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).

Claims		
Insurance	**Medicaid**	**Analysis**
General Standards		
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)	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	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

	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	

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<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>
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Prior Authorization/Utilization Management		
Insurance	**Medicaid**	**Analysis**
Medical Services		
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	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	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.

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.	

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<tr><td colspan="3">Prescription Drugs</td></tr>
<tr><td>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.</td><td>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.</td><td>Federal Medicaid law is more restrictive than state standards for private MCOs regarding prescription drugs:
• Drug formulary
• Drug use review standards</td></tr>
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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.

Network Adequacy		
Insurance	**Medicaid**	**Analysis**
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.	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	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.

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.	