Administrative Services Organizations (ASOs):

An alternative to mandatory enrollment of individuals with disabilities into managed care?

March, 2006

I. Introduction

Administrative services organizations (ASOs) are loosely-defined managed care entities. Without bearing any financial or medical risk, ASOs can be designed to coordinate services for high-risk populations and publicly-funded health plans. Whether ASOs are a “good” or “bad” form of managed care depends on risk allocation, ownership options (e.g., private or public), incentives to contain costs, and access for beneficiaries to services and quality care. It may also depend on the benefits and populations covered by the ASO contract. Several states, such as Texas, have already modified their Medicaid managed care programs to include ASOs. Notably, these ASOs target high-cost Medicaid populations (e.g., aged, blind and disabled), and overlay the existing fee-for-service system with an administrative organization aimed at care coordination and utilization management.

This issue brief will describe the various forms and functions of administrative services organizations and previous experiences of public agencies with this type of managed care. It will also discuss the incentives for an ASO to contain costs and ensure quality of care. It will describe a number of existing ASO programs and proposals and will highlight how this type of organization fits within federal regulations for Medicaid managed care. This issue brief will conclude with a brief discussion of whether an ASO might be a viable alternative to mandatory enrollment of individuals with disabilities into managed care, taking into account necessary consumer safeguards.

II. Background

An administrative services organization (also referred to as “administrative services only”) is a form of managed care. But, unlike “traditional” managed care organizations, ASOs do not bear medical risk. Employers developed ASOs as a means to manage care for high-cost

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beneficiaries, without shifting medical risk to the managed care entity. Today, some states are using ASOs and others are considering ASOs as a way to manage care for high-cost Medicaid beneficiaries. As with any form of managed care, ASOs may provide several financial and clinical benefits, but they also raise a number of concerns regarding access to care and quality services for vulnerable populations.

A. What is an administrative services organization (ASO)?

An ASO is a contractual arrangement under which an insurance company or other independent organization handles the administration of claims, benefits and other functions for a self-insured group or on behalf of a public entity, such as a state Medicaid program. While an ASO manages risk, it usually does not assume any medical risk of its own. Rather, the self-insured group or public entity assumes all medical and financial risk for the covered population.

Beyond this core definition, ASOs take on a variety of forms and functions, and perform a broad array of administrative and medical management services. Administrative functions include planning and marketing; human resources management; regulatory compliance; development of information systems; contract management; provider and member services; claims administration; and data reporting. An ASO might also conduct utilization management and prospective review or authorization for health care services. In addition, it may provide retrospective review and case management, as well as develop clinical guidelines and credentialing services. An ASO may perform other functions, beyond those of traditional managed care, such as physician billing and office staffing, physician recruitment, community services, health promotion campaigns and wellness and prevention services.

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2 Glossary of Managed Care Terms, at https://www.capbluecross.com/FAQs/Glossary+of+Terms/A.htm (July 2, 2004); Glossary of Managed Care Terms, at http://www.opga.com/glossary.htm (July 2, 2004). An ASO can also be community-owned or directed, allowing the community to "exert local control and promote local values," instead of the values and motives of a large regional or national managed care organization. Mike Fadden, Administrative Services Organization (ASO), CAL. INST. FOR RURAL HEALTH MGMT., available at http://www.cirhm.org/newsletters/win99_fadden.asp (July 6, 2004).
3 Fadden, supra note 2.
5 Fadden, supra note 2.
6 Id.
7 Id.
ASOs incorporate other important elements of managed care. In particular, risk allocation and reimbursement schemes define and shape these contractual arrangements. But, unlike other traditional managed care entities, an ASO usually does not bear medical or financial risk: insurers reimburse ASOs with a fixed administrative fee, rather than a monthly fee based on the number of covered beneficiaries (i.e., capitation). In this sense, then, an ASO does bear some “administrative risk” for any costs which exceed its monthly contract fee. However, a key question is whether an ASO, without medical risk, has an incentive to meet the primary goals of managed care—to both contain costs and provide high quality health services.

B. ASOs and the evolution of managed care

ASOs developed out of insurers’ experiences with managed behavioral health care. During the 1990s, private employers began to experiment with “carve-outs” by creating managed care contracts for mental health benefits only. Under this scenario, managed care vendors received a fixed administrative fee per enrollee or employee (i.e., capitation) and did not share any medical risk. Employers “outsourced” their health benefits management and administration to managed care organizations, while retaining the economic risk of employees’ mental health costs.

The public sector also experimented with mental health carve-outs. In California, at the state and county level, ASOs were used to provide mental health benefits for specific populations, such as Medicaid beneficiaries. By the end of the decade, an estimated 28% of all managed behavioral health enrollees were in risk-based plans, and another 21% were in non-risk ASO plans. An additional nineteen percent of private and public sector enrollees were in plans that performed only utilization review and case management services.

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9 A fixed administrative fee may be based on the number of eligible beneficiaries for a specified period of time (e.g. one year), rather than a monthly determination. Or, a fixed administrative fee may be an actual lump sum negotiated in exchange for ASO services over a specified period of time.
10 See William Goldman et al., Costs and Use of Mental Health Services Before and After Managed Care, 17 Health Affairs 40, 42 (Mar./Apr. 1998).
11 Id.
12 Jeff Goldsmith, The Internet and Managed Care: A New Wave of Innovation, 16 HEALTH AFFAIRS 42, 45 (Nov./Dec. 2000).
13 Dewane, supra note 8.
15 Id.
Today, ASOs still perform “typical” HMO functions, but are usually not reimbursed on a capitation basis. Instead, they are paid a fixed administrative fee for performing a specified number of services, such as medical care management and provider network contracting. This contracting scheme can be appealing for public agencies that insure high-risk populations. Because capitation may underestimate actual health care costs for a pool of high-risk beneficiaries, a fixed administrative fee may be easier to negotiate. It may also give ASOs greater predictability in budgeting for fixed service expenditures. On the other hand, a set administrative fee may still force some risk on ASOs, if administrative costs in any given contract period exceed that amount. Most likely, ASOs and insurers will "contract around" this problem by negotiating a base fee with additional reimbursement for services or activities with “extraordinary” costs.

C. Cost and quality of care

A central issue in ASO financing is whether capitation for medical services is necessary to contain costs, or whether an ASO can reduce costs while improving the efficiency of health care services. It is said that capitation may reduce the costs to the payer and theoretically improve efficiency through the elimination of unnecessary care. However, capitation can also act as a barrier to necessary care for individuals who frequently need healthcare services, particularly expensive or specialty services. Capitation schemes may give rise to adverse selection and incentives to under-serve or deny claims for the covered population. This may be especially detrimental for persons with chronic conditions and persons with disabilities, as well as those receiving public medical assistance.

Some health economists argue that ASO contracts create only “weak incentives for a vendor to contain costs, compared with those in which the vendor also acts as the insurer (risk contracts).” Proponents believe that when ASOs perform administrative services, such as disease and case management, for a fee (instead of capitation), they may achieve the same

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16 Transcript of Conference Call, ASO & Care Coordination, Western University of Health Sciences (2003) (on file with Nat'l Health Law Program).
17 Id. For instance, the fixed fee may be based on a percentage of the risk-bearing entity’s premium revenue. Fadden, supra note 2; see also Goldsmith, supra note 13.
18 See Dewane, supra note 8.
20 Id.
21 Goldman, supra note 10, at 42-43.
money-saving goals without under-serving individuals or under-providing health care.  

Because the costs of disease and case management are detached from the actual costs of care, the ASO will—at least in theory—focus on following appropriate clinical protocols, not on the downstream costs of care. Thus, the ASO “can provide all the managed care functions that a prepaid health plan provides but with lower administrative fees since the ASO will be concentrating on the mechanics of the healthcare delivery system . . .”

Some evidence suggests that the economic outcomes of ASO contracts are similar to full risk contracts. For instance, one study of a mental health “carve-out” revealed that managed care could achieve cost reduction in the absence of direct contractual incentives that shift risk for health care costs to the managed care organization. Goldman and his colleagues tracked initial health care access, utilization and costs for a private employer who carved mental health benefits out of its medical plan and introduced managed care. The ASO received a fixed administrative fee per employee and did not share any risk with the employer. As a part of the contract, the ASO was responsible for concurrent review and “require[ed] regular clinical updates . . . to substantiate medical necessity and the need for further continued authorization for care.”

Care managers, who were licensed mental health care professionals, provided the ASO with clinical updates. Care managers also evaluated patients’ symptoms, risk factors and medications and decided whether patients’ treatment plans were consistent with providers’ diagnoses and documented clinical risk factors. And, unlike some other types of managed care, there were no financial incentives for providers to restrict care because the ASO contracted with independent providers who were paid on a fee-for-service basis. Despite the

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22 Principles for Addressing the Medi-Cal Managed Care Proposals, supra note 20.
23 James P. Mason, Proposal for Expanding Medi-Cal Managed Care: ASO proposal for counties not participating in Medi-Cal managed care, available at http://www.medi-calredesign.org/pdf/feedback Managed Care Synermed.pdf (July 6, 2004). According to this proposal, California can reap the benefits of an ASO model that does not include development of provider networks, marketing and providing member services. In contrast, existing ASO arrangements in California—like that of San Bernardino County for provision of mental health services to minors—are based on provider network development and administration. See also Mental Health Administrative Services Organization Agreement Between ValueOptions, Inc. and County of San Bernardino, available at http://www.co.sanbernardino.ca.us/sbco/cob/AG061504/ITM64/W0080283.PDF (July 6, 2004).
24 Goldman, supra note 10, at 51.
25 Id.
26 Id. at 42. This financing scheme is contrasted with traditional capitation or “per member per month” payment.
27 Id. at 44
28 Id.
29 Id.
30 Id. at 45.
absence of provider financial incentives, the employer’s mental health costs dropped dramatically after the transition to a mental health carve-out. For example, the cost of mental health care per member per month in the year before the carve-out was $17.93. In the year following the transition to carve-out, mental health costs dropped to $9.76 per member per month. Over the remaining five years of the study, researchers observed a continuous (albeit smaller) decline in costs, about 3.5% annually.

Goldman’s study found that the reduced cost was not attributable to a decrease in initial access. Enrollees initially accessed benefits by telephone by contacting the ASO who referred the consumer to a network provider based on the member’s clinical, cultural and geographic needs. To manage cost, the ASO emphasized regular clinical updates on patient’s status to substantiate continued medical necessity and the need for further continued authorization of care.

The study found that the decrease in costs resulted from four changes in the use of care including: 1) fewer outpatient sessions per user; 2) Reduced probability of inpatient admission; 3) Reduced length of stay for an inpatient admission; 4) Substantially lower costs per unit of service.

Although initial access was studied, there were no findings on quality of care, continued access or outcomes by consumers. One survey was completed by 2000 patients in 1996 where 89% responded that they had seen improvement in themselves or their children. Without any other context, these numbers are not meaningful because they could reflect the typically positive answers to satisfaction surveys.

Despite Goldman’s positive findings, other observers are less optimistic about the economic motives and viability of ASOs:

“The ASO market is a low-margin, labor-intensive, commodity business staffed by low-skill clerical and nursing personnel laboring in rooms full of grim cubicles. Typically, ASO fees represent 2-5 percent of premiums, not counting claims-processing costs, and profit margins are at best 1 percent . . .

Health insurers pursue these arrangements not for the economic returns from

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31 ld. at 45-46.
32 ld. at 46.
33 ld.
34 ld.
35 ld at 44.
36 ld. at 41.
37 ld. at 49.
the ASO contracts themselves, but to improve their bargaining leverage with hospitals and doctors by increasing the pool of lives they represent.\textsuperscript{38}

Thus, the ASO may allow insurers to leverage prices from healthcare providers. This may have both positive and negative benefits. It may lower the cost of health care is one area or for one population but providers may seek higher reimbursement in other areas.

Other concerns about ASOs and managed care include the danger of minimizing the role of experienced professionals in treating particular populations. While studying the effects of a Maryland contract agreement with an ASO to manage the finances of the public mental health system, including Medicaid, where the core service agencies gave up some of their responsibilities for funding and administering local services, Richard Frank noted: “A surprising result is that in many states the mental health agency has a much more limited role in defining the mental health programs for low-income people with mental disorders than it did just fifteen years ago. It is striking that a consequence of the successes in using Medicaid to expand financing of care is that the public agency with specialized expertise is increasingly taking a secondary role in regulating and managing public resources for treating people with mental and addictive disorders.”\textsuperscript{39}

Moreover, while an ASO may be a successful managed care alternative in the private sector, it may not be successful for a public agency seeking to provide health benefits for a high-risk, vulnerable population. Although a public agency covers a large number of beneficiaries, the populations eligible for medical assistance often face higher burdens of chronic conditions and unmet health care needs. As a result, fixed administrative fees may not account for the actual costs of managing care for these populations. Hence, public agencies may find it difficult to negotiate competitive contracts with managed care organizations, which are unlikely to find ASOs financially attractive, while ensuring that beneficiaries receive the same access and quality of care.

\textbf{III. Analysis}

\textsuperscript{38} Goldsmith, \textit{supra} note 13 (emphasis added).
\textsuperscript{39} See Richard G. Frank, et al., \textit{Medicaid and Mental Health: Be Careful What you Ask For}, 22 Health Affairs 101, 110 (Jan./Feb 2003)
When considering an ASO model, three main issues must be taken into account. First, the state will want to consider the basic design of the ASO contract—who will it cover; what services will it provide; will it be state or county-based; and how will it be reimbursed? Second, the state will want to consider federal laws and regulations mandating certain features and assurances in the Medicaid managed care program. As such, the state must also give serious thought to how an ASO must be designed to meet these requirements and, accordingly, whether the state need to apply for or modify its 1915(b) waiver with the Centers for Medicare & Medicaid Services. Third, the state must consider how an ASO contract would be devised to ensure that beneficiary access and quality of care is maintained.

A. Potential Models

An ASO model may fit within a Medicaid program in a variety of ways, depending on the overall aim and direction of the states managed care expansion. For instance, an ASO may cover a broad range of beneficiaries who are not currently in managed care programs (by county), or it may coordinate care only for beneficiaries with disabilities, who typically have more service and cost-intensive health care needs. As described above, an ASO may also encompass a spectrum of health care services, from primary care to acute, inpatient care, or, it may function solely within an integrated primary care model, similar to the one recently implemented in Texas. Below are descriptions of these alternative models and how they might serve Medi-Cal beneficiaries. Two models have already been implemented, one in California and one in Texas. The other two models are based on proposals for the California Medi-Cal redesign.

1. County mental health contracts

In 1998, the California Mental Health Directors Association (CMHDA) decided to contract with an ASO to manage mental health services for Medi-Cal-eligible minors in out-of-county foster care. CMHDA needed an ASO to credential its mental health providers, authorize outpatient services and provide a streamlined billing and payment process. In 1999, CMHDA awarded the ASO contract to ValueOptions, a private managed behavioral health care

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company. However, in February 2004, CMHDA voted to discontinue the ASO arrangement and its role as administrative agent (effective June 30, 2004). CMHDA cited two reasons for the decision: 1) The increasing administrative burden of the ASO on the CMHDA staff; and 2) “unexpected external circumstances.” Although the CMHDA has discontinued its management of the ASO, the way in which ValueOptions provides authorization for mental health services and conducts provider recruitment will remain intact. Now, under the “California Counties” plan, individual counties can continue the ASO arrangement by contracting directly with ValueOptions. San Bernardino County has opted to continue the ASO. The County’s approved contract illustrates how this ASO is structured to serve a target population in Southern California.

Under the San Bernardino contract, the ASO’s main functions include authorization of outpatient mental health services; maintenance of a panel of providers qualified and licensed to provide mental health services to the target Medi-Cal population; claims processing; and quality review and management. The County bears ultimate responsibility as payor of the mental health services. However, ValueOptions is responsible for the selection of providers and the administration of provider agreements. ValueOptions will also provide a customized plan Web site and a toll-free number available 24/7 to members and providers for making requests for referrals, complaints and grievances. For its services, ValueOptions is paid monthly, in an amount equal to $28.08 per eligible beneficiary for whom claims were paid in the preceding month. Thus, reimbursement is tied to the actual provision of services and claims payment, not to the number of eligible beneficiaries in any given month (i.e., traditional capitation).

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41 See ValueOptions, Inc., at http://www.valueoptions.com/index.htm (July 6, 2004). ValueOptions provides administrative services for employer groups, health plans, the public sector and federal agencies.
42 About the ASO, supra note 39.
44 ASO, supra note 42.
45 Report & Recommendation to the Board of Supervisors of San Bernardino County, California and Record of Action, available at http://www.co.san-bernardino.ca.us/sbco/cob/AG061504/ITM64/W0080281.PDF (July 6, 2004). According to this report, the Board recommended approval of the agreement with Value Options, an Administrative Services Organization (ASO), in the amount of $400,000 for the period July 1, 2004 through June 30, 2005 for the management of a network of specialty mental health service providers.
46 Mental Health Administrative Services Organization Agreement, supra note 24.
47 Id.
48 Id.; Report & Recommendation, supra note 43 (indicating that the ASO will receive $400,000 for a one-year period).
49 See Report & Recommendation, supra note 43. It is not clear whether the ASO is reimbursed a fixed administrative fee for one year, or whether it is reimbursed monthly, in an amount equal to $28.08 per eligible beneficiary for whom claims were paid in the preceding month. In either case, the ASO is not paid monthly based solely on the number of eligible beneficiaries. Rather, reimbursement seems to be
The features of the San Bernardino contract shed some light on how publicly-funded ASOs operate. Like the ASO in the Goldman study, ValueOptions does not share any medical risk with the insurer. But, in contrast to the Goldman ASO, ValueOptions’ payment is tied directly to the actual provision of services and claims payment. This scheme may work for San Bernardino County since, unlike a large private employer, the number of beneficiaries is relatively low (i.e., minors in out-of-county foster care). Moreover, a fee tied to the actual provision of services means that an ASO is more likely to cover its costs, whereas an ASO paid a fixed fee may, in any given month, incur costs which exceed reimbursement.

Like the ASO in the Goldman study, ValueOptions is responsible for concurrent review and authorization for care. ValueOptions’ other main responsibility is provider recruitment. While there is little documented evidence of how or why this function helps meet managed care goals, the particular needs of the county may help explain why provider recruitment is so important. For instance, the county may lack the expertise or infrastructure to identify and negotiate contracts with providers. And since the county has contracted to provide services for beneficiaries who reside out-of-county, the ability of a private national organization, like ValueOptions, to negotiate contracts and provide services across county lines may be useful.

San Bernardino County began the contract with ValueOptions in July of 2004. However, no studies or surveys indicating consumer access, quality of care or outcomes could be located.

2. CalWORKs beneficiaries in non-managed care counties

This model is based on a consultant’s proposal submitted to the California Medi-Cal Redesign workgroup. The goal of this ASO model is to manage care for all CalWORKs-linked enrollees in counties that do not currently participate in managed care. Mr. Mason, the submitting consultant, estimates that if this model was used for all Medi-Cal enrollees, the State could realize an estimated $1.6 billion in cost-savings per year, or a monthly savings of $42 in administrative costs per member. Mr. Mason posits that this ASO model has four key benefits: (1) low administrative overhead; (2) the elimination of overlapping administrative services; (3) cost-saving benefits associated with managed care; and (4) continued use of the existing fee-for-service and Medi-Cal infrastructure. This system would, in theory, maintain lower overhead tied to the actual provision of services—measured either as a fixed annual fee or by the actual provision of services to the beneficiary pool.

because it would focus on the mechanics of care delivery; it would not develop provider networks, nor would it provide member services. Instead, it would utilize existing networks, while eliminating the current system of dual administrative oversight.

For instance, in the current Los Angeles County system, the County relies on two contractors—Health Net and LA Care—to coordinate services for Medi-Cal enrollees. In addition, providers contracting through Health Net or LA Care charge their own administrative fees, resulting in what Mr. Mason estimates to be $20.63 in overlapping costs per member per month. Under the ASO system, the county health authority would not delegate administrative oversight to the health plans (which in turn delegate additional administrative oversight to individual providers). The ASO would report directly to DHS and would undertake all administrative functions for the county service area. As with other managed care programs, the State may need to apply for or modify its 1915(b) waiver through CMS before it can implement this model (see discussion below CMS approval and requirements).

Although Mr. Mason notes the financial gains made by eliminating the so-called “middleman” it is important to note why such a “middleman” may be useful. Specifically, by having a third party involved, there is potential additional oversight, more accountability and additional access to public information regarding the company’s performance. If this third party were to be eliminated, it would be essential to ensure that oversight, accountability and public access to information were maintained at the state level.

3. Community-based ASOs for beneficiaries with disabilities

Because beneficiaries with disabilities often need a wide array of health and social services, there is a great need for management and coordination of their care.51 In May of 2003, the State Assembly Budget Committee considered an ASO proposal for beneficiaries with disabilities and noted that, “[c]ompared to fee-for-service Medi-Cal, enrolling the beneficiaries with disabilities in some form of managed care delivery system could help the state generate budget savings and theoretically higher quality care and more accessible care.”52

As an alternative to an HMO model, the ASO model considered by the Subcommittee on Health and Human Services would be community-based. Like the mental health ASO described above, it would require a governing board of local stakeholders, who would be responsible for

52 Id.
directing each community administrative services organization, or “CASO.” This CASO would accept little or no medical risk; rather, the State would retain all the risk for costs of care for Medi-Cal beneficiaries with disabilities. The CASO would bear administrative risk. For a monthly administrative fee, the CASO would arrange and coordinate services for beneficiaries. Unlike the ASO described by Mr. Mason, this CASO would be responsible for a broader, more comprehensive range of service coordination and delivery functions. For instance, it would develop and maintain a provider network; be responsible for case management functions and service authorization; credential providers; monitor quality of care; and provide health education for its communities. Like the Mason proposal, the CASO would also “cut out the middleman,” being accountable directly to the State and its covered beneficiaries. It would also continue to rely on fee-for-service reimbursement mechanisms (presumably, in counties/programs that do not currently use managed care for beneficiaries with disabilities).

The creation of the ASO’s own network could be positive if specialists were also able to provide primary care and if no prior authorization were required. However, the new network could be negative for consumers, specifically, beneficiaries with disabilities who have a provider who is not included in the new network. To minimize harm caused to beneficiaries because of out-of-network providers, the ASO must ensure that they recruit providers who are experienced in treating seniors and beneficiaries with disabilities, provide for exemptions for particular situations, and, in some circumstances, allow a beneficiary to continue to see their previous provider (see discussion on necessary safeguards below).

4. The Texas Integrated Care Model (ICM) for aged, blind and disabled beneficiaries

Policy analysts and advocates question mandatory enrollment in managed care for beneficiaries with disabilities: because of the high-cost needs of this population, managed care—with its goal of cost reduction—may not be well-aligned to the interests and needs of beneficiaries with disabilities. Nevertheless, because beneficiaries with disabilities as a group account for the largest percentage of annual Medicaid costs, lawmakers often look to this population for ways to reduce overall expenditures.

53 See Kaiser Family Foundation, State Medicaid Fact Sheets: California vs. United States, http://www.kff.org/mfs/index.jsp (11/18/05). For instance, in California, twenty-five percent of residents are Medi-Cal beneficiaries, and 9.4% of those beneficiaries qualify as blind or disabled (over 800,000 residents). These beneficiaries account for nearly 39% of all Medi-Cal spending. Id.
As part of the Texas Medicaid managed care expansion project, the State legislature and its Governor approved an expansion of an existing primary care case management (PCCM) model for aged, blind, and disabled Medicaid beneficiaries. (See Section B below for a more detailed description of Medicaid-based PCCMs). On June 18, 2005, the Governor of Texas signed into law this ASO-based integrated care management (ICM) model (Tex. Gov. Code, Chp. 533, § 533.061). The State also created an Integrated Care Management Advisory Committee “to assist the Health and Human Services Commission in the development and implementation of the [ICM] model to serve the aged/blind/disabled populations in certain service delivery areas across the state.” Like the Mason proposal, the ICM maintains the State’s existing non-capitated service model for beneficiaries with disabilities and overlays it with a primary care case management system operated by an ASO. The ASO must perform care coordination and ensure other functions of the ICM, including assignment of beneficiaries to a medical home; utilization management; conducting needs assessment; mechanisms to reduce inappropriate ER use by providing after-hours primary care; mechanisms of care coordination and disease management; and education of beneficiaries about effective use of health care delivery system. In addition, the Commission may require the ASO to establish pay-for-performance incentives for network providers.

This model is relatively new: the state’s enacting legislation required that the managed care models be implemented by September 1, 2006. Thus, how well this will work in practice remains to be seen. As such, states may wish to contact the Texas Integrated Care Management Advisory Committee to find out more about that program’s implementation as well as a preliminary evaluation of its efficacy in serving disabled beneficiaries in that state.

B. Must a state modify its 1915(b) waiver to include beneficiaries with disabilities in an ASO? What requirements must an ASO meet as a Medicaid managed care contractor?

54 http://www.hhsc.state.tx.us/Medicaid/MMCEP.html; http://www.hhsc.state.tx.us/Medicaid/MMCEP/PCCMExp.html
56 http://www.hhsc.state.tx.us/Medicaid/statewide_committee.html (Dec. 2, 2005). "ASO" means an entity that performs administrative and management functions, such as the development of a physician and provider network, care coordination, service coordination, utilization review and management, quality management, and patient and provider education, for a noncapitated system of health care services, medical services, or long-term care services and supports.
Implementing an ASO for individuals with disabilities would require that the state seek a modification of its 1915(b) waiver. Although the Balanced Budget Act of 1997 made it easier for states to enact managed care without having to go through the waiver process, Medicare Related beneficiaries, who make up the majority of individuals who would be affected by an ASO for individuals with disabilities, are exempt from this process.\textsuperscript{57} Therefore, for a state to implement managed care or an ASO for individuals who are dually eligible for Medicaid and Medicare or for individuals who are elderly or have a disability and are Qualified Medicare Beneficiaries they must comply with the 1915(b) or 1115 waiver process. Although an ASO is a variation of a managed care entity, in this case it would qualify as a Primary Care Case Manager (PCCM) and thus as a managed care entity for the purposes of this section.\textsuperscript{58} A PCCM is defined as a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager.\textsuperscript{59}

Pursuant to 42 C.F.R. Part 438, the U.S. Department of Health and Human Services (or its regional CMS authority) must approve the methods of administration of Medicaid managed care. In particular, HHS oversees managed care programs which rely on “comprehensive risk contracts”—contracts which require the organization through capitation payments or other arrangements to bear medical risk, and which provide inpatient hospital services as well as a variety of other medical services (e.g., EPSDT, family planning, outpatient hospital, physician services).\textsuperscript{60}

Because ASOs do not bear medical risk, they would not be considered “managed care organizations” for the purposes of Medicaid managed care approval and implementation. Nevertheless, ASOs may fall within one of a number of “non-risk” contract categories which are still subject to HHS oversight.\textsuperscript{61} Depending on the form, an ASO may be a prepaid inpatient health plan (PIHP), a prepaid ambulatory health plan (PAHP), or a PCCM, all of which are forms of managed care administration, but do not involve financial risk associated with changes in utilization or health care costs that exceed Medicaid’s upper payment limits.\textsuperscript{62} Instead, these

\textsuperscript{57} 42 USC §1396u-2(a)(2)(B)
\textsuperscript{58} 42 USC §1396u-2(B)(ii)
\textsuperscript{59} 43 USC §1396d(t)(2)
\textsuperscript{60} § 438.2
\textsuperscript{61} 438.6
\textsuperscript{62} 438.2.
forms of managed care may be reimbursed by the State at the end of the specified contract period on the basis of incurred costs.\(^{63}\)

1. PIHP, PAHP and PCCM requirements

The CMS Regional Office must review all managed care, PIHP, and PAHP contracts, including risk and non-risk contracts.\(^{64}\) However, because they are non-risk contracts, PIHPs and PAHPs are not subject to the detailed requirements of Title 42, which regulate managed care capitation rates, incentive arrangements, and use of utilization data. Like MCO’s, PIHPs and PAHPs may cover services that are not included under the Medicaid State plan, although costs for these services may not be included in Medicaid payment rates.\(^{65}\)

Notably, the PCCM is not subject to contracting requirements and CMS regional approval under 438.6. However, along with PIHPs and PAHPs, PCCMs are subject to broad contracting assurances and compliance provisions, including anti-discrimination\(^{66}\) and compliance with all applicable federal and state laws (e.g., the Americans with Disabilities Act and due process standards).\(^{67}\) In addition, federal regulations spell out rules specific to PCCM contracts. For instance, a PCCM must provide reasonable and adequate hours of operation including 24-hour availability of information, referral and treatment for emergency medical conditions.\(^{68}\) A PCCM must also make arrangements with or referrals to a sufficient number of physicians and other practitioners to ensure services provided promptly and without compromise to quality of care.\(^{69}\)

All Medicaid managed care organizations, including PIHPs, PAHPs, and PCCMs, must include provisions for disenrollment.\(^{70}\) Each contract must specify the reasons for which the organization may request disenrollment of a beneficiary (e.g., loss of Medicaid eligibility);\(^{71}\) those reasons may not include any adverse changes in the beneficiary’s health status, utilization of services, diminished mental capacity, or uncooperative or disruptive behavior resulting from special needs. This requirement is particularly important for an ASO targeted at

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\(^{63}\) Id.

\(^{64}\) 438.6. Unless subject to prior approval under 438.806, which applies only to MCO and risk contracts.

\(^{65}\) 438.6(f).

\(^{66}\) (438.6(d)) – will not on the basis of health status or need discriminate against eligible individuals; nor discriminate on basis of race, color, national origin

\(^{67}\) 438.6(f)

\(^{68}\) 438.6(k).

\(^{69}\) Id.

\(^{70}\) 438.56

\(^{71}\) A State plan MAY provide for automatic reenrollment if recipient disenrolled solely because she loses Medicaid eligibility for a period of two months or less.
populations with significant needs, such as disabled or mentally ill populations.\textsuperscript{72} In addition, each managed care organization must provide that a recipient or beneficiary may request disenrollment for cause at any time, or without cause during 90 days following enrollment.\textsuperscript{73} Allowable reasons for disenrollment by the beneficiary include a move out of the service area, or because the plan because of moral or religious objections does not provide the service the beneficiary seeks.\textsuperscript{74} The organization may approve the disenrollment request or it may refer the request to the applicable State agency.\textsuperscript{75}

C. Consumer Safeguards

In any assessment of whether managed care or ASOs should be used for seniors and beneficiaries with disabilities, effective consumer safeguards must be thoughtfully considered and put into place. Protection & Advocacy detailed these safeguards in their Catalog of Consumer Protections Needed in Any Managed Care Plan Incorporating Persons with Disabilities Including Seniors.\textsuperscript{76} Among these protections are:

1) Complying with due process;
2) Stakeholder involvement of consumers and advocates through advisory boards and ad hoc committees;
3) Education and outreach to recipients;
4) Establishment of independent and local ombudsman programs;
5) ADA and Section 504 access;
6) Title VI access;
7) Development and enforcement by the department of performance standards;
8) Transition standards that ensure that seniors and beneficiaries with disabilities do not have their system of care interrupted;
9) Contingency plans in the event that a plan has financial stability problems or has difficulty meeting performance standards;
10) Review by the department of the plan’s pattern of compliance;

\textsuperscript{72} Id.
\textsuperscript{73} Id.
\textsuperscript{74} Id.
\textsuperscript{75} Id. if organization fails to make determination within timeframes specified (e.g., no later than first day of second month following request), disenrollment considered approved.
\textsuperscript{76} State agency may require that enrollee seek redress through organization’s grievance process before state makes a determination; notice and appeals procedures must be provided, in addition to state agency determination.

Protection & Advocacy, Catalog of Consumer Protections Needed in any Managed Care Plan Incorporating Persons with Disabilities Including Seniors, \url{www.pai-ca.org/BulletinBoard/ABD-MgdCare-Checklist08302005.pdf}.  

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10) A provider network that provides access to providers with experience and expertise in addressing the particular disability and medical condition needs of the population served;
11) Plans to minimize adverse consequences among providers within the plan;
12) Public and enrollee access to information;
13) Transfer to plan of the state’s administrative responsibility under 42 CFR §431.53 to assure recipients can get to and from appointments;
14) Departments responsibility to identify individuals with “special health care needs” and provide data to enrollment broker and plans;
15) Provide exemptions from mandatory enrollment for individuals with particular conditions or certain service needs;
16) Maintain access to current provider;
17) Allow an appropriate time period for selecting a plan and when a plan is not selected within time period make sufficient efforts to contact the beneficiary;
18) Provide an alternative to default assignment such as deferring the assignment;
19) Provide rates that are sufficient to attract and retain providers with experience and expertise with the particular disabilities of the SPD population. 

When deciding whether to contract with an ASO, the state must consider these safeguards and ensure that the ASO comply with them. To ensure accountability and the protections of the rights of beneficiaries the contract should specify what services are the state or county responsibility and what responsibility belongs to the ASO.

D. Is an ASO a viable alternative to mandatory enrollment of beneficiaries with disabilities into managed care?

In the best-case scenario, an ASO model could offer efficient, high-quality care, while allowing a state “to keep the cost savings generated in the private sector through applied managed care principles.” Yet, it is not clear that an ASO can actually fulfill these high expectations. The potential benefits of this type of managed care arrangement must, of course, be weighed against the potential concerns.

Among an ASOs claimed benefits are the ability to create a state-wide managed care model and implement managed care principles with high-risk populations. A state-created

77 Id.
ASO may be able to continue to reward providers who deliver cost-effective quality care, but without the risk of incentives to under-serve a vulnerable population.\textsuperscript{79} An ASO might also alleviate the need for a vendor to require a high volume of enrollees since the vendor itself bears no financial risk.\textsuperscript{80} Thus, an ASO might be feasible in lightly populated areas that could not support multiple health plans. Moreover, an ASO can be quickly implemented since it does not require a separate insurance license, and, as the models described above illustrate, the state can use its existing fee-for-service network.\textsuperscript{81}

On the other hand, there are several concerns with ASOs. First, a Medicaid-based ASO does not allow the state to transfer any medical risk. Thus, the state would not see any budget predictability or “day one” cost savings.\textsuperscript{82} Second, the state could expect only minor savings from implementation of the ASO service delivery model with its “thin” profit margins. The state must create incentives to align its financial interest with that of the ASO vendor, especially if the state seeks to implement an ASO for a broader population (e.g., something more than mental health services alone). Third, the state must ensure consumer safeguards so that beneficiaries receive access and quality services.

\textsuperscript{78} Dewane, supra note 8.
\textsuperscript{79} See id.
\textsuperscript{80} Monahan, supra note 1. But see Goldman, supra note 10, at 50-51 (suggesting that in employer-based contracts, a large volume of covered lives is an attractive feature of ASO contracts).
\textsuperscript{81} Monahan, supra note 1.
\textsuperscript{82} Id.