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MEMORANDUM

TO:	**Don Clayback, Executive Director, NCART**
FROM:	**Lewis Golinker; Garth Corbett**
RE:	**Obligations of Medicaid Managed Care Organizations**
Date:	**December 14, 2010**

Medicaid programs are authorized to contract with managed care organizations (MCOs) for administration of recipients' benefits requests. This memo reviews Part 438 of the federal Medicaid regulations, 42 C.F.R. § 438, which state the obligations of Medicaid programs that establish managed care contracts, and the obligations of the MCOs regarding provision of covered benefits.

It is important to note that managed care is an *administrative* mechanism, not a substitute or an otherwise different program than the fee-for-service Medicaid program that existed and operated in the state. *Medicaid recipients sacrifice no substantive benefits by enrolling or being enrolled in managed care.* The MCO regulations declare:

> East State must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs.

42 C.F.R. § 438.206(a).[1]

[1] *See also,* 42 C.F.R. §§ 438.10(e)(2)(ii)((A)(requiring MCOs to provide notice to "potential enrollees" [Medicaid recipients who are required to join MCOs or who may elect to join an MCO, § 438.10(a)] in easily understandable language, of the benefits covered by the MCO) and § (e)(2)(ii)(E)(requiring MCOs to provide notice to "potential enrollees" of the "benefits that are available under the state plan but are not covered under the contract, including how and where the enrollee may

By definition, a MCO is an entity that

> Makes the services it provides to its Medicaid recipients as accessible (in terms of timeliness, amount, duration and scope) as those services are to other Medicaid recipients within the area served by the entity.

42 CFR § 438.2 [Definition of Managed Care Organization, at ¶ (2)(i)].

Note the phrase "the services it provides" in the above-quoted MCO definition. The scope of an MCO's authority or responsibility does not have to extend to all covered Medicaid services. Rather, the state may transfer administrative control of only some covered Medicaid services to managed care. The regulations state that each contract with an MCO must

> identify, define and specify the amount, duration and scope of each service that the MCO is required to offer.

42 C.F.R. § 438.210(a)(1).[2]

In addition, for each covered Medicaid service to be administered through an MCO contract, there are specific operational obligations imposed on the MCO. For those MCOs responsible for administration of the DME benefit, the MCO is required to cover *every item of DME that is covered under the state Medicaid program, and*, *may not use criteria to determine eligibility for DME items that are more restrictive than, or that otherwise lead to a different outcome than would result from application of the criteria applied by the fee-for-service Medicaid program.*

> (a) Each contract with an MCO must do the following:
>
> (1) Identify, define and specify the amount, duration and scope of each service that the MCO is required to offer.
>
> (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in § 440.230.
>
> (3) Provide that the MCO:

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obtain those benefits…"). Read together, these regulations confirm that "potential enrollees" in managed care will continue to have access to all services covered by the Medicaid state plan upon enrollment – either through the MCO, or some other administrative mechanism.

[2] *See also* § 438.10(e)(2)(ii)(A)(requiring MCO's to provide notice to prospective enrollees in easily understandable language of the covered Medicaid benefits it offers); § 438.10(e)(2)(ii)(E)(requiring MCO's to provide notice to prospective enrollees in easily understandable language of the covered Medicaid benefits it will not offer, and how prospective enrollees can access those benefits)

(i) Must ensure that the services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished

(ii) May not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

42 C.F.R. § 438.10(a).

MCOs must ensure operational equivalence to fee-for-service Medicaid: all substantive and procedural aspects of coverage must be equivalent. The items that are covered by the MCO, and the standards used to determine eligibility for access must be the same, or can be no more restrictive, than those used by fee-for-service Medicaid.

This operational equivalence also extends to the assessment of "medical need."

(3) Provide that the MCO:

(iii) May place appropriate limits on a service:

A. On the basis of criteria applied under the state plan, such as medical necessity; or
B. For the purposes of utilization control, provided the services furnished can reasonably be expected to achieve their purpose as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes medically necessary services in a manner that –

(i) Is no more restrictive than that used in the state Medicaid program …

42 C.F.R. § 438.10(a).

These regulations will restrict MCOs, such as insurance companies, from, *e.g.:*

- substituting (applying) their own medical coverage policies or guidelines to determine eligibility for DME items, when those policies or guidelines impose different procedural requirements (e.g., evaluations by different or additional professionals) or different substantive requirements (e.g., adopting the Medicare "in the home" standard for mobility devices when the Medicaid program did not do so) than are applicable to requests for the same equipment items under fee-for-service Medicaid; and
- determining that covered items are experimental for certain uses, such as for enrollees with specific diagnoses or ages, when no comparable limits exist under fee-for-service Medicaid.

MCOs have no ability to declare that any equipment item previously covered by fee-for-service Medicaid is not covered, either as a response to a specific prior authorization

request or by reference to an exclusive list of covered items or a list of expressly non-covered items. The "State Medicaid Director" letter issued September 4, 1998 in response to the De Sario decision is applicable to MCOs in the same manner and with the same force as it is applicable to fee-for-service Medicaid.

In sum, an MCO will be authorized to stand in the shoes of the Medicaid agency, and follow in the Medicaid agency's footsteps. But it is not permitted to chart its own course regarding the procedural or substantive aspects of DME item coverage.

Please contact me if there are specific concerns not addressed by this memorandum.