Medicaid Managed Care Contracting

An Advocacy Guide for State Associations of Behavioral Health Providers

PREPARED FOR THE
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH BY:

Adam J. Falcone, Esq.
Daryl M. Berke, Esq.

Feldesman Tucker Leifer Fidell LLP

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The primary author of this document can be contacted at:

Adam J. Falcone, Esq.
Feldesman Tucker Leifer Fidell LLP
1129 20th Street NW, Suite 400
Washington, DC 20036
Telephone (202) 466-8960
Email: afalcone@ftlf.com

FELDESMAN+TUCKER+LEIFER+FIDELL

Preface

This Advocacy Guide seeks to assist state associations of behavioral health providers address challenges that their members face — or challenges their members may soon face — under contracts with managed care organizations ("MCOs") to furnish services to Medicaid enrollees.

Many behavioral health providers lack the leverage to negotiate fair provisions in their participation agreements with MCOs. Out of necessity, behavioral health providers will often accept the contract terms, resulting in uncompensated services, to say nothing of delays or denials of treatment for their patients.

State associations cannot negotiate MCO participation agreements on behalf of their organizational members due to federal and state antitrust laws. State associations may however, without risk of violating those same laws, seek to influence policies emanating from state legislatures and regulatory agencies that would protect their members from unfair participation agreements, or even from competition between members that otherwise would suppress reimbursement rates. This is a consequence of two U.S. Supreme Court decisions that established the Noerr-Pennington Doctrine, which immunizes government petitioning as protected conduct under the First Amendment.[1]
The Noerr-Pennington Doctrine provides the basis for an effective – and lawful – strategy by state associations to "level the playing field" through securing language in state contracts between Medicaid agencies and MCOs. When such language is required by the state, fair terms will already be reflected in the standard participation agreements offered to providers.

This Advocacy Guide contains thirteen chapters, each devoted to a topic that frequently arises for behavioral health providers related to participation in Medicaid managed care contracts. Each chapter provides an overview of the topic, model language for state contracts that would address the contracting issues that have been identified, and talking points that can be used in advocacy efforts with state agencies.

State associations should, in consultation with their members, identify and prioritize among the various contracting issues described in this Advocacy Guide. Some issues may already be addressed through existing state laws or existing contracts with MCOs, while others might be addressed more comprehensively through broader changes to state law that would apply to populations beyond Medicaid. The optimal strategy for state associations will depend on state-specific political and policy considerations.

[1] *See E. R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 135 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657, 670 (1965).

Executive Summary

Behavioral health providers frequently experience unfair contracting practices by MCOs that:

- Refuse to contract with behavioral health providers that do not accept proposed contract terms, thereby limiting patient choice in accessing behavioral health services.
- Require "All Products Clauses" that force a behavioral health provider to accept low reimbursement levels in one product as a condition of participation in another.
- Exclude certain services from the scope of the provider's participation agreement, depriving the provider of payment for such services and denying patients with access to those services from his or her provider of choice.
- Implement claims processing practices that deny timely payments for services, including short timeframes for submitting claims, denials of claims without sufficient explanation, and delayed payments.
- Reimburse behavioral health providers at levels below those paid by a Medicaid agency in its the Fee-For-Service ("FFS") program.
- Recover potential overpayments from behavioral health providers without prior notice (or an opportunity to appeal) by offset against current amounts payable.
- Each apply their own standards for determining medical necessity, creating inconsistent coverage determinations, denied requests for prior authorization, and denied claims for services rendered.
- Require behavioral health providers to participate in duplicative credentialing activities for their practitioners, adding administrative costs without any benefit in the quality of care to enrollees.
- Permit MCOs to unilaterally amend their participation agreements without obtaining the behavioral health provider's consent, forcing acceptance of unfavorable contract terms and loss of desirable ones.
- Permit MCOs to downstream state imposed regulatory penalties onto providers, thereby absolving the MCO of any responsibility.
- Include anti-assignment clauses, requiring termination of participation agreements when one behavioral health provider merges with another or forms a new legal entity that succeeds existing entities.
- Make numerous data requests, imposing significant costs and administrative burden due to each MCO establishing unique data reporting requirements and specifications.
- Apply a patchwork of drug formularies and prior authorization policies from MCOs, creating disparate coverage across Medicaid enrollees and imposing high administrative costs on providers.

State Medicaid agencies can address the most egregious contracting practices by including specific requirements in their contracts with MCOs. When such requirements exist, fair participation terms can provide financial stability to all

behavioral health providers and preserve access to services for Medicaid enrollees.

Chapter 1. Refusals to Contract

KEY POINTS

To prevent behavioral health providers from being excluded from MCO provider networks, Medicaid contracts with MCOs could:

- Require MCOs to accept any behavioral health provider willing to accept an MCO's standard terms and conditions as a participating provider; or, alternatively,
- Impose an affirmative obligation on MCOs to contract with specific types or categories of behavioral health providers.

Overview

State-specific network adequacy standards typically establish certain time and distance standards for the inclusion of behavioral health contractors in each MCO's provider networks. Within those standards, MCOs are free to selectively contract with providers, establishing a network of providers that each MCO believes will favorably impact its bottom line. Upon demonstrating capacity to serve their expected enrollee population by meeting those network adequacy standards, an MCO may refuse thereafter to contract with additional behavioral health providers.

Consequently, a very real threat of managed care is the exclusion of certain behavioral health providers from participation in MCO networks. Because Medicaid is the largest funder of behavioral health services in the nation, exclusion from participation in Medicaid managed care would deny many behavioral health providers a necessary and vital source of revenue, potentially leading to bankruptcy, to say nothing of the harm to Medicaid enrollees who would no longer be able to access those providers' services. This devastating possibility significantly undermines any leverage to negotiate favorable terms of participation with MCOs.

One approach to address this problem has been for Medicaid contracts to require MCOs to accept any willing behavioral health provider as a participating provider. Under an "Any Willing Provider" mandate, Medicaid MCOs would be required to contract with any qualified behavioral health provider that is willing to accept the MCO's standard terms and conditions. The downside to Any Willing Provider mandates is that the provider must accept the standard terms and conditions offered by the MCO — and such terms and conditions may be less than desirable for the behavioral health provider.

An alternate approach to Any Willing Provider mandates has been a provision in state contracts requiring MCOs to include certain, specified types or categories of behavioral health providers in provider

networks. The advantage to this approach is that it imposes an affirmative obligation upon MCOs to contract with these designated providers, not simply offer these providers the standard participation agrement. Consequently, behavioral health providers can often exert greater leverage in securing favorable terms of participation, as the MCOs are obligated to include the behavioral health provider in their networks.

Model Contract Language

IOWA

Iowa established an Any Willing Provider mandate requiring each MCO to offer community mental health centers the opportunity to participate in the MCO's provider network during the first two years of the MCO's contract with the state. Iowa does not explicitly define "opportunity to participate" but requires the MCO, at minimum, to make three attempts to offer a reasonable rate to the provider during negotiations.[2]

Network Development and Maintenance – Section 6.2.2.6

As permitted by law, for the first (2) years of the Contract, the Contractor3 shall give all of the following providers, who are currently enrolled as Agency providers, the opportunity to be part of its provider network: (i) community mental health centers (CMHCs); (ii) 1915(i) HCBS Habilitation Services providers; (iii) nursing facilities; (iv) ICF/IDs; (v) health homes; (vi) 1915(c) HCBS waiver providers, with the exception of case managers and care coordinators; and (vii) substance use disorder treatment programs that are also in the IDPH-funded network. The Contractor shall document at least three attempts to offer a reasonable rate as part of the contracting process.

ILLINOIS

Illinois established an Any Willing Provider mandate requiring each MCO to contract with any qualified provider willing to accept the MCO's standard terms and conditions as a participating provider. Under the provision, Illinois defines minimum requirements to be considered a qualified provider during the first year of the contract; however, the MCO is free to establish additional qualification standards in subsequent years, subject to state approval, and contract only with providers that meet those additional standards.[4]

Network Providers – Section 5.7.1.2

During the first year of this Contract for all Contracting Areas, Contractor shall enter into a contract with any willing and qualified Provider in the Contracting Area that renders [behavioral health] services . . . so long as the Provider agrees to Contractor's rate and adheres to Contractor's QA requirements. To be considered a qualified Provider, the Provider must be in good standing with the

[2] Iowa Dep't of Human Servs., MCO Contract-MED-16-021, Special Terms Appendix 1 – Scope of Work§ 6.2.2.6, *available at* https://dhs.iowa.gov/sites/default/files/WellCare_Contract.pdf.

[3] The term "Contractor" refers to a Managed Care Organization (MCO).

[4] Ill. Dep't of Healthcare and Family Servs., Medicaid Managed Care Organization Request for Proposals (2018), Appendix I: Draft Model Contract § 5.7.1.2, *available at* https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP/Documents/2018-24-001%20Appendix%20I.pdf.

Department's FFS Medical Program. Contractor may establish quality standards

in addition to those State and federal requirements and, after the first year of this Contract, contract only with Providers that meet such standards. Such standards must be approved by the Department . . . .

WASHINGTON STATE

Washington State imposes an affirmative obligation on MCOs to contract with specific categories of behavioral health providers.[5]

Network Requirements – Sections 6.2.4.3 and 6.2.4.4

The Contractor shall establish and maintain contracts with providers determined by HCA to be Essential Behavioral Health Providers (EBHP):

- *Certified residential treatment providers*
- *DBHR Licensed Community MH Agencies*
- *DBHR-certified CD Agencies*
- *DOH-certified medication assisted treatment providers*
- *DBHR-certified opiate substitution providers*
- *DOH-licensed and DBHR-certified free-standing inpatient, hospitals or psychiatric inpatient facilities that provide Evaluation and Treatment services*
- *DOH-licensed and DBHR certified detox facilities*
- *DOH licensed and DBHR certified residential treatment facility to provide crisis stabilization services*
- *Certified wraparound and intensive services (WISe) provider*

* * *

- *Office-based opioid treatment qualifying providers operating under a DATA waiver*

Advocacy Talking Points

- MCOs may refuse to contract with behavioral health providers once an MCO meets network adequacy standards, limiting patient choice in accessing behavioral health services.
- The State should adopt a so-called "Any Willing Provider" mandate for behavioral health providers, which would guarantee that any behavioral health provider could participate in an MCO's provider network, so long as the provider accepted the MCO's standard terms and conditions.
  - An Any Willing Provider mandate for behavioral health providers would expand patient access to behavioral health services, offering patients a greater choice of providers for such services.
  - [In states shifting away from Medicaid fee-for-service (FFS):] Any Willing Provider mandates reduce financial uncertainty for behavioral health providers during the transition to managed care and ensure that they will have the opportunity to participate in managed care provider networks.
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[5] Wash. State Health Care Auth., Washington Apple Health-Fully Integrated Managed Care Contract, §§ 6.2.4.3-6.2.4.4, *available at* https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf.

[Alternative Policy Option]

- The State should impose an affirmative obligation on MCOs to contract with behavioral health providers in order to ensure access to these providers and level the playing field so that behavioral health providers may negotiate favorable terms of participation.
  - *[In states shifting away from Medicaid fee-for-service (FFS):*] Imposing an affirmative obligation on MCOs to contract with specified behavioral health providers reduces financial uncertainty during the transition to managed care and assures patients of continued access to their provider of choice.

Chapter 2. All Products Clauses

KEY POINTS

To ensure behavioral health provider have a right to choose whether to participate in any MCO product, Medicaid contracts with MCOs could:

- Prohibit All Products Clauses in managed care participation agreements, or
- Prohibit MCOs from requiring a provider to participate in an MCO's non-Medicaid products as a condition of participation in the MCO's Medicaid product.

Overview

Many MCOs serve other populations aside from Medicaid enrollees such as Medicare beneficiaries, state employees, and individuals who receive health insurance through employers or state insurance exchanges. To that end, an MCO will typically desire to use the same provider network to serve enrollees insured under the MCO's non-Medicaid products.

Providers should be wary of "All Products Clauses" in their participation agreements with MCOs that require a behavioral health provider to participate in all of the MCO's insurance products and accept (for some products) less favorable reimbursement terms. As a result, an All Products Clause denies a behavioral health provider the right to refuse participation in one or more of the MCO's products. Some All Products Clause would also require a behavioral health provider to participate in products offered by an MCO in the future and accept any reimbursement terms that are later established for that product.

An example of an All Products Clause is as follows:

> *MCO has identified in the Attachments to this Agreement those MCO Products in which Provider shall participate. Provider agrees to be bound by the terms and conditions of each MCO product upon execution of this Agreement. MCO may introduce, modify, or eliminate Provider's participation in any Product during the term of this Agreement.*

The above provision requires the provider to agree to participate in all of the products (and at rates associated with each of those products) included in the contract exhibits as well as any new product subsequent introduced by the MCO.

MCOs that use All Products Clauses create an "all or nothing" proposition for provider participation. A provider that agrees to serve Medicare and Medicaid enrollees can do so only at the cost of serving commercially insured patients and, in many cases, must accept compensation levels below sustainable levels. As a consequence of an All Products

Clause, a provider has no leverage to refuse individual insurance products or negotiate more favorable reimbursement rates.

In response to advocacy efforts by providers, six states have established bans on All Products Clauses under state law.[6] For states that have not banned such clauses, state Medicaid contracts with MCOs might prohibit MCOs from requiring a provider to participate in an MCO's non-Medicaid products. By banning All Products Clauses, a provider would have the right to consider participation in each insurance product individually, thereby increasing the provider's leverage to negotiate favorable reimbursement terms for participation in each product.

Model Language

NEW YORK STATE

New York State amended its Managed Care Model Contract to bar Medicaid MCOs from requiring providers to participate in non-Medicaid products as a condition of participation in the MCO's Medicaid product.[7]

Provision of Services through Provider Agreements - Section 22.3(b)

Under no circumstances shall the contractor condition the participation of a Behavior Health Provider . . . upon . . . such Provider's agreement to participate in the Contractor's non-Medicaid lines of business.

Advocacy Talking Points

- "All Products Clauses" require behavioral health providers to agree to participate in all current and future insurance products offered by an MCO, forcing providers to accept unreasonably low reimbursement levels in one product as a condition of participation in products with more favorable compensation.
- All Products Clauses undermine price competition for a behavioral health provider's services, allowing an MCO to exploit its market power in one product (such as Medicaid) to extract lower reimbursement rates from providers in other products, depriving the behavioral health provider of fairly negotiated reimbursement levels, while giving the MCO an unfair advantage over competitors.
- The State should ban "All Products Clauses" in participation agreements to ensure that behavioral health providers always retain the opportunity to negotiate reimbursement terms in any products offered by an MCO and preserve their right to decline participation in products that do not offer adequate reimbursement levels.

[6] *See* John F. Buckley IV & Nicole D. Prysby, *2017 State by State Guide to Managed Care Law,* § 6.05 "Mental Health Coverage Mandates" (2016). The six states banning All Products Clauses are Alaska, Florida, Kentucky, Maryland, Minnesota, and Virginia. *Id.*

[7] N.Y. State Dep't of Health, Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract, § 22.3(b), p. 22-1 (amended Oct. 1, 2015) *available at* https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

[Alternative Policy Option]

- The State Medicaid agency should prevent an MCO from requiring behavioral health providers to participate in the MCO's non-Medicaid product lines as a condition of participation in the MCO's Medicaid product.
  - This approach ensures that behavioral health providers' participation in non-Medicaid products lines do not undermine the financial sustainability of providers that have historically served the Medicaid community.

Chapter 3. Scope of Services and Covered Services

KEY POINTS

To ensure coverage and payment of all services offered by a behavioral health provider, Medicaid contracts with MCOs could prohibit MCOs from contracting for less than all of the provider's services, or alternatively, for less than all of the provider's services under the applicable state license or certification.

Overview

To the surprise of many behavioral health providers, not every service furnished to patients – even if the service is a covered benefit under a state Medicaid program – will necessarily be reimbursed by an MCO under the provider's participation agreement. These discrepancies result from a variety of reasons, including:

- Inconsistent covered services across MCOs or insurance products
- Incomplete fee schedules or procedural codes set forth in the participation exhibits (and scope of services which have been defined relative to these exhibits)
- Establishment of separate participation agreements by an MCO for particular services or provider types (*i.e.*, professional services agreement for mental health services, professional services agreement for primary care services, and facility-based services agreement for in-patient, partial hospitalization, crisis or detox services)
- Ambiguous or vague scope of service definitions
- Incomplete credentialing of providers

The impact of these discrepancies typically manifest in denials of payment when a behavioral health provider submits claims to the MCO. In some cases, a behavioral health provider will not realize that certain services are not reimbursable until the provider submits a claim for payment and receives a denial from the MCO. Correcting the underlying problem, if possible, can be time-consuming for behavioral health providers, especially if the correction involves amending the participation agreement, signing a new participation agreement, or submitting a revised credentialing application.

To address inconsistencies in covered services across MCOs and insurance products, most states mandate insurers provide a minimum level of mental health coverage in insurance products. Thirty-seven states mandate some level of coverage of mental health services, while an additional seven states mandate that some

level coverage be offered to each employer.[8] In general, these laws set minimum coverage levels for outpatient and inpatient care, though some allow insurers to set a limit on total lifetime benefits, which in some states must be no less than limits on lifetime benefits for physical illness.[9]

To address inconsistencies in the scope of services reimbursed by MCOs under identical coverage requirements, state agencies might prohibit an MCO from contracting for less than all of the behavioral health provider's services, or less than all of the provider's services under the provider's state license or certification. To comply with this requirement, an MCO might request a behavioral health provider to identify its scope of services as part of the contracting or credentialing process or define a provider's scope of services in relation to a particular state license or certification.

Model Language

NEW YORK STATE

New York State established network contracting requirements that require MCOs to contract for the entire scope of services available under the behavioral health clinic's state license.[10]

Network Contracting Requirements – Section 3.6(H)

Plans that contract with clinics holding a state integrated license shall contract for the full range of services available pursuant to that license.

Advocacy Talking Points

- MCOs can exclude some of a behavioral health provider's services that are covered under Medicaid from the scope of services covered under the provider's participation agreement, depriving the behavioral health provider of payment for some such services and denying patients with access to those services from his or her provide of choice.
  - This is particularly confusing for MCO enrollees as they reasonably expect access to all of the services offered by a particular behavioral health provider — especially Medicaid covered services – from their provider, as a consequence of the behavioral health provider participating in the MCO's provider network.
- The State should require MCOs to contract with behavioral health providers for the full range of Medicaid-covered services available from those providers.

[Alternative Policy Option]

- The State should require participation agreements with behavioral health providers to include all of the services available under a behavioral health provider's applicable state license.

[8] *See* Buckley, *supra* note 10, at § 3.07.
[9] *Id.*
[10] N.Y. Dep't of Health, New York Request for Qualifications for Adult Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans, § 3.6(H) (July 3, 2015), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/plan_process/docs/2015-7-3_nys_adult_behavior_hlth_ros.pdf.

Chapter 4. Prompt Payment

KEY POINTS

To improve timely payment from MCOs, Medicaid contracts with MCOs could:

- Define a minimum number of days after rendering services that providers have available to submit claims;
- Establish "prompt payment" requirements in conjunction with a favorable definition of "clean claim"; and
- Require MCOs to provide detailed explanation for any denied claims.

Overview

Behavioral health providers, not unlike other providers, frequently encounter difficulties in receiving timely payment from MCOs for services. MCOs may set unreasonably short timelines for the submission of claims or create ambiguities in the amount of information needed to be submitted to support a claim. In addition, MCOs may fail to make payments promptly, or may deny payment without explanation or recourse. These issues can have detrimental impacts on cash flow, increase administrative costs, and result in financial losses.

Although forty-nine states have enacted requirements applicable to timely payment of provider claims by MCOs, there is wide variation among the scope of these laws as well as their applicability beyond commercial insurance to Medicaid managed care.[11] Medicaid contracts with MCOs can be written to ensure state laws apply to MCOs processing claims for Medicaid enrollees as well as to supplement those laws to make up for any statutory shortcomings. Such provisions might address:

Claims Submission. Medicaid contracts could require MCOs to allow a minimum number of days for behavioral health providers to submit claims after rendering services. To avoid expiration of claims submission timeframes in circumstances outside of the provider's control, Medicaid contracts could establish exceptions to these timeframes such as when individuals are retroactively enrolled in MCOs or when individuals have secondary insurance coverage.

Prompt Payment. Medicaid contracts could require MCOs to adopt a particular definition of "clean claim" and to pay such clean claims within a maximum number of days. From a provider's perspective, a favorable definition of clean claim is a claim that can be processed by the MCO without any additional information from the provider, as opposed to defining a clean claim as one that meets all of the technical requirements imposed by the MCO's provider. Not only could Medicaid contracts specify the time frame for payment of clean claims, but they can also subject late payment of claims to interest, generally 12-18% under state prompt pay

[11] *See* Buckley, *supra* note 6, at § 6.03.

laws, and require such interest be added automatically to payment of the claim without providers taking additional action.

Claims Denial. Medicaid contracts could also require MCOs to provide a detailed explanation of the reason for any denied claims. In many situations, claims are denied with very little explanation, if any, to the provider. Resubmitting the claim can be costly and time-consuming for the provider, whose staff must contact the MCO for additional information related to the claims denial. In addition, Medicaid contracts could require MCOs to request, within a specified time period, additional information for any claims that are found not to be clean, prior to denial of the claim.

Model Language

WASHINGTON STATE

The Washington State Office of Insurance Commissioner established, through regulation, prompt payment terms and conditions that must be present in every Medicaid managed care provider contract. These terms and conditions have been incorporated by reference into Washington State's Model Contract.

Taken together, the Model Contract and the regulations define a "Clean Claim," set the number of days for behavioral health providers to submit claims after rendering services, establish a prompt payment requirement for MCOs, and mandate that MCOs provide a detailed explanation of the reason for any denied claims.

Reproduced below are the relevant provisions from Washington State's Model Contract, and in footnotes, the regulatory provisions that the Model Contract incorporates by reference.[12]

Washington State Model Contract – Claims Payment Standards – Sections 9.12.1 and 9.12.6

9.12.1 The Contractor shall meet the timeliness of payment standards . . . specified for health carriers in WAC 284-170-431[13]. . . . [T]he Contractor shall pay providers and facilities as soon as practical but subject to the following minimum standards:

> (i) Ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and
>
> (ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to

[12] Wash. State Health Care Auth., *supra* note 5, at §§ 9.12.1, 9.12.6.

[13] Wash. Admin. Code § 284-170-431 (2017) provides:

> (1) Every participating provider and facility contract shall set forth a schedule for the prompt payment of amounts owed by the carrier to the provider or facility and shall include penalties for carrier failure to abide by that schedule. At a minimum, these contract provisions shall conform to the standards of this section.
>
> (2)(a) For health services provided to covered persons, a carrier shall pay

or deny, and shall require subcontractors to pay or deny, ninety-five percent (95%) of clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) calendar days of receipt and ninety-nine percent (99%) of clean claims within ninety (90) calendar days of receipt.

9.12.1.1 A claim is a bill for services, a line item of service or all services for one (1) Enrollee within a bill.

9.12.1.2 A clean claim is a claim that can be processed without obtaining additional information from the provider.

9.12.6 The Contractor shall allow providers 365 days to submit claims for services provided under this Contract . . . .

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in writing by the parties on a claim-by-claim basis.

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(d) Any carrier failing to pay claims within the standard established under subsection (2) of this section shall pay interest on undenied and unpaid clean claims more than sixty-one days old until the carrier meets the standard under subsection (2) of this section. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by the carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

(3) For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

(4) Denial of a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then the carrier upon request of the provider or facility must also promptly disclose the supporting basis for the decision. For example, the carrier must describe how the claim failed to meet medical necessity guidelines.

TENNESSEE

Tennessee has also incorporated statutory provisions into its Model Contract to mandate payment to a provider within a specific timeframe upon the MCO's receipt of a clean claim. The Model Contract also requires MCOs to provide a detailed explanation for any denied claims.[14]

Prompt Payment – Section A.2.22.4

A.2.22.4.2 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.

A.2.22.4.3 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all claims for covered services delivered to a TennCare enrollee.

A.2.22.4.7 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

NEBRASKA

Nebraska sets out the schedule within which the MCO must pay or deny claims, and also requires MCOs to automatically apply interest to late payments. When claims are denied for lack of documentation, Nebraska requires MCOs to identify the information missing from the original claim, and to allow providers to resubmit the claim. These resubmitted claims are considered new claims for purposes of establishing the prompt payment time frame for claims processing.[15]

Claims Processing - Section IV.S.3

a. *Except for claims from pharmacy providers, the MCO must ensure that all provider claims are processed according to the following timeframes:*
   i. *Within five (5) business days of receipt of a claim, the MCO must provide an initial screening and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.*
   ii. *Process and pay or deny, as appropriate, a minimum of 90% of all clean claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the claim.*
   iii. *Process and pay or deny, as appropriate, a minimum of 99% of all clean claims for medical services*

[14] Tenn. Dep't of Fin. & Admin., Statewide Contract with Amendment, § A.2.22.4 (July 1, 2017), *available at* https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.

[15] State Purchasing Bureau, State of Neb., Request for Proposal for Contractual Services, RFP 5151 Z1, §§ IV.S.3, IV.S.5-6 (Oct. 21, 2015), *available at* http://das.nebraska.gov/materiel/purchasing/5151/5151Z1%20MCO%20SPB%2010%2020%2015%20djo.pdf.

provided to members within 60 calendar days of the date of receipt.

iv. Fully adjudicate (pay or deny) all other claims within six (6) months of the date of receipt.

b. For pharmacy providers, the MCO must establish, at a minimum, a weekly payment cycle so that a minimum of 90% of all clean claims from pharmacy providers for covered services are paid within seven calendar days of receipt and 99% of all clean claims are paid within 14 calendar days of receipt, except to the extent providers have agreed to an alternative payment schedule set forth in the provider contract. Any alternative payment schedules must be reported to MLTC within three business days of their implementation.

c. Rejected Claims

i. The MCO may reject claims because of missing or incomplete information. In those circumstances, the original claim must be returned to the provider accompanied by a rejection letter.

ii. A rejected claim should not appear on a remittance advice because it will not have been entered into the MCO's claims processing system.

iii. *The rejection letter must indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. The letter must contain, at a minimum, the following information:*

a) Member name and Medicaid ID number.
b) Provider ID number.
c) Date of service.
d) Total billed charges.
e) A list of known defects or reasons for rejection.
f) MCO's name.
g) The date the letter was generated.

d. Pended Claims

If a clean claim is received, but additional information is required for adjudication, the MCO may pend the claim and request in writing (notification via e-mail, website/provider portal, or an interim explanation of benefits (EOB) satisfies this requirement) all necessary information so the claim can be adjudicated within established timeframes.

Payments to Providers - Section IV.S.5

e. The MCO must pay providers interest at an annualized rate of 12%, calculated daily for the full period in which a payable clean claim remains unpaid beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated, and reported on the encounter submission to MLTC or its designee.

Remittance Advice - Section IV.S.6

a. *The MCO must produce a remittance advice that reflects the MCO's payments or denials to providers. Each remittance advice generated by the MCO to a provider must clearly identify for each claim:*

i. Name of the member.
ii. Unique member Medicaid identification number.
iii. Patient claim number or patient account number.
iv. Date of service.
v. Total provider charges.
vi. Member liability, specifying any coinsurance, deductible, copayment, or non-covered amount.
vii. Amount paid by the MCO and/or the amount denied and the HIPAA-compliant reasons for denial.

viii. An attachment to the RA if the claim was denied due to a TPL, including but not be limited to, TPL carrier information such as carrier code, policy number, and mailing address.

ix. A description of provider rights for claims disputes.

* * *

d. If a claim is partially or totally denied because the provider did not submit required information or documentation with the claim, then the remittance advice must specifically identify all the required information and documentation not submitted. Resubmission of a claim with the necessary information/documentation shall constitute a new claim for purposes of establishing the time frame for claims processing

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Advocacy Talking Points

- MCO claims processing activities create significant obstacles for behavioral health providers receiving timely payments for services.
  - Frequently encountered issues include short timeframes for submitting claims, denials of claims without sufficient explanation, and delayed payments.
- Payment denials and delays create cash flow challenges that severely impact behavioral health providers' ability serve their vulnerable patient populations.
  - Behavioral health providers operate on tight budgets and continue to render care and incur costs while waiting on MCOs to adjudicate claims for reimbursement.
  - Payment delays impede cash flow, which can jeopardize facility operations, staff compensation, and payments to vendors, thus placing the quality of patient care at risk.
- To address these payment issues, the State Medicaid agency should establish claims processing standards for all MCOs. Such standards should include:
  - A uniform definition of a "Clean Claim" that is based on whether an MCO has adequate information to adjudicate a particular claim as well as a requirement to provide a detailed explanation of the reason for any denied claims.
  - A minimum amount of time for providers to submit claims for reimbursement, including additional time for individuals retroactively enrolled in an MCO or who have secondary insurance coverage.
  - A prompt payment standard that requires interest to be added automatically to late claims without providers taking additional steps.

Chapter 5. Payment Rates

KEY POINTS

To promote adequate payment to all behavioral health providers, Medicaid contracts with MCOs could:

- Establish a payment floor no less than current Medicaid fee-for-service rates; and
- Require MCOs to apply any state-mandated rate changes immediately upon taking effect and make retrospective adjustments to any previously paid claims subject to the rate increase.

To promote payment to Certified Community Behavioral Health Clinics (CCBHCs), Medicaid contracts with MCOs could:

- Require MCOs to contract with all CCBHCs serving the enrolled population;
- Prohibit scrutiny of CCBHC claims beyond that applied to other providers or services; and
- For states that make wrap-around payments to CCBHCs, offer a special appeals process for MCOs that deny underlying claims or reimburse CCBHCs at their full PPS rate in the event that an MCO denies a claim.

Overview

MCOs generally have authority to establish payment rates at any amount, including levels below those established by the Medicaid agency under its Fee-For-Service ("FFS") program. Not only can this expose behavioral health providers to financial losses, it can become a barrier to enrollees accessing services when a behavioral health provider reduces capacity to limit financial losses. To ease the transition to managed care, or to provide a safeguard against unreasonably low reimbursement rates, state Medicaid contracts with MCOs could mandate a payment floor for behavioral health providers.

Even when state Medicaid contracts establish a payment floor equivalent to Medicaid rates, MCOs can delay the effective date of increases to those payment rates. MCO participation agreements frequently include provisions that permit MCOs to delay application of rate increases as much as 60 days beyond the effective date established by the state and to deny retrospective adjustment of paid claims for dates of service otherwise subject to the payment rate increase.

Not only do these provisions deny providers protection under the payment floor, they can also allow MCOs to pocket the difference between higher capitated rates (based on the new FFS rates) and the amounts paid to providers under existing fee schedules. Consequently, similarly situated providers can be paid different amounts for the same service depending on the date of submitted claims.

To address these issues, state Medicaid contracts could mandate that MCOs apply rate changes immediately upon the rate

change becoming effective and make retrospective adjustments to any previously paid claims subject to the rate increase.

For behavioral health providers operating a Certified Community Behavioral Health Clinic ("CCBHC") in a federal demonstration program, managed care poses unique challenges to receiving the rates established under the Prospective Payment System ("PPS") methodology. In some demonstration states, Medicaid agencies incorporated PPS rates into capitation payments made to the MCOs. In these states, MCOs have an incentive to avoid contracting with CCBHCs and to avoid paying CCBHC claims, as PPS rates are generally higher than FFS rates. To address these issues, Medicaid contracts could require MCOs to contract with all CCBHCs serving the enrolled population and prohibit scrutiny of CCBHC claims beyond that applied to other providers or services.

In other demonstration states, Medicaid agencies make supplemental "wraparound" payments to CCBHCs to compensate for the difference between the PPS rate and the reimbursement paid by the MCO. CCBHCs may be ineligible for these wraparound payments in circumstances in which an MCO denies payment on the underlying claim. Medicaid policies could address this problem by offering a special appeals process to CCBHCs that receive denials for the underlying claims or by requiring states to reimburse CCBHCs at their full PPS rate in the event that an MCO denies the underlying claim.

Model Language

NEW YORK STATE

To ease the transition from fee-for-service to managed care for behavioral health providers, New York State required that MCOs pay licensed or certified behavioral health providers the Medicaid fee-for-service rates during the first 24 months of the provider's agreement with the MCO.[16]

Network Monitoring Requirements – Section 3.6(I)

MCO's will be required to reimburse [state]-licensed and [state]-certified behavioral health providers including ambulatory service providers, CPEP and EOB programs, and Residential Addiction Services at the [M]edicaid FFS rates for at least 24 months after the effective date of the transition.

COMMONWEALTH OF PENNSYLVANIA

CCHBCs can model favorable language on provisions related to the Federally Qualified Health Centers (FQHCs). For example, Pennsylvania's RFP with MCOs that arrange physical health services establishes a payment floor at each FQHC's Prospective Payment System (PPS) and requires MCOs to contract with each FQHC located within its service area that is willing to accept the PPS rate as payment in full. Notably, it requires payment to the FQHC regardless of whether the FQHC is the enrollee's assigned primary care provider.[17]

[16] N.Y. State Dep't of Health, *supra* note 10, at § 3.6(I).

[17] Dep't of Human Servs., Commonwealth of Pa., HealthChoices Physical Health Agreement (Jan. 1, 2017), *available at* http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040149.pdf.

Payments to FQHCs and Rural Health Centers (RHCs) – Section VII(E)(5)

Effective with dates of services beginning on or after January 1, 2016, the PH-MCO must pay all FQHCs and RHCs rates that are not less than the FFS Prospective Payment System (PPS) rate(s), as determined by the Department. . . . The PH-MCO must also include in its Provider Network every FQHC and RHC located within this HealthChoices Zone that is willing to accept PPS rates as payment in full. The PH-MCO must pay all FQHCs and/or RHCs in the Network for eligible visits regardless of whether the FQHC and/or RHC is the Member's primary care physician. This requirement applies to any Subcontractor of the PH-MCO, as required by Section V.O.2.

Advocacy Talking Points

- MCOs generally have authority to establish provider payment rates at any amount, and in some cases, have reimbursed providers at levels below those paid by a Medicaid agency in its the Fee-For-Service ("FFS") program.
  - Low and inadequate payment rates expose behavioral health providers to financial losses, and because Medicaid is generally the largest source of payment, jeopardizes continued financial viability.
  - Persistently low and inadequate payment rates will lead some behavioral health providers to refuse to participate in Medicaid MCOs, thereby denying those Medicaid enrollees access to their provider of choice.
- To ease the transition to managed care, or to provide a safeguard against unreasonably low reimbursement rates, the State Medicaid contracts with MCOs should mandate a payment floor for behavioral health providers. Such payment floors should ensure that:
  - Behavioral health providers are paid at rates no less than those rates applicable to a state's FFS program; and
  - MCOs immediately implement adjustments to provider rates based on changes to state FFS rates, as MCO delays on the effective date of such rate changes can permit MCOs to pocket the difference between new premiums set higher as a result of FFS rate adjustments and provider payment rates.

[CCBHC Demonstration States]

- The State should address the unique issues arising from payment under the Prospective Payment System ("PPS") related to its participation in the Certified Community Behavioral Health Clinics (CCBHCs) demonstration project.
  - *[For states requiring MCOs to pay CCBHCs their full PPS rate:]* The State's policy that MCOs pay a CCBHC its full PPS rate can create a financial incentive for MCOs to avoid contracting with CCBHCs or, if they do contract with a CCBHC, to avoid paying claims as a consequence of PPS rates generally exceeding the level MCOs would otherwise reimburse a behavioral health provider for those services.

- To avoid discouraging payment to CCBHCs when MCOs must pay a CCBHC its full PPS rate, the State should require MCOs to contract with every CCBHC serving the enrolled population and prohibit scrutiny of CCBHC claims beyond that applied to other providers or services.

- *[For states requiring supplemental "wraparound" payments to CCBHCs:]* CCBHCs can find themselves ineligible for these wraparound payments when an MCO denies payment on the underlying claim.
  - To ensure CCBHCs receive payment at its full PPS rate for a valid encounter, the State should reimburse CCBHCs at their full PPS rate in the event that an MCO denies the underlying claim or, alternatively, offer a special appeals process to CCBHCs that receive denials for an underlying claim.

Chapter 6. Payment Recoupments

KEY POINTS

To protect behavioral health providers from overpayment recoupments by MCOs, Medicaid contracts with MCOs could:

- Restrict the circumstances and time period in which an MCO may recoup overpayments and establishing notice and appeal rights prior to recoupment;
- Permit an MCO to retain premium payments that had already been used to pay claims submitted by providers;
- Prohibit MCOs from recouping payments related to retroactive disenrollment, and authorize them to pursue collections from other MCOs; and
- Permit providers to resubmit claims through fee-for-service Medicaid, in the event of a recoupment subsequent to a retrospective disenrollment.

To protect behavioral health providers in the event an MCO uses sampling to uncover overpayments, Medicaid contracts with MCOs could:

- Require the MCO to accept a provider's review of the actual claims; and
- Allow providers to identify potential underpayments from MCOs, and to seek additional compensation if underpayments are uncovered.

Overview

MCOs generally have the right to recover overpayments made to behavioral health providers. In addition to recouping overpayments arising from duplicate payments or other billing errors, MCOs often utilize provider payment recoupments in response to the state's recoupment of premium payments from MCOs due to the retroactive disenrollment of a Medicaid enrollee who is no longer eligible for benefits. While payment recoupments are not objectionable in principle, the practice should be rare because they create cash-flow issues, financial uncertainty, and unforeseen financial losses for behavioral health providers.

Nevertheless, provisions addressing payment recoupments in participation agreements tend to be very broadly written in favor of MCOs, denying providers prior notice and the opportunity to appeal. In particular, recoupment provisions typically permit an MCO the right to offset a claimed overpayment against current claims payments. Not only do offsets create accounting hassles, the recoupment may well be masked by the payment to the provider and go unnoticed. In situations that the provider receives adequate notification of the recoupment, MCOs may not provide any meaningful appeals process to contest the overpayment determination, as there would have been if the claim had been originally denied.

In addition, MCOs may take an aggressive approach to overpayment recovery, conducting retrospective audits of providers that reach back several years and engaging in a single recoupment event rather than structuring recoupments over a long-term repayment plan. In addition, MCOs may also identify overpayments by claim sampling and determine the value of total overpayments by extrapolation, rather than identifying individual instances of overpayments, resulting in a significant payment recoupment.

Medicaid contracts could protect behavioral health providers from overpayments by restricting the circumstances and time period in which an MCO may recoup overpayments and establishing notice and appeal rights prior to recoupment. In the context of retroactive disenrollment of enrollees, Medicaid contracts could permit an MCO to retain premium payments that had already been used to pay claims submitted by providers, effectively requiring the state to bear financial risk for eligibility determinations. Medicaid contracts could permit providers to submit claims through the state's fee-for-service Medicaid program, in the event the MCO recoups payment subsequent to a retroactive disenrollment and the beneficiary was otherwise eligible for benefits under the state's fee-for-service Medicaid program. Alternatively, Medicaid contracts could prohibit MCOs from recouping payments related to retroactive disenrollment, requiring MCOs to bear the financial risk for Medicaid enrollees whose eligibility changed, and authorizing them to pursue collections from other MCOs, if any, that had been financially responsible for an enrollee's health benefits.

If MCOs identify overpayments by claim sampling and extrapolation, Medicaid contracts could require the MCO to accept a provider's review of the actual claims. In fairness to providers, Medicaid contracts could allow providers to identify potential underpayments from MCOs, and the ability to seek additional compensation. This would open an additional avenue of relief for behavioral health providers that overlooked payment errors and did not appeal payment decisions within the time period allotted by MCOs.

Model Language

NEW YORK STATE

New York State Insurance Law restricts the time period in which an MCO may recoup overpayments. The time limit does not apply, however, in the case of fraud or misconduct, or where recoupment is required by law. Similar language can be utilized in state RFPs to protect behavioral health providers.[18]

Rules Relating to the Processing of Health Claims and Overpayments to Physicians – Section 32224-b

(b)(3) A health plan shall not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts that are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, . . . or (iii) required or authorized by a state or federal government program or coverage that is provided by

[18] N.Y. Ins. Law § 3224-b(b)(3) (Consol. 2017).

this state or a municipality thereof to its respective employees, retirees or members.

COMMONWEALTH OF KENTUCKY

Kentucky contained an unusual provision in its managed care RFP that permitted MCOs to retain capitation payments used to pay providers for services rendered to an enrollee under some circumstances. This provision could be modified to permit MCOs to retain capitation payments used to pay providers for services rendered to an enrollee under any circumstances in which a state makes an error in making payment to the MCO or subsequently determines that an enrollee is ineligible for services.[19]

Payment Adjustments – Section 30.060.30.10.50

In the event that a Member does not *appear on the Member Listing Report, but the Department has paid the MCO for a Member, the Department may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to the MCO within the previous twenty-four (24) months for which the MCO has not provided Covered Services to the Member or otherwise made payments on behalf of the Member.*

In the event a Member appears on the Member Listing Report but is determined to be ineligible, the Department may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to the MCO within the previous twelve (12) months.

Advocacy Talking Points

- MCOs frequently recover potential overpayments from behavioral health providers without prior notice (or the opportunity to appeal) and generally by offset against current amounts payable to providers from approved claims.
  - Payment recoupments create cash-flow issues, financial uncertainty, and unforeseen financial losses.
- The State should establish standards relating to recovery of potential overpayments. Such standards should include:
  - A maximum of two years from the date of payment to a provider to recover potential overpayments.
  - A requirement to notify providers of the potential overpayment, with sufficient explanation, along with a reasonable opportunity to appeal.
  - Standards for statistical validity when the amount of the overpayment is determined by sampling and extrapolation.
  - Exclusion of overpayments arising from retroactive disenrollments of individuals.
- Behavioral health providers should not bear financial risk for changes in enrollee eligibility made by state Medicaid programs.

[19] Fin. & Admin. Cabinet, Commonwealth of Ky., Solicitation # RFP 758 1300000399, Request for Proposal § 30.060.30.10.50 (June 11, 2013), *available at* http://000417b6df56f4ae5bbf-f6bd2cfeac0f4625637eac684e9e6a05.r25.cf1.rackcdn.com/06/8266898f9d8b3028cecaae15c48ef2aa.pdf?id=208062.

Chapter 7. Medical Necessity Determinations

KEY POINTS

To minimize the risk of inconsistent coverage determinations, denied requests for prior authorization, and denied claims for services rendered, Medicaid contracts with MCOs could:

- Mandate MCOs use the same standards and methodologies for determining medical necessity as had been previously used by the state FFS program; and
- Require that staff making medical necessity decisions have certain licenses or training, as well as possess specialized clinical experience relevant to the denial.

Overview

MCOs administer utilization review and utilization management programs to determine whether specific health care services are appropriate for coverage under an enrollee's health benefit plan. The critical factor in making those coverage determinations – and therefore whether the provider will be paid by the MCO — is whether the service is or was "medically necessary."

At present, more than half of all states define "medical necessity" by statute.[20] Nevertheless, each MCO may apply its own standards for determining medical necessity, or apply standards for determining medical necessity different than those applied under the state's FFS Medicaid program. As a result, behavioral health providers experience frustrations due to inconsistent coverage determinations, denied requests for prior authorization, and denied claims for services rendered.

Although Medicaid agencies generally incorporate statutory definitions of medical necessity into their contracts with MCOs, MCOs can still apply their own standards to evaluate medical necessity for behavioral health services. To provide more uniformity of medical necessity decisions, Medicaid contracts could mandate that MCOs use the same standards, tools, and methodologies for determining medical necessity as had been previously used by the state under its FFS Medicaid program, or that are subsequently issued by the state.

In addition, Medicaid contracts could require that staff making medical necessity decisions have certain licenses or training, as well as possess specialized clinical experience relevant to the denial. For example, Medicaid contracts could require a physician board certified in general psychiatry to review all inpatient level of care denials for psychiatric treatment and a physician certified in addiction treatment to review all inpatient level of care denials for substance use disorder ("SUD") treatment denials. Medicaid contracts could also

[20] *See* Buckley, *supra* note 6, at § 5.02.

require denials to be peer-to-peer such that the credential of the licensed clinician denying the care be at least equal to that of the recommending clinician.

Model Language

NEBRASKA

Nebraska prohibited Medicaid MCOs from establishing medical necessity standards that are more restrictive than the state's medical necessity determination protocol under fee-for-service Medicaid.[21]

Medically Necessary Services – Section IV.E.4

a. *The MCO must specify what constitutes "medically necessary services" in a manner that is no more restrictive than the State Medicaid program and addresses the extent to which the MCO is responsible for covering services related to the following:*

    i. The prevention, diagnosis, and treatment of health impairments.
    ii. The ability to achieve age-appropriate growth and development.
    iii. The ability to attain, maintain, or regain functional capacity.

b. *The MCO may not limit services beyond the limitations in the State's Medicaid program.*

NEW YORK STATE

New York State requires that MCO staff making medical necessity decisions or reviewing provider grievances have clinical experience relevant to the denial or clinical issues related to the provider's grievance.[22]

Utilization Management – Section 3.9(B)

B. The Plan shall establish prior authorization and concurrent review protocols that comport with NYS Medicaid medical necessity standards, federal and State parity requirements, the New York State Model Medicaid Managed Care Contract, and other related standards that may be developed by [state agencies], for the services listed in Table 1.

Level of Care – Section 3.9(E)

E. The Plan shall develop and implement BH-specific UM protocols, including policies and procedures (P&Ps) and level of care guidelines that comply with the following requirements:

i. UM protocols and level of care guidelines shall be specific to NYS levels of care and consistent with the State's medical necessity criteria and guidance.
ii. [The state agency] will identify the level of care guidelines that all Plans must use for SUD services. The LOCADTR 3.0 tool will be used for making prior authorization and continuing care decisions for all SUD services.

Clinical Guidance – Section 3.9(L)

L. The Plan shall comply with NYS Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review. Specifically, Plans must incorporate the following into their guidance:

[21] State of Neb., *supra* note 15, at § IV.E.4., at p. 53.

[22] N.Y. State Dep't of Health, *supra* note 10, at § 3.9.

i. *OMH Clinic Standards of Care: (www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html) and OASAS Clinical Guidance (http://www.oasas.ny.gov/treatment/documents/ClinicalGuidance-Final.pdf)*

Utilization Management Decision Making – Section 3.9(O)-(P)

O. The Plan shall ensure that decision makers on BH denials, grievances, and appeals . . . have clinical expertise in treating the member's condition or disease, stratified by age, if any of the following apply:

i. *An appeal of a denial based on lack of medical necessity.*
ii. *A grievance regarding the Plan denial of a request for an expedited resolution of an appeal.*
iii. *Any grievance or appeal involving clinical issues.*
iv. *An appeal of a decision to authorize a service in an amount, duration, or scope that is less than requested.*

P. *In general, denials, grievances, and appeals must be peer-to-peer—that is, the credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician for any denials. In addition, the reviewer should have clinical experience relevant to the denial (for example, a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist). In addition:*

i. *A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment.*
ii. *A physician certified in addiction treatment must review all inpatient level of care denials for SUD treatment.*

Advocacy Talking Points

- Each MCO generally applies its own standards for determining medical necessity, creating inconsistent coverage determinations, denied requests for prior authorization, and denied claims for services rendered.
- The State should standardize the definition of medical necessity used by MCOs and ensure that it is interpreted using the same methodologies, algorithms, and tools used by the state in its Fee-For-Service (FFS) Medicaid program.
  - A standard definition and interpretation of medical necessity would establish uniform coverage decisions for all Medicaid managed care enrollees without regard to the enrollee's MCO.
- The State should establish credential requirements to ensure that all MCO staff involved in medical necessity and coverage determinations for behavioral health services are made by clinicians with sufficient clinical expertise in mental health and addictions.
  - Staff credential requirements will reduce rates of inappropriate denials and decisions reversed on appeal, creating a more efficient system for patients and providers.

Chapter 8. Credentialing

KEY POINTS

To reduce duplicative or inconsistent credentialing standards, Medicaid contracts with MCOs could:

- Incorporate statutory protections for providers, if any, explicitly into contracts with MCOs, and prohibit MCOs from imposing other standards;
- Establish a detailed timeline for each step of the credentialing process;
- Deem state licensure or certification as satisfaction of the MCO's credentialing standards; and
- Require MCOs to credential behavioral health providers at the organizational level rather than credentialing individual staff members.

Overview

State and federal credentialing requirements mandate each MCO to verify the licensure and qualifications of contracted providers. While prudent in theory, credentialing requirements force providers to participate in duplicative credentialing activities with each contracted MCO, no matter the number of enrollees who receive care from the provider. When accounting for all MCOs operating commercial, Medicaid, and Medicare products within a geographic region, it is not unusual for providers to participate in credentialing activities with a dozen or more different MCOs.

Even if a behavioral health provider has established a contract with an MCO, a provider's reimbursement is usually contingent on completing any required credentialing procedures. Consequently, not only does credentialing with each MCO result in administrative costs, delays in credentialing activities can prevent billing for any of the provider's services, or result in subsequent denials of claims for services properly rendered. It is not uncommon for credentialing activities to take at least 60 to 90 days to complete, and in some extreme cases, providers have reported waiting six months or a year for an MCO to complete credentialing.

Further complicating matters, MCOs may apply credentialing standards different from each other or the state's Medicaid FFS program, resulting in inconsistent credentialing decisions. In some cases, an MCO will apply a more stringent standard to a provider's or practitioner's qualifications than expected, which limits the provider from rendering a type of service, or using a particular type of licensed practitioner to render a service, even if the provider or practitioner is appropriately licensed or certified under state law.

In states that have established statutory protections for providers related to credentialing standards and processes, Medicaid contracts should also seek to incorporate those protections explicitly into their contracts with MCOs, prohibiting

the MCO from imposing additional or more stringent standards. In states without statutory protections, Medicaid contracts could establish maximum time periods for each step of the credentialing process, such as time periods for informing the provider of any deficiencies in the credentialing application, requesting additional information from the provider, completing the credentialing process, and notifying the provider of credentialing decisions.

Additionally, Medicaid contracts can address credentialing of behavioral health providers through the states' contracts with MCOs, reducing administrative burden and delays associated with typical credentialing activities. In states that license or certify behavioral health providers, Medicaid contracts could require MCOs to accept such licensure or certification as having met the MCO's credentialing standards. MCOs also could be required to credential certain designated entities, including behavioral health providers, at the organizational level and bar them from separately credentialing individual staff members employed or contracted by the entity.

Model Language

NEBRASKA

Nebraska has established a detailed timeline for the provider credentialing process and mandated a specific set of criteria by which all Medicaid MCOs in the state must abide. Nebraska also enumerates certain standard forms and sources of information relevant to the credentialing process that all Medicaid MCOs must accept from providers.[23]

Provider Credentialing and Re-Credentialing – Section IV.I.14

b. The MCO must completely process credentialing applications from all provider types within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. "Completely process" means that the MCO must:

i. *Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or*

ii. Deny the application and ensure that the provider is not used by the MCO. A provider whose [credentialing/re-credentialing] application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.

e. *The MCO must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare (CAQH) system. The MCO must also accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.*

f. The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.

[23] State of Neb., *supra* note 15, at § IV.I.14., pp. 100-01.

NEW YORK STATE

New York State requires MCOs to accept state licensure or certification as having met the MCOs' credentialing standards. New York State simultaneously requires MCOs to credential behavioral health providers at the organizational level rather than credentialing individual staff members.[24]

Network Monitoring Requirements – Section 3.7(H)

Plans shall credential [state agency] licensed or certified programs and the license certification will suffice for the Plan's credentialing process. Plans contracting with [state agency] licensed or certified programs may not separately credential individual staff members in their capacity as employees of these programs and must contract for the full range of services offered under their license.

COMMONWEALTH OF VIRGINIA

Virginia has established, through regulation, a detailed provider credentialing procedure and timeline.[25] Virginia's Model Contract with MCOs incorporates these regulatory provisions by reference and requires MCOs to design their credentialing processes in accordance with them.[26]

Credentialing/Recredentialing Policies and Procedures – Section 3.4.A

The Contractor shall have the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the Contractor or its subcontractor(s) are qualified to perform their medical or clinical services. The Contractor shall have written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with 12 VAC 5-408-170.

Advocacy Talking Points

- Credentialing requirements of each MCO force behavioral health providers to participate in duplicative credentialing activities for their practitioners, adding administrative costs without any benefit in the quality of care to enrollees.
- Frequent credentialing delays by MCOs reduce the number of practitioners available to render care to patients (because an uncredentialed practitioner cannot furnish services to enrollees) and cause financial losses for behavioral health providers (because claims for services rendered by a non-credentialed practitioner will be denied by MCOs).
- The State should establish uniform credentialing standards. Such standards should require that MCOs:
  - Review credentialing applications and notify the provider of a decision within 30 days, with administrative penalties for MCOs that regularly fail to meet this credentialing timeline.
  - Accept any standardized credentialing form or application approved by the state Medicaid agency.

[24] N.Y. State Dep't of Health, *supra* note 10, at § 3.7(H).
[25] 12 Va. Admin. Code § 5-408-170 (2017).
[26] Commonwealth of Virginia, Department of Medical Assistance Services, Medallion 3.0 Managed Care Contract at § 3.4.A (July 1, 2015).

  - Accept a provider's state licensure or certification as having met the MCO's credentialing standards.
  - Credential behavioral health providers as an organization, rather than credentialing individual provider employed by the entity.
- Uniform credentialing standards would generate efficiencies and reduce administrative costs for both behavioral health providers and MCOs.
  - Behavioral health providers would no longer need to submit multiple, redundant credentialing and re-credentialing applications.
  - Behavioral health practitioners could more easily move between behavioral health providers and newly hired practitioners could see patients more quickly.

Chapter 9. Contract Amendments

KEY POINTS

To protect behavioral health providers from MCOs making unilateral changes to participation agreements, Medicaid contracts with MCOs could:

- Prohibit MCOs from amending their participation agreements without the behavioral health provider's passive or active consent.

Overview

Some provider participation agreements authorize an MCO to unilaterally amend the agreement without first obtaining the behavioral health provider's consent. When exercised, MCOs can remove or revise hard-won provisions, modify payment rates downward, add new insurance products, or otherwise change the contract terms.

For example, one national MCO that won a state Medicaid contract used this right to add the new Medicaid product and related provisions to the participation agreements it had been using in the state for commercial products. Behavioral health providers already participating in the MCO's commercial products suddenly found themselves participating in the MCO's Medicaid product and without any opportunity to negotiate the terms of that participation.

An example of a provision permitting an MCO to unilaterally amend the participation agreement is as follows:

> *(a) MCO may unilaterally amend the Agreement, or any exhibit, schedule, or appendix of the Agreement, by giving thirty (30) days' notice to Provider. Except as provided in subdivision (b), the amendment will take effect thirty (30) days after the effective date of the notice.*
>
> *(b) If the Provider is unwilling for the Agreement to continue as amended, it may terminate the Agreement by giving notice to the amending party no later than the effective date of the amendment.*

Notably, a clause such as section (b) above, which permits the provider to terminate the participation agreement if it objects to the proposed amendment is of little value. That is because it forces the provider to discontinue participation altogether in the MCO – potentially resulting in lost revenue and requiring the behavioral health provider to turn away existing patients – when the provider desires nothing more than to have the existing terms of participation remain as they were.

To address this issue, Medicaid contracts could prohibit MCOs from amending their participation agreements without the behavioral health provider's passive or active consent. This policy would continue to permit "auto-amendment," the practice of obtaining the provider's passive consent through inaction, *i.e.*, the provider fails to object to the proposed amendment within a specified period. Also, this policy could

maintain an exception permitting MCOs to make amendments to the participation agreement to comply with changes in law or legal requirements under state contracts.

Model Language

1.0 Except as necessary to comply with law, regulation or this Model Contract, the Contractor is prohibited from amending an agreement with a provider without the provider's express or implied consent.

2.0 In the event that the Contractor amends an agreement with a provider to comply with changes in law, regulation or this Model Contract, the Contractor shall inform the provider of the specific change in law, regulation or this Model Contract that necessitates the amendment.

WASHINGTON STATE

Section 48.39.010 of the Revised Code of Washington provides:

Notice of material amendments to contract—Failure to comply.

(1) A third-party payor shall provide no less than sixty days' notice to the health care provider of any proposed material amendments to a health care provider's contract with the third-party payor.

(2) Any material amendment to a contract must be clearly defined in a notice to the provider from the third-party payor as being a material change to the contract before the provider's notice period begins. The notice must also inform the providers that they may choose to reject the terms of the proposed material amendment through written or electronic means at any time during the notice period and that such rejection may not affect the terms of the health *care provider's existing contract with the third-party payor.*

(3) A health care provider's rejection of the material amendment does not affect the terms of the health care provider's existing contract with the third-party payor.

(4) A failure to comply with the terms of subsections (1), (2), and (3) of this section shall void the effectiveness of the material amendment.

Advocacy Talking Points

- Certain participation agreements with behavioral health providers permit an MCO to unilaterally amend the agreements without first obtaining the behavioral health provider's consent.
  - Unilateral amendments force the behavioral health provider to accept unfavorable contract terms or permit an MCO to remove unwanted provisions.
- The State should adopt uniform contract amendment standards. Such standards should ensure that:
  - Amendments without the behavioral health provider's active or passive consent are permitted only for the purpose of compliance with changes in law, regulation, or policy, and any such unilateral amendment require notice to the behavioral health provider of the specific change in law, regulation or contract that necessitated the amendment.

  - An objection to an amendment results in the amendment not taking effect, ensuring that the existing terms of the agreement remain in force, and does not require the provider to terminate the agreement.
- The above contract amendment standards would protect behavioral health providers from unilateral contract amendments, while maintaining the efficiency of any passive consent provisions.

Chapter 10. Regulatory Penalties

KEY POINT

To relieve behavioral health providers of penalties intended to be imposed on MCOs by the state, Medicaid contracts with MCOs could prohibit MCOs from seeking contributory payments from its participating providers other than through formal legal actions against the provider.

Overview

Some Medicaid contracts authorize the state to levy monetary penalties on MCOs that do not comply with contractual obligations. Such penalties are well intentioned and presumably encourage MCOs to exercise greater attention to maintaining contractual compliance. However, some MCOs have responded to such provisions by establishing provisions in their participation agreements that allow the MCO to downstream all or part of the financial penalty to its participating providers.

Under typical provisions, if the MCO determines that the penalty arose in part from the providers' non-compliance with obligations under the participation agreement or MCO policies, then the provider becomes liable for some portion of the regulatory penalty. Under some participation agreements, the MCO has the authority to collect payment by off-setting current or future payments due to the provider.

An example of a typical provision reads as follows:

> *Provider agrees that to the extent penalties, fines, or sanctions are assessed against Plan by a regulatory agency with governing authority over the services provided under this Agreement, Provider shall be responsible for the immediate payment of such penalties, fines, or sanctions if they arise from Provider's failure to comply with Provider's obligations under this Agreement, including but not limited to, Provider's failure to comply with the terms of Plan's Provider Manual. In the event such payment is not made in a timely manner, Plan shall have the right to offset claim payments to Provider by the amount owed by Provider to Plan.*

The financial exposure for a behavioral health provider of agreeing to such a provision is unlimited, as the provider is agreeing to indemnify the MCO for any and all financial penalties imposed upon the MCO that the provider may have, but not necessarily, contributed to by action or inaction.

For instance, suppose an MCO becomes non-compliant with network adequacy standards allegedly arising from a behavioral health provider's failure to notify the MCO that it had reached capacity and closed its panel, as required under its terms of participation. Even if the provider failed to notify the MCO, that

failure does not necessarily mean that the MCO would have been compliant with its state contract if the provider had made the required notification. It is still possible that the MCO would not have been able to contract with another behavioral health provider and meet the network adequacy standard. Regardless of the arguments advanced by a behavioral health provider, the provider would have no standing to appeal the penalty imposed upon the MCO.

Medicaid contracts could address this financial risk for all providers, including behavioral health providers, by prohibiting MCOs from seeking contributory payments from its participating providers other than through formal legal actions against the provider for breach of contract or indemnification. This would provide some measure of protection to behavioral health providers by making it harder to downstream regulatory penalties.

Model Language

1.0 Other than instituting formal legal action, the Contractor is prohibited from seeking payment, in whole or in part, by offset or otherwise, from a network provider of any penalty assessed against the Contractor for non-compliance with this Model Contract.

Advocacy Talking Points

- Some MCOs insert provisions in their participation agreements with behavioral health providers that allow an MCO to downstream all or part of the state imposed regulatory penalty onto providers, thereby absolving the MCO of any responsibility.
- The State should prohibit MCOs from shifting the costs of regulatory penalties onto behavioral health providers, as it eliminates an MCO's financial interest in ensuring compliance with state legal requirements.
- Even when a regulatory penalty results in part from a behavioral health provider breaching its contractual obligations, an MCO can already recover from the provider through existing contractual provisions, such as indemnification.

Chapter 11. Prohibitions on Assignment

KEY POINT

To ensure continuity of participation in MCO networks and to provide flexibility in responding to market changes, state Medicaid contracts with MCOs could mandate that MCOs accept a provider's assignment of participation agreements under certain conditions.

Overview

Assignment clauses address whether a party to a contract may transfer their rights or obligations under the contract to third parties. Participation agreements generally deny providers the right to assign the contract. In the event that a behavioral health provider merges with another provider, or forms a new legal entity that succeeds current operations, the existing participation agreement will terminate.

The prohibition on assignment thereby diminishes the valuation of a behavioral health provider – as an expected revenue stream may be lost in the transaction -- and the successor entity must renegotiate a participation agreement with each MCO, even if one of the original entities had been contracted with the MCO as a participating provider.

In light of the broader changes occurring in the health care delivery system, prohibitions on assignment can create future obstacles in corporate restructuring and consolidation efforts pursued by behavioral health providers. Furthermore, it is not uncommon for providers to lose revenue during corporate restructuring and consolidation. This is frequently due to a gap in participation with MCOs arising from re-contracting and credentialing activities, or alternatively, denials of payment arising from discrepancies in Tax Identification Number (TIN) between the provider receiving prior authorization from the MCO and the provider billing for the service.

To offer behavioral health providers greater flexibility in responding to market changes, Medicaid contracts could require MCOs to permit assignment of participation agreements under specified circumstances. These circumstances permitting assignment might include a provider merging with another entity or forming a new successor entity with another provider.

This policy would not preclude an MCO from conducting credentialing of the newly merged entity or the successor entity but the timeline should be accelerated in order to prevent any gaps in participation and a loss of revenue.

Model Language

1.0 Provided that sufficient notice is furnished to the Contractor, a provider

shall have the right to assign its agreement with an MCO to another legal entity when that provider implements a corporate restructuring activity or merges with another legal entity.

Advocacy Talking Points

- MCOs often include anti-assignment clauses in their contracts with behavioral health providers that are overbroad and require termination of participation agreements when one provider merges with another or forms a new legal entity that succeeds one or more existing entities.
- Overly broad anti-assignment clauses create barriers to mergers and corporate restructuring, require duplicative contracting and credentialing activities with the MCO, and in some cases, negatively impact continuity of patient care by removing a behavioral health provider from participating status in the MCO's provider network.
- The State should ensure that anti-assignment clauses in MCO participation agreements provide exceptions that permit assignment when it results from a merger or formation of new legal entities.

Chapter 12. Data Reporting Requirements

KEY POINTS

To diminish the cost associated with data reporting obligations, Medicaid contracts with MCOs could:

- Define the format and general requirements for reporting and collecting data in order to standardize collection activities; or
- Require all participating MCOs agree upon a single specification standard for collecting data from participating providers.

To reduce the frequency and breadth of data requests, Medicaid contracts with MCOs could:

- Require any data reporting and collection specification to be shared with participating providers in advance, and entitle providers an opportunity to comment on the proposed specifications.

Overview

MCOs frequently request data, particularly data not otherwise captured from claims submitted for payment, from behavioral health providers. Data collection efforts can require significant internal resources, not only for behavioral health providers that do not store the requested data in electronic formats, but also for those that do and must bear the financial expense of establishing interoperability with an MCO's electronic data systems.

Further contributing to the expense, each MCO establishes its own data requirements and specifications for delivering that data. Even when similar data is requested by MCOs, behavioral health providers may need to modify or adjust data prior to reporting to comply with each MCO's specifications, requiring additional staffing resources.

Medicaid contracts could diminish the cost associated with MCO data reporting requirements without undermining the purposes for collecting such data, or revealing proprietary information associated with the data requests. For example, when MCOs collect data from behavioral health providers to satisfy their own contractual requirements with the state, Medicaid contracts could dictate the format and general requirements for reporting and collecting that data from providers in order to standardize collection activities.[27] Alternatively, Medicaid contracts could require that all participating MCOs agree upon a single specification standard for collecting data from participating providers.

To reduce the frequency or breadth of data requests, Medicaid contracts could require MCOs to abide by certain notice and

[27] For more information on clinical measures for behavioral health in Medicaid, see Appendix A.

comment procedures by which any proposed data reporting and collection efforts would need to be shared with participating providers in advance, and behavioral health providers would be entitled to an opportunity to comment on the proposed data reporting specifications.

Medicaid contracts could impose additional obligations on MCOs related to data collection such as requiring them to estimate the time and costs that behavioral health providers will incur in furnishing the requested data, the purpose of the data request, and whether the MCO is subsidizing or bearing the costs for the collection efforts.

Model Language

1.0 If the Contractor requests from a provider any patient information, statistical data, clinical data, or medical record data pertaining to Covered Services that is not otherwise captured in claims submissions, or requested from a provider in order to process, investigate, or review claims submissions, then the Contractor shall accept data from providers substantially in the form of Attachment X to this Model Contract or as otherwise defined by the state.

2.0 Prior to contracting with a provider, the Contactor must fully disclose to the provider any and all relevant data reporting and collection specifications, requirements, and policies and procedures.

2.1 In the event that the Contractor seeks to modify or introduce new data reporting and collection specifications, requirements, or policies and procedures subsequent to contracting with a provider, the Contractor must furnish affected providers at least a 60-day notice and comment period. The Contractor must consider all relevant matters presented during the comment period, respond in some form to all comments received, and submit the final data reporting and collection specifications, requirements, or policies and procedures, to the affected providers and state.

Advocacy Talking Points

- MCOs make numerous data requests from participating providers, which imposes significant costs and administrative burden on behavioral health providers as a result of unique data reporting requirements and specifications established by each MCO.
- The State should establish uniform standards for data requests. At a minimum, the standards should:
  - Require at least sixty days' notice to providers for requests of information.
  - Require disclosure of data reporting specifications to providers in the contracting process to permit providers to consider the costs of data reporting.
  - Require notice and comment procedures before an MCO may impose new reporting specifications on participating providers, ensuring that providers have input in the data reporting specifications.
- Uniform standards for data requests would increase efficiency and reduce administrative costs for both behavioral health providers and MCOs.

Chapter 13. Drug Formularies and Preferred Drug Lists

KEY POINTS

To reduce the administrative burden of prior authorization processes for off-formulary prescribing, and to protect professional decision-making, state Medicaid contracts with MCOs could:

- Require MCOs to follow the state's formulary used in its Medicaid fee-for-service program, and establish a standard prior authorization protocol; and
- Prohibit MCOs from implementing Fail First or Step Therapy policies in behavioral health.

Overview

In states that include a pharmacy benefit as part of the MCOs' required scope of services, MCOs frequently negotiate drug prices with manufacturers and limit prescriptions to a pre-defined list of drugs, known as a formulary or Preferred Drug List ("PDL"). A drug's inclusion in the formulary is, in part, driven by cost-effectiveness considerations. Typically, if a practitioner wishes to prescribe a non-formulary drug, the practitioner must obtain prior authorization by demonstrating a specific need for the non-formulary drug.

An MCO may also implement a "Fail First" or "Step Therapy" policy in which the practitioner must prescribe the lowest-cost clinically effective drug first, stepping up incrementally to more expensive alternatives as the less expensive options fail. Formularies and other prescription drug policies can vary significantly among MCOs within the same state.

While an MCO's desire to control drug costs is not intrinsically objectionable, inconsistent MCO formularies and fail first protocols result in frustrations for both behavioral health providers and patients. Providers and their staff are forced to spend extra time interacting with MCOs through the prior approval processes to justify prescribing decisions.

Inconsistent prior approval policies among MCOs can lead to practitioners treating clinically similar patients differently, as multiple MCOs perform independent cost-effectiveness analysis in setting their formulary. Moreover, under a Fail First policy a practitioner's autonomy to customize a treatment plan is curtailed, and the Fail First policy may force patients to undergo rounds of ineffective treatment before a practitioner can prescribe the ideal drug.

To address these issues, state Medicaid contracts could incorporate terms that require greater consistency among MCOs. For example, some states have established a PDL in Medicaid fee-for-service. In those states, Medicaid contracts could restrict all MCOs to the state's fee-for-service PDL. State Medicaid contracts could also establish a uniform prior authorization protocol, and prohibit MCOs from developing their own. Finally, state Medicaid contracts could prohibit MCOs

from implementing Fail First or Step Therapy policies in behavioral health.

Model Language

TEXAS

Texas required all MCOs to use the same formulary established for its fee-for-service Medicaid program, which had been developed by the Health and Human Services Commission ("HHSC"), thus standardizing the formulary across all Medicaid MCOs.[28]

Formulary and Preferred Drug List – Section 8.1.21.1

The MCO must provide access to covered outpatient drugs, biological products, certain limited home health supplies (LHHS), and vitamins and minerals through formularies and a preferred drug list (PDL) developed by HHSC. HHSC will maintain separate Medicaid and CHIP formularies, and a Medicaid PDL. The MCO must administer the PDL in a way that allows access to all non-preferred drugs that are on the formulary through a structured PA process.

The MCO must educate Network Providers about how to access HHSC's formularies and the Medicaid PDL on HHSC's website. In addition, the MCO must allow Network Providers access to the formularies and Medicaid PDL through a free, point-of-care webbased application accessible on smart phones, tablets, or similar technology.

Texas also standardized prior authorization policies and procedures across Medicaid MCOs. The RFP incorporates by reference a state law which requires all state contracts with Medicaid MCOs to include provisions that bind the MCO to prior authorization policies established by the Texas Prior Authorization Program, which is a protocol used by Texas in its Medicaid fee-for-service program.[29]

Compliance with State and Federal Prior Authorization Requirements – Section 8.1.8.1

The MCO must adopt prior authorization (PA) requirements that comply with state and federal laws governing authorization of health care services and prescription drug benefits, including . . . Texas Government Code §§ 531.073 and 533.005(a)(23).[30]

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[28] Texas Health & Hum. Servs. Commission, Attachment B-1 – Medicaid and CHIP Managed Care Services RFP, Uniform Managed Care Terms & Conditions, Version 2.24, § 8.1.21.1, at p. 8-129, https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf

[29] *Id.* § 8.1.8.1.

[30] Tex. Gov't Code Ann. § 533.005(a)(23) (West 2017) provides:

> (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain: . . .
>
> (23) ...a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients: . . .
>
> (B) that adheres to the applicable preferred drug list . . .
>
> (C) that includes the prior authorization procedures and requirements prescribed by or

Advocacy Talking Points

- Behavioral health providers face a patchwork of drug formularies (often known as a Preferred Drug List, or "PDL") and prior authorization policies from MCOs, creating disparate coverage across Medicaid enrollees and imposing high administrative costs on providers.
- The State should establish a uniform PDL for all MCOs and adopt a uniform prior authorization protocol for prescription drugs.
  - The State should prohibit "Fail First" and "Step Therapy" policies in which a practitioner must prescribe the lowest-cost clinically effective drug first, step up incrementally to more expensive alternatives as the less expensive options fail.
  - While such policies may sound good in theory, such policies permit the MCO to override the clinical decision making of medical professionals and prolong a patient's treatment regimen, requiring multiple rounds of ineffective therapy.
- A uniform PDL and uniform prior authorization process will allow behavioral health practitioners to use a single database to determine which drugs are preferred and a consistent, predictable process for practitioners to access non-preferred drugs when necessary.

implemented under . . . the vendor drug program.

Appendix A

Sources for Behavioral Health Clinical Measurement

Centers for Medicare & Medicaid Services, "2018 Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set)", available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-bh-core-set.pdf

New York Department of Health, "Behavioral Health Chronic Conditions: Behavioral Health Clinical Advisory Group Value Based Payment Recommendation Report", October 2016, available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2016-10-28_bhcc_rpt.pdf

Substance Abuse and Mental Health Services Administration, "Metrics and Quality Measures for Behavioral Health Clinics, Technical Specifications and Resource Manual" April 2016, available at: https://www.samhsa.gov/section-223/quality-measures/notices

U.S. Department of Health and Human Services, "Development and Testing of Behavioral Health Quality Measures for Health Plans: Final Report", March 2015, available at: https://aspe.hhs.gov/system/files/pdf/258891/BHQMfr.pdf

Washington Health Alliance, "Washington State Common Measure Set, April 2018, available at: https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf