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Devon Green, Agency of Administration

Definition of MCO:

18 VSA § 9402(14) "Managed care organization" means any financing mechanism or system that manages health care delivery for its members or subscribers, including Health Maintenance Organizations and any other similar health care delivery system or organization.

Example of MCO: Blue Cross Blue Shield because it has in-network and out-of-network providers, wellness plans, etc.

Example of not an MCO: Indemnity insurance company that simply pays back requested claims without anything further.

Statutory Charge

Section 44 of Act 54 requires the Director of Health Care Reform to consult regularly with interested stakeholders to reexamine existing Managed Care Organization standards and determine the best oversight for such standards. The following group met ten times, and this bill reflects the consensus recommendations of the stakeholder group.

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

<u>Sections 1 & 2: Hospital Community Reports/Health Needs Assessment</u>

Allows hospitals to meet community health needs assessment through meeting the IRS community health needs assessment requirement for nonprofit hospitals.

Updates hospital community reports as a statewide comparative report rather than individual hospital reports to be posted on hospital websites for ease of public and provider use.

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Section 3 & 4: Uniform Provider Credentialing

This moves enforcement authority for uniform credentialing of providers by hospitals from DFR to the Department of Health's licensing statute. DFR normally oversees insurers, not hospitals, and Department of Health licenses hospitals.

Section 5 & 6: Health Care Provider Bargaining Groups

Transitions oversight of health care provider bargaining groups bargaining with the State under 18 V.S.A. § 9409 from DFR to the Green Mountain Care Board. DFR does not typically oversee providers.

In overseeing health care provider bargaining groups, GMCB may rely on current DFR rules until they adopt new rules. When it adopts new rules, the new rules will provide at least the same amount of protection for provider bargaining groups as the DFR rule.

Current Provider Bargaining Groups: Medical Society, Healthfirst, Vermont Chiropractic Association, Vermont Psycological Association, Dental Society

Section 7: Quality Assurance for Managed Care

Requires 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 annual reporting by health insurers 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. DFR will provide a report of its aggregated complaints to the Health Care Advocate.

Section 8: Annual Reporting by Health Insurers

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

Section 9

Technical correction

Section 10

Acknowledges the group's findings that the health care landscape is currently shifting and requires the Director of Health Care Reform to look for opportunities for alignment between ACOs, MCOs, and Medicaid and report back by December 15, 2017.