Medicaid Managed Care

What to Ask: A Checklist for Advocates

Managed care is an approach to financing and delivering health care that attempts to control costs and ensure or improve quality of care. Increasingly, states are looking to managed care as a strategy to contain the cost of mental health care in Medicaid programs.

Managed care ranges from Primary Care Case Management (PCCM) models that provide payments for case management and care coordination services, while financing most other services on a fee-for-service (FFS) basis, to full-risk capitated models.

This checklist is intended as a first step to help advocates ask the right questions and request pertinent information, particularly for full or partial-risk managed care plans.

✔ ASK FOR A COPY OF THE CONTRACT, RFI AND RFP

The managed care contract is an agreement between the purchaser (state Medicaid program or employer) and the Managed Care Entity (MCE) that documents the program structure, deliverables and fiscal requirements. The contracting process typically involves the following phases:

- **Request for Information (RFI):** The purchaser sends an open inquiry to the managed care field asking, "What will you do for us if we contract with you?"
- **Request for Proposal (RFP):** The purchaser announces contract requirements to the managed care field and invites submission of proposals.
- **Contract:** The agreement between the purchaser and the managed care plan regarding the service provider network, services to be performed, quality indicators, customer service requirements, etc.

ADVOCACY TIPS

Who to ask: State Medicaid Director

When to ask: Request a copy of the managed care contract(s) at any time. Ask when contracts expire and request draft documents (RFI, RFP and contract) early in the renewal process in order to help shape final products. Plan to advocate for modifications three to six months in advance of deadlines.

Get help: Managed care contracts are lengthy and technical documents, so plan to find an independent expert or coalition to provide guidance.

✔ ASK HOW MENTAL HEALTH BENEFITS ARE MANAGED

A managed care plan may manage all physical health, addictions and mental health benefits (integrated plan), maintain responsibility for mental health benefits but subcontract management of the benefit to another entity (subcontracted plan), or separate entities may be responsible for the mental health benefit and physical health benefits (carve-out or separate plan).

- Each management structure has pros and cons. Within each structure, it is the contractual requirements, fiscal incentives, processes, responsibilities, oversight and leadership that impact how a managed care plan will meet the needs of children and adults living with mental illness and co-occurring disorders.

✔ ASK HOW INDIVIDUALS AND FAMILIES AFFECTED BY MENTAL ILLNESS WILL BE ACTIVELY ENGAGED

Managed care plans may be required to involve stakeholders in planning and oversight, including advising on covered services, priorities, goals and benchmarks. In addition, managed care plans may be required to employ people living with disabilities, including serious mental illness.

A managed care plan should:

- specify how system stakeholders, including families and individuals who live with serious mental illness, will be included in planning and oversight and in employed roles with the managed care plan; and
- indicate how it will incorporate advocate recommendations, priorities and feedback into operations.

✔ ASK FOR A LIST OF COVERED MENTAL HEALTH SERVICES

Managed care contracts specify which mental health services managed care plans are responsible for providing.

A managed care plan should:

- include clear definitions of each covered service and eligibility criteria, as well as authorization requirements regarding the amount, duration and scope of services;
- include both coverage of and definitions of what is meant by evidence-based and promising practices for mental illnesses; and
- promote provider practices and approaches that engage and support families, including opportunities to pilot non-traditional services for underserved populations.

✔ ASK FOR THE PLAN'S DEFINITION OF "MEDICAL NECESSITY"

Medical necessity definitions and criteria are used by managed care plans to allow or disallow plan benefits (services, equipment, pharmaceuticals, etc.) for individual enrollees.

- The medical necessity definition and criteria should be public information and should support provision of recovery-focused mental health treatment and supports.

✔ ASK FOR THE MEDICAL LOSS RATIO REQUIREMENT

Medical Loss Ratio (MLR) refers to the percentage of each health care dollar that must be spent on direct services.

A managed care plan should:

- be required to spend a high percentage of its revenue on direct service; and
- be specific enough in its definition of "direct services" to ensure that costs that could be considered administrative or marketing are not included.

ADVANCED ADVOCACY TIP

Who to meet: Managed Care Plan Director of Behavioral Health (or similar title)

What to discuss:

- Introduce your organization and the resources it provides that contribute to wellness and recovery for children, adults and families affected by serious mental illness.
- Ask how the managed care plan addresses areas outlined in this checklist.
- Offer to provide feedback when the managed care plan prepares a proposal or seeks a contract renewal.

✔ ASK FOR PROVIDER NETWORK AND QUALITY ASSURANCE REQUIREMENTS

Managed care plans are responsible to establish a provider network capable of delivering the required array of services throughout the contracted geographic region.

A managed care plan's:

- quality assurance standards should ensure high quality, culturally competent mental health services, including evidence-based and promising practices; and
- provider network should include well-trained mental health providers in numbers and locations adequate to provide timely and accessible services.

✔ ASK FOR MEASURABLE STANDARDS FOR ACCESS TO CARE

Managed care contracts include requirements by service type for timeliness, geographical access, cultural competence and enrollee choice.

- A managed care plan should provide enrollees the choice of at least two providers for most mental health services within a reasonable range (usually a 30–60 minute drive) of the enrollee's home and should specify reasonable maximum wait times and the availability of language interpretation services.

✔ ASK FOR CUSTOMER SERVICE, GRIEVANCE AND APPEALS PROCEDURES

Managed care plans are required to provide information to health plan members on coverage, services, providers and assistance to resolve issues.

- Procedures for grievances (complaints) and appeals (requests to reconsider decisions) should be readily available in writing, user-friendly, with clear steps and required response times.

✔ ASK HOW CARE WILL BE COORDINATED OR INTEGRATED

Care coordination, disease management and other integrated care models help identify and coordinate services for people living with chronic or complex health conditions, such as serious mental illness and co-occurring mental health, substance use and/or other medical disorders.

- A managed care plan should indicate how mental health care will be integrated or coordinated with addictions and primary care and should include incentives at the clinical level, such as billing codes for care coordination, flexibility regarding service delivery location and incentives to establish "health homes" (medical homes).