As required by 26B-3-138, enacted by HB 413 (2021 General Session), the Department shall:

(2) On or before May 31, 2022, the department shall convene a working group to collaborate with the department on:

(a) establishing specific and measurable metrics regarding:

(i) compliance of managed care organizations in the state with federal Medicaid managed care requirements;

Department proposal: Our current UMIC contracts already require that plans comply with federal Medicaid managed care requirements. 14.1.1 of Attachment B of the UMIC contract outlines corrective action plans and the monitoring steps the Department will take if a plan is placed on corrective action.

(ii) timeliness and accuracy of authorization and claims processing in accordance with Medicaid policy and contract requirements;

Department proposal: 42 CFR 447.45 requires that Medicaid pay 90% of clean claims within 30 days and 99% of clean claims within 90 days. These standards also apply to the UMIC plans.

Under the current UMIC contract language, standard service authorizations are allowed 14 calendar days (or as expeditiously as the enrollee's condition requires). In order to comply with upcoming CMS proposed interoperability rules, our SFY 2025 contracts will shorten this timeframe to 7 calendar days. Pharmacy service authorizations will remain at a 24 hour turn-around time.

(iii) reimbursement by managed care organizations in the state to providers to maintain adequacy of access to care;

Department proposal: For critical behavioral health services, the Department has established an Essential Provider Fee Schedule, which applies to UMIC plans. In addition, the Department will be pursuing a quality pool (similar to what it did with legacy ACOs) to incentivise UMICs to maintain adequacy of access to care.

(iv) availability of care management services to meet the needs of Medicaid-eligible individuals enrolled in the plans of managed care organizations in the state; and

Department proposal: Each managed care organization will provide a policy outlining how individuals are identified for case/care management services

including the screening tool used and who will provide the service (e.g.. behavioral health case manager, nurse, community health worker).

The Department will establish a ratio of case managers to TAM members in the SFY 2025 contracts. In addition, the UMICs will need to establish a process with the [essential providers] regarding care coordination of their enrollees. Included in our quality pool will be required care management activities regarding primary care access, preventative care, and behavioral healthcare.

(v) timeliness of resolution for disputes between a managed care organization and the managed care organization's providers and enrollees;

Department proposal: Managed care plans will meet federal managed care timeframes for adjudicating standard appeals (within 30 calendar days of receipt or an additional 14 calendar days if follow extension requirements) and for adjudicating expedited appeals (within 72 hours of receipt or an additional 14 calendar days if follow extension requirements) 95 percent of the time. Managed care plans will meet the timeframe for adjudicating grievances (within 90 calendar days of receipt) 95 percent of the time.