clients in all aspects of the NHC.

4.1.1 Initial Measure: A work plan that identifies the Contractor's strengths and areas for improvement in the above stated goal, a proposed corrective action plan, and the method that will be utilized by the Contractor to evaluate the effectiveness of the activities.

The work plan shall address the Contractor's cultural sensitivity training for staff and providers, participation in/sponsorship of community events, increased numbers of culturally diverse staff and providers, as mutually agreed to by the parties and contingent upon availability of qualified, culturally diverse staff and providers, with definition of culturally diverse mutually agreed to by the parties. The work plan shall include specific activities, dates/times, targeted audiences, and designated staff responsible for the activity. The initial work plan shall address the first two years of the contract, and shall be submitted and approved by the Department prior to July, 1999.

Proposed printed materials shall be included as part of the work plan, along with a timetable for development and printing that incorporates the requirement for review by the Department, and an anticipated distribution Contractor.

4.1.2 Ongoing Measure: A progress report that identifies the outcome of the proposed work plan identified above. The progress report shall be submitted and approved by the Department on a quarterly basis and shall address activities completed during the reporting period.

The Contractor shall be required to address specific issues, problems and how the Contractor resolved such issues in the quarterly report. The Department shall evaluate the Contractor's understanding of the requirement and how well the contractor has incorporated the requirement into its daily operations.

4.1.3 Minimum Requirement: The Contractor shall be considered in compliance with this requirement as long as the procedures are effectively being utilized by the Contractor on an ongoing basis. The Contractor shall demonstrate compliance with all related NHC policy and procedures. The Department will not unreasonably withhold approval, and shall work with the Contractor to meet this requirement.

At a minimum, the Contractor shall complete at least one activity to promote cultural diversity and sensitivity on a quarterly basis. Contractor staff must receive cultural competency training on an annual basis. ***Nebraska Contract, p. 36.***

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"11.6 Cultural Sensitivity and Diversity: HHS is a culturally diverse environment that

exercises zero tolerance of any acts of discrimination, racism, or prejudice. Understanding, valuing and promoting cultural sensitivity and diversity shall be a part of the ongoing philosophy of the Department of Health and Human Services and any of its programs. The Contractor shall promote this philosophy with the client, providers and within the work place. ***Nebraska Contract, p. 119***.

Nebraska, New York, Pennsylvania, and Washington address services for persons whose primary language is not English. For example, the Nebraska contract requires that adequate numbers of providers maintain minimum language capabilities with respect to their members, and to "assist the client in the resolution of problems relating to the accessibility of health care delivery, including but not limited to language barriers."

The New York contract indicates that PCCMs must provide written materials and interpreter services in languages other than English, "whenever five percent or more of … membership … speak a particular language other than English as a first language and do not speak English."

e. *Access for persons with disabilities*. Contracts from Nebraska, New York, and Pennsylvania address disability access or what is expected as a matter of reasonable accommodation:

7.21 ADA Requirements: The Contractor shall comply with all requirements of the American with Disabilities Act (ADA), and ensure:
(a) Appropriate accommodations are made for clients with special needs; and
(b) That PCPs and specialists are equipped in appropriate technologies, e.g., TTY/TDD.
Nebraska Contract, p. 73.

***

The (PCPCP/PCP/Contractor) also must make available appropriate methods for communicating with visually and hearing impaired Enrollees, consistent with the Americans with Disabilities Act standards. ***New York Contract, p. 34.***

9. Quality Assurance. With varying degrees of specificity, PCCM contracts contain provisions that require contractors to adhere to certain performance standards related to health care quality. For example, Indiana's contract provides as follows:

The PMP must adhere to universally accepted standards or periodicity schedules, or preventive care for pregnant women, infants, children, adolescents and adults. PMP performance in these standards will be reviewed and reported to the PMP on a quarterly basis. These periodicity schedules are endorsed by the Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Society of Internal Medicine. These scheduled standards/guidelines are listed in the Hoosier Healthwise Provider Manual."
Indiana Contract, p. 3.

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California directs contractors to develop and maintain internal quality assurance programs:

Establish a Quality Assurance (QA) program that is directed by providers and that documents that the quality of care provided to members is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. . . .

In addition to the internal quality of care review system, Contractor will *** design and implement reasonable procedures for continuously reviewing the standards for acceptable medical care, the

performance of health care professionals, and the utilization of services and facilities, and costs; and for conducting professional review activities." ***California Contract, pp. 17, 27, 30.***

By far the most extensive contract in the area of performance standards is Florida's agreement, whose quality improvement standards are reproduced at length below because they span both structural requirements and clinical care standards:

Credentialing standards. It is agreed that the agency and/or Medicaid program will enroll primary care providers or group providers who have met the following credentialing standards:

n. Have sent a completed Medicaid agreement with a copy of each provider's current medical license to Medicaid's fiscal agent and are approved Medicaid providers. The practitioner's active licensure shall suffice in lieu of verification of education, training and professional liability coverage:
o. Have not received any revocation or suspension of the provider's *** license ***;
p. Have no sanctions imposed *** by Medicaid or Medicare ***;
q. Have no ongoing investigations by Medicaid Program Integrity, Medicare, Medical Quality Assurance, or other governmental entities;
r. Have good standing of privileges at the hospital designated at the primary admitting facility *** or if the provider does not have admitting privileges, good standing of privileges at the hospital by another physician with whom the primary care provider has entered into an agreement for hospital coverage;
s. Have submitted copies of valid Drug Enforcement Administration certificates where applicable;
t. Have attested that the total active patient load (all populations with Medicaid fee-for-service, Medicaid prepaid health plan, HMO, Medicare, or commercial coverage) is not more than 3000 patients per PCP. An active patient is one that is seen by the professional a minimum of three times per year;
u. Have passed a criminal background check with in the previous 12 months ***;
v. Have received a good standing report on a credentialing site visit survey;
w. Have attested to the correctness *** of the ***provider application;
x. Have made a statement regarding the history of loss or limitation of privileges or disciplinary activity.

Recredentialing standards. The process for periodic recredentialing shall include the following:

a. Recredentialing shall be implemented at least every two years.
b. MediPass or its agent shall conduct periodic reviews of information from the National Practitioner Data Bank, State Medical Board, HCFA and other performance data.

Quality of care standards. Providers will adhere or exceed the quality assurance standards established by MediPass.

a. Childhood immunizations. ***The MediPass Primary Care Provider will provide or manage services such that children will receive vaccinations for diphtheria, tetanus, pertussis, polio, measles, haemophilus influenza b, and hepatitis B according to the recommended immunization schedule issued by the AAP and the ACIP and/or the AAFP.
b. Child health checkup. ***Consistent with the child health checkup, formerly called the EPSDT and the Medicaid child health monitoring standards, Medicaid has adopted the goal that over 80% of recipients will receive *** screenings by age one month; during 2, 4, 6, 9, 12, 15 and 18 months of age, and once per year for ages 2 through 20 years of age. The MediPass primary care provider will provide or managed services such that all recipients under 21 *** will receive any appropriate child health check up screenings.
c. Adult health screening. ***The MediPass provider will provide or manage services such that a health screening will be performed, if due, on recipients aged 21 years or older in accordance with the recommendations in the Medicaid Physicians coverage and limitations handbook.

d. Comprehensive diabetes care.

1. Diabetes retinal examinations. MediPass is committed to reducing the incidence of diabetes inducing blindness in MediPass recipients. *** Based on guidelines proposed by the American College of Physicians, the American Diabetic Association, and the American Academy of Ophthalmology, the MediPass primary care provider will provide or manage services such that recipients with a history of diabetes will receive at least one fundoscopic exam every 12 months.
2. Glycohemoglobin levels. MediPass acknowledges that tight control of blood glucose levels can delay the onset and slow the progression of many of the side effects from diabetes. Glycohemoglobin is one laboratory indicator of how well a recipient's blood sugar is controlled. Consistent with the American Diabetes Association recommendations, the MediPass Primary Care Provider will provide or manage services such that recipients with a history of diabetes will receive glycohemoglobin determinations at least twice a year.
3. Lipid levels. MediPass recognizes the direct link between hyperlipidemia, secondary hyperlipoprotienemias and diabetes melitus. By closely monitoring lipids and lipoprotein levels in diabetics, better control and maintenance is possible. Consistent with the recommendations of the American Diabetes Association, the MediPass provider will manage services such that recipients with a history of diabetes will receive lipid and lipoprotein determinations annually. If any anomalies are found in the annual baseline, additional studies should be conducted as medically necessary.

e. Mammography screening. MediPass recognizes that breast cancer is one of the most common malignancies affecting women. Early detection and treatment of breast cancer improves the probability of long term survival. *** The MediPass primary care provider will provide or manage services such that female recipients will receive mammography screening consistent with the recommendations of the Medicaid Physician Coverage and Limitations handbook.

f. Cervical cancer screening. MediPass is committed to reducing the incidence of cervical cancer. *** Consistent with the recommendations by the American College of Obstetricians and Gynecologists. American Medical Association, American Cancer Society, and the U.S. Preventive Service Task Force, the MediPass Primary Care provider will provide or manage services such that female recipient's [sic] between ages 18 and 64 years, or if younger than 18 years, who have been sexually active, will receive at least one Pap smear every two years.

g. Initiation of prenatal care. MediPass is committed to improved pregnancy outcomes. Pregnancy outcomes can be enhanced by early entry into prenatal care. Consistent with Healthy People 2000: National Health Promotion and Disease Prevention Objective and in the Health Plan Employee Data and Information Set (HEDIS). The MediPass primary care provider will provide or manage services such that prenatal care is initiated in the first trimester of pregnancy, or, if the recipient is pregnant when enrolling with the provider, within four weeks of enrollment.

h. Postpartum care. MediPass recognizes the importance of checkups after delivery for female recipients. MediPass is committed to providing adequate and ongoing follow-up and preventive care of the postpartum female recipients. As recommended in the health plan employee data and information set (HEDIS), the MediPass primary care provided will provide or manage services such that a female recipient will receive a postpartum visit and exam between 21 and 56 days after delivery.

i. Access to Care. MediPass is a primary care case management program that will result in improved access to care for recipients. *** Two goals *** are discussed below:

1. Twenty-four hour coverage. MediPass realizes that an important aspect of a gatekeeping function is based on the availability of providers. A MediPass provider must be continuously accessible to render clinical decisions *** All providers will arrange for primary care coverage for services, consultation or approval for medically necessary referrals 24 hours per day, seven days per week. The MediPass provider will provide or manage services such that the chosen method of 24-hour coverage will connect a recipient's call to someone who can render a clinical decision.

2. Utilization. In the MediPass model primary care providers are expected to monitor the costs and medical appropriateness of care provided to recipients. MediPass is committed to

increasing the quality of care that recipients receive, while reducing the use of unnecessary services. MediPass has adopted the goal that all recipients will receive appropriate authorized care for medically necessary covered services. The MediPass primary care provider will review and assess patient utilization and cost reports provided by the Medicaid program and report any noted error, omissions or discrepancies ***

j. Low birthweight. MediPass recognizes that socioeconomic status is one of many factors that affect the incidence of low birthweight infants ***. While many factors that affect birthweight are beyond a provider's control, many variables may be influenced through timely and appropriate prenatal care. Consistent with recommendations in Medicaid HEDIS, the MediPass provider will provide or manage services such that timely and early prenatal care will be initiated during the first trimester or pregnancy, or if the recipient is pregnant when enrolling with the provider, within four weeks of enrollment. ***

k. Domestic violence. MediPass providers shall routinely screen their patient for signs of domestic violence and shall provide referral services to applicable community domestic violence prevention agencies. ***Florida Contract, pp. 14-17***.

10. Provision of Data and Information. With only one exception, the contracts do not specify particular groupings of data, beyond general specifications requiring contractors to furnish data upon request to the agency. In addition, with the exception of the tuberculosis reporting requirements noted previously, the PCCM contracts do not require contractors to furnish certain data to public health or other agencies. However, the Florida contract specifies the data that the state will furnish to providers each month and provides for maintenance of privacy in accordance with federal regulations.

Next Steps

Studies of PCCMs suggest that these models do not adversely affect access to primary care and may even enhance access to certain types of procedures.[13] These studies were carried out prior to the expansion of the PCCM model into the disability community. To the extent that PCCM arrangements are enjoying a resurgence and expanded use for patient populations whose health needs extend beyond the capabilities of most MCOs, the findings from this study suggest the need for several types of interventions:

- ***Policy development regarding the appropriate role of a primary care case manager***. To what extent can various Medicaid sub-populations receive appropriate management from providers trained in a primary care specialty? Is there a need for additional performance standards in the areas of coverage decision-making and formalized relationships with consulting experts and referral specialists? Is this an area in which state Medicaid agencies can and should play a greater supporting role to their PCCM contractors by offering such tools?

- ***Specialized primary care case management agreements for special populations.*** Can it be assumed that any primary care specialist can manage any patient? What are the implications of asking practitioners with only generalized knowledge regarding physical and mental conditions and disabilities to case manage all sub-populations covered by a mandatory system? Do certain conditions merit highly specialized agreements?

- ***Arrangements with other providers and programs.*** Are there certain related providers and programs with which all PCCM contractors should be expected to demonstrate an ongoing arrangement? For example, should affiliation with a state program for children with special needs, the state mental health or substance abuse agency or developmental disabilities agency, be a requirement in all contracts? What types of support should PCCM contractors expect from these agencies?

- ***Quality performance and improvement.*** Are there certain types of performance standards in the areas of physical and mental health that state agencies should build into PCCM contracts? How should performance be monitored and by whom?

- ***Beneficiary safeguards.*** Only one contract reviewed contains detailed specifications regarding what constitutes a coverage determination and the obligations of the contractor under such circumstances. What is the best approach for handling this matter and for allocating the respective duties of the state and its contractor in these circumstances?

- ***Payment.*** The contracts generally contemplate a small monthly case management fee. Are fee levels sufficient given the range of responsibilities undertaken, particularly where the actual number of enrolled patients is low?

- ***Comparison of different Medicaid approaches to managed care.*** Do different Medicaid approaches to managed care yield different results for different populations? Even though other studies have considered the effects of different approaches to Medicaid managed care, we believe that further investment in comparative studies is worthwhile, particularly in the case of special needs populations. Past studies of PCCM arrangements suggest that

they can achieve cost effective use of services and at least some improvement in patient outcomes. Yet Medicaid agencies tend to see these systems as lesser alternatives to MCO-style contracting, precisely because they must be able to operate an internal MCO, something that many agencies may be unable to do because of a lack of resources and political support. The use of PCCM arrangements might be greater if it was determined that at little or no cost, PCCMs yield better outcomes (particularly for higher need patients), more satisfied patients, or more stable and satisfied providers than MCO systems. If on the other hand there are real differences in cost and quality between the two models, the prospects for widespread resurgence of PCCM systems are probably more limited.

- ***Procedural safeguards***. The findings from this analysis suggest that Medicaid agencies vest their PCCM providers with considerable discretion to make treatment decisions and determinations regarding the allocation of Medicaid resources, particularly specialty and inpatient care. Federal law provides beneficiaries with specific procedural protections for treatment decisions made by managed care organizations. These procedural safeguards are in addition to the basic Medicaid fair hearing requirements, which are constitutionally required and which provide for advance notice and impartial review of any decision to deny, reduce, or terminate assistance. Under federal grievance requirements, MCOs must provide internal systems for review of grievances and these systems must include expedited procedures where resolution of a dispute urgently must take place.[14]

  There is no federal requirement for a grievance and appeals process in the case of PCCM systems. We found very few instances in which PCCM contracts call for the PCCM to notify beneficiaries of their fair hearing rights. Nor is it clear that the more than 40 states that in recent years have established external review systems for state residents enrolled in managed care arrangements[15] extend these systems (that typically are part of a state's insurance laws) to Medicaid PCCM arrangements, which are not otherwise subject to state insurance law. Because PCCM providers are vested with extraordinary discretion to make treatment decisions, the need for external and rapid review of their determinations is considerable.

- ***The competency of PCCM providers to make treatment decisions.*** The procedural safeguards discussed above are closely linked to how PCCM providers make treatment decisions for Medicaid beneficiaries, including those with special needs. No contract specifies the competencies of PCCM providers that are vested with treatment decision-making powers.[16] This is an important issue, and one that has received attention in managed care reform over the past several years. Where larger managed care organizations are concerned, many state Medicaid programs specify extensive standards regarding the competency of treatment decision makers.[17] Legislation now pending in Congress would more heavily regulate the utilization review process of health benefit plans, including the competency of the decision maker. Yet, Medicaid PCCM contracts pay little or no attention to this problem.

All of these questions are equally applicable to MCO-style arrangements, but the debate over standards in the case of MCO-style managed care is relatively long-standing. Much less has been done to foster quality and performance improvement in the case of PCCM arrangements because of their reputation for "structural modesty." The findings from this study suggest otherwise and

suggest the need for a broader initiative in the area of primary care case management improvement.

Appendix I
List of Reviewed Documents

Alabama	Patient 1st Primary Medical Provider Manual
Arkansas	Arkansas Medicaid Primary Care Physician Medicaid Care Program, Primary Care Physician Participation Agreement
California	Primary Care Case Management Program Capitation Rates – Attachment B 99-85886 PCCM Plan: Molina Medical Centers Project.
Florida	Agreement for Participation in Medipass Medicaid Provider Access System (Medipass)
Georgia	Georgia Better Health Care Primary Care Case Management Provider After Hours Telephone Care Agreement Policies and Procedures for Georgia Better Health Care Services
Idaho	Idaho Healthy Connections Coordinated Care Provider Agreement
Indiana	Addendum to the Internal Medicine Provider Agreement for Participation as a Primary Management Program in the Hoosier Healthwise Primary Case Management Provider Network
Iowa	Iowa Department of Human Services Agreement for Participation as a Patient Manager in the Medicaid Patient Access to Service System
Kansas	Managed Care Contract between the Kansas Department of Social Rehabilitation Services and (*FILL IN PROVIDER NAME*) to Provide Primary Care Case Management Services Health Connect Primary Care Case Management Contract
Kentucky	Kentucky Medical Assistance Program, Agreement for Participation as a Primary Physician or Clinic in the Kentucky Patient Access and Care System
Louisiana	Louisiana PE-50 Community Care Provider Supplement Agreement and Revisions to Provider Agreement
Maine	Department of Human Services, Bureau of Medical Services, Maine Primecare Rider Terms and Conditions
Massachusetts	Massachusetts Behavioral Health Partnership, NMS Contract
Mississippi	Division of the Medicaid in the Office of Governor, State of Mississippi Medicaid Title XIX Participation Agreement for Health MACS Primary Care Provider

Montana	State of Montana Department of Public Health and Human Services Medicaid Services Bureau, Health Policy and Services Division, Agreement for Participation as a Primary Care Provider in the Montana Medicaid PASSPORT TO HEALTH Program
Nebraska	Contract for Services between the State of Nebraska, Nebraska Department of Health and Human Services Finance and Support and HMO Nebraska, Inc.
New York	1) Medicaid Model Contract for Partially Capitated Managed Care Providers 2) New York State Department of Health Member Handbook Guidelines for Medicaid Enrollees 3) Appendix L – Model Medicaid Benefit Package for Physician-Based Partially Capitated Providers
North Carolina	State of North Carolina Department of Human Resources Division of Medical Assistance, Agreement for Participation as a Primary Care Provider in North Carolina's Patient Access and Coordinated Care Program
North Dakota	North Dakota Purchase of Service Agreement, Contract #415-03486
Oklahoma	Oklahoma Health Care Authority SoonerCare Choice (Physician) Three-Year Contract (Years IV, V, VI)
Pennsylvania	1) Pennsylvania Department of Public Welfare Grant Agreement to Administer the Primary Care Case Management Program in Lancaster County 2) Lancaster Community Health Plan Program Standards 3) Standard Contract, Terms & Conditions 4) DPW Addendum to Standard Contract Terms & Conditions
South Dakota	South Dakota Provider Agreement to Participate in the South Dakota Medicaid Program
Texas	1) PCCM Star Network Administrator Contract Between the Texas Department of Health and Birch & Davis Health Management Corporation, Amendment #1 2) Request for Proposal – Star Network Program Administrator, Texas Department of Health
Vermont	Agreement for Participation, Office of Vermont Health Access, Primary Care Case Management Program (Primary Care Plus)
Virginia	Commonwealth of Virginia, Department of Medical Assistance Services, Medical Assistance Program, Participation Agreement

Washington	1) Washington Basic Indian Nation Contract 2) Indian Nation Agreement for Healthy Options Primary Care Case Management
West Virginia	Agreement for Physician or Clinic Participation as a Primary Care Provider in the West Virginia Physician Assured Access System

Appendix II
PCCM Contracts Review Instrument

I. Enrollment

Enrollment Procedure
Enrollee selection of provider
Time-line for provider selection
Enrollee ability to change providers

Auto-Enrollment Procedure
Auto-enrollment process
Time-line for auto-enrollment
Prohibited populations
Limits on proportion of eligible population to be auto-enrolled
Enrollee ability to change plans
Existence of algorithm for allocation of enrollees

Special Enrollment Procedures
Adults with mental illness
Adults with addictive disorders
Children with addictive disorders
Children with mental illness
Children in foster care or out-of-home placement.
Homeless persons
Migrant families
Newborns
Non-English speakers
Persons in ongoing treatment
Persons in inpatient settings
Persons in residential treatment
Pregnant women

Information for Enrollees on Coverage Rules and Provider Participation
Service coverage, limits, and exclusions
Obtaining Medicaid covered services not in plan contract
Urgent care
Emergency care
Translation services
Transportation services
Participating providers
Primary care provider openings
Other

Information for Enrollees on Plan Policies and Procedures
Prior authorization procedures
Grievances and complaints procedures
Disenrolled by plan procedures
Disenrolled by enrollee procedures
Confidentiality policies
Physician incentive agreements
Access to fair hearings

Plan Disenrollment of Enrollees
Plan disenrollment for loss of coverage or eligibility
Plan disenrollment for cause
Agency approval process for plan disenrollment
Protections against plan disenrollment

II. Coverage and Benefits

General Services
Hospital inpatient services
Hospital outpatient services
Laboratory and X-ray
Physician services
Nurse midwife services
FQHC and rural health clinics
EPSDT
Home health care
Nurse practitioners
Dental care
Durable medical equipment
Mental health and substance abuse
Prescription drugs
Case management
Other
Treatment services for individuals with dual diagnosis

Urgent Care and Emergency Care Services
Urgent care
Urgent care: Coverage
Urgent care: Definition

Emergency care
Emergency care: Coverage
Emergency care: Definition

Coverage for urgent and emergency services out-of-plan

Definition of emergency specific to mental health or substance abuse
Definition of pediatric emergency
Definition of pregnancy-related emergency

Medical Necessity Standards
General coverage rule
Medical necessity standard
Pediatric medical necessity standard
Mental health or substance abuse related medical necessity standard
Pregnancy medical necessity standard
TB medical necessity standard
Dual diagnosis medical necessity definition

III. Service Duties

Provider Coordination and Standards
Hospitals and other institutions
Mental health substance abuse providers
Obstetric providers
Pediatric providers
Pharmacies
Role of primary care providers
Definition of primary care
Definition of case management and scope of case management duties
Specialty care/other providers
Traditional and safety-net providers
Dual diagnosis providers

Translation Services and Cultural Competence
Multi-lingual providers in network
Disability-communication capacity required in network
Materials in other language or in form useful to people with disabilities
Services for persons whose primary language is not English
Services for persons with speech, language, hearing, or vision related disabilities
Provision of easily understood information

Cultural Competence
Cultural competence requirement
Cultural competence defined

Access Time Standards
Emergency care
First appointments for new enrollees
Medically necessary/acute care adult visits
Medically necessary/acute care pediatric visits

Specialty specific services
Preventive pediatric visits
Preventive adult visits
Services for mental illness
Services for pregnant women
Services for substance abuse disorders
Urgent care

Geographic Access Standards
For primary care providers
For specialty or inpatient care providers
For other benefits or services

IV. Public Health and Social Service Agency Relationships
Relationships with Other Public Agencies

Adult correction
Adult welfare
Child welfare
Children with special health care needs
Early intervention
Homeless health
Juvenile justice
School health clinics
Special education
State/local public health
State/local mental health
State/local substance abuse
State senior services
WIC Supplemental Nutrition
Head Start

V. Quality Assurance, Data, and Reporting

Internal QA system
External review of plan's performance
Clinical studies
Clinical guidelines
Profiling provider performance
Evaluation of grievances and complaints
Corrective action plan
Linkage between performance measures and services duties

General Data Reporting
Access data

Complaints and grievances
Encounter data
Financial data
General authorization
Outcomes data
Performance data
Utilization data
Other

Mental Health and Substance Abuse Data Reporting
Care process and outcome data for mental health and substance abuse treatment
Discharge data for addictive disorder
Hospitalization for addictive disorder
Hospitalization for mental illness
Identified substance abuse
Identified domestic abuse
QA/Utilization measures for mental health/substance abuse treatment
Other

Maternal and Child Health Data Reporting
Prenatal care
EPSDT
Immunization

VI. General Qualifications and Requirements

Contract term and termination, for cause, without cause

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Endnotes

[1] Note that Colorado has established a PCCM program, but uses a Letter of Agreement, instead of a contract. The Letter of Agreement was not collected.
[2] The following states were reviewed: Alabama, Arkansas, California, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, Nebraska, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Dakota, Texas, Vermont, Virginia, Washington, and West Virginia.
[3] Rosenbaum S., et. al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts.* The George Washington University Medical Center, Center for Health Policy Research, Washington D.C. 1st – 3rd ed. 1997-1999, available at www.gwhealthpolicy.org.
[4] This analysis highlights the findings in each of the core issues; however, the PCCM searchable database will include additional language that may not be outlined in this report. The database, which includes full information from our other contract studies, may be accessed from the Center for Health Services Research and Policy's website at www.gwhealthpolicy.org.
[5] *Medicaid and the Uninsured, Key Facts*. The Henry J. Kaiser Family Foundation. Dec. 2001. www.kff.org.
[6] For further discussion on primary care case management, see Smith V. K., PhD., et. al. *Exemplary Practices in Primary Care Case Management, A Review of State Medicaid PCCM Programs.* Center for Health Care Strategies, June 2000. www.chcs.org.
[7] The use of a common type of primary care specialist for all sub-populations is illustrated by the following excerpt from Georgia's contract: "Membership in [the Georgia PCCM program] is mandatory for all Medicaid recipients except those residing in nursing facilities, personal care homes, mental health hospitals, and other domiciliary facilities, as well as Right-from-the Start Medicaid mothers and other recipients with short-term Medicaid enrollment. Recipients covered by both Medicare and Medicaid are eligible, but not required, to become members of [the PCCM program]." *Georgia PCCM contract, Part II, Program Overview (unnumbered page).* Under the terms of this agreement, the contract would cover any individual for whom the PCCM system is either mandatory or optional; the contractor must of course satisfy the performance standards of the agreement, but the agreement presumes that an "eligible" practitioner would be capable of furnishing PCCM services to any of the enumerated sub-populations. The Georgia contract defines "eligible" practitioner as "a physician routinely providing services characteristic of practice in: (a) family practice; (b) general practice; (c) pediatrics; (d) internal medicine; or (e) gynecology; a nurse practitioner specializing in: (a) family practice; (b) pediatrics; or (c) gynecology; and other entities including rural health centers, community health centers, primary care public health department clinics, or primary care hospital outpatient clinics. *Georgia PCCM contract*, part II. Ch. 600.
[8] An "at-will" employment contract provides that, absent express agreement to the contrary, either employer or employee may terminate their relationship at any time, for any reason. These contracts have no specific duration.
[9] §1905(t)(4) of the Social Security Act, 42 USC §1396d(t)(4).
[10] §1905 (a) of the Social Security Act, 42 USC §1396d(a).
[11] Since Florida does not expressly reserve the right to decide what evidence amounts to a "not satisfactory" arrangement, the agreement would presumably be construed to give the health professional the discretion to decide when an arrangement is in fact unsatisfactory (i.e., a subjective judgment rather than an agency-imposed objective judgment).
[12] Our reading of this reference is unclear; we presume that it means HIV and STD services as well as immunizations.
[13] Smith V. K., PhD., et. al. *Exemplary Practices in Primary Care Case Management, A Review of State Medicaid PCCM Programs.* Center for Health Care Strategies, June 2000. www.chcs.org.
[14] For more information see, Rosenbaum S., et. al. *Designing A Complaint and Grievance System and Other Member Services under Medicaid Managed Care.* SAMHSA Issue Brief Series 7. Available at www.samhsa.gov.
[15] *State Statutory Managed Care Protections*. Families USA and Health Policy Tracking Service, March 2001.
[16] For more see, Rosenbaum S., et. al. "Who Should Determine When Health Care is Medically Necessary?," *New England Journal of Medicine.* 229. January 21, 1999.
[17] *Negotiating the New Health System,* op cit.