OPTIONAL PURCHASING SPECIFICATIONS:
MEMORANDUM OF UNDERSTANDING BETWEEN
PUBLIC HEALTH AGENCIES AND
MEDICAID MANAGED CARE ORGANIZATIONS

A TECHNICAL ASSISTANCE DOCUMENT

(December, 2002)

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This document, “Optional Purchasing Specifications: Memorandum of Understanding Between Public Health Agencies and Medicaid Managed Care Organizations” was prepared by The George Washington University Center for Health Services Research and Policy (CHSRP) in consultation with officials from the Centers for Disease Control and Prevention (CDC).

This technical assistance document may be used as a tool to assist interested state and local public health officers in negotiating memoranda of understanding (MOUs) with managed care organizations (MCOs) from which the state Medicaid agency is purchasing services on behalf of individuals eligible for Medicaid. The document may also be useful to public health officers in developing working arrangements with MCOs that enroll state or local employees or other employer groups but that do not contract with the state Medicaid agency. CHSRP has also prepared a similar document relating to MOUs between public health agencies and Medicaid primary care case management (PCCM) systems.¹

These sample purchasing specifications are optional, and do not necessarily reflect the views of the CDC, the Centers for Medicare & Medicaid Services (CMS), or the Health Resources and Services Administration (HRSA).

Background

Nationally, more than half of all Medicaid beneficiaries – some 18 million children and adults – are enrolled in some form of managed care, mainly risk-based MCOs. As Rosenbaum et al. have noted, enrollment of such large numbers of low-income individuals in MCOs has important implications for state and local public health agencies, because these populations are at the greatest risk for many public health conditions, including sexually transmitted diseases (STDs), tuberculosis (TB), and HIV/AIDS. These implications extend beyond the MCOs serving Medicaid beneficiaries; as the Institute of Medicine noted in its seminal 1996 report on the future of public health, "if the proper kind of partnerships between managed care organizations and government public health departments are developed, managed care can indeed make an important contribution to improving the health of the public."

A 1999 evaluation by the HHS Office of Inspector General (OIG) concluded that there were a number of challenges to collaborations between MCOs and public health agencies, particularly in the area of population-based activities. After reviewing these constraints, OIG concluded "constructive movement toward collaborations to further essential public health population-based activities is hard pressed based on good will efforts alone." OIG noted that CMS, HRSA, and CDC had entered into a formal interagency agreement to support data sharing between state Medicaid and public health agencies. The OIG offered some options for consideration, including the following suggestions: "[CMS] could encourage States to require that managed care plans contracting with Medicaid specify how they will work with State and local health agencies to identify and achieve public health goals; encourage state Medicaid programs to examine sample purchasing specifications as they prepare contracts with managed care providers and encourage managed care plans to share HEDIS or other appropriate data with State public health departments in order to enhance their surveillance function."

The function of an MOU is to enable public health agencies and Medicaid MCOs to clarify their respective roles and responsibilities in meeting the public health needs of Medicaid enrollees and the community as a whole. These MOUs are not uncommon. A review of contracts between state Medicaid agencies and MCOs in effect in 2000 found that 31 of 51 contracts contained provisions addressing the relationship between MCOs and state or local public health agencies.

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5 The CMS website on Medicaid and Public Health Data Sharing Activities, [http://www.hefa.gov/medicaid/mpdhmpg.mpdhmpg.htm](http://www.hefa.gov/medicaid/mpdhmpg.mpdhmpg.htm), states that "Data sharing between Medicaid and public health agencies is an essential component of any state's strategy to maximize the goal of improving the health care of vulnerable populations."
Unlike the contract between a state Medicaid agency and an MCO, an MOU between a state or local public health agency and an MCO does not involve the furnishing of a specified set of services to a defined population in exchange for a fixed monthly capitation payment. The duties of the MCO set forth in this technical assistance document do not exist by virtue of payments received from the state or local public health agency. Instead, the MCO’s duties reflect either (1) obligations set forth in the contract between the MCO and the state Medicaid agency or (2) obligations set forth under state public health law or regulation.

Similarly, the public health agency’s duties under this illustrative MOU language are derived from state law or regulation, not from payments made to the agency by the MCO. The public health agency is assumed not to have affiliated itself with the MCO as a provider participating in its provider network. This illustrative language deals principally with the duties of the public health agency in connection with its core public health function of community health surveillance or assessment. It does not address the role of the agency in connection with its other core public health functions, policy development and health care assurance.

Process for Developing this Technical Assistance Document

Since 1995, CHSRP has conducted an intensive examination of contracts between state Medicaid agencies and MCOs. This analytic work has produced four editions of a comprehensive study of contract provisions. The most recent version is CHSRP's Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 4th Edition (2001), www.gwhealthpolicy.org. The study breaks down the contracts into a series of analytic tables. Table 4.1 addresses relationships with state and local public health and social services agencies.

Negotiating the New Health System is part of a broader analytic studies and technical assistance project on managed care contracts financed by numerous funders, including CDC, HRSA, the David and Lucile Packard Foundation, and the Substance Abuse and Mental Health Services Administration (SAMHSA). Original funding for this project was supported by Pew Charitable Trusts and the Annie E. Casey Foundation. The development of purchasing specifications for managed care products constitutes one component under this project. The specifications are available at http://www.gwhealthpolicy.org/managedcare_purchasingspecs.htm.

In March of 2000, CHSRP prepared for the Kaiser Family Foundation an analysis of the agreements between state public health agencies and managed care organizations with respect to the prevention and control of sexually transmitted diseases. The study, entitled Public Health in a Changing Health Care System: Linkages Between Public Health Agencies and Managed Care Organizations in the Treatment and Prevention of Sexually Transmitted Diseases (March 2000), http://www.kff.org/content/2000/1575/STD.pdf, found that the movement of Medicaid programs toward managed care creates major opportunities as well as challenges for the achievement of public health objectives.
Organization and Structure of this Technical Assistance Document

This document is organized into two basic sections. The first (§101) sets forth illustrative duties of a state or local public health agency; the second (§102) sets forth illustrative duties of an MCO. Within each of these sections, responsibilities vis-a-vis particular public health conditions (e.g., STDs, TB, HIV/AIDS) are addressed. There is also a short section (§103) that defines key terms. This structure is designed to enable interested public health officials to select the illustrative language applicable to their particular circumstances and to incorporate it into their MOUs without having to reformat their documents or to include language that does not reflect their policy preferences.

As discussed above, CHSRP has developed a number of purchasing specifications that are designed to assist state Medicaid agencies (and other state purchasers) buy services from MCOs for various public health conditions, including vaccine-preventable diseases, STDs, HIV/AIDS, lead poisoning, and TB. The duties of the MCOs set forth in §102 of this technical assistance document have been drafted to conform to the duties of MCOs in the applicable purchasing specifications. Similarly, the duties of the public health agencies set forth in §101 of this document correspond to the duties implied in the relevant public health purchasing specifications. Because public health agencies are not parties to the contracts between state Medicaid agencies and MCOs, their roles and responsibilities are not articulated in the illustrative language of these purchasing specifications.

This document does not specify any procedural timeframes. Instead, a bracket ([ ] ) is supplied as a placeholder, indicating that the public health agency should insert a timeframe of its own choosing. Similarly, this document uses the convention “[drafter insert…]” where the context requires a case-specific reference rather than generic language. For example, the definition of the term “Public Health Agency” in §103(c) is “[drafter insert name of state or local public health agency entering into MOU with managed care plan].”

This document focuses on certain responsibilities of public health agencies and MCOs. It does not address all of the provisions that are generally found in MOUs between public health agencies and MCOs, including provisions relating to term, termination, modification of agreement, access to books and records, conflict of interest, nondiscrimination, assignment, remedies in the event of breach, effective date, etc. Illustrative language for such provisions of general applicability is found in Appendix: The Use of Memoranda of Understanding and Implications for Sexually Transmitted Disease Prevention and Control Programs (March 2000). 8

It should be emphasized that MOUs do not impose new duties upon MCOs or state (or local) public health agencies. Instead, MOUs are intended to clarify responsibilities of the parties to the MOU that derive from other sources, e.g., state or local public health laws or regulations.

8 This Appendix is available from CHSRP; contact 202.296.6922 or colleens@gwu.edu.
How to Use this Technical Assistance Document

The drafting format used in these sample specifications is as follows:

• Each Part is divided into sections, identified by “§.”

• Each section, in turn, is divided into one or more subsections: “(a),” “(b),” etc.

• A subsection may be divided into one or more paragraphs: “(1),” “(2),” etc.

• A paragraph may be divided into one or more subparagraphs: “(A),” “(B),” etc.

• A subparagraph may be divided into one or more clauses: “(i),” “(ii),” etc.

Every state purchaser has its own drafting format. The particular format used in these purchasing specifications is NOT intended as a substitute for each state’s own format. Instead, it is intended simply to divide each suggested provision into the smallest practicable policy elements. This division and subdivision format is designed to enable a user to identify quickly the policy choices contained in each provision and to identify which, if any, of the elements the user wishes to adopt. This format also serves as a detailed checklist for those users who wish to compare portions of their current purchasing documents with the relevant portions of these purchasing specifications.

Other CHSRP Purchasing Specifications

CHSRP has also developed a number of purchasing specifications which are listed in Table 1 below. The dated specifications are posted on CHSRP's website, http://www.gwhealthpolicy.org/managedcare_purchasingspecs.htm. All other listed specifications are under development.

Several of these purchasing specifications contain provisions relating to MOUs between Medicaid MCOs and state agencies other than the state Medicaid agency. For a guide to these provisions, see the Appendix to this document.
## Population-Based Specifications

- Adults with Behavioral Health Needs (December 2001)
- Child Welfare (December 2001)
- Children with Behavioral Health Needs (October 2000)
- Children with Special Health Care Needs (August 2000)
- Pediatric Services (Medicaid) (November 1999)
- Pediatric Services (SCHIP) (April 2002)
- Individuals Who Are Homeless (June 2000)

## Service-Related Specifications

- Child Development Services (August 2000)
- Immunizations (May 1998)
- Pediatric Dental Care (March 2000)
- Pharmaceuticals and Pharmaceutical Services (December 2001)
- Prevention of Lead Poisoning (November 1998)
- Reproductive Health (May 2000)
- School-based Health Center Services (January 2002)
- Tobacco-Use Prevention and Cessation (October 2002)

## Public Health Conditions Specifications

- Asthma
- Diabetes (July 2000)
- Epilepsy (June 2002)
- HIV/AIDS (August 1999)
- Sexually Transmitted Diseases (November 1999)
- Tuberculosis (August 1999)

## Specifications for Operational Issues

- Access to Services (July 2000)
- Cultural Competence (November 2001)
- Data and Information
- Memorandum of Understanding Relating to Public Health (December 2002)

## Integrated Specifications

- User's Guide Relating to Behavioral Health (December 2001)
- User's Guide Relating to Public Health Conditions and Services
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§101. Duties of Public Health Agency (PHA)

(a) Surveillance of Notifiable Conditions

Commentary: The following illustrative language relating to case surveillance assumes that the MCO has entered into a purchasing agreement with the state Medicaid agency under which the MCO has duties relating to the reporting of certain diagnoses, conditions, or interventions to the state or local public health agency. Illustrative language setting forth these MCO contractual obligations is found in various CHSRP public health purchasing specifications cited in accompanying footnotes. In some circumstances, these duties could be subsumed under state or local law or regulation.

(1) HIV/AIDS

(A) In General — PHA (as defined in §103(c)) shall provide to all clinical laboratories identified by MCO (as defined in §103(a)) as furnishing laboratory services to enrollees of the MCO specifications for the format and timeframe for reporting cases of HIV/AIDS among enrollees of the MCO as required under [drafters insert reference to provisions of contract between MCO and State Medicaid Agency relating to reporting of HIV/AIDS cases].

(B) Perinatal Exposure — PHA shall provide to MCO, and to all maternity care providers participating in the MCO provider network (as defined in §103(b)), specifications for the format and timeframe for reporting cases of infants exposed to HIV during gestation as required

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9 For illustrative language concerning reporting of HIV test results by clinical labs to the state public health agency, see §205(a) of CHSRP, HIV/AIDS Purchasing Specifications (August 1999).

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under [drafter insert reference to provisions of contract between MCO and State Medicaid Agency relating to reporting of infants exposed to HIV].\textsuperscript{10}

(2) **Immunizations** — PHA shall provide to MCO, and to providers participating in the MCO provider network who are licensed to furnish immunizations under [drafter insert reference to applicable state law], specifications for the format and timeframe for reporting cases of enrollees with a reportable vaccine preventable disease under [drafter insert reference to state law regarding vaccine preventable diseases].\textsuperscript{11}

(3) **Lead Poisoning**

(A) **Medical Information** — PHA shall provide to MCO, and to providers participating in the MCO provider network who furnish services to children, specifications for the type and format of the individual medical information relating to screening for, and clinical management of, lead poisoning that PHA requires under [drafter insert reference to applicable state law or regulation concerning monitoring of lead screening and treatment activities].\textsuperscript{12}

(B) **Case Surveillance** — PHA shall provide to all clinical laboratories identified by MCO as furnishing laboratory services to the MCO’s enrollees specifications for the format and timeframe for reporting cases of elevated blood lead levels among the enrollees of the MCO as required under [drafter insert reference to provisions of contract between MCO and State Medicaid Agency relating to reporting of cases of lead poisoning].\textsuperscript{13}

(4) **Sexually Transmitted Diseases (STDs)**

(A) **Medical Information** — PHA shall provide to MCO, and to providers participating in the MCO provider network, specifications for the type and format of the individual medical information relating to screening for, and clinical management of, sexually transmitted diseases that PHA requires under [drafter insert reference to applicable state law or

\textsuperscript{10} For illustrative language concerning reporting of cases of infants exposed to HIV virus, see §205(c) of CHSRP, HIV/AIDS Purchasing Specifications (August 1999).

\textsuperscript{11} For illustrative language concerning the duties of MCOs relating to reporting of cases with reportable vaccine-preventable diseases, see §009(e) of CHSRP, Immunizations Purchasing Specifications (May 1998).

\textsuperscript{12} For illustrative language concerning an MCO’s corresponding duty to give the state public health agency access to screening and treatment data, see §009(b) of CHSRP, Childhood Lead Poisoning Purchasing Specifications (November 1998).

\textsuperscript{13} For illustrative language concerning an MCO’s corresponding duty to report cases of lead poisoning to the state public health agency, see §009(c) of CHSRP, Childhood Lead Poisoning Purchasing Specifications (November 1998).
regulation concerning monitoring of the incidence and treatment of STDs].  

(B) **Case Surveillance** — PHA shall provide to all clinical laboratories identified by MCO as furnishing laboratory services to enrollees of the MCO specifications for the format and timeframe for reporting cases of sexually transmitted diseases among enrollees of the MCO as required under [drafted insert reference to provisions of contract between MCO and State Medicaid Agency relating to reporting of cases of STDs].

(5) **Tuberculosis (TB)**

(A) **Medical Information** — PHA shall provide to MCO, and to providers participating in the MCO provider network, specifications for the type and format of the individual medical information relating to clinical management of active tuberculosis that PHA requires under [drafted insert reference to applicable state law or regulation concerning control of TB].

(B) **Case Surveillance** — PHA shall provide to all clinical laboratories identified by MCO as furnishing laboratory services to enrollees of the MCO specifications for the format and timeframe for reporting cases of tuberculosis among enrollees of the MCO as required under [drafted insert reference to provisions of contract between MCO and State Medicaid Agency relating to surveillance of cases of TB].

(b) **Partner Notification and Treatment Services** — PHA shall provide to MCO and providers participating in the MCO provider network, information regarding the manner in which enrollees of the MCO and their partners may access the partner notification and treatment services furnished by PHA to individuals with sexually transmitted diseases under [drafted insert reference to applicable state law or regulation].

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14 For illustrative concerning the corresponding duties of MCOs relating to case reporting with respect to enrollees with sexually transmitted diseases, see §204(a) of CHSRP, STD Purchasing Specifications (November 1999).

15 For illustrative concerning the corresponding duties of MCOs relating to case surveillance with respect to enrollees with sexually transmitted diseases, see §204(b) of CHSRP, STD Purchasing Specifications (November 1999).

16 For illustrative language concerning the corresponding duties of MCOs relating to making medical information available to state public health authorities with respect to enrollees with tuberculosis, see §205(d) of CHSRP, Tuberculosis Purchasing Specifications (August 1999).

17 For illustrative language concerning the corresponding duties of MCOs relating to case surveillance with respect to enrollees with tuberculosis, see §205(c) of CHSRP, Tuberculosis Purchasing Specifications (August 1999).

18 For illustrative language concerning the corresponding duties of an MCO relating to referral of partners of enrollees with STDs to state public health agency services, see §104(b)(1)(C) of CHSRP, STD Purchasing Specifications (November 1999). Note that the federal privacy rule (65 Fed Reg 82462, December 28, 2000) governs the disclosure of individually identifiable health information by MCOs and health care providers. For a summary of the circumstances under which information may be disclosed for...
(c) **Vaccine Registry** — PHA shall provide to MCO specifications for the reporting format (written or electronic) and timeframe through which each physician and other practitioner participating in the MCO provider network shall comply with its obligations under [drafted cite appropriate state law or regulation imposing duty on providers to report immunization status of children or adults].

(d) **Referral of MCO Enrollees**

**Commentary:** The following illustrative language clarifies the circumstances under which the PHA is to provide services directly to an MCO enrollee. It assumes that the PHA is not an MCO network provider; these issues are addressed in the subcontract between the MCO and the PHA, and an MOU provision would be unnecessary. (Even when a PHA is an MCO network provider for purposes of its public health service delivery, it may still wish to enter into an MOU with the MCO for purposes of its case surveillance responsibilities).

The language below assumes that, under the master contract between the MCO and the State Medicaid Agency, the MCO is responsible for provision of public health services (e.g., immunizations, treatment of STDS, etc.) to its enrollees in all but emergency situations. The language therefore provides for referral by the PHA of any MCO enrollee who seeks non-emergency services from the PHA. However, in a case in which an MCO enrollee in need of emergency services presents at a PHA's clinic, and the PHA has the capability to provide the needed care, the illustrative language assumes that the PHA will provide the needed care, and that the MCO will reimburse the PHA for the emergency services furnished to its enrollee. Note that under the federal Medicaid statute, Medicaid MCOs are responsible for providing coverage for emergency services without regard to prior authorization, §1932(b)(2)(A) of the Social Security Act, 42 U.S.C. §1396u-

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For illustrative language concerning the corresponding duties of an MCO to participate in a vaccine registry, see §009(c) of CHSRP, *Immunization Purchasing Specifications* (May 1998).

An alternative model would give the PHA a role in the furnishing of specified (non-emergency) public health services to MCO enrollees. Under this approach, the PHA would be responsible for providing specified non-emergency public health services (e.g., immunizations) to MCO enrollees who present for services at the PHA’s facilities. The MCO would not be responsible for reimbursing the PHA for the provision of those services to its enrollees. Instead, Medicaid payments that would otherwise be made to the MCO network providers for the delivery of these services could, at state option, be paid directly to the PHA to help offset its costs. Suggested language reflecting this arrangement follows:

(a) **Provision of Public Health Services to MCO Enrollees**

1. **Duty to Furnish** — PHA shall furnish the public health services enumerated in paragraph (2) to enrollees of the MCO under the same circumstances, to the same extent, and on the same financial terms as PHA furnishes the services to other residents of the service area of the MCO.

2. **Public Health Services Specified** — Public health services enumerated in this paragraph are:

   (A) [drafted insert list of public health services (e.g., immunizations) that PHA furnishes directly].
2(b)(2)(A). This responsibility is implemented at 42 C.F.R. §438.114(b). Corresponding illustrative language setting forth the MCO's duties in this regard appears in §102(c).

(1) Duty to Refer Enrollees Not Requiring Emergency Services — In the case of an MCO enrollee who seeks health care from PHA but does not require emergency services (as defined in paragraph (3)), PHA shall refer an enrollee of MCO to a provider participating in the MCO provider network designated by MCO.

(2) Duty to Treat Enrollees Requiring Emergency Services

(A) PHA has Capability to Furnish Required Emergency Services — In the case of an MCO enrollee who seeks health care from PHA and who is determined by PHA to require emergency services (as defined in paragraph (3)) that PHA has the capability to furnish, PHA shall stabilize the enrollee's medical condition until a provider participating in the MCO provider network assumes responsibility for the medical management of the enrollee.

(B) PHA does not have Capability to Furnish Required Emergency Services — In the case of an MCO enrollee who seeks health care from PHA and who is determined by PHA to require emergency services (as defined in paragraph (3)) that PHA does not have the capability to furnish, PHA shall comply with [draft insert reference to state law or regulation regarding PHA obligation to emergency care patients in such circumstances].

(3) Emergency Services — Emergency services described in this paragraph are items and services needed to evaluate or stabilize an emergency medical condition as defined in §1932(b)(2)(C) of the Social Security Act, 42 U.S.C. §1396u-2(b)(2)(C), 42 C.F.R. §438.114(a). 21

(e) Technical Assistance — PHA shall, upon request of MCO, provide technical assistance to MCO and providers participating in the MCO provider network in understanding and complying with their duties under this memorandum and under [draft reference applicable state public health laws and regulations].

(f) Liaison — PHA shall, within [] after the effective date of this memorandum, provide MCO the name and contact information for the employee designated as liaison with MCO for purposes of implementing this memorandum.

21 §1932(b)(2)(C) defines an "emergency medical condition" as "a medical condition manifesting itself by acute systems of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."
§102. Duties of Managed Care Organizations (MCO)

Commentary: As discussed in the introduction, an MOU between a public health agency and an MCO does not impose new legal obligations or duties for an MCO and its network providers. Instead, the MOU is intended to clarify responsibilities of the parties to the MOU that derive from other sources, e.g., state or local public health laws or regulations, or provisions in the risk contract between the MCO and the state Medicaid agency. The first of these duties addresses those functions essential to enabling the state or local public health agency (PHA) to carry out its responsibilities under state law: compliance by network providers with reporting and other requirements relating to notifiable conditions and the carrying out of case surveillance (subsection (a)). The second duty is to make provider contact information available to the PHA to enable it to make appropriate referrals of MCO enrollees seeking non-emergency services (subsection (b)). The third duty is to enable PHA to obtain payment for emergency services furnished to MCO enrollees (subsection (c)). Finally, the MCO would have a duty to identify a liaison to the PHA for purposes of implementing the MOU.

(a) Network Provider Compliance with State Public Health Laws

(1) Provider Participation Agreement — MCO (as defined in §103(a)) shall include in its written agreement with each physician or other practitioner participating in the MCO provider network (as defined in §103(b)) a requirement that the physician or practitioner comply with:

(A) a request by PHA (as defined in §103(c)) for access to individual medical records in the possession of the physician or practitioner for purposes of case surveillance as authorized under state law; and

(B) the following requirements in the contract between MCO and [drafty insert name of state Medicaid agency] with respect to:

(i) HIV/AIDS [drafty insert reference to provisions setting forth public health duties of MCO in relation to enrollees with HIV/AIDS and their partners].

Note that the federal privacy rule (65 Fed Reg 82462, December 28, 2000) governs the disclosure of individually identifiable health information by MCOs and health care providers. Such information may be disclosed without the individual's written consent to a public health agency authorized by law to collect information to prevent or control disease or conduct public health surveillance. See Phyllis C. Borzi, Protecting Individual Medical Records: A Description of Key Requirements of the Final Regulations Applicable to Group Health Plans (May 2002), p.10, www.gwhealthpolicy.org.

For illustrative language concerning the duties of MCOs in relation to Medicaid enrollees with HIV/AIDS, see CHSRP, HIV/AIDS Purchasing Specifications (August 1999), §205(b) (relating to state public health agency access to medical information regarding MCO enrollees with HIV/AIDS held by providers and laboratories participating in the MCO's provider network) and §205(c) (relating to case surveillance of infants exposed to HIV).
(ii) **Immunizations** [drafter insert reference to provisions setting forth the MCO’s public health duties relating to vaccinations, including provision of enrollee vaccination status to state vaccine registry];\(^{24}\)

(iii) **Lead Poisoning** [drafter insert reference to provisions setting forth the MCO’s public health duties to prevent childhood lead poisoning];\(^{25}\)

(iv) **STDs** [drafter insert reference to provisions setting forth MCO’s public health duties in relation to enrollees with STDs and their partners];\(^{26}\)

(v) **TB** [drafter insert reference to provisions in contract setting forth MCO’s public health duties in relation to enrollees with tuberculosis];\(^{27}\) and

(vi) **Other Notifiable Conditions** [drafter insert reference to provisions setting forth MCO’s public health duties in relation to enrollees with notifiable conditions other than those specified above].

(2) **Ensuring Compliance** — If PHA notifies MCO that a physician or other practitioner participating in the MCO provider network is not making medical records available for case surveillance under paragraph (1)(A) or not reporting notifiable conditions under paragraph (1)(B), MCO shall ensure compliance by the physician or practitioner with the requirements under paragraph (1) that are included in the provider’s written agreement with MCO to participate in the MCO provider network.

(b) **Provider Network Contact Information**

(1) **Surveillance and Related Functions** — In order to enable PHA to carry out its duties under §101(a), (b), and (c) (relating to notifiable conditions, partner notification, and vaccine registry), MCO shall, within [___] days of the effective

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\(^{24}\) For illustrative language concerning the duties of MCOs relating to maintenance of immunization records and reporting of immunization-related data, see §009 of CHSRP, *Immunizations Purchasing Specifications* (May 1998).

\(^{25}\) For illustrative language concerning the duties of MCOs relating to maintenance of medical records and reporting of information regarding lead poisoning, see §009 of CHSRP, *Childhood Lead Poisoning Purchasing Specifications* (November 1998).

\(^{26}\) For illustrative language concerning the duties of MCOs relating to case reporting and case surveillance with respect to enrollees with sexually transmitted diseases, see §204 of CHSRP, *STD Purchasing Specifications* (November 1999).

\(^{27}\) For illustrative language concerning the duties of MCOs relating to case reporting and case surveillance with respect to enrollees with tuberculosis, see §205 of CHSRP, *Tuberculosis Purchasing Specifications* (August 1999).
date of this memorandum, furnish to PHA contact information for each physician and other practitioner participating in the MCO provider network.

(2) **Referral of MCO Enrollees Not Requiring Emergency Services** — In order to enable PHA to carry out its duty under §101(d)(1) to refer an enrollee of MCO who seeks services other than emergency services (as defined in §101(d)(3)), MCO shall, within [__] days of the effective date of this memorandum, furnish to PHA information regarding the primary care providers to which enrollees seeking non-emergency services shall be referred.

**Commentary:** The following illustrative language sets forth duties for the MCO that correspond to duties of the PHA under §101(d). These reciprocal provisions assume that, under the risk contract between the MCO and the State Medicaid Agency, the MCO is responsible for the provision of public health services (e.g., immunizations, treatment of STDs, etc.) to its enrollees in all but emergency situations. The language in §101(d) provides for referral by the PHA of any MCO enrollee who seeks non-emergency services from the PHA. However, in a case in which an MCO enrollee in need of emergency services presents at a PHA's clinic, and the PHA has the capability to provide the needed care, the illustrative language in §101(d) assumes that the PHA will provide the needed care. The reciprocal language below assumes that the MCO will reimburse the PHA for these emergency services furnished to its enrollee. Note that under the federal Medicaid statute, Medicaid MCOs are responsible for providing coverage for emergency services without regard to prior authorization, §1932(b)(2)(A) of the Social Security Act, 42 U.S.C. §1396u-2(b)(2)(A).

(c) **Payment for Emergency Services** — In the case of an MCO enrollee described in §101(d)(2)(A) who has received an emergency services (as defined in §101(d)(3)) from PHA, MCO shall reimburse PHA in the same amounts, and on the same terms, as MCO would reimburse a provider participating in the MCO provider network for the same service.  

(d) **Liaison** — MCO shall provide to PHA the name and contact information for the employee designated as liaison with PHA for purposes of implementing this memorandum.

§103. **Definitions**

(a) Managed Care Organization (MCO) –  [draft insert name of managed care plan entering into MOU with state or local public health agency].

(b) MCO Provider Network – A health care practitioner, clinic, hospital, or licensed provider that has entered into enforceable written agreements with MCO to furnish, or arrange for the furnishing of, covered items and services to individuals enrolled in the MCO.

(c) Public Health Agency (PHA) – [draft insert name of state or local public health agency entering into MOU with managed care plan].

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28 An alternative option would be to require MCO in such cases to reimburse the PHA at the same rate that the state’s Medicaid program would pay a provider for the same service on a fee-for-service basis.
Appendix: Memorandum of Understanding Between MCOs and Other State Agencies

Commentary: Some of the CHSRP purchasing specifications contain provisions that would require contracting Medicaid MCOs to coordinate with state (or local) agencies (other than the state Medicaid agency) that have responsibility for furnishing services needed by MCO enrollees. These specifications concern the relationship between Medicaid MCOs and the larger public health system within which these MCOs operate. The coordination mechanism is a memorandum of understanding (MOU) between the MCO and the state agency. The illustrative language specifies the elements of the memorandum, including responsibility for furnishing and payment of covered and uncovered services, coordination of treatment plans, continuation of services upon disenrollment, disposition of court orders, data sharing, designation of liaisons, and resolution of disputes.

[On-Line Navigation: To see the full language of a purchasing specification, click on the name in the left column. To see a specific language reference, click on the section number in the right column.]

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MEDICAID = Medicaid Pediatric Services; SCHIP = SCHIP Pediatric Services; HOMELESS = Homeless Purchasing Specifications; CSHCN = Children with Special Health Care Needs Purchasing Specifications; ABHN = Adults with Behavioral Health Needs Purchasing Specifications; CBHN = Children with Behavioral Health Needs Purchasing Specifications; CW = Child Welfare Purchasing Specifications