Senate Study Bill 1253 - Introduced

SENATE FILE _____
BY (PROPOSED COMMITTEE ON
HUMAN RESOURCES BILL BY
CHAIRPERSON MATHIS)

A BILL FOR

1 An Act relating to Medicaid program transformation and
2 oversight.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. NEW SECTION. **249A.9 Medicaid transformation and**
2 **oversight commission —— findings, goals, and intent.**
3 1. The general assembly finds that state Medicaid program
4 initiatives have consistently advanced the goals of a health
5 care delivery system that improves population health, enhances
6 the experiences and outcomes of patients, reduces the costs of
7 care, and integrates and coordinates services and supports to
8 address social determinants of health. Existing initiatives,
9 including the healthiest state initiative, the balancing
10 incentive program, the Iowa health and wellness plan created
11 pursuant to chapter 249N, and the state innovation models
12 initiative, all reflect these consistent goals. Each of
13 these programs and initiatives has been formulated to realign
14 the health care delivery system to provide whole-person,
15 patient-centered care while moving toward a value and
16 risk-based model of reimbursement.
17 2. Legislative involvement and oversight is essential to
18 ensure stakeholder input, consumer protection, and quality
19 assurance in the transformation of the Medicaid program. A
20 transition to a managed care system, especially one that
21 affects vulnerable populations so diverse in medical and
22 functional needs and that involves such a wide spectrum of
23 providers and state agencies, requires intentional planning
24 and attention. The state must also provide for appropriate
25 and adequate infrastructure, resources, and funding to ensure
26 accountability to and compliance with state policy, rules, and
27 contract requirements.
28 3. Given the challenges presented, a Medicaid
29 transformation and oversight commission is created to provide
30 a formal venue for guidance and oversight of and stakeholder
31 engagement in, the design, development, and implementation of
32 Medicaid program transformation.
33 4. *a.* The commission shall include all of the following
34 members:
35 (1) The co-chairpersons and ranking members of the

1 legislative joint appropriations subcommittee on health
2 and human services, or members of the joint appropriations
3 subcommittee designated by the respective co-chairpersons or
4 ranking members.
5 (2) The chairpersons and ranking members of the
6 human resources committees of the senate and house of
7 representatives, or members of the respective committees
8 designated by the respective chairpersons or ranking members.
9 (3) The chairpersons and ranking members of the
10 appropriations committees of the senate and house of
11 representatives, or members of the respective committees
12 designated by the respective chairpersons or ranking members.
13 *b.* The members of the commission shall receive a per diem as
14 provided in section 2.10.
15 *c.* The commission shall meet at least quarterly, but may
16 meet as often as necessary. The commission may use sources of
17 information deemed appropriate, and the department of human
18 services and other agencies of state government shall provide
19 information to the commission as requested. The legislative
20 services agency shall provide staff support to the commission.
21 *d.* The commission shall select a chairperson, annually, from
22 its membership. A majority of the members of the commission
23 shall constitute a quorum.
24 *e.* The commission may contract for the services of persons
25 who are qualified by education, expertise, or experience to
26 advise, consult with, or otherwise assist the commission in the
27 performance of its duties. The commission may specifically
28 enlist the assistance of entities such as the university of
29 Iowa public policy center to provide ongoing evaluation of the
30 Medicaid program and to make evidence-based recommendations to
31 improve the program.
32 5. The commission shall do all of the following:
33 *a.* Provide overall long-term and real-time guidance for the
34 Medicaid program including but not limited to:
35 (1) Developing a strategic plan to provide a predictable

1 guide for transformation prior to any transition. The
2 strategic plan shall address health care delivery and payment
3 reforms that reflect a holistic, integrated, patient-centered,
4 primary care-focused, value-based model and extend beyond a
5 medical model to address the social determinants of health.
6 (2) Reviewing, recommending, and approving the design,
7 development, and implementation of all initiatives under the
8 Medicaid program, and making additional recommendations for
9 Medicaid program reform.
10 (3) Monitoring progress in obtaining federal approval of
11 proposals such as those relating to benefit design, service
12 delivery, payment reform, and quality and cost containment
13 measures.
14 (4) Reviewing other states′ models of health care delivery
15 and payment reform and specifically those related to Medicaid
16 managed care to determine best practices and inform future
17 state Medicaid program initiatives.
18 (5) Ensuring that at each stage of transformation, existing
19 models, provider networks, reimbursement methodologies, and
20 performance and quality metrics are honored, retained, and
21 incorporated into the subsequent stage to provide consistency
22 and reliability.
23 (6) Ensuring that the state has a clearly articulated
24 vision for the Medicaid program, which is reflected in contract
25 expectations, oversight, incentives, and penalties under the
26 program.
27 (7) Assessing state agencies including those involved
28 in the Medicaid program, child welfare, aging and disability
29 services, and public health to articulate clear roles and
30 responsibilities and to promote state program interoperability.
31 (a) The commission shall review and make recommendations
32 regarding potential integration of various service delivery
33 systems including public health, aging and disability services
34 agencies, and mental health and disability services regions to
35 more efficiently and effectively address consumer needs.

1 (b) The commission shall ensure that state agencies provide
2 leadership and have the appropriate organizational structures,
3 adequate resources and funding, and qualified staff with
4 specialized skills, training, and expertise to provide the
5 level of expertise and scrutiny required to administer and
6 oversee the various transformation initiatives, including those
7 related to Medicaid managed care.
8 (8) Ensuring that state Medicaid managed care initiatives
9 comply with the guidance to states using 1115 demonstrations
10 or 1915(b) waivers for managed long-term services and supports
11 programs published by the centers for Medicare and Medicaid
12 services of the United States department of health and human
13 services on May 20, 2013, including those relating to adequate
14 planning, stakeholder engagement, enhanced provision of home
15 and community-based services, alignment of structures and
16 goals, support for beneficiaries, a person-centered process, a
17 comprehensive, integrated service package, qualified providers,
18 consumer protections, and quality.
19 (9) Reviewing the performance under and outcomes of
20 contracts including but not limited to those between the
21 state and the Iowa Medicaid enterprise and managed care
22 organizations, to determine compliance.
23 (10) Ensuring that the various Medicaid populations are
24 managed at all times within funding limitations and contract
25 terms. The commission shall also monitor service delivery
26 and utilization to ensure the responsibility for provision of
27 services to Medicaid consumers is not shifted to non-Medicaid
28 covered services solely to attain savings, and that such
29 responsibility is not shifted to mental health and disability
30 services regions, local public health agencies, aging and
31 disability resource centers, or other entities unless agreement
32 to provide, and provision for adequate compensation for, such
33 services is agreed to in advance.
34 *b.* Address provider access and workforce adequacy issues.
35 (1) As the state moves toward integration of long-term

1 services and supports into Medicaid managed care, the
2 commission shall provide for a comprehensive review of
3 long-term services and supports and make recommendations to
4 create a sustainable, person-centered approach that increases
5 health and life outcomes, supports maximum independence,
6 addresses medical and social needs in a coordinated, integrated
7 manner, and provides for sufficient resources including a
8 stable, well-qualified workforce.
9 (a) The commission shall provide a forum for open and
10 constructive dialogue among stakeholders representing
11 individuals involved in the delivery and financing of long-term
12 services and supports, address the cost and financing of
13 long-term services and supports, the coordination of services
14 among providers, and the availability of and access to a
15 well-qualified workforce, and consider methods to educate
16 consumers and enhance engagement of consumers in the broader
17 conversation regarding long-term services and supports.
18 (b) The commission shall recommend ways to eliminate Iowa's
19 institutional bias and come into full compliance with the
20 Olmstead decision.
21 (2) The commission shall review current and projected
22 overall health care workforce availability to determine
23 the most efficient utilization of the roles, functions,
24 responsibilities, activities, and decision-making capacity
25 of health care professionals and make recommendations for
26 improvement. The commission shall encourage the use of
27 alternative modes of health care delivery, as appropriate.
28 (3) The commission shall ensure the linguistic and cultural
29 competency of providers and other program facilitators.
30 *c.* Provide for consumer engagement, address consumer
31 choice and satisfaction, and provide for consumer appeal and
32 grievance procedures. The commission shall provide for input
33 from the medical assistance advisory council created in section
34 249A.4B, the mental health and disabilities services commission
35 created in section 225C.5, the commission on aging created

1 in section 231.11, the medical home system advisory council
2 created in section 135.159, the bureau of substance abuse of
3 the department of public health, and other appropriate entities
4 to provide advice to the commission.
5 *d.* Review and make recommendations regarding reimbursement
6 and rate setting to ensure adequate compensation for all
7 providers of services and supports to the Medicaid population,
8 an adequate provider network, and timely access to services for
9 consumers.
10 *e.* Define the desired outcomes and the metrics by which
11 improvement is determined. The commission shall provide for
12 consistency and uniformity of metrics and required outcomes
13 across payors and providers to the greatest extent possible.
14 *f.* Ensure that care coordination and case management are
15 provided in a patient-centered manner that requires a knowledge
16 of community supports, a reasonable ratio of care coordinators
17 to consumers, standards for frequency of contact with the
18 consumer, and specific and adequate reimbursement.
19 *g.* Address health information technology and data collection
20 and sharing.
21 6. The commission shall submit a report of its findings
22 and recommendations to the governor and the general assembly
23 by January 15, annually.
24 Sec. 2. TRANSITION TO MEDICAID MANAGED CARE —
25 DIRECTIVES. In order to ensure a seamless transition of
26 Medicaid consumers to Medicaid managed care, all of the
27 following circumstances shall be considered and all of the
28 following conditions shall be met in any design, development,
29 or implementation of Medicaid managed care on or after March
30 1, 2015:
31 1. The state shall engage in a thoughtful and deliberative
32 planning process that permits sufficient time to outline a
33 clear vision for the program, solicit and consider stakeholder
34 input, educate program consumers, assess readiness, and
35 develop safeguards and oversight mechanisms to ensure a

1 smooth transition to and effective ongoing implementation of
2 Medicaid managed care. The movement to Medicaid managed care
3 shall retain an emphasis on choice, consumer-driven care and
4 services, a community-based infrastructure, and promotion of
5 community-based alternatives. The state shall demonstrate
6 that systems and processes are in place between state agencies
7 to support the populations enrolled in Medicaid managed care
8 such as elders, persons with physical, intellectual, and
9 developmental disabilities, persons with chronic diseases, and
10 persons with mental health or substance abuse issues.
11 2. a. Prior to the transition to Medicaid managed care
12 of any population, and especially to ensure that high-risk
13 populations are provided continuity of care and do not
14 experience gaps in coverage or access to care issues, the state
15 shall perform a readiness assessment to ensure that managed
16 care organizations are in compliance with network adequacy
17 requirements, that necessary consumer and provider outreach and
18 education has been conducted, and that programmatic gaps have
19 been identified prior to the system becoming operational.
20 b. A managed care contract shall include a provision
21 for continuity and coordination of care for a consumer
22 transitioning to managed care, including maintaining existing
23 provider-consumer relationships and honoring the amount and
24 duration of an individual´s authorized services under an
25 existing service plan, based on individual assessment and
26 needs. In the initial transition of a consumer to Medicaid
27 managed care, to ensure the least amount of disruption, managed
28 care organizations shall provide, at a minimum, a one-year
29 transition of care period for all provider types, regardless of
30 network status with an individual managed care organization.
31 c. The state shall ensure that if an individual is
32 auto-enrolled in a Medicaid managed care plan, there are
33 sufficient staff and safeguards available to ensure continuity
34 of care for the consumer through the consumer´s existing
35 provider.

1 d. The state shall administratively credential existing
2 Medicaid providers, rather than requiring such providers to
3 complete a new credentialing process, to ensure a seamless
4 transition to the new managed care system and to ensure rapid
5 development of managed care provider networks.
6 e. The state shall retain external managed care experts to
7 guide patient transition, system implementation, and oversight
8 until the department of human services is able to develop the
9 internal staff capacity to confidently operate independently.
10 Such external experts shall be selected through a request for
11 proposals process and the state shall ensure that such experts
12 are not affiliated with any of the managed care organizations
13 selected in order to provide unbiased and appropriate guidance.
14 3. a. The state shall establish a specific, enforceable
15 process to ensure managed care organizations grievance and
16 appeals procedures are fully accessible to patients regardless
17 of physical, intellectual, behavioral, or sensory barriers.
18 b. Managed care contracts shall include consumer
19 protections including a statement of consumer rights and
20 responsibilities, a critical incident management system with
21 safeguards to prevent abuse, neglect, and exploitation, and
22 fair hearing protections including the continuation of services
23 during an appeal.
24 4. The state shall utilize public forums, public input
25 surveys, stakeholder workgroup sessions, and other effective
26 formal channels for stakeholder engagement in the design,
27 development, and implementation of Medicaid managed care. The
28 state shall utilize the medical assistance advisory council
29 established pursuant to section 249A.4B to provide a forum
30 for oversight of managed care organizations and to advise the
31 department regarding systemic issues identified by the council.
32 5. a. The state shall ensure that a managed care
33 organization develops and maintains a network of qualified
34 providers who meet state licensing, credentialing, and
35 certification requirements, as applicable, which network shall

1 be sufficient to provide adequate access to all services
2 covered under the managed care contract. The state shall
3 ensure that managed care organizations incorporate existing and
4 traditional providers, including but not limited to those that
5 comprise the Iowa collaborative safety net provider network
6 created in section 135.153.
7 b. Managed care contracts shall specify provider network
8 composition and access requirements including continuity of
9 care provisions and rules for when and how consumers may
10 access out-of-network providers. Managed care plans shall
11 provide reports of compliance with state network composition
12 and access standards and the state shall include financial
13 incentives and disincentives as management tools to support
14 state expectations.
15 c. The state shall review managed care organization
16 credentialing processes to provide consistency across such
17 organizations and to simplify and streamline the credentialing
18 process.
19 d. The state shall ensure that management of care for the
20 population served is provider-led.
21 e. The state shall monitor and enforce access standards
22 to ensure that consumers are able to access appropriate care
23 as close to their own homes as possible. The state shall
24 review, at least quarterly, network adequacy compliance and
25 require the dissemination of easily accessible and updated
26 provider directories to ensure consumers have the most accurate
27 information possible regarding the number, location, type, and
28 current capacity of providers contracted with the individual
29 managed care organization. The state shall ensure that
30 noncompliance results in swift corrective action.
31 f. The state shall require managed care plans to remove
32 administrative barriers to, provide reimbursement for,
33 and utilize emerging technologies such as e-health, mobile
34 technologies, and telehealth in health care delivery in a
35 medically appropriate manner in order to expand access to

1 services and extend the reach of approved provider networks
2 into rural and underserved areas of the state. Reimbursement
3 for telehealth shall be at the same rate as in-person services.
4 g. The state shall require managed care organizations to
5 implement tools and strategies that support community-level
6 system integration between acute care, long-term services and
7 supports, and community-level agencies and organizations to
8 further population health goals.
9 6. a. (1) The state shall require managed care
10 organizations to align economic incentives, delivery system
11 reform, and performance and outcome metrics with those of the
12 state innovation models initiative and Medicaid accountable
13 care organizations.
14 (2) The state shall develop a common, uniform set of
15 process, quality, and consumer satisfaction measures across
16 all Medicaid payors and providers that align with those
17 developed through the state innovation models initiative and
18 shall ensure that such measures are expanded and adjusted to
19 address additional populations and to meet population health
20 objectives. Measures considered may include but are not
21 limited to those related to consumer education, transition
22 to and ongoing implementation of managed care, monitoring
23 and oversight, consumer input and rights, network adequacy
24 and access to care including services that address social
25 determinants of health, the provision of preventive services
26 and supports as well as those that address chronic conditions,
27 continuity of care, long-term services and supports, provider
28 standards, and evaluation and quality measures.
29 b. Managed care contracts shall include long-term
30 performance goals that reward success in achieving population
31 health goals such as improved community health metrics.
32 c. The state shall require consistency and uniformity
33 of processes and forms across all managed care organizations
34 including but not limited to the use of uniform cost and
35 quality reporting and uniform prior authorization procedures.

1 7. The state shall require the provision of independent
2 choice counseling, education, functional assessment, and
3 enrollment and disenrollment from a managed care plan by
4 an entity free of conflicts. The state shall ensure an
5 independent advocate is available to assist consumers in
6 navigating the Medicaid managed care landscape, understanding
7 their rights, responsibilities, choices, and opportunities,
8 and helping to resolve any problems that arise between
9 the consumer and the managed care organization. Unless
10 such an entity declines, the aging and disability resource
11 centers and the long-term care ombudsman shall provide such
12 independent, conflict-free services in an accessible, ongoing,
13 and consumer-friendly manner, and shall be provided adequate
14 resources and reimbursement for provision of such services.
15 8. The state shall require the use of a uniform,
16 standardized, person-centered, and state-approved instrument
17 to assess a consumer's physical, psychosocial, and functional
18 needs, including current health status and treatment needs;
19 social, employment, and transportation needs and preferences;
20 personal goals; consumer and caregiver preferences for
21 care; back-up plans for situations in which caregivers are
22 unavailable; and informal networks. The information collected
23 from these assessments shall be used to identify health risks
24 and social determinants of health that impact health outcomes.
25 Plans and providers shall use this data in care coordination
26 and interventions to improve patient outcomes and to drive
27 program designs that improve the health of the population.
28 Managed care organizations shall share aggregate assessment
29 data for consumers with providers on a routine basis.
30 9. The state shall establish guidelines for care
31 coordination across managed care organizations to ease
32 administrative burdens on providers and help streamline
33 access to care. Coordinated care shall utilize the team-based
34 care model by connecting a Medicaid consumer to a single
35 primary care provider. The state shall require managed care

1 organizations to coordinate data sharing and analytics across
2 providers to facilitate care coordination. A managed care plan
3 shall provide for identification of the care coordination needs
4 of a consumer including those related to social determinants of
5 health, ensure that appropriate care coordination services are
6 provided, and provide evidence on an ongoing basis to the state
7 that both have occurred.
8 10. The state shall review and integrate the activities of
9 state agencies, including those agencies with public health,
10 child welfare, aging and disabilities, and ombudsman functions
11 to ensure there is no wrong door for consumers to access the
12 medical and social services and supports necessary for improved
13 outcomes. Managed care organizations shall provide or ensure
14 that consumers are connected with or referred to providers
15 and services to meet social determinants of health, even if
16 provision of services is outside their provider network.
17 Managed care contracts shall encourage partnerships between
18 managed care organizations and local public health agencies,
19 aging and disability resource centers, child welfare agencies,
20 mental health and disability services regions, and others to
21 address the holistic needs of the consumer and shall provide
22 for adequate reimbursement for such services.
23 11. a. Managed care plans shall include policies, plans,
24 and procedures to prepare consumers for transitions between
25 care settings to improve the quality of care for all consumers,
26 reduce avoidable rehospitalizations, and allow individuals to
27 live and receive services in the setting of their choice.
28 b. The state shall require managed care organizations
29 to have in place nursing facility diversion programs. The
30 state shall provide for the use of incentives in managed care
31 contracts for transition of consumers from a nursing facility
32 to home and community-based services.
33 12. The state shall ensure a sufficient and sustainable
34 state infrastructure for monitoring managed care organizations.
35 There shall be sufficient resources for the state to evaluate

1 contractually required quality reports and financial reports,
2 evaluate the impact or effectiveness of incentive programs,
3 conduct quality-focused audits, provide quality-related
4 technical assistance, validate that managed care organization
5 corrective actions have been implemented, analyze quality
6 findings and develop reports to assess quality trends and
7 to identify areas for improvement, develop, implement, and
8 evaluate performance improvement projects, solicit and analyze
9 consumer feedback, and investigate and follow up on critical
10 incident events.
11 13. Managed care contracts shall require that a portion
12 of the savings achieved by a managed care organization be
13 reinvested in innovations and longer-term community investments
14 to address population health, infrastructure, the healthcare
15 workforce, and improved service delivery and capacity.
16 14. a. The state shall ensure that savings achieved
17 through Medicaid managed care does not come at the expense
18 of further reduction in already inadequate provider rates.
19 The state shall ensure that managed care organizations use
20 reasonable reimbursement standards for all provider types and
21 compensate providers for covered services at not less than
22 current Medicaid fee-for-service levels, as determined in
23 conjunction with actuarially sound rate setting procedures.
24 Such reimbursement shall extend for the entire duration of a
25 managed care organization's contract.
26 b. The state shall address rate setting and reimbursement
27 of the entire scope of services provided under the Medicaid
28 program to ensure the adequacy of the provider network and to
29 ensure that providers that contribute to the holistic health
30 of the consumer, whether inside or outside of the provider
31 network, are compensated for their services.
32 c. The state shall ensure that managed care organizations do
33 not arbitrarily deny coverage for medically necessary services
34 solely based on financial reasons.
35 15. a. In order to provide adequate access to care for

1 vulnerable Iowans, managed care organizations shall extend
2 nonemergency transportation services to all consumers.
3 b. The state shall ensure that dental coverage, if not
4 integrated into an overall managed care contract, is provided
5 and is part of the overall integrated coverage for physical,
6 behavioral, and long-term services and supports provided to a
7 Medicaid consumer.
8 c. The state shall ensure that the existing formulary for
9 pharmacy benefits under the Medicaid state plan is honored and
10 continued.
11 d. Managed care plans shall ensure consumers receive
12 services and supports in the amount, duration, scope, and
13 manner as identified through the person-centered assessment and
14 service planning process.
15 16. a. The state shall utilize the application of
16 liquidated damages in contracts to be paid from moneys other
17 than those paid by the state to hold managed care organizations
18 accountable regarding such provisions as timely claims
19 processing and claims payment accuracy, compliance with
20 licensure and background check requirements, timely provision
21 of an approved service, continuation of benefits pending
22 appeal, timely development of a plan of care, initiation
23 of long-term services and supports, and completion of care
24 coordination contacts.
25 b. The state shall review and approve or deny approval
26 for contract amendments on an ongoing basis to provide for
27 continuous improvement in Medicaid managed care.
28 Sec. 3. EFFECTIVE UPON ENACTMENT. This Act, being deemed of
29 immediate importance, takes effect upon enactment.
30 EXPLANATION
31 The inclusion of this explanation does not constitute agreement with
32 the explanation's substance by the members of the general assembly.
33 This bill relates to Medicaid program transformation.
34 The bill establishes the Medicaid transformation and
35 oversight commission, to provide for legislative involvement

1 and oversight and ensure stakeholder input, consumer
2 protection, and quality assurance in the transformation of the
3 Medicaid program. The membership of the commission consists
4 of the co-chairpersons and ranking members of the legislative
5 joint appropriations subcommittee on health and human services,
6 or a member of the joint appropriations subcommittee designated
7 by the respective co-chairperson or ranking member; the
8 chairpersons and ranking members of the human resources
9 committees of the senate and house of representatives, or a
10 member of the respective committee designated by the respective
11 chairperson or ranking member; and the chairpersons and
12 ranking members of the appropriations committees of the senate
13 and house of representatives, or a member of the respective
14 committee designated by the respective chairperson or ranking
15 member. The bill provides that the members are to receive
16 a per diem, and that the commission shall meet at least
17 quarterly, but may meet as necessary. The commission may use
18 sources of information deemed appropriate, and the department
19 of human services and other agencies of state government are
20 required to provide information to the commission as requested.
21 The legislative services agency will provide staff support to
22 the commission. The commission is to select a chairperson,
23 annually, from its membership and a majority of the members
24 of the commission constitute a quorum. The bill authorizes
25 the commission to contract for the services of persons who are
26 qualified by education, expertise, or experience to advise,
27 consult with, or otherwise assist the commission in the
28 performance of its duties, and provides that the commission
29 may specifically enlist the assistance of entities such as the
30 university of Iowa public policy center to provide ongoing
31 evaluation of the Medicaid program and to make evidence-based
32 recommendations to improve the program.
33 The bill specifies the duties of the commission including:
34 to provide overall long-term and real-time guidance for the
35 Medicaid program, addressing provider access and workforce

1 adequacy, providing for consumer engagement, addressing
2 consumer choice and satisfaction, and providing for consumer
3 appeal and grievance procedures; reviewing and making
4 recommendations regarding reimbursement and rate setting to
5 ensure adequate compensation for all providers of services
6 and supports to the Medicaid population, an adequate provider
7 network, and timely access to services for consumers; defining
8 the desired outcomes and the metrics by which improvement is
9 determined; ensuring that care coordination and case management
10 are provided in a patient-centered manner; and addressing
11 health information technology and data collection and sharing.
12 The commission is required to submit a report of findings and
13 recommendations to the governor and the general assembly by
14 January 15, annually.
15 The bill also specifies directives for the transition to
16 Medicaid managed care. The directives relate to overall
17 policy and planning, transition of Medicaid members to
18 managed care, appeals and grievance procedures, consumer
19 protections, stakeholder input, provider networks and access,
20 uniform processes, conflict-free consumer choice, education,
21 enrollment and disenrollment, care coordination, state agency
22 readiness and infrastructure, the use of savings by managed
23 care organizations, health care delivery alternatives,
24 required benefits, metrics and outcomes, and penalties for
25 noncompliance.