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Robin Lunge, Director

MEMORANDUM

To: House Committee on Health Care
Senate Committee on Health and Welfare
Senate Committee on Finance
Health Reform Oversight Committee

From: Robin Lunge, Director of Health Care Reform

Date: December 15, 2015

Re: Act 54, Sec. 44 Findings and Recommendations on Uniform Forms and Mental Health Quality Assurance

STATUTORY CHARGE

This memorandum is submitted to fulfill the requirements for the evaluation of uniform forms and mental health quality assurance pursuant to Section 44 of Act 54 of 2015.

Sec. 44. UNIFORM FORMS; MENTAL HEALTH QUALITY ASSURANCE; EVALUATION

(a) The Director of Health Care Reform in the Agency of Administration, in collaboration with the Green Mountain Care Board and the Department of Financial Regulation, shall evaluate:

(1) the necessity of maintaining provisions regarding common claims forms and procedures, uniform provider credentialing, and suspension of interest accrual for failure to pay claims if the failure was not within the insurer's control, as those provisions are codified in 18 V.S.A. §§ 9408, 9408a(b), 9408a(e), and 9418(f);

(2) the necessity of maintaining provisions requiring the Commissioner to review and examine a managed care organization's administrative policies and procedures, quality management and improvement procedures, credentialing practices, members' rights and responsibilities, preventive health services, medical

records practices, member services, financial incentives or disincentives, disenrollment, provider contracting, and systems and data reporting capacities, as those provisions are codified in 18 V.S.A. § 9414(a)(1);

(3) the necessity of maintaining provisions directing the Commissioner to require health insurance companies to submit materials related to mental health quality assurance pursuant to 8 V.S.A. § 4089b(g);

(4) the appropriate entity to assume responsibility for any such function that should be retained and the appropriate enforcement process; and

(5) the requirements in federal law applicable to the Department of Vermont Health Access in its role as a public managed care organization in order to identify opportunities for greater alignment between federal law and 18 V.S.A. § 9414(a)(1).

(b) In performing the evaluation required by subsection (a) of this section, the Director shall consult regularly with interested stakeholders, including health insurance and managed care organizations, as defined in 18 V.S.A. § 9402; health care providers; and the Office of the Health Care Advocate.

(c) On or before December 15, 2015, the Director shall provide his or her findings and recommendations to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Health Reform Oversight Committee.

Stakeholder Process

Section 44 of Act 54 requires the Director of Health Care Reform to consult regularly with interested stakeholders, including health insurance and managed care organizations, health care providers, and the Office of the Health Care Advocate. The following group met ten times:

Act 54, Sec. 44 Stakeholders	
Organization	**Participants**
Agency of Administration	Robin Lunge and Devon Green
BlueCross BlueShield of Vermont	Rebecca Heintz and Cory Gustafson
Cigna Health Insurance	Peggy Rupp and Jeanne Kennedy
Department of Financial Regulation	David Martini and Shannon Salembier
Department of Mental Health	Jay Batra
Department of Vermont Health Access	Sarah Kinsler
Green Mountain Care Board	Pat Jones and Brian Martin
MVP Health Care	Susan Gretkowski and Lou McLaren
Office of the Health Care Advocate	Trinka Kerr and Lila Richardson
Vermont Association of Hospitals and Health Systems	Jill Olson
Vermont Department of Health	Debra Wilcox
Vermont Medical Society	Paul Harrington and Madeleine Mongan

The stakeholder group took a ground-up approach and examined the Department of Financial Regulation rule H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations, which sets out in detail the standards and enforcement of 18 V.S.A. § 9414. Once the group determined the necessary changes in the details of the rule, they were able to come to consensus on the broader standards required by statute. For other requirements, such as the hospital community reports and provider credentialing, the group formed subgroups that met outside of the group and came back to the larger group with recommendations.

FINDINGS AND RECOMMENDATIONS

General Overview

Many of the state standards examined during this process were created during the 1990s when health maintenance organizations were prevalent. The intent behind the statutes was to provide protections to ensure a certain standard of provider availability for Vermonters. Currently, Vermont's health care system is moving

away from an MCO-based standard of care and towards a provider-based standard of care, such as capitated payments with quality measures. As a result, it is necessary to reexamine MCO-based standards of care statutes and other statutes that may be outdated.

In examining the statutes at issue, the group agreed that Vermont is in a transformative period for health care providers, Accountable Care Organizations (ACOs), and provider payment and delivery system models in general. As a result, some or all of these items may require revisiting in the near future as the provider payment and delivery system landscape becomes more concrete.

The stakeholder group was able to come to consensus on most issues, as evident in the "Recommended Statutory Changes" and "No Statutory Change Required" portions of the memo. The following issues are worth highlighting as larger changes or outstanding issues:

- DFR will require all managed care organizations to participate in the Blueprint for Health and be accredited by a national independent accreditation organization.
- Act 54 repealed the managed care organization's triennial reporting requirement of quality assurance standards; however, the standards themselves remain in place. Some standards, such as network adequacy, will be reported on the managed care organization's website in a way that is consistent with national accreditation standards. DFR will enforce the remaining standards in § 9414 through its complaint process.
    - In response to this proposed change from reporting of standards to enforcement by complaint, the Office of the Health Care Advocate and Vermont Medical Society are requesting extensive reporting of the complaints processed by DFR.
    - DFR maintains that the information sought by the Health Care Advocate is "confidential and privileged and shall not be subject to subpoena or available for public disclosure" under 18 V.S.A. § 9414. Also, DFR reports that it will need more resources to meet the Medical Society and Health Care Advocate's request for extensive reporting and that such reporting will negatively affect its ability to track trends and to perform market conduct investigations.
    - The Health Care Advocate and the Vermont Medical Society strenuously object to DFR's refusal to provide this information. They dispute that the information sought is confidential and maintain that only a modest one-time investment in resources is needed to create a reporting system.

- The legislature is asked to determine whether complaint information may be disclosed and, if so, what type of complaint information DFR shall disclose.

- DFR currently enforces the use of uniform credentialing forms for insurers and hospitals. DFR will continue to enforce uniform credentialing forms for insurers, but it typically does not have enforcement authority over hospitals. The Department of Health has agreed to enforce uniform credentialing for hospitals, but the details of this enforcement remain under discussion. The AoA will have proposed legislation for the legislative session.
- As required by Act 54, the AoA has analyzed federal Medicaid MCO regulations with state MCO regulations. Provider groups like the Vermont Association of Hospitals and Health Systems and the Vermont Medical Society are concerned that the standards that apply to private insurance companies do not apply to DVHA, even though it is a managed care entity. They are particularly concerned about issues like utilization management decisions. The AoA is concerned about a blanket application of statewide managed care rules to DVHA because of possible conflicts with federal law. The regulatory comparison shows where there may be areas of regulatory flexibility, but the AoA strongly urges the legislature to provide further guidance and allow for comprehensive policy and operational analysis.
- While not a part of the Act 54, Sec. 44 requirements, the AoA requests that the oversight for health care provider bargaining groups under 18 V.S.A. § 9409 transition from DFR to the Green Mountain Care Board because DFR does not typically oversee providers. Although not discussed with the stakeholder group, the legislation resulting from the stakeholder process is an appropriate vehicle for this change and AoA will have a proposed statutory language for the legislative session.

Recommended Statutory Changes

Sec. 1 & 2: 18 V.S.A. §§ 9405a & 9405b-- Updating Hospital Community Reports

Findings:

- § 9405a requires updating to reflect IRS rules for community health needs
- Reports would be more manageable for both the public and providers as a statewide comparative report rather than individual hospital reports

Recommendations:

- Update this section to reflect IRS rules for community health needs assessments implementation plans that passed as part of the Affordable Care Act.

- Add a requirement to post the community health needs assessment implementation plan's progress on the hospital's website.
- Eliminate the requirement for a dedicated individual hospital report while maintaining the requirement for a statewide comparative report.
- Maintain requirements for posting information such as how to make a complaint on the hospital's individual website in the absence of a dedicated individual hospital report.
- Add a requirement that hospitals post a link to the statewide comparative hospital quality report on their websites.

Sec. 3: 18 V.S.A. § 9408a: DFR must recommend the form used by an insurer or a hospital that performs credentialing.

Findings:

- Uniform credentialing forms for providers: Providers may require credentialing across various insurers and hospitals. To ensure uniformity, DFR has recommended a credentialing form as required by 18 V.S.A. § 9408a. DFR enforces this standard through its complaint process and can continue to do so for insurers. DFR does not normally enforce standards as to hospitals, and this authority may be better placed in a different agency.

Recommendation:

- DFR will maintain enforcement of insurers. DFR's authority to enforce this standard as it pertains to hospitals will be deleted from 18 V.S.A. § 9408a(e). The Department of Health will take on enforcement of this standard for hospitals. The AoA will have proposed legislation for the legislative session.

Sec. 4: 18 V.S.A. § 9414(a)(1)—DFR is required to review and examine a managed care organization's administrative policies and procedures, quality management and improvement procedures, credentialing practices, members' rights and responsibilities, preventive health services, medical records practices, member services, financial incentives or disincentives, disenrollment, provider contracting, and systems and data reporting capacities.

Findings:

- As mentioned in the General Overview, the group agreed to make recommendations based on the health care system as it is today while acknowledging that the system may change with the further

development of ACOs or implementation of an All-Payer Model. Accordingly, these recommendations may need to be revisited in the future.

- DFR does not have the resources to continue enforcement of § 9414 standards through collection and analysis of reports from insurers.
- Many of the standards found in § 9414 are consistent with national accreditation standards, and all of Vermont's managed care organizations are currently accredited with independent national organizations.
- Many of the standards found in § 9414 are consistent with the Blueprint for Health standards. Current law requires all managed care organizations to participate in the Blueprint for Health.
- Network adequacy requirements should be reported in a way that is consistent with national accreditation standards and available to the public and advocates.
- Rule H-2009-03 contained grievance and appeals reporting requirements, which were inconsistent or duplicative with the reporting required in § 9414a.

Recommendations:

- Require that all managed care organizations be accredited by a national independent accreditation organization approved by DFR.
- DFR will enforce the requirement that all managed care organizations participate in the Blueprint for Health. The Director consulted with DVHA on this matter, and they confirmed that they have the resources to help managed care organizations meet this requirement.
- DFR will continue to maintain the reporting requirements found in § 9414a.
- The reporting requirements under 18 V.S.A. § 9414 were repealed in Act 54, but the standards remain in place. Some standards, such as network adequacy, will be reported on the managed care organization's website in a way that is consistent with national accreditation standards. DFR will enforce the remaining standards in § 9414 through the complaint process.
  - In response to this proposed change from reporting of standards to enforcement by complaint, the Office of the Health Care Advocate and Vermont Medical Society are requesting extensive reporting of the complaints processed by DFR.
  - DFR maintains that the information sought by the Health Care Advocate is "confidential and privileged and shall not be subject to subpoena or available for public disclosure" under 18 V.S.A. § 9414. Also, DFR reports that it will need more resources to meet the Medical Society and Health Care Advocate's request for extensive reporting and that such reporting will negatively affect its ability to track trends and to perform market conduct investigations.

- The Health Care Advocate and the Vermont Medical Society strenuously object to DFR's refusal to provide this information. They dispute that the information sought is confidential and maintain that only a modest one-time investment in resources is needed to create a reporting system.
- The legislature is asked to determine whether complaint information may be disclosed and, if so, what type of complaint information DFR shall disclose.

Sec. 5: 18 V.S.A. § 9414a-- Annual reporting by health insurers

Findings:

- Rule H-2009-03 contained reporting similar in content to that in § 9414a.

Recommendation:

- Update § 9414a with the grievance and appeals requirements in Rule H-2009-03 to keep reporting requirements consistent.

Sec. 6: 18 V.S.A. § 1854(a)—Updated language to reflect the changes made in Sec. 2

This section updates a referencing statute to reflect the changes made in Section 2 of the proposed legislation.

Sec. 7: 18 V.S.A. § 9409—Transition oversight of provider bargaining groups from DFR to the GMCB.

Findings:

- Currently, DFR has oversight for health care provider bargaining groups. DFR does not typically oversee providers.

Recommendation:

- While not a part of the Act 54, Sec. 44 requirements, the AoA requests that the oversight for health care provider bargaining groups under 18 V.S.A. § 9409 transition from DFR to the Green Mountain Care Board because DFR does not typically oversee providers. Although not discussed with the stakeholder group, the legislation resulting from the stakeholder process is an appropriate vehicle for this change and AoA will have a proposed statutory language for the legislative session.

No Statutory Change Required

Sec. 8: 8 V.S.A § 4089b(g)-- Mental Health Task Force reporting requirements to DFR.

Findings:

- This statute was repealed in Act 54.
- The group went over the mental health provisions in Rule H-2009-03 and found that most of the mental health provisions were standards to be enforced or already reported

Recommendations:

- In Rule H-2009-03, require that the managed care organization ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits shall apply in the same manner and to the same extent as primary care services.
- Delete duplicative reporting provisions in Rule 09-03
- Put non-duplicative mental health reporting requirements in reporting statute 18 V.S.A. § 9414a

Sec.9: Uniform provider credentialing 18 V.S.A. § 9408-- Requirement that uniform health insurance claims forms and uniform standards and procedures for the processing of claims be used.

Findings:

- Uniform forms for insurers: DFR has developed the required forms and standards. DFR currently enforces violation of standards as an unfair trade practice.

Recommendations:

- DFR has the most experience and the most comprehensive regulatory authority of insurers, as opposed to providers. DFR will continue to enforce uniform claims forms and uniform standards for insurers as an unfair trade practice.

Sec. 10: 18 V.S.A. § 9418(f)-- The Commissioner may suspend the accrual of interest if the Commissioner determines that the health plan's failure to pay a claim within the applicable time limit is the result of a major disaster, act-of-God, or unanticipated major computer system failure or that the action is necessary to protect the solvency of the health plan.

Findings:

- DFR would like to maintain this provision. It provides DFR with the flexibility to address an unanticipated event.

Recommendations:

- DFR will continue to have the flexibility to suspend accrual of interest in the case of a major unanticipated event or if the action is necessary to protect the solvency of the health plan.

Section 11: Identifying opportunities for greater alignment between federal law and 18 V.S.A. § 9414(a)(1)

Findings:

- Provider groups like the Vermont Association of Hospitals and Health Systems and the Vermont Medical Society are concerned that the standards that apply to private insurance companies do not apply to DVHA, even though it is a managed care entity. They are particularly concerned about issues like utilization management decisions.
- The AoA is concerned about a blanket application of statewide managed care rules to DVHA because of possible conflicts with federal law.

Recommendations:

- Further investigation is needed to determine if adopting the state insurance standards for certain situations where federal regulations allow for flexibility is operationally feasible or desirable for the Medicaid program. See attached chart for regulatory analysis.

1 Introduced by Senators Ayer and Lyons
2 Referred to Committee on
3 Date:
4 Subject: Health; health insurance; Department of Financial Regulation
5 Statement of purpose of bill as introduced: This bill proposes to require
6 hospitals to provide information to the public about their community health
7 needs and to allow public participation in the community health needs
8 assessment process. It would establish a statewide comparative hospital
9 quality report and modify the regulation of managed care organizations. The
10 bill would also expand the information health insurers must report annually to
11 include detailed information regarding claims processing, denials, grievances,
12 and provider satisfaction, and it would require insurers to post all of the
13 information their websites.

14 An act relating to regulation of hospitals, health insurers, and managed care
15 organizations

16 It is hereby enacted by the General Assembly of the State of Vermont:
17 Sec. 1. 18 V.S.A. § 9405a is amended to read:
18 § 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING
19 <u>(a)</u> Each hospital shall have a protocol for meaningful public participation
20 in its strategic planning process for identifying and addressing health care

1 needs that the hospital provides or could provide in its service area. Needs
2 identified through the process shall be integrated with the hospital's long-term
3 planning. ~~The process shall be updated as necessary to continue to be~~
4 ~~consistent with such planning and capital expenditure projections, and~~
5 ~~identified needs shall be summarized in the hospital's community report.~~ Each
6 hospital shall post on its website a description of its identified needs, strategic
7 initiatives developed to address the identified needs, annual progress on
8 implementation of the proposed initiatives, and opportunities for public
9 participation. Hospitals may meet the community health needs assessment and
10 implementation plan requirement through compliance with the relevant
11 Internal Revenue Service community health needs assessment requirements for
12 nonprofit hospitals.
13 (b) When a hospital is working on a new community health needs
14 assessment, the hospital shall post on its website information about the process
15 for developing the community needs assessment and opportunities for public
16 participation in the process.
17 Sec. 2. 18 V.S.A. § 9405b is amended to read:
18 § 9405b. HOSPITAL COMMUNITY REPORTS
19 (a) The Commissioner of Health, in consultation with representatives from
20 hospitals, other groups of health care professionals, and members of the public
21 representing patient interests, shall adopt rules establishing a ~~standard format~~

1 ~~for community reports, as well as the contents, which~~ statewide comparative
2 hospital quality report. Hospitals located outside this State which serve a
3 significant number of Vermont residents, as determined by the Commissioner
4 of Health, shall be invited to participate in the community report process
5 established by this section. The report shall include:
6 (1) Measures of quality, including process and performance measures,
7 that are valid, reliable, and useful, including comparisons to appropriate
8 national benchmarks for high quality and successful results.
9 (2) Measures of patient safety that are valid, reliable, and useful,
10 including comparisons to appropriate industry benchmarks for safety;
11 (3) Measures of hospital-acquired infections that are valid, reliable, and
12 useful, including comparisons to appropriate industry benchmarks.
13 (4) Valid, reliable, and useful information on nurse staffing, including
14 comparisons to appropriate industry benchmarks for safety. This information
15 may include system-centered measures such as skill mix, nursing care hours
16 per patient day, and other system-centered measures for which reliable industry
17 benchmarks become available.
18 (5) Measures of the hospital's financial health, including comparisons to
19 appropriate national benchmarks for efficient operation and fiscal health.

~~(5)~~(6) A summary of the hospital's budget, including revenue by source, the one-year and four-year capital expenditure plans, the depreciation schedule for existing facilities, and quantification of cost shifting to private payers.

~~(6)~~(7) Data that provides valid, reliable, useful, and efficient information for payers and the public for the comparison of charges for higher volume health care services.

(b) Each hospital shall publish on its website:

~~(7)~~(1) ~~The~~ the hospital's process for achieving openness, inclusiveness, and meaningful public participation in its strategic planning and ~~decision-making.~~ decisionmaking;

~~(8)~~(2) ~~The~~ the hospital's consumer complaint resolution process, including identification of the hospital officer or employee responsible for its implementation~~.~~;

~~(9) Information concerning recently completed or ongoing quality improvement and patient safety projects.~~

~~(10) A description of strategic initiatives discussed with or derived from the identification of health care needs; the one-year and four-year capital expenditure plans; and the depreciation schedule for existing facilities.~~

~~(11)~~(3) ~~Information~~ information on membership and governing body qualifications, a listing of the current governing body members, and means of

obtaining a schedule of meetings of the hospital's governing body, including times scheduled for public participation~~.~~; and

(4) A link to the comparative statewide hospital quality report.

~~(12) Valid, reliable, and useful information on nurse staffing, including comparisons to appropriate industry benchmarks for safety. This information may include system-centered performance measures, such as skill mix, nursing care hours per patient day, and other such system-centered performance measures as reliable industry benchmarks become available in the future.~~

~~(b) On or before January 1, 2005, and annually thereafter beginning on June 1, 2006, the board of directors or other governing body of each hospital licensed under chapter 43 of this title shall publish on its website, making paper copies available upon request, its community report in a uniform format approved by the Commissioner of Health and in accordance with the standards and procedures adopted by rule under this section. Hospitals located outside this State which serve a significant number of Vermont residents, as determined by the Commissioner of Health, shall be invited to participate in the community report process established by this subsection.~~

(c) ~~The community reports shall be provided to the Commissioner of Health.~~ The Commissioner of Health shall publish the ~~reports~~ statewide comparative hospital quality report on a public website and shall ~~develop and include a format for comparisons of hospitals within the same categories of~~

~~quality and financial measures~~ update the report at least annually beginning on June 1, 2017.

Sec. 3. 18 V.S.A. § 9408a is amended to read:

§ 9408a. UNIFORM PROVIDER CREDENTIALING

* * *

(e) ~~The commissioner may enforce compliance with the provisions of this section as to insurers and as to hospitals as if the hospital were an insurer under 8 V.S.A. § 3661.~~ [Repealed.]

* * *

Sec. 4. 18 V.S.A. § 9414 is amended to read:

§ 9414. QUALITY ASSURANCE FOR MANAGED CARE

(a) The Commissioner shall have the power and responsibility to ensure that each managed care organization provides quality health care to its members, in accordance with the provisions of this section.

(1) In determining whether a managed care organization meets the requirements of this section, the Commissioner ~~shall~~ may review and examine, in accordance with subsection (e) of this section, the organization's administrative policies and procedures, quality management and improvement procedures, utilization management, credentialing practices, members' rights and responsibilities, preventive health services, medical records practices, grievance and appeal procedures, member services, financial incentives or

disincentives, disenrollment, provider contracting, and systems and data reporting capacities. The Commissioner ~~may~~ shall establish, by rule, specific criteria to be considered under this section.

* * *

(4) The Commissioner or designee may resolve any consumer complaint arising out of this subsection as though the managed care organization were an insurer licensed pursuant to Title 8. As used in this section, "complaint" means a report of a violation or suspected violation of the standards set forth in this section or adopted by rule pursuant to this section and made by or on behalf of a consumer or provider.

(b)(1) A managed care organization shall assure that the health care services provided to members are consistent with prevailing professionally recognized standards of medical practice.

(2) A managed care organization shall participate in ~~establish a chronic care program as needed to implement~~ the Blueprint for Health established in chapter 13 of this title. ~~The program~~ If needed to implement the Blueprint, a managed care organization shall establish a chronic care program, which shall include:

(A) appropriate benefit plan design;

(B) informational materials, training, and follow-up necessary to support members and providers; and

1 (C) payment reform methodologies.
2 (3) Each managed care organization shall have procedures to assure
3 availability, accessibility, and continuity of care, and ongoing procedures for
4 the identification, evaluation, resolution, and follow-up of potential and actual
5 problems in its health care administration and delivery.
6 (4) Each managed care organization shall be accredited by a national
7 independent accreditation organization approved by the Commissioner.
8 (c) ~~The~~ Consistent with participation in the Blueprint for Health pursuant to
9 subdivision (b)(2) of this section and the accreditation required by subdivision
10 (b)(4) of this section, the managed care organization shall have an internal
11 quality assurance program to monitor and evaluate its health care services,
12 including primary and specialist physician services, and ancillary and
13 preventive health care services, across all institutional and noninstitutional
14 settings. The internal quality assurance program shall be fully described in
15 written form, provided to all managers, providers, and staff and made available
16 to members of the organization. The components of the internal quality
17 assurance program shall include~~, but not be limited to,~~ the following:
18 (1) a peer review committee or comparable designated committee
19 responsible for quality assurance activities;
20 (2) accountability of the committee to the Board of Directors or other
21 governing authority of the organization;

(3) participation by an appropriate base of providers and support staff;

(4) supervision by the medical director of the organization;

(5) regularly scheduled meetings; and

(6) minutes or records of the meetings which describe in detail the actions of the committee, including problems discussed, charts reviewed, recommendations made, and any other pertinent information.

(d)~~(1) In addition to its internal quality assurance program, each managed care organization shall evaluate the quality of health and medical care provided to members. The organization shall use and maintain a patient record system which will facilitate documentation and retrieval of statistically meaningful clinical information.~~

~~(2) A managed care organization may evaluate the quality of health and medical care provided to members through an independent accreditation organization.~~ [Repealed.]

* * *

Sec. 5. 18 V.S.A. § 9414a is amended to read:

§ 9414a. ANNUAL REPORTING BY HEALTH INSURERS

(a) As used in this section:

(1) “Adverse benefit determination” means a denial, reduction, modification, or termination of, or a failure to provide or make payment in whole or in part for, a benefit, including:

1 (A) a denial, reduction, modification, termination, or failure to
2 provide or make payment that is based on a determination of the member's
3 eligibility to participate in a health benefit plan;
4 (B) a denial, reduction, modification, or termination of, or failure to
5 make payment in whole or in part for, a benefit resulting from the application
6 of any utilization review; and
7 (C) a failure to provide coverage for an item or service for which
8 benefits are otherwise provided because the item or service is determined to be
9 experimental, investigational, or not medically necessary or appropriate.
10 (2) "Claim" means a request for payment for a covered service that a
11 member or the member's health care provider submits to the insurer at or after
12 the time that health care services have been provided.
13 (3) "Concurrent review" means utilization review conducted during a
14 member's stay in a hospital or other facility, or during another ongoing course
15 of treatment.
16 (4) "Grievance" means a complaint submitted by or on behalf of a
17 member regarding:
18 (A) an adverse benefit determination;
19 (B) the availability, delivery, or quality of health care services;
20 (C) claims payment, handling, or reimbursement for health care
21 services; or

1 (D) matters relating to the contractual relationship between a member
2 and the managed care organization or health insurer offering the health benefit
3 plan.
4 (5) "Independent external review" means a review of a health care
5 decision by an independent review organization pursuant to 8 V.S.A. § 4089f.
6 (6) "Post-service review" means the review of any claim for a benefit
7 that is not a pre-service or concurrent review.
8 (7) "Pre-service review" means the review of any claim for a benefit
9 with respect to which the terms of coverage condition receipt of the benefit in
10 whole or in part on approval of the benefit in advance of obtaining health care.
11 (8) "Utilization review" means a set of formal techniques designed to
12 monitor the use, or evaluate the clinical necessity, appropriateness, efficacy, or
13 efficiency, of health care services, procedures, or settings, including
14 prescription drugs.
15 (b) Health insurers with a minimum of 2,000 Vermont lives covered at the
16 end of the preceding year or who offer insurance through the Vermont Health
17 Benefit Exchange pursuant to 33 V.S.A. chapter 18, subchapter 1 shall
18 annually report the following information to the Commissioner of Financial
19 Regulation, in plain language, as an addendum to the health insurer's annual
20 statement:

(1) the health insurer's state of domicile and the total number of states in which the insurer operates;

(2) the total number of Vermont lives covered by the health insurer;

(3) the total number of claims submitted to the health insurer;

(4) the total number of claims denied by the health insurer, including the total number of denied claims for mental health services, treatment for substance use disorder, and prescription drugs;

(5) data regarding the number and percentage of denials of service by the health insurer ~~at the preauthorization level,~~ based on utilization review, including utilization review at the pre-service review, concurrent review, and post-service review levels and including denials of mental health services, services for substance use disorder, and prescription drugs broken out separately, including:

(A) ~~the total number of~~ denials of service by the health insurer ~~at the preauthorization level~~;

(B) ~~the total number of~~ denials of service ~~at the preauthorization level~~ appealed to the health insurer at the first-level grievance and, of those, the total number overturned;

(C) ~~the total number of~~ denials of service ~~at the preauthorization level~~ appealed to the health insurer at any second-level grievance and, of those, the total number overturned;

(D) ~~the total number of~~ denials of service at the ~~preauthorization~~ pre-service level for which external review was sought and, of those, the total number overturned;

(6) the total number of adverse benefit determinations made by the health insurer, including:

(A) the total number of adverse benefit determinations appealed to the health insurer at the first-level grievance and, of those, the total number overturned;

(B) the total number of adverse benefit determinations appealed to the health insurer at any second-level grievance and, of those, the total number overturned;

(C) the total number of adverse benefit determinations for which external review was sought and, of those, the total number overturned;

(7) ~~the total number of claims denied by the health insurer because the service was experimental, investigational, or an off-label use of a drug, was not medically necessary, involved access to a provider that is inconsistent with the limitations imposed by the plan, or was subject to a preexisting condition exclusion;~~ [Repealed.]

(8) the total number of claims denied by the health insurer as duplicate claims, as coding errors, or for services or providers not covered;

(9) the percentage of claims processed in a timely manner;

1 (10) the percentage of claims processed correctly;
2 (11) the composite percentage of claims processed in a timely manner
3 and correctly;
4 (12) the number and percentage of utilization review decisions meeting
5 the timelines described in subdivisions (A)–(D) of this subdivision, including
6 timeliness data for all utilization review decisions and timeliness data for
7 physical health, mental health, substance use disorder, and prescription drug
8 utilization review decisions broken out separately:
9 (A) concurrent reviews within 24 hours;
10 (B) urgent pre-service reviews within 48 hours of receipt of the
11 request;
12 (C) non-urgent pre-service reviews within two business days of
13 receipt of request; and
14 (D) post-service reviews within 30 days of receipt of request;
15 (13) data regarding the number of grievances related to availability,
16 delivery, or quality of health care services or matters relating to the contractual
17 relationship between a member and the health insurer, including:
18 (A) health care provider performance and office management issues;
19 (B) plan administration;
20 (C) access to health care providers and services;
21 (D) access to mental health providers and services; and

1 (E) access to substance use disorder providers and services;
2 (14) the total number of claims, including separate numbers for claims
3 related to mental health services, services for substance use disorder, and
4 prescription drugs, denied by the health insurer on the grounds that the service
5 was experimental, investigations, or an off-label use of a drug; was not
6 medically necessary; or involved access to a provider that is inconsistent with
7 the limitations imposed by the plan;
8 (15) results of surveys evaluating health care provider satisfaction with
9 the health insurer;
10 (16) the health insurer's actions taken in response to the prior year's
11 health care provider survey results;
12 (17)(A) the titles and salaries of all corporate officers and board
13 members during the preceding year;
14 (B) the bonuses and compensatory benefits of all corporate officers
15 and board members during the preceding year;
16 ~~(10)~~(18) the health insurer's marketing and advertising expenses during
17 the preceding year;
18 ~~(11)~~(19) the health insurer's federal and Vermont-specific lobbying
19 expenses during the preceding year;
20 ~~(12)~~(20) the amount and recipient of each political contribution made by
21 the health insurer during the preceding year;

~~(13)~~(21) the amount and recipient of dues paid during the preceding year by the health insurer to trade groups that engage in lobbying efforts or that make political contributions;

~~(14)~~(22) the health insurer's legal expenses related to claims or service denials during the preceding year; and

~~(15)~~(23) the amount and recipient of charitable contributions made by the health insurer during the preceding year.

~~(b)~~(c) Health insurers may indicate the extent of overlap or duplication in reporting the information described in subsection ~~(a)~~(b) of this section.

~~(c)~~(d) The Department of Financial Regulation shall create a standardized form using terms with uniform, industry-standard meanings for the purpose of collecting the information described in subsection (a) of this section, and each health insurer shall use the standardized form for reporting the required information as an addendum to its annual statement. To the extent possible, health insurers shall report information specific to Vermont on the standardized form and shall indicate on the form where the reported information is not specific to Vermont.

~~(d)~~(e)(1) The Department of Financial Regulation and the Office of the Health Care Advocate shall post on ~~its website~~ their websites links to the standardized form completed by each health insurer pursuant to this section. Each health insurer shall post its form on its own website.

(2) The Department of Vermont Health Access shall post on the Vermont Health Benefit Exchange established pursuant to 33 V.S.A. chapter 18, subchapter 1 an electronic link to the standardized forms posted by the Department of Financial Regulation pursuant to subdivision (1) of this subsection.

~~(e)~~(f) The Commissioner of Financial Regulation may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this section.

Sec. 6. 18 V.S.A. § 1854(a) is amended to read:

(a) A hospital shall make public the maximum patient census and the number of registered nurses, licensed practical nurses, and licensed nursing assistants providing direct patient care in each unit during each shift. Each unit's information shall be reported in full-time equivalents, with either every eight hours or 12 hours worked by a registered nurse, licensed practical nurse, or licensed nursing assistant during the shift as one full-time equivalent. The reporting of this information shall be in a manner consistent with the requirements for public reporting for measures of nurse staffing selected by the ~~commissioner of financial regulation~~ Commissioner of Health under subdivision ~~9405b(a)(12)~~ 9405b(a)(4) of this title, but shall not in any way change what is required to be posted as set forth in this subsection. Each unit's information shall be posted in a prominent place that is readily accessible to

1 patients and visitors in that unit at least once each day. The posting shall
2 include the information for the preceding seven days.
3 Sec. 7. EFFECTIVE DATES
4 (a) Secs. 1 (hospital needs assessment) and 2 (hospital community reports)
5 and this section shall take effect on passage.
6 (b) The remaining sections shall take effect on July 1, 2016.

Comparison of Federal Law and State MCO Requirements

NOTE: The federal government put out proposed Medicaid MCO regulations on June 1, 2015. As of December 15, 2015, the regulations had not been finalized.[1] Final regulations may change this analysis. In addition, while the AoA tried to capture most relevant regulations and processes pertaining to the areas below, it is possible it did not capture all regulations and relevant processes.

Claims		
Insurance	**Medicaid**	**Analysis**
Timing of Payment		
18 V.S.A. § 9418 • Insurer must pay no later than 30 days; or • Notify provider that claim is contested or denied within 30 days • Acknowledge receipt of electronic claim within 24 hours	42 C.F.R. §§ 447.45 & 447.46 require: • State must pay 90% of all clean claims within 30 days • State must pay 99% of all clean claims within 90 days • State must pay all other claims within 12 months of receipt with exceptions such as retrospective payment and when a provider is under investigation for fraud or abuse • MCO and providers may establish an alternative payment schedule 42 C.F.R. § 435.914 • Requires retroactive eligibility of three months	Federal Medicaid regulations differentiate between clean claims and all claims, but the requirements are similar. There may be opportunity for alignment, but further analysis is needed. Retroactive eligibility is required by federal law and may affect timing of payment

[1] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed Reg 31097 (June 1, 2015) (amending 42 C.F.R. § 431, 42 C.F.R. § 433, 42 C.F.R. § 438, 42 C.F.R. § 440, 42 C.F.R. § 457, and 42 C.F.R. § 495).

<table>
<tr><th colspan="3">Claims</th></tr>
<tr><th>Insurance</th><th>Medicaid</th><th>Analysis</th></tr>
<tr><td colspan="3">General Standards</td></tr>
<tr>
<td>18 V.S.A. § 9418
• Interest accrues to insurer if no payment after 30 days and exception does not apply
• Insurer may make routine recovery of payment within 12 months or after 12 months if fraud, incorrect, etc.
• Insurer must provide 30 days' notice of overpayment recovery (exception for routine recoveries)</td>
<td>DVHA Medicaid Covered Services Rule § 7105.2
• Provider must meet Medicare or Medicaid standards
• Provider must accept rate established by Medicaid rate schedule
• No Medicaid payment for claims received later than 6 months, unless extenuating circumstances—definitely no payment or more than 24 months
• For duals, provider must accept assignment of Medicare payment in order to receive Medicaid payment
• DVHA dictates claims and claims documentation

42 C.F.R. § 433.112 & § 433.113
• States receive enhanced federal match if they develop a mechanized claims processing and information retrieval system that meets specific federal requirements
• Reduced federal match if state fails to operate mechanized claims processing and information retrieval system that meets specific federal requirements

42 C.F.R. § 433.139
• Medicaid is the payer of last resort. If the state determines that there is another payer for a claim, the state must reject the claim and require the provider to bill the third party</td>
<td>Some federal Medicaid regulations and state standards for private MCOs are similar, including some timeframes and notice requirements.

Federal Medicaid regulations require:
• Assignment of Medicare payment for duals
• Medicaid is payer of last resort
• Enhanced federal match for claims system that meets federal requirements
• Pre-payment and post-payment claims review</td>
</tr>
</table>

	42 C.F.R. § 447.45 For all claims, the state must conduct a prepayment claims review, including: • Verification that the beneficiary was included in the eligibility file and that the provider was authorized to furnish the service at the time the service was furnished; • Checks that the number of visits and services delivered are logically consistent with the beneficiary's characteristics and circumstances, such as type of illness, age, sex, service location; • Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed; • Verification that a payment does not exceed any reimbursement rates or limits in the State Plan; and The state must also conduct post-payment claims review to deal with fraud and utilization control. DVHA Medicaid Covered Services Rule § 7108.2 • DVHA may make adjustments or recovery when payment is inappropriate DVHA Medicaid Covered Services Rule § 7201.6 • Reimbursement for inpatient services is in Provider Manual, State Plan, and Billing Manual	

<table>
<tr><th colspan="3">Claims</th></tr>
<tr><th>Insurance</th><th>Medicaid</th><th>Analysis</th></tr>
<tr><td colspan="3">Public Claims Reporting</td></tr>
<tr><td>18 V.S.A. § 9414a
• the total number of claims submitted to the health insurer;
• the percentage of claims processed in a timely manner;
• the percentage of claims processed correctly;
• the composite percentage of claims processed in a timely manner and correctly;
• the total number of claims denied by the health insurer; including the total number of denied claims for mental health services, substances abuse services and pharmaceutical services;
• the total number of claims denied by the health insurer as duplicate claims, as coding errors, or for services or providers not covered;</td><td>42 C.F.R. §433.37
• The state must be able to report provider payments to the IRS

42 C.F.R. § 447.45
• The state must provide all reports required by the Administrator at CMS

Medicaid Provider Manual 3.4
• DVHA and HP require use of current form, including prior authorizations and patient consent forms</td><td>There needs to be further analysis of what claims reporting may be publically reported under federal law. There may be an opportunity for alignment.</td></tr>
</table>

<table>
<tr><th colspan="3">Prior Authorization/Utilization Management</th></tr>
<tr><th>Insurance</th><th>Medicaid</th><th>Analysis</th></tr>
<tr><td colspan="3">Medical Services</td></tr>
<tr>
<td>18 V.S.A. § 9418b
• Insurer shall furnish list to provider
• Insurer shall accept national transaction info, such as HIPAA 278 standards or a uniform form developed by DFR
• Insurer shall respond within 48 hours for urgent requests and 2 business days for non-urgent

DFR rule H-2009-03 Part 3.1
• MCOs shall have a written utilization management (UM) program that describes all activities
• UM shall use documented utilization review guidelines that are based in generally accepted medical practices and periodically reviewed and updated and available upon request
• UM review shall be reasonable, not compromise safety, and take into account conditions that affect member's ability to follow UM
• Mental health and substance abuse UM must follow parity and contact providers prior to denial
• RN or physician available by telephone 7 days a week, 24 hours per day
• Contracts cannot incentivize denials

Act 79 of 2013, Sec. 5.b</td>
<td>SSA Section 1902(a)(30)
• Requires state plan to provide methods and procedures to safeguard against unnecessary utilization of care and services. Failure to do so will result in a penalty under SSA Section 1903(g)(1)

42 CFR § 438.10
• requires notice and due process for emergency care

42 CFR § 438.210
• Have a uniform process
• Consult with the requesting provider when appropriate
• Standard authorization must be shorter than 14 days with possible extension of 14 days (28 days total)
• Expedited—3 working days, which can be extended to 14 days
• Contracts shall not incentivize denials
• Must follow notice requirements 42 CFR 438.404 (appeals)

Medicaid Provider Manual Section 7
• Website has list of codes that require prior authorization
• Clinical Practice Guidelines posted
• Medicaid prior authorization necessary if no other insurance coverage
• Medical necessity form required
• Exceptions to prior authorization prior to date of service include emergencies and retroactive eligibility</td>
<td>Federal Medicaid regulations require state to have a utilization management program. Some federal requirements may be more restrictive than state requirements, including:
• Requirements for inpatient visits

Some state requirements are more restrictive than federal requirements, including:
• An insurer shall respond within 48 hours for urgent care and 2 business days for non-urgent
• An RN or physician available by telephone 24 hours per day, 7 days a week

Further analysis of specific proposed changes needed.</td>
</tr>
</table>

DFR shall ensure that as of 1/1/15 health insurers shall include full transparency of prior authorization guidelines and other utilization review provisions, including the source or basis in evidence for the standards and guidelines.	• DVHA must make determinations within 3 working days – longest wait time is 28 days. Written confirmation of receipt within 24 hours • All in-state hospitals must notify DVHA of admission by next business day. Prior authorization needed if patient stay exceeds 13 days • Special rules for out of state hospitals, elective surgery, and rehab therapy Act 79 of 2013, Sec 5.b. • DVHA shall ensure that benefit management contracts, as of 1/1/17, include full transparency of prior authorization guidelines, and other utilization review provisions, including the source or basis in evidence for the standards and guidelines. • DVHA's RFP for MMIS shall ensure that the MMIS will include full transparency of edit standards, payment rules, prior authorization guidelines, and other utilization review provisions, including the source or basis in evidence for the standard and guidelines.	

Prior Authorization/Utilization Management		
Insurance	**Medicaid**	**Analysis**
Prescription Drugs		
DFR rule H-2009-03 Part 3.2 • All prescription drug requests considered urgent unless otherwise noted • If denial of prescription drug coverage is overturned, the MCO shall continue to refill as long as the provider keeps the treatment the same and the drug continues to be considered safe and effective Act 79 of 2013, Sec. 5.b • DFR shall ensure that as of 1/1/15 health insurers shall include full transparency of prior authorization guidelines and other utilization review provisions, including the source or basis in evidence for the standards and guidelines.	Section 1927 of SSA • Prescription drugs must be under a rebate program, unless the state determines that the availability of the drug is essential to the health of beneficiaries, the drug has been given an 1-A rating • The drug use review program shall assess data on drug used using standards set out by the American Hospital Formulary Service Drug Information; U.S. Pharmacopeia-Drug Information; DRUGDEX information system; peer-reviewed medical literature • For prior authorization, the state must provide a response by telephone or other device within 24 hours of request and dispense at least a 72 hour supply (with exceptions) Act 79 of 2013, Sec 5.b. • DVHA shall ensure that benefit management contracts, as of 1/1/17, include full transparency of prior authorization guidelines, and other utilization review provisions, including the source or basis in evidence for the standards and guidelines. • DVHA's RFP for MMIS shall ensure that the MMIS will include full transparency of edit standards, payment rules, prior authorization guidelines, and other utilization review provisions, including the source or basis in evidence for the standard and guidelines.	Federal Medicaid law is more restrictive than state standards for private MCOs regarding prescription drugs: • Drug formulary • Drug use review standards

Prior Authorization/Utilization Management		
Insurance	**Medicaid**	**Analysis**
	Grievances and Appeals	
DFR rule H-2009-03 Part 3.3 • Grievance review process is for members dissatisfied with the availability or delivery of services and includes adverse benefit determinations, claims payments, or any other matter pertaining to contract • All pre-approval of prescription drug requests; pre-service mental health and substance abuse requests; or any grievance designated as urgent by a provider or a member are considered urgent unless otherwise noted • MCO shall provide no more than 2 levels of grievance, with the second level being voluntary. • For the first level, the member has at least 180 days after receipt of a notice of adverse benefit determination • The member has at least 90 days after notice of adverse determination to make a request a second level grievance. The MCO shall provide information to the member about her rights at the second level, including the right to meet with one or more of the reviewers before final determination	Section 1902(a)(3) of SSA requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. Section 1932(b)(4) of SSA requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. 42 CFR § 438, Part F Beneficiaries may appeal actions, which include: • Denial or limited authorization of requested service • Reduction, suspension, or termination of previously authorized service • Denial of payment for service • Failure to provide service in a timely manner • Failure for the MCO to act within prescribed timeframes • For rural area—right to obtain services outside of network	There are several differences between federal Medicaid and state standards for private MCOs for grievances and appeals. • Federal regulations define grievances differently than state regulations. • Federal regulations also require that enrollees have access to a state fair hearing process, which is not available under a private MCO. • Medicaid is subject to Constitutional due process requirements under *Goldberg v. Kelly*, unlike private MCOs.

• Members must be allowed to submit written comments, documents, and records related to the grievance • The MCO must give members reasonable access to information about the grievance upon request and free of charge within 2 business days, or immediately if urgent • Grievance review must not give deference to previous determination • Reviewer at voluntary secondary level must not have been involved at previous levels • For first level grievance of an adverse benefit determination that is based on medical judgment, the reviewers shall include at least one clinical peer of the member's treating provider and identify that provider and ensure the provider was not involved in previous determinations. The MCO's medical director or designee shall also offer to directly communicate with the member's treating provider before a determination is made • MCO provides reasonable accommodations for members with disabilities • Provide information in requested language to members for whom English is not a primary language • Allow for members to request a grievance orally if unable to file a written grievance • MCO must promptly reinstate services when adverse benefit determination has been reversed	Grievances include: • Quality of care or services • Rudeness of provider or employee • Failure to respect enrollee's rights The state must have the following in place: • Grievance process • Appeals process and expedited appeals process required. All expedited appeal determinations must be made within 3 days. • Access to fair hearing Authority to file • A enrollee may file a grievance, appeal, or request for fair hearing—the enrollee may file orally or in writing • Provider may file and appeal and may file grievance or request for fair hearing if allowed by the state and authorized to do so Notice of Action • Notice must be in language and format required by regulation • Notice must include the action the MCO intends to take, the reason for the action, the right to file an appeal, the right to request a fair hearing, the procedure for exercising such rights, the circumstances for	

Timeframes of Determinations • First- or second-level concurrent grievance—no later than 24 hours of receipt of the grievance • First-or second-level urgent, pre-service grievance—no later than 72 hours after receipt of grievance • First-or second-level non-urgent, pre-service grievance—no later than 30 calendar days • First-or second-level post-service grievance—no later than 60 calendar days • First-or second-level grievance unrelated to an adverse benefit determination—within 60 calendar days	expedited resolutions and how to request an expedited resolution, and the enrollee's right to have benefits continue during appeal Timeframe to request a fair hearing • No later than 90 days from the adverse action General requirements • MCOs must give enrollees reasonable assistance in completing forms and taking other procedural steps, including interpreter services • Acknowledge receipt of each grievance and appeal • Ensure that individuals making decisions on grievances and appeals were not involved at a lower level • Have clinicians make determinations on clinical issues • Provide the enrollee an opportunity to present evidence • Provide the enrollee an opportunity to examine the case file 42 CFR § 438.416 • MCOs must maintain records of grievances and appeals and the state must review it as part of the state quality strategy	

Reporting Requirements		
Insurance	**Medicaid**	**Analysis**
18 V.S.A. § 9414a Insurers must report: • Number of Vermont lives • Number of claims submitted • Number of claims denied • Data on denials, including total number at each level of appeal and number overturned, number of adverse benefit determinations at each review level, claims denied b/c experimental or not medically necessary, and errors • Titles and salaries of corporate officers • Marketing and advertising expenses • Lobbying expenses • Political contribution • Dues to trade groups • Legal expenses • Charitable contributions	42 CFR § 431.16 State must: • Submit all reports required by the Secretary • Follow the Secretary's instructions with regard to the form and content of those reports • Comply with any provisions necessary to verify correctness of reports 42 C.F.R. § 438.204 • Assess quality of care received by Medicaid enrollees • Identify race, ethnicity, and primary language of each Medicaid enrollee • National performance measures that may be identified and developed by CMS • Annual independent reviews of quality outcomes and timeliness of, and access to, services 42 C.F.R. § 438.300 et seq. External quality review must report: • Validation of performance improvement projects • Validation of performance measures to comply with 438.204(b)(2) • Review within 3 year period to ensure compliance with standards	Some state standards for private MCOs do not apply in the context of Medicaid, such as dues to trade groups and political contributions. Federal Medicaid regulations require an external quality review report. It is unclear whether there is flexibility within that report to include state standards for private MCOs. It is unclear whether reports required by the Secretary include or exclude state standards for private MCOs. Further analysis is needed.

<table>
<tr><th colspan="3">Network Adequacy</th></tr>
<tr><th>Insurance</th><th>Medicaid</th><th>Analysis</th></tr>
<tr>
<td>DFR rule H-2009-03
Part 5.1
Travel time standards
• 30 minutes to office-based care, including primary care and mental health and substance abuse services
• 60 minutes to outpatient care; inpatient mental health and substance abuse; laboratory pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services;
• Ninety (90) minutes for major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery; and
• Reasonable accessibility for other specialty services, including major burn care, organ transplantation, and specialty pediatric care

Waiting time standards
• Immediate access for emergency care
• 24 hours for urgent care
• 2 weeks for non-emergency, non-urgent care
• 90 days for preventive care
• 30 days for routine laboratory, imaging, general optometry, and all other routine services.</td>
<td>42 CFR § 438.206
MCO maintains and monitors a network of appropriate providers to provide adequate access and must consider the following:
• The anticipated Medicaid enrollment.
• The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations
• The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
• The numbers of network providers who are not accepting new Medicaid patients.
• The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
• Provides female enrollees with direct access to a women's health specialist
• Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
• If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee</td>
<td>There may be flexibility to align standards, because state standards for private MCOs are more detailed than some Federal Medicaid MCO standards.

Federal Medicaid regulations have additional requirements, including direct access to women’s health services and delivery of services in a culturally competent manner.</td>
</tr>
</table>

Each MCO shall develop standards and report that it is meeting the above requirements	Timely access—each MCO must do the following: • Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. • Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. • Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. • Establish mechanisms to ensure compliance by providers. • Monitor providers regularly to determine compliance. • Take corrective action if there is a failure to comply. Cultural considerations. The MCO must promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	