

APPENDICES

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Appendix A

Specifications for the Annual Rule 9-03 Data Filings

Introduction

Appendix A is designed to assist Managed Care Organizations (MCOs) in preparing for the annual March 31st and July 15th data filings required under Vermont Rule H-2003-09 (“Rule 9-03”). This appendix contains instructions for these two filings, as well as copies of forms and checklists designed to assist MCOs in assuring that all filing requirements are met.

As specified in Section 6.6(B), each MCO must file a copy of its quality improvement work plan with the Department by March 31st. The contents of the quality improvement work plan, as specified in Section 6.3(C), are as follows:

- “a written description of clinical and administrative quality improvement activities, including
 - improvement goals and attendant measures,
 - project timelines,
 - accountable persons,
 - data collection activities and how the activities meet objectives of the quality management program.
- the quality improvement goals agreed upon with the Department (or, at the discretion of the Department, selected by the managed care organization) and reported to the Department under Section 6.4(B).”

In addition, MCOs are also required to submit joint quality improvement goals as outlined in 6.3(D).

Reporting requirements for July 15th are specified in Section 6.6(B)(1) through (15) of Rule H-2009-03. These reporting requirements are explained in the remainder of Appendix A and are organized by type and source of data: HEDIS[®], CAHPS[®], and Rule 9-03-specific measurement requirements. Data submission tables developed by the Department for use by the MCOs are available as Excel spreadsheets.

At the end of Appendix A are two checklists to further assist in preparing the July filing – one for Managed Mental Health Care Organizations and a separate one for non-Managed Mental Health Care organizations.

A. HEDIS[®] Data Filing

HEDIS data submissions are required to meet the filing requirements specified in the following sections of Rule H-2009-03:

- 6.6(B)2
- 6.6(B)3
- 6.6(B)5
- 6.6(B)9
- 6.6(B)13

The Department's filing requirements are updated annually and track with the changes published in the most current NCQA HEDIS[®] Volume 2: Technical Specifications. The Department's requirements also reflect NCQA's annual rotation of reported measures. NCQA typically finalizes HEDIS[®] measures in October of each year. MCOs must submit HEDIS[®] data for their Vermont members only.

HEDIS[®] data may be filed using either the tables included in Appendix A or the NCQA IDSS report (exported into Excel), so long as the measures are based on Vermont member data only and include all required information. HEDIS RRU[®] measures must be reported in an XML format.

As of 2010, Managed Mental Health Care Organizations are required to submit only the following HEDIS[®] measure:

- Mental Health Utilization - % of members receiving any services, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED services

All MCOs must provide verification that NCQA specifications were followed by submitting one of the following:

- HEDIS Compliance Audit;
- attestation from vendor, or
- vendor certification from NCQA.

The table on the following page lists the HEDIS[®] measures required for the next July 15 data filing. This table may be used as a checklist to assist in preparing an MCO's filing. This listing of required HEDIS[®] measures is repeated within the checklist at the end of this appendix. A copy of the checklist with each submitted data item checked off **must be submitted** as part of the MCO's filing.

HEDIS[®] Measures for July 15, 2012

Effectiveness of Care Measures:	
	Table ABA-1/2/3: Adult BMI Assessment
	Table WCC-1/2: Weight Assessment/Counseling for Children/Adolescents
	Table CIS 1/2: Childhood Immunization Status
	Table AIM 1/2: Immunizations for Adolescents
	Table HPV 1/2: Human Papillomavirus Vaccine for Female Adults
	Table BCS-1/2/3: Breast Cancer Screening
	Table CCS-1/2: Cervical Cancer Screening
	Table COL 1/2: Colorectal Cancer Screening
	Table CHL-1/2: Chlamydia Screening in Women
	Table CWP-1/2: Appropriate Testing for Children with Pharyngitis
	Table URI-1/2: Appropriate Treatment for Children with Upper Respiratory Infection
	Table AAB-1/2: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
	Table SPR-1/2/3: Use of Spirometry Testing in the Assessment of and Diagnosis of COPD
	Table PCE-1/2/3: Pharmacotherapy Management of COPD Exacerbation
	Table ASM-1/2/3: Use of Appropriate Medications for People with Asthma
	Table MMA - 1/2: Medication Management for People with Asthma
	Table CMC - 1/2/3: Cholesterol Management for Patients with Cardiovascular Conditions
	Table BPH-1/2/3: Persistence of Beta-Blocker Treatment after a Heart Attack
	Table CDC-1/2/3: Comprehensive Diabetes Care
	Table ART-1/2/3: Disease Modifying Anti-Rheumatic Drug Therapy for RA
	Table LBP-1/2: Use of Imaging Studies for Low Back Pain
	Table AMM-1/2/3: Antidepressant Medication Management
	Table ADD-1/2: Follow-up Care for Children Prescribed ADHD Medication
	Table FUH-1/2/3: Follow-up After Hospitalization for Mental Illness
	Table MPM-1/2/3: Annual Monitoring for Patients on Persistent Medications
	Aspirin Use and Discussion (ASP) (2-year rolling average--CAHPS)
	Medical Assistance with Smoking and Tobacco Use Cessation (2-year rolling average--CAHPS)
	Flu Shots for Adults Ages 50-64 (2-year rolling average--CAHPS)
Access/Availability of Care:	
	Table AAP-1/2/3: Adults' Access to Preventive/Ambulatory Health Services
	Table CAP-1/2: Children's and Adolescents' Access to Primary Care Practitioners
	Table IET-1/2/3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	Table CAT: Call Answer Timeliness
	Table CAB: Call Abandonment
Use of Services:	
	Table W15-1/2/3: Well-Child Visits in the First 15 Months of Life
	Table W34-1/2: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
	Table AWC-1/2: Adolescent Well-Care Visits
	Table FSP-1&2: Frequency of Selected Procedures
	Table AMB-2/3: Ambulatory Care
	Table IPU-2/3: Inpatient Utilization General Hospital/Acute Care
	Table IAD-1/2/3: Identification of Alcohol and Other Drug Services
	Table MPT-1/2/3: Mental Health Utilization
	Table ABX-1/2/3: Antibiotic Utilization
	Table PCR - 2/3 Plan All-Cause Readmissions
Relative Resource Use:	
	Relative Resource Use for People with Diabetes (RDI) ¹
	Relative Resource Use for People with Asthma (RAS)

¹ For 2011 NCQA has changed the method for reporting Relative Resource Measures and requires the submission of XML data through the IDSS and no longer provides a visual presentation of the data. As such the Department cannot provide Excel tables for this submission. MCOs should provide RRU data in XML format to NCQA.

HEDIS[®] Measures for July 15, 2012	
	Relative Resource Use for People with Cardiovascular Conditions (RCA)
	Relative Resource Use for People with Uncomplicated Hypertension (RHY)
	Relative Resource Use for People with COPD (RCO)
Health Plan Descriptive Information:	
	Table ENP-2: Member Months of Enrollment by Age and Sex (Specify Product)

B. CAHPS® Data Filing

CAHPS® data submissions are required to meet the filing requirements specified in Section 6.6(B)11 of Rule H-2009-03:

All Non-Managed Mental Health Care Organizations must file the results of the CAHPS® Health Plan Survey, 4.0H Adult Version.

MCOs are to report survey results for Vermont members only.

The CAHPS® survey must have been administered during the year in which it is submitted to the Department as part of the annual data filing requirements. The survey must be administered by an NCQA-certified vendor according to the most current NCQA CAHPS® survey administration and reporting protocols. Each MCO must include with its filings any one of the following three documents as evidence that this requirement has been met:

- a document from its NCQA-certified vendor attesting that in administering the surveys it followed NCQA specifications for sample selection, survey administration and data analysis;
- a certificate from NCQA certifying the vendor to be an NCQA-approved vendor, or
- a copy of the NCQA compliance audit.

MCOs may submit their results using tables included in this appendix or using NCQA banner tables. If banner tables are used, the submission must include each of the data items specified in the tables for each of the required questions.

The Department has provided the following four tables to assist MCOs in reporting CAHPS® results:

- CAHPS® Table 1: Demographics
- CAHPS® Table 2: Overall Ratings
- CAHPS® Table 3: Composite Table
- CAHPS® Table 4: Care Management Questions Table

These four tables are available as Excel spreadsheets.

C. Utilization Review Decisions Data Filing

Utilization review data submissions are required to meet the filing requirements specified in Section 6.6(B)8 of Rule 9-03.

UR data shall be submitted for dates covering the prior calendar year; that is, for a July 2011 submission, UR data must cover calendar year 2010.

The following are the categories of UR decision and the timeframes within which decisions must be made to be in compliance with Rule 9-03.

<u>UR Category</u>	<u>Rule 9-03 Timeframe</u>
• concurrent review	<1 day
• urgent, pre-service review	≤72 hours
• non-urgent, pre-service review	≤15 days
• post service review	≤30 days

Reporting must be in terms of calendar days.

In calculating timeframes by which decisions have been made, MCOs should consider the following clarifications regarding how timeframes are calculated:

Pre-service urgent reviews

Section 3.2(D) allows the MCO a total of 72 hours to make a decision. If the MCO gives the member/provider additional time to supply additional requested information, the 72-hour countdown stops while the MCO waits for the member/provider to supply the requested information. Therefore, if a member is notified at hour 24 that additional information is needed, 48 hours remain of the 72-hour time period. When the MCO receives the additional information, the clock starts up again, giving the MCO 48 hours to render a decision.

Pre-service non-urgent reviews

Section 3.2(E) allows the MCO a total of 15 days to render a decision under ordinary circumstances and 30 days if the MCO is facing circumstances beyond its control, including needing additional information from the member/provider. The section also provides the member/provider with at least 45 days to provide the additional needed information. The decision time clock stops as soon as the MCO requests additional information from the member or provider. The clock will commence where it left off as soon as the MCO receives the additional information. Therefore, if an MCO tells a member on day five that additional information is needed, once the additional information is received, the MCO will have 25 days (10 days from the initial timeframe and a 15 day extension) to render a decision.

Post-service reviews

Section 3.2(F) allows the MCO a total of 30 days to render a decision under ordinary circumstances and 45 days if the MCO is facing circumstances beyond its control. As in Section 3.2(E), this section also requires MCOs to give members/providers at least 45 days to provide additional needed information. The decision time clock must stop at the time the member is notified of the need for additional information and commences as soon as the information is received. For example, if an MCO tells a member on day 15 that additional information is needed, the MCO will have 30 days (15 days from the initial timeframe and a 15 day extension) to render a decision once the requested information is received.

Sampling options

MCOs may report any or all of the four UR measures based on a randomly drawn sample or on the entire population of reviews. If using a sample, the sample size must be at least 60 denials within the category being measured. If during the reporting year the MCO had fewer than 60 denials within the category being measured, the MCO must report on the entire population of denials, and then randomly sample from approvals within the category being measured until the total number of reported reviews equals 60.

Sampled reviews should include reviews conducted for both inpatient and outpatient services. The precise sampling methodology is left to the MCO's discretion providing that it results in the defined random sample as described above.

D. Grievance Review Data Filing

Grievance review data submissions are required to meet the filing requirements specified in Section 6.6(B)7 of Rule 9-03.

Beginning July 2011, grievance data shall be reported for the prior calendar year (January 1 – December 31).

Grievance tables and registries

To assist in the reporting of grievances the Department has developed the following three tables:

- Table 2: Grievance Frequency and Outcome
- Table 3: Grievance Resolution Process - Days to Make a Decision from the Date on which the Grievance was Received
- Table 4: Number and Percent of Grievances per Member

The categories of grievances and the levels of grievances to be reported are specified in Tables 2 and 3. There is no differentiation between physical health and mental health/substance abuse grievances for reporting purposes when the grievances are unrelated to an adverse benefit determination. Pharmacy grievances must be included in grievance reporting.

In addition to submitting the required tables, MCOs are required to submit grievance registers that contain the following information:

- unique identifying number;
- general description of grievance;
- date grievance received by MCO;
- dates of review and hearing;
- whether grievance was resolved at first level or required second level review;
- date all necessary information was received in event of extension, and
- grievance resolution & date of resolution.

Examples of Grievances

The following scenarios provide examples of the application of the definitions of grievance stated above. The scenarios are presented in no particular order.

	Grievance yes/no	Scenario	Reason/Grievance Type
1	Yes	A member calls to request reconsideration of a denial of service because no PA was obtained.	Yes, because member is requesting reconsideration of a denial. <i>(Grievance concerning service denials or coverage)</i>
2	No	A member calls to ask why services coverage was denied and learns that PA was required. Member accepts explanation.	Member did not request further recourse.
3	Yes	A member calls about a claim denial issue related to service coverage, and requests that the claim be covered.	Yes, further recourse is requested. <i>(Grievance concerning service denials or coverage)</i>
4	Yes	A member calls to make a request for reconsideration of a decision to approve only a partial coverage of services requested. (Member does not know the reason for denial).	Yes, if MCO accepts oral grievances. Member requests plan recourse about a denial. <i>(Grievance concerning service denials or coverage)</i>
5	No	A member calls to inquire why there was a claims payment denial and learns it was due to use of an unauthorized out-of-network provider. Member understands.	No recourse sought.
6	Yes	A member calls about a claim denial issue related to an error on the claim and requests that it be fixed. The MCO is unable to resolve the error during the call. In the same scenario, if the issue is resolved on the phone, it is not a grievance because no further recourse is sought after the initial call.	Yes, recourse sought. <i>(Grievance Unrelated to an Adverse Benefit Determination: plan administrative performance)</i>
7	No	During a follow-up call about a claim denial issue, the MCO explains that the claim was paid erroneously due to MCO error, and the member expresses satisfaction with the result.	Member requests no further action.
8	Yes	During a follow-up call two months later when the MCO explains that the claim was paid erroneously due to MCO error, the member expresses dissatisfaction with how MCO handled this issue and how long it took to do so and wants recourse, e.g., member requests that his unhappiness be noted by the MCO and MCO staff manager be notified.	Yes, member requests further recourse. Date of receipt of grievance is date of this follow-up call to member. Time between initial member contact and resolution call is immaterial. Only the member's expression of dissatisfaction is material. <i>(Grievance unrelated to an adverse benefit determination: plan administrative performance)</i>
9	No	Member calls to find out if specific services are covered, learns they are not. Member is not happy to hear this, but accepts the explanation.	Member did not ask for any further recourse.
10	Yes	Member calls to find out if specific services are covered, learns they are not. Member is not happy to hear this, and asks to pursue the MCO making an exception.	Yes, member seeks further recourse from the MCO. <i>(Grievance concerning service denials or coverage)</i>

	Grievance yes/no	Scenario	Reason/Grievance Type
11	Yes	Member sends a letter expressing dissatisfaction that does not necessarily include the words “grievance” or “appeal.”	Dissatisfaction expressed in writing. <i>(Type of grievance will depend on letter content)</i>
12	No	Member calls CEO to express dissatisfaction, and issue is resolved between member and CEO (this could include CEO transferring call to member services).	CEO resolves or transfers call to member services where grievance calls are logged. Member services will handle it and will log it as a grievance if content warrants.
13	Yes	Member calls to express dissatisfaction about physician balance billing, but does not necessarily use the words, “grievance,” “complaint” or “appeal. The member wants the MCO to contact the physician.	Yes, because member is seeking recourse. <i>(Grievance unrelated to an adverse benefit determination: grievance about provider performance)</i>
14	Yes	Member calls to complain that member ID card has not arrived in the mail and wants to receive it.	Yes, member is seeking recourse. <i>(Grievance unrelated to an adverse benefit determination: grievance about plan administration)</i>
15	No	MCO’s sales rep is at a health fair and talks to a current member who says that she is thinking of switching to a new MCO because of problems around physician billing.	Member not seeking recourse from sales rep.
16	Yes	Member calls to complain about a provider’s rude office staff. Member insists that the MCO registers the complaint.	Yes, member is seeking recourse. <i>(Grievance unrelated to an adverse benefit determination: grievance about provider performance)</i>
17	Yes	Member writes to express anger at how long it took the MCO to address a concern about a claim error that resulted in an inappropriate denial.	Yes. <i>(Grievance unrelated to an adverse benefit determination: grievance about plan performance)</i>
18	Yes	Member writes to request a reconsideration of a denial of a covered service she received out of network.	Yes. <i>(Grievance about a service denial not requiring expedited review)</i>
19	Yes	Member writes to tell the MCO about how unhappy she is with the treatment she is receiving from her PCP and his office staff.	Yes. <i>(Grievance unrelated to an adverse benefit determination: grievance about provider performance)</i>
20	Yes	Member writes to complain that there are too few choices of a particular specialty type provider in her geographic area.	Yes. <i>(Grievance unrelated to an adverse benefit determination: grievance about access)</i>
21	Yes	Member calls to request an expedited review of a service denial.	Yes, oral expression of dissatisfaction is request for expedited review. <i>(Grievance about a service denial requiring expedited review)</i>

E. Annual Provider Satisfaction Survey Data Filing

Provider satisfaction survey data submissions are required to meet the filing requirements specified in Section 6.6(B)11 of Rule 9-03.

All MCOs must submit the results of an annual survey of, at a minimum, a sample of network providers. Rule 9-03 states that MCOs must use a standardized state-approved survey instrument. The Department has provided a core set of standard questions for the provider satisfaction survey. MCOs are expected to use at least this minimum set of standardized questions in their provider satisfaction surveys.

MCOs must also summarize any corrective actions taken based on the MCO's prior year provider satisfaction survey.

The questions should be scored on a five point scale with the following responses:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

The questions are:

1. Overall, I am satisfied with [MCO].
2. I would recommend [MCO] to other practitioners and to my patients.
3. [MCO's] staff is responsive when I need assistance.
4. [MCO's] quality of communications, such as care management tools, policy bulletins and manuals, is adequate.
5. [MCO] provides adequate support to patients with chronic conditions, or other serious illness.
6. [MCO's] prescription drug formulary is adequate.*
7. The amount of time spent obtaining [MCO] pre-approval for select prescription drugs is appropriate.*
8. The amount of time spent obtaining [MCO] pre-approval for services (other than prescription drugs) for my patients is appropriate.
9. I have adequate access to [MCO's] Vermont utilization management department (e.g., when coverage for a service has been denied).
10. [MCO's] reimbursement levels are adequate.
11. [MCO's] claims payments are timely.
12. [MCO's] claims processing is accurate.
13. There are an adequate number and breadth of practitioners in [MCO's] network when I need to refer patients for other services.

* Not applicable to managed mental health care organizations. Managed mental health care organizations also do not need to include "(other than prescription drugs)" in question #8 in their surveys.

F. Access: Travel Time Data Filing

Access data submissions, measured in terms of travel times to provider offices or facilities, are required to meet the filing requirements specified in Section 6.6(B)1 of Rule 9-03.

The travel time standards, detailed in Section 5.1(A) of Rule 9-03 are as follows:

<u>Provider Type</u>	<u>Travel Time Standard</u>
• Primary Care Provider	30 minutes
• Mental health/Substance Abuse (routine)	30 minutes
• Outpatient specialty care	60 minutes
• Intensive outpatient, partial hospitalization, residential or inpatient MH/SA services	60 minutes
• Laboratory	60 minutes
• Pharmacy	60 minutes
• General optometry	60 minutes
• Inpatient services	60 minutes
• Imaging	60 minutes
• Inpatient medical rehabilitation services	60 minutes
• Kidney transplantation	90 minutes
• Major trauma treatment	90 minutes
• Neonatal intensive care	90 minutes
• Tertiary-level cardiac services	90 minutes

The report shall include data on travel in terms of minutes, not mileage. When calculating travel time, the following assumptions regarding travel speed must be used: in urban areas – 25 mph; in suburban areas – 40 mph; in rural areas – 50 mph. These are the default values used by GeoAccess software to calculate travel times.

All geographic access reports for MCOs must be reported separately by county and at an aggregate state level. MCOs should not submit reports by town or zip code.

MCO are required to submit access reports on the following provider types annually:

Access within 30 minutes:

- Adult PCPs
- Pediatric PCPs
- Outpatient mental health and substance abuse services

For Adult PCPs and Pediatric PCPs reporting requirements only, MCOs should consider any member to be a “child” until the member’s 20th birthday.

Access within 60 minutes:

- Outpatient physician specialty care (specific specialties rotate annually – see checklist for current requirements)
- Intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services

MCO are required to submit access reports on the following provider types on a rotating basis. The specific provider types are identified in the annual checklist update:

Access within 60 minutes:

- Laboratory
- Pharmacy
- General optometry
- Inpatient
- Imaging
- Inpatient medical rehabilitation services

Access within 90 minutes:

- Kidney transplantation
- Major trauma treatment
- Neonatal intensive care
- Tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery

With respect to measures relative to travel to primary care services, MCOs must follow these guidelines:

- The report must include only primary care practices with open panels (i.e., practices are accepting new patients).
- MCOs must run separate reports for adult primary care and pediatric primary care providers.
- Measurement of adult primary care access must include internists and family practitioners and may include OB/Gyns, but only if they are actively serving MCO members in the capacity of a primary care provider.
- Measurement of pediatric care access should include pediatricians and family practitioners.
- MCOs must report information on network composition any time between April 1st and June 30th of the year in which the report is being filed.
- Health centers and clinics are not to be considered providers as part of the geographic access report. Instead, all individual practitioners, regardless of work location (e.g., private office, group practice, clinic), are to be included in the report.

With respect to travel time to outpatient mental health and substance abuse services, MCOs must:

- Report access to mental health and substance abuse services separately and also separately by provider type (e.g. inpatient, intensive outpatient/partial hospitalization, and outpatient/emergency department). HEDIS[®] definitions are to be used for all terms.
- Report by professional credentials for outpatient mental health services. Include master's level trained psychologists with other master's level trained professionals, such as licensed clinical social workers. Exclude ED facilities from this portion of the analysis.
- When reporting travel time to outpatient/ED mental health services, MCOs operating special integrated programs to serve dually diagnosed patients may report the programs serving this population in both the mental health and the substance abuse categories. This is also the case for other provider organizations that include both substance abuse and mental health treatment specialists on their staffs.

G. Access: Waiting Time Data Filing

Access data submissions, measured in terms of waiting times for provider services, are required to meet the filing requirements specified in Section 6.6(B)1 of Rule 9-03.

The waiting time standards, delineated in Rule 9-03, Section 5.1(B), are as follows:

<u>Service Type</u>	<u>Waiting Time Standard</u>
• Emergency services	Immediately
• Urgent care	24 hours
• Non-emergency, non-urgent care	2 weeks
• Preventive care	90 days
• Routine lab, imaging, general optometry, and all other routine services	30 days

With respect to appointment waiting time, MCOs may elect to:

- use MCO-defined data collection methods for assessing performance against Rule 9-03 appointment wait time requirements, or
- sample their membership rather than report information for their entire membership, provided that the MCO provides a written description of the sampling methodology when submitting its survey results.

MCOs are required to report on the following categories for physical health care services:

- Emergency care;
- Urgent care;
- Non-emergency, non-urgent care;
- Preventive care and routine physical examinations, and
- Routine laboratory, imaging, general optometry.

MCOs are required to report on the following categories for mental health/substance abuse services:

- Emergency care;
- Urgent care, and
- Non-emergency, non-urgent care.

Waiting time for mental health and substance abuse services must be distinguished and reported separately from waiting time for physical health care.

H. Current and Terminated Providers Data Filing

Data submissions regarding provider-initiated and plan-initiated terminations are required to meet the filing requirements specified in Section 6.6(B)10 of Rule 9-03.

MCOs must list all provider-initiated and plan-initiated terminations between January 1st and December 31st of the measurement year.

- Providers should not be considered “terminated” if they have died, retired or relocated.
- MCOs must group terminated contracts by MCO-defined categories of “reasons for termination” such as “documented quality problem” or “unwillingness to adhere to MCO UR and referral policies.”
- The precise reason for termination must be indicated.
- The type of provider must be specified.

I. Provider Directories

Submission of provider directories is required to meet the filing requirements specified in Section 6.6(B)10 of Rule 9-03.

Provider directories may be submitted in hard copy or in electronic copy.

J. Delegated Functions

MCOs are required to submit information regarding delegated functions. Requirements are specified within Section 6.6(B)15 of Rule 9-03.

MCOs that delegate functions to contracted providers must submit information in Table 5: List of Delegated Functions.

K. Coordination and Continuity of Care Indicators

Data submissions regarding coordination and continuity of care indicators are required to meet the filing requirements specified in Section 6.6(B)4.

MCOs should submit data for the HEDIS® measure Plan All-Cause Readmissions (Table PCR – 2/3) to meet this requirement. This measure is included in the checklist under HEDIS® measures Use of Services.

L. Blueprint for Health Data Filing

MCO are required to submit data on specific measures to assess provider adoption and MCO support for Blueprint for Health concepts to meet Section 6.6(B)6 requirement of Rule 9-03:

1. Percent of contracted primary care providers (PCPs) receiving enhanced payment to support medical home operation.
 - The numerator for this measure is the number of contracted PCPs receiving enhanced payment to support medical home operations. The denominator for this measure is the total number of contracted PCPs in the network. MCOs are required to report this information in Table 6.
2. Per member per month (PMPM) value of enhanced practice payments to support medical home operation.
 - MCOs should report the total PMPM value of the enhanced practice payments they are making to support medical home operations. Total PMPM value should be calculated as the total enhanced practice payments over the total member months. MCOs are required to report this figure in Table 7.
3. Names and the percentage of Vermont Hospital Service Areas where the MCO is making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms
 - MCOs should indicate the Vermont Hospital Service Areas (VSAs) to which they are making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms by putting a “Y” next to the relevant HSA. They should then calculate what percentage of all Vermont HSAs are receiving such payments. MCOs are required to report this in Table 8.

CHECKLIST FOR NON-MANAGED MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING

<p>HEDIS®</p>	<p>Effectiveness of Care Measures:</p> <p>___ Table ABA-1/2/3: Adult BMI Assessment</p> <p>___ Table WCC-1/2: Weight Assessment/Counseling for Children/Adolescents</p> <p>___ Table CIS 1/2: Childhood Immunization Status</p> <p>___ Table AIM-1/2: Immunizations for Adolescents</p> <p>___ Table HPV 1/2: Human Papillomavirus Vaccine for Female Adults</p> <p>___ Table BCS-1/2/3: Breast Cancer Screening</p> <p>___ Table CCS-1/2: Cervical Cancer Screening</p> <p>___ Table COL 1/2: Colorectal Cancer Screening</p> <p>___ Table CHL-1/2: Chlamydia Screening in Women</p> <p>___ Table CWP-1/2: Appropriate Testing for Children with Pharyngitis</p> <p>___ Table URI-1/2: Appropriate Treatment for Children with Upper Respiratory Infection</p> <p>___ Table AAB-1/2: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</p> <p>___ Table SPR-1/2/3: Use of Spirometry Testing in the Assessment of and Diagnosis of COPD</p> <p>___ Table PCE-1/2/3: Pharmacotherapy Management of COPD Exacerbation</p> <p>___ Table ASM-1/2/3: Use of Appropriate Medications for People with Asthma</p> <p>___ Table MMA - 1/2: Medication Management for People w/ Asthma</p> <p>___ Table CMC - 1/2/3: Cholesterol Management for Patients with Cardiovascular Conditions ___</p> <p>___ Table BPH-1/2/3: Persistence of Beta-Blocker Treatment after a Heart Attack</p> <p>___ Table CDC-1/2/3: Comprehensive Diabetes Care</p> <p>___ Table ART-1/2/3: Disease Modifying Anti-Rheumatic Drug Therapy for RA</p> <p>___ Table LBP-1/2: Use of Imaging Studies for Low Back Pain</p> <p>___ Table AMM-1/2/3: Antidepressant Medication Management</p> <p>___ Table ADD-1/2: Follow-up Care for Children Prescribed ADHD Medication</p> <p>___ Table FUH-1/2/3: Follow-up After Hospitalization for Mental Illness</p> <p>___ Table MPM-1/2/3: Annual Monitoring for Patients on Persistent Medications</p> <p>___ Aspirin Use and Discussion (ASP) (2-year rolling average--CAHPS)</p> <p>___ Medical Assistance with Smoking Cessation (2-year rolling average--CAHPS)</p> <p>___ Flu Shots for Adults Ages 50-64 (2-year rolling average--CAHPS)</p> <p>Access/Availability of Care:</p> <p>___ Table AAP-1/2/3: Adults' Access to Preventive/Ambulatory Health Services</p> <p>___ Table CAP-1/2: Children's and Adolescents' Access to Primary Care Practitioners</p> <p>___ Table IET-1/2/3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</p> <p>___ Table CAT: Call Answer Timeliness</p> <p>___ Table CAB: Call Abandonment</p> <p>Satisfaction with the Experience of Care:</p> <p>___ HEDIS/CAHPS 4.0H: Adult survey</p> <p>___ Mental health/substance abuse member satisfaction survey required by Act 129</p>	<p>___ HEDIS Submission Tool</p> <p>___ Verification that NCQA specifications were followed: ___ HEDIS Compliance Audit, or ___ Attestation from vendor, or ___ Vendor certification from NCQA</p>
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CHECKLIST FOR NON-MANAGED MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING

<p>HEDIS®</p>	<p>Use of Services:</p> <p>___ Table W15-1/2/3: Well-Child Visits in the First 15 Months of Life</p> <p>___ Table W34-1/2: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life</p> <p>___ Table AWC-1/2: Adolescent Well-Care Visits</p> <p>___ Table FSP-1&2: Frequency of Selected Procedures</p> <p>___ Table AMB-2/3: Ambulatory Care</p> <p>___ Table IPU-2/3: Inpatient Utilization General Hospital/Acute Care</p> <p>___ Table IAD-1/2/3: Identification of Alcohol and Other Drug Services</p> <p>___ Table MPT-1/2/3: Mental Health Utilization</p> <p>___ Table ABX-1/2/3: Antibiotic Utilization</p> <p>___ Table PCR – 2/3 Plan All-Cause Readmissions</p> <p>Relative Resource Use²:</p> <p>___ Relative Resource Use for People with Diabetes (RDI)</p> <p>___ Relative Resource Use for People with Asthma (RAS)</p> <p>___ Relative Resource Use for People with Cardiovascular Conditions (RCA)</p> <p>___ Relative Resource Use for People with Uncomplicated Hypertension (RHY)</p> <p>___ Relative Resource Use for People with COPD (RCO)</p> <p>Health Plan Descriptive Information:</p> <p>___ Table ENP-2: Member Months of Enrollment by Age and Sex (Specify Product)</p>	
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² For 2011 NCQA has changed the method for reporting Relative Resource Measures and requires the submission of XML data through the IDSS and no longer provides a visual presentation of the data. As such the Department cannot provide Excel tables for this submission. MCOs should provide RRU data in XML format.

CHECKLIST FOR NON-MANAGED MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING

<p>Access: Travel Time</p> <p>Access to outpatient MH and CD facilities</p>	<p>Verify (check) that each parameter is met: _____ access to MH and CD providers are reported separately</p>	<p>Two separate GeoAccess reports for each of the following (one representing the entire Vermont service area and one depicting access by county)</p> <p>Outpatient/ED mental health by provider type within 30 minutes</p> <p>VT County</p> <p>_____ psychiatrist</p> <p>_____ psychologist (doctoral level only)</p> <p>_____ master of social work and other master's level (including all master's level psychologists)</p> <p>_____ all outpatient MH providers (single aggregate report of all the above categories of MH provider types)</p> <p>_____ all ambulatory CD providers (single aggregate report of all the above categories of CD provider types)</p>
<p>Access: Travel Time</p> <p>Access to specialty services</p>		<p>Separate GeoAccess reports for access within 60 minutes to each of the following services:</p> <p>Specialty service by provider type within 60 minutes</p> <p>VT County</p> <p>_____ pharmacy,</p> <p>_____ inpatient mental health,</p> <p>_____ inpatient chemical dependency,</p> <p>_____ intensive outpatient/partial hospitalization mental health providers</p> <p>_____ intensive outpatient/partial hospitalization chemical dependency providers</p> <p>selected outpatient specialty care specified by the Department. For the July 2012 filing, submit access reports for the following outpatient specialties:</p> <p>_____ Midwifery (Certified Nurse Midwife or Licensed Midwife</p> <p>_____ Otolaryngologists</p>

CHECKLIST FOR NON-MANAGED MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING

		<p>___ ___ Gastroenterologists</p>
<p>Access: Waiting Time</p>	<p>Waiting time is assessed separately for combined mental health/substance abuse services. Please check the methodology used for assessing waiting times:</p> <p>___ entire membership</p> <p>___ sampled membership</p> <p>___ if used a sample, verify that written description of sampling methodology was provided</p>	<p>Results of waiting time assessment for each of following services: (separate assessments should be provided for mental health/substance abuse and for physical health)</p> <p>Phy. MH/SA</p> <p>___ ___ urgent care</p> <p>___ ___ non-emergent, non-urgent care and follow-up</p> <p>___ <u>NA</u> preventive care (including routine physical exam)</p> <p>___ <u>NA</u> routine laboratory</p> <p>___ <u>NA</u> imaging</p> <p>___ <u>NA</u> general optometry</p>
<p>Grievances</p>	<p>MCOs should note that there is no differentiation between physical health and mental health/substance abuse services for reporting purposes for grievances unrelated to an adverse benefit determination.</p> <p>Grievance data should be submitted for the previous 12-month period (January 1–December 31).</p> <p>Pharmacy grievances must be included in grievance reporting.</p>	<p>___ Table 2: Grievance frequency and outcome</p> <p>___ Table 3: Grievance resolution process - days to make a decision</p> <p>___ Table 4: Number and percent of grievances per member</p> <p>___ Grievance Register</p> <p>Grievance register must contain:</p> <p>___ unique identifying number for each grievance</p> <p>___ general description of grievance</p> <p>___ date grievance received by MCO</p> <p>___ dates of review and hearing</p> <p>___ whether grievance was resolved at first level or required second level review</p> <p>___ date all necessary information was received in event of extension</p> <p>___ grievance resolution & date of resolution</p>

CHECKLIST FOR NON-MANAGED MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
Lists of Current and Terminated Providers		_____ list of terminated providers ³ (by MCO action) and reason for termination
Annual Provider Satisfaction Survey		_____ blank copy of provider satisfaction survey _____ results of provider satisfaction survey _____ summary of corrective actions taken based on prior year's provider satisfaction survey
Rule H-2009-03 Delegated Functions		_____ Table 5: List of Delegated Functions & Entities (provide effective dates for any newly delegated functions over the past reporting period)
Coordination and Continuity of Care Indicators		_____ HEDIS [®] Table PCR – 2/3 Plan All-Cause Readmissions (Included in HEDIS [®] section)

³ MCOs should only report on those providers whose contracts were terminated due to MCO action, and not those terminated due to retirement, death, those who choose to end contracts, or relocation outside of Vermont.

CHECKLIST FOR NON-MANAGED MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING

Blueprint for Health		<p>_____ Table 6: Percent of contracted PCPs receiving enhanced payment to support medical home operation</p> <p>_____ Table 7: PMPM value of enhanced practice payments to support medical home operation</p> <p>_____ Table 8: Names and the percentage of Vermont Hospital Service Areas where the MCO is making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms</p>
Material Changes	MCOs are required to submit information regarding material changes to policies, procedures, member communications, provider contracts or any other documents required by this rule.	_____ Material changes submitted

Checklist for MBHO

CHECKLIST FOR MANAGED MENTAL HEALTH CARE ORGANIZATION RULE 9-03 JULY 15TH DATA FILING		
HEDIS®	<input type="checkbox"/> MH Utilization - % of members receiving any services, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED services	<input type="checkbox"/> HEDIS Submission Tool <input type="checkbox"/> Verification that NCQA specifications were followed: <input type="checkbox"/> HEDIS® Compliance Audit, or <input type="checkbox"/> Attestation from vendor, or <input type="checkbox"/> Vendor certification from NCQA
Act 129 Mental Health/Substance Abuse Member Satisfaction Survey	See separate Department instructions regarding compliance with Act 129 for instructions on completing the mental health/ substance abuse member satisfaction survey	<input type="checkbox"/> survey and survey results
Access: Travel Time	Verify (check) that the parameter is met: <input type="checkbox"/> access to MH and CD providers are reported separately	Two separate GeoAccess reports for each of the following (one representing the entire Vermont service area and one depicting access by county) : Outpatient/ED mental health by provider type within 30 minutes, except as otherwise indicated: VT County <input type="checkbox"/> psychiatrist <input type="checkbox"/> psychologist (doctoral level only) <input type="checkbox"/> master social work and other masters level (including all masters level psychologists) <input type="checkbox"/> all outpatient MH providers (single aggregate report of all the above categories of MH provider types) <input type="checkbox"/> all ambulatory CD providers (single aggregate report of all the above categories of CD provider types) <input type="checkbox"/> intensive outpatient/partial hospitalization mental health providers within <u>60 minutes</u> <input type="checkbox"/> intensive outpatient/partial hospitalization chemical dependency providers within <u>60 minutes</u>

CHECKLIST FOR MANAGED MENTAL HEALTH CARE ORGANIZATION RULE 9-03 JULY 15TH DATA FILING

<p>Access: Waiting Time</p>	<p>Waiting time is assessed separately for combined mental health/substance abuse services. Please check the methodology used for assessing waiting times: <input type="checkbox"/> entire membership <input type="checkbox"/> sampled membership <input type="checkbox"/> if used a sample, verify that written description of sampling methodology was provided</p>	<p><input type="checkbox"/> results of waiting time assessment for the following service: <input type="checkbox"/> urgent care <input type="checkbox"/> non-emergent, non-urgent care and follow-up</p>
<p>UR Decisions</p>	<p>Please check the methodology used for generating the sample: <input type="checkbox"/> 60 prospective reviews, or <input type="checkbox"/> entire population of denials and then randomly sampled approvals until sample size equals 60</p> <p>Verify (check) that this parameter is met: <input type="checkbox"/> reporting is in terms of calendar days</p>	<p><input type="checkbox"/> Table 1: Time to make UR decisions from receipt of request</p>
<p>Grievances</p>	<p>Please note that grievance data should be submitted for the previous 12-month period (January 1– December 31).</p>	<p><input type="checkbox"/> Table 2: Grievance frequency and outcome <input type="checkbox"/> Table 3: Grievance resolution process - days to make a decision <input type="checkbox"/> Table 4: Number and percent of grievances per member</p> <p><input type="checkbox"/> Grievance Register</p> <p>Grievance register must contain: <input type="checkbox"/> unique identifying number for each grievance <input type="checkbox"/> general description of grievance <input type="checkbox"/> date grievance received by MCO <input type="checkbox"/> dates of review and hearing <input type="checkbox"/> whether grievance was resolved at first level or required second level review <input type="checkbox"/> date all necessary information was received in event of extension <input type="checkbox"/> grievance resolution & date of resolution</p>

CHECKLIST FOR MANAGED MENTAL HEALTH CARE ORGANIZATION RULE 9-03 JULY 15TH DATA FILING

Lists of Current and Terminated Providers		<input type="checkbox"/> Provider directory (hard copy or electronic) <input type="checkbox"/> list of terminated providers ⁴ (by MCO action) and reason for termination
Annual Provider Satisfaction Survey		<input type="checkbox"/> blank copy of provider satisfaction survey <input type="checkbox"/> results of provider satisfaction survey <input type="checkbox"/> summary of corrective actions taken based on prior year's provider satisfaction survey
Rule H-2009-03 Delegated Functions		<input type="checkbox"/> Table 5: List of Delegated Functions & Entities (provide effective dates for any newly delegated functions over the past reporting period)
Material Changes	MBHOs are required to submit information regarding material changes to policies, procedures, member communications, provider contracts or any other documents required by this rule.	<input type="checkbox"/> Material changes submitted

⁴ MCOs should only report on those providers whose contracts were terminated due to MCO action, and not those terminated due to retirement, death, those who choose to end contracts, or relocation outside of Vermont.

Appendix B - Part 1

Rule 9-03 Member Policy, Certificate and Handbook Checklist

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
2.2 (A) 1: The text shall be at least eleven-point font in hard copy;		
2.2 (A) 1: continued plain language at no greater than an eighth grade reading level, or less if required by law; <u>Clarification:</u> The Department accepts the Flesch-Kincaid Grade Level or the Flesch Reading Ease tests as appropriate tests of grade level.		
2.2 (A) 1: continued shall be organized in a way that is visually easy to read and use; and		
2.2 (A) 1: continued shall include a table of contents., and		
2.2 (A) 1: continued a definitions section.		
2.2 (A) 2: The documents shall be made available in hard copy,		
2.2 (A) 2: continued on the internet and		
2.2 (A) 2: continued in a format suitable for mailing;		
2.2 (A) 2: continued provided to each member in the format requested upon enrollment		
2.2 (A) 2: continued and upon any changes thereafter; and		
2.2 (A) 2: continued shall also be made available upon request to prospective members prior to enrollment.		
2.2 (A) 2: continued Information shall be provided to members regarding how to obtain necessary translation or interpretation of the document.		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
<p>2.2 (A) 3 and 3a.: At least the following information shall be contained in the policy form or certificate and, if a handbook is used, in the handbook. The health benefit plan's coverage provisions, including a clear description of the service area, if applicable,</p> <p><u>Clarification:</u> To meet this requirement, a handbook may reference the plan details included in the member Policy or Certificate. MCOs are not required to duplicate in the handbook the member information included in those documents.</p>		
<p>2.2 (A) 3: a. continued health care benefits,</p>		
<p>2.2 (A) 3: a. continued benefit maximums,</p>		
<p>2.2 (A) 3: a. continued benefit limitations,</p>		
<p>2.2 (A) 3: a. continued exclusions from coverage (including procedures deemed experimental or investigational by the managed care organization),</p>		
<p>2.2 (A) 3: a. continued restrictions on referral or treatment options,</p>		
<p>2.2 (A) 3: a. continued requirements for prior authorization,</p>		
<p>2.2 (A) 3: a. continued utilization review,</p>		
<p>2.2 (A) 3: a. continued notification of hospital admission or other member obligations to notify the managed care organization,</p>		
<p>2.2 (A) 3: a. continued the use of formularies, and</p>		
<p>2.2 (A) 3: a. continued any other limitations on the services covered under the member's enrollment plan.</p>		
<p>2.2 (A) 3: a. continued All plan materials, including a handbook if one is used, shall clearly explain the legal effect of each plan document.</p>		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
<p>2.2 (A) 3: b. If prior authorization or utilization review is required before obtaining treatment or services, the process the member must use to obtain that authorization or review,</p>		
<p>2.2 (A) 3: b. continued including any time lines that apply and</p>		
<p>2.2 (A) 3: b. continued how to obtain an expedited review</p>		
<p>2.2 (A) 3: c. The financial inducements offered to any health care provider or health care facility for the reduction or limitation of health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or specific details of any financial arrangement between a managed care organization and a health care provider unless otherwise required by law.</p>		
<p>2.2 (A) 3: d. The member’s responsibility for payment of premiums,</p>		
<p>2.2 (A) 3: d. continued coinsurance,</p>		
<p>2.2 (A) 3: d. continued copayments,</p>		
<p>2.2 (A) 3: d. continued deductibles,</p>		
<p>2.2 (A) 3: d. continued and any other charges,</p>		
<p>2.2 (A) 3: d. continued annual limits on a member’s financial responsibility,</p>		
<p>2.2 (A) 3: d. continued caps on payments for covered services,</p>		
<p>2.2 (A) 3: d. continued and the member’s financial responsibility for non-covered procedures, treatments or services.</p>		
<p>2.2 (A) 3: e. The member’s financial responsibility for payment when services are provided by a health care provider who is not a contracted provider with the managed care organization, as applicable,</p>		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
<p>2.2 (A) 3: e. continued or by any provider after an adverse benefit determination by the managed care organization.</p>		
<p>2.2 (A) 3: f. A description of the grievance process used to resolve disputes between a member and the managed care organization,</p>		See Part 2 Checklist
<p>2.2 (A) 3: f. continued and how a member can access that process.</p>		See Part 2 Checklist
<p>2.2 (A) 3: g. A summary of the managed care organization’s quality management program.</p>		
<p>2.2 (A) 3: h. An explanation that emergency services do not require prior authorization;</p>		
<p>2.2 (A) 3: h. continued that coverage for emergency services outside of the service area will be the same as for emergency services within the service area;</p>		
<p>2.2 (A) 3: h. continued that it is the responsibility of the managed care organization or health insurer to respond to, defend against and resolve any request or claim by a non-contracted provider of emergency services for payment exceeding the amount it was paid or reimbursed by the member’s managed care organization or health insurer;</p>		
<p>2.2 (A) 3: h. continued and the point of contact at the managed care organization or health insurer for a member who receives any such request or claim.</p>		
<p>2.2 (A) 3: i. How members seeking information or authorization can contact the appropriate department or staff member of the managed care organization.</p>		
<p>2.2 (A) 3: j. How the member may obtain the most current provider directory and provider lists in a manner and format readily accessible to the member.</p>		
<p>2.2 (A) 3: k. The process for selecting primary care providers (if selection is encouraged or required) and</p>		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
2.2 (A) 3: k. continued for obtaining access to other providers under contract with the managed care organization,		
2.2 (A) 3: k. continued including any restrictions on the use of contracted specialists.		
2.2 (A) 3: l. The procedure for changing primary and specialty care providers under contract with the managed care organization,		
2.2 (A) 3: l. continued including any restrictions on changing providers, where applicable.		
2.2 (A) 3: m. How members can obtain standing referrals to contracted specialists.		
2.2 (A) 3: m. continued or use specialists or specialized facilities to provide and coordinate their primary and specialty care pursuant to the requirements of this rule, where applicable.		
2.2 (A) 3: n. The waiting time and travel time standards established by this rule.		
2.2 (A) 3: o. Opportunities for member participation in the development of managed care organization policies, and		
2.2 (A) 3: o. continued in the managed care organization's quality management activities.		
2.2 (A) 3: p. Information regarding consumer information and services, including local and toll-free consumer or member services telephone numbers for the managed care organization,		
2.2 (A) 3: p. continued the Department and		
2.2 (A) 3: p. continued the Vermont Office of Health Care Ombudsman,		
2.2 (A) 3: p. continued with an explanation of each organization's respective role.		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
<p>2.2 (A) 3: q. A list of all information available to the member upon request, as required by this rule.</p>		
<p>2.2 (A) 3: r. If the managed care organization manages pharmaceutical benefits, the disclosure shall also explain in a clear and prominent manner that pharmaceutical benefit management with respect to particular drugs may change frequently; and</p>		
<p>2.2 (A) 3: r. continued how and where members and providers can access the primary source of up-to-date pharmaceutical benefit information,</p>		
<p>2.2 (A) 3: r. continued including but not limited to lists of the specific drugs subject to pharmaceutical benefit management;</p>		
<p>2.2 (A) 3: r. continued whether, how and under what conditions a particular drug is or is not covered by the plan; and</p>		
<p>2.2 (A) 3: r. continued the process by which grievances and exceptions to the pharmaceutical benefit management decisions may be made.</p>		
<p>4.1(B) The primary source of information for members and providers regarding drugs subject to a pharmaceutical benefit management program (PBMP) includes a description of or reference to:</p> <ul style="list-style-type: none"> o The nature of the clinical information required o By whom, how and where the information must be submitted o How to confirm receipt o Contact information for customer services o Telephone, fax and other contact information for the reviewing entity(ies), in order to request: 		
<p>4.1(B)1 prior authorization</p>		
<p>4.1(B)2 exceptions from PBMP criteria; and</p>		
<p>4.1(B)3 a grievance related to a PBMP</p>		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
<p>4.2(A)(3) if a member requests a fill or refill of a prescription written prior to publication of the change or receipt of the notice required by Subsection (A)1 or (2) of this section; the prescription remains valid; and it is not possible to timely obtain a prescription consistent with the changed requirement, coverage will be provided for an interim supply of the drug and, if relevant, any additional supply that is medically necessary to safely discontinue the drug for up to ninety (90) days or until the prescribing provider can order a new prescription; or, if necessary, until the grievance and independent review process can be initiated and completed. A managed care organization shall not be required to cover an interim supply if:</p> <ul style="list-style-type: none"> a. member's prescribing provider explicitly consents to the change; or b. the drug has been determined to be unsafe for the treatment of the member's disease or medical condition, has been discontinued from coverage for safety reasons or cannot be supplied by or has been withdrawn from the market by the drug's manufacturer. 		
<p>4.3(B) A managed care organization shall grant an exception to a PBMP requirement and shall provide coverage on the same terms as it would have for the PBMP requirement if the member's prescribing health care provider certifies, based on relevant clinical information about the particular member and sound medical or scientific evidence or the known characteristics of the drug, that the PBMP requirement:</p> <ul style="list-style-type: none"> 1. has been ineffective or is reasonably expected to be ineffective or significantly less effective in treating this member's condition such that an exception is medically necessary; or 2. has caused or is reasonably expected to cause adverse or harmful reactions in this member. 		
<p>4.3(D)1 ...plan documents ... related to a prescribed drug shall include a detailed explanation of:</p>		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
the information required to be submitted to comply with PBMP requirements for requesting exceptions from PBMP criteria and, if necessary, to file a grievance related to a PBMP;		
4.3(D)2 by whom the request and clinical or other required information is to be submitted;		
4.3(D)3 how and where information must be submitted, including telephone, fax and other contact information for the reviewing entity(ies);		
4.3(D)4 under what circumstances and how an interim supply of medication may be obtained; and		
4.3(D)5 the fact that a denial of a request for a PBMP exception is a determination subject to independent external review under Vermont law, and shall include any applicable notice required by the Department and a reference to descriptions of the independent external review process in relevant plan documents.		
4.3(E)1 As long as a drug continues to be prescribed for a member and is considered safe for the treatment of the member's condition, a member who has previously been prescribed an otherwise covered drug that is the subject of PBMP prior authorization, other review and/or denial shall be entitled to coverage for a supply of the drug sufficient to continue treatment through the following time periods, as well as any additional supply that is medically necessary to safely discontinue the drug if the denial is ultimately upheld: until the PBMP has completed the prior authorization or other review process;		
4.3(E)2 if applicable, until all requested internal expedited grievances have been exhausted; and		
4.3(E)3 until the independent external review decision is issued, if expedited independent external review is requested within twenty-four (24) hours of the receipt of the final grievance decision and notice of appeal rights		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
by the member, and expedited independent external review is conducted in accordance with the time frames specified by law.		

Appendix B - Part 2
Rule 9-03 Evaluation of Policy, Certificate and Handbook
Grievance Section

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
<p>3.3 (C) 4. a. Provide sufficient information...including: a statement that the decision of a member as to whether or not to pursue the voluntary second level grievance will have no effect on the member's rights to any other benefits; and</p>		
<p>3.3 (C) 4. b. Provide sufficient information...including: information about the applicable rules, the member's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker.</p>		
<p>3.3 (C) 5. The MCO shall not impose any fees or costs on a member or provider who elects to pursue a voluntary second level grievance;</p>		
<p>3.3 (C) 6. The managed care organization shall...</p> <ul style="list-style-type: none"> • include the right of the member to meet with one (1) or more of the reviewers, at the member's request, before a final determination is made on the voluntary second level grievance. • provide for either an in-person meeting or a telephone meeting; however, if it is inconvenient for the member to participate in the manner offered by the managed care organization, the other method of meeting must be made available to the member. • [ensure that] the member's treating provider(s) and any other person(s) requested by the member is (are) entitled but not required to participate in such a meeting or call. • [ensure that] the meeting date shall be arranged in consultation with the member. • not unreasonably deny a request for postponement of the review made by a member. • [ensure that] the right to have a voluntary second level grievance considered shall not be made conditional on a member's appearance either in person or by telephone at such a meeting. 		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
<p>3.3 (D) 1. The grievance process...provides members at least one hundred eighty (180) calendar days following receipt of a notification of an adverse benefit determination within which to request a first level grievance and at least ninety (90) calendar days following receipt of notification of an adverse determination on a first level grievance within which to request a voluntary second level grievance;</p>		
<p>3.3 (D) 2. The grievance process...provides members the opportunity to submit written comments, documents, records, and other information relating to the grievance;</p>		
<p>3.3 (D) 3. The grievance process...provides that a member has reasonable access to, and copies of, all documents, records, and other information relevant to the member’s grievance upon request and free of charge within two (2) business days or, in the case of a concurrent or urgent pre-service review, immediately upon request. Whether a document, record, or other information is relevant to a grievance shall be determined by reference to the definition of “relevant document, record or other information” in this rule;</p>		
<p>3.3 (D) 4. The grievance process...provides for a review that takes into account all comments, documents, records, and other information submitted by the member relating to the grievance, without regard to whether such information was submitted or considered in the initial benefit determination or during the first level grievance, in the case of a voluntary second level grievance;</p>		
<p>3.3 (D) 5. The grievance process...provides for a review that does not afford deference to the initial adverse benefit determination or the adverse determination on first level grievance, in the case of a voluntary second level grievance;</p>		
<p>3.3 (D) 6. The grievance process...ensures that the person or persons reviewing a first level grievance on behalf of the managed care organization shall not have been involved with the adverse benefit determination or other issue that is the subject of the grievance, nor shall such person or persons be the subordinate(s) of any individual who was involved with the initial determination or other issue that is the subject of the grievance;</p>		
<p>3.3 (D) 7. The grievance process...ensures that the person or persons reviewing a voluntary second level grievance on behalf of the managed care organization shall not have been involved with the adverse benefit determination or other issue that is the subject of the grievance, or the adverse determination in the first level grievance; nor shall such person or persons be the subordinate(s) of any individual who was involved with the initial determination or other issue that is the subject of the grievance or the first level grievance;</p>		

REQUIREMENT	SCORE	EXPLANATION/DISCUSSION
<p>3.3 (D) 8. The grievance process...provides that,</p> <ul style="list-style-type: none"> • in deciding a first level grievance of an adverse benefit determination that is based in whole or in part on a medical judgment,...or based in whole or in part on any other adverse benefit determination that is an appealable decision pursuant to Vermont’s independent external review laws, the reviewers shall include at least one (1) clinical peer of the member's treating provider. • the managed care organization’s medical director or the medical director’s designee shall offer to...directly communicate with the member’s treating provider or the treating provider’s designee before a resolution of the grievance is made; 		

Appendix C

Rule 9-03 Provider Directory Scoring Checklist

REQUIREMENT	SCORE	EVALUATION/DISCUSSION
Section 2.2(B)1: Provider directories shall be available on the Internet and made available upon request in hard copy and in a format suitable for electronic mailing. The provider directory may be separate from the policy form or handbook if the policy form or handbook clearly indicates how the member or prospective member can access the most up-to-date version of the directory.		
Section 2.2(B)2a: Provider directories shall: be updated, audited and corrected (by addendum or otherwise) at least once every six (6) months by the managed care organization, and shall be updated whenever new information is submitted by providers;		
Section 2.2(B)2b: include, and internet directories shall be searchable by, provider name, geographic region, provider specialty and, for facilities, by facility type;		
Section 2.2(B)2c: include provider names, telephone numbers, and addresses; and		
Section 2.2(B)2d: in the case of physicians, include information about board certification, and in the case of primary care providers, indicate whether they are accepting new patients.		
Section 2.2(B)3: Provider directories shall indicate at least the following practice limitations if reported by contracted providers: limitations as to patient age groups and specific conditions. This requirement shall not be construed to require indication of practice limitations that are evident based on a provider's specialty.		
Section 2.2(B)4: Provider directories shall explain that the member (and/or the member's representative) may obtain active assistance from the managed care organization to locate a provider, from a clinical representative if preferred and requested. For the purposes of this subsection, "active assistance" shall include but not be limited to generating a provider list; assisting members in identifying providers who are qualified to deliver the type of care being sought, who are currently taking new patients, and who provide services that are generally considered to be covered benefits; and facilitating appointments with providers if such assistance is required. Provider directories shall explain that the member should contact the managed care organization if the member has been unable to locate a provider using the list or with assistance previously provided.		
Section 2.2(B)5: If a case or care management or chronic care program is available, the provider directory shall explain the benefits of participation and how the member may obtain the service or shall reference the plan documents that contain this information.		

REQUIREMENT	SCORE	EVALUATION/DISCUSSION
<p>Section 2.2(B)6: Provider directories shall explain that coverage is not guaranteed until the requirements for utilization review have been completed and documentation of authorization has been issued. Such explanation shall include a description of or reference to certificate or handbook provisions that explain how to seek authorization; how to seek authorization if the member (and/or the member's representative) believes the necessary care is not available from contracted providers; how to initiate a grievance if coverage has been denied, reduced, modified or terminated; and the potential consequences if authorization is not obtained.</p>		
<p>Section 2.2(B)7a: Provider directories shall also, with respect to mental health and substance abuse services: explain in a clear and prominent manner that a given provider's availability to new patients may change frequently;</p>		
<p>Section 2.2(B)7b: Provider directories shall also, with respect to mental health and substance abuse services: clearly indicate when there are program, clinic or similar organizationally-based requirements that limit or prevent general plan membership from directly accessing a provider practicing in such a setting. In such cases, the directory shall list the program, clinic or organization name above or together with the individual provider's name, and shall list the relevant intake phone number and address. If the provider has a separate practice that may be accessed directly by general plan membership, that practice shall be listed separately;</p>		
<p>Section 2.2(B)7c: Provider directories shall also, with respect to mental health and substance abuse services: explain that any provider of mental health or substance abuse services not currently under contract with the managed care organization that is willing to meet the terms and conditions for participation may apply for contracted status and may become contracted after successful completion of credentialing; and</p>		
<p>Section 2.2(B)7d: Provider directories shall also, with respect to mental health and substance abuse services: in addition to being updated, audited and corrected whenever new information is submitted by providers, be updated based on current information from individual contracted providers that is obtained in response to active solicitation by the managed care organization at least once every six (6) months.</p>		

Appendix D

Managed Care Organization Quality Improvement Goal Template

_____ Goal Year

MCO Name: _____

Goal: _____

Goal Objectives:

1. _____
2. _____
3. _____
4. _____

Baseline Data and Measurable Goal Results:

Measure	Baseline Data (Time Period)	Interim Data (Time Period)	Target Goal (# or %)

Managed Care Organization Quality Improvement Goal Template

_____ Goal Year Reporting

Mid-Year Reporting

Goals and Measures of Progress for the 1st (mid-year) Simi-annual Goal Review Meeting:
(measures should be quantifiable whenever feasible and appropriate.)

- 1.
- 2.
- 3.
- 4.

Year-End Reporting

Measures of Progress and Goal Attainment for the 2nd (year-end) Semiannual Goal Review Meeting *(measures should be quantifiable whenever feasible and appropriate)*

- 1.
- 2.
- 3.
- 4.
- 5.

Managed Care Organization Quality Improvement Goal Template Example

MCO Name: Example MCO

Goal:

Example: Improve glycemic control among enrolled diabetic members and achieve a statistically significant improvement in the HbA1c control rate for diabetics.

Goal Objectives:

1. *Implement an on-line system for monitoring and self-management of diabetic members*
2. *Enroll 90% of high-risk diabetic members in the DM Program*
3. *Reduce voluntary turnover rate in DM Program to no more than 10*
4. *Implement a quality incentive program that rewards a) PCPs who have been able to achieve glycemic control for 60% of their patients, and b) individual members who achieve glycemic control*

Baseline Data and Measurable Goal Results:

Measure	Baseline Data (Time Period)	Interim Data (Time Period)	Target Goal (# or %)
<i>HbA1c control</i>	40%	42%	60%
<i>High-risk diabetic enrollment in DM Program</i>	NA	60%	90%
<i>Diabetes DM turnover rate</i>	NA	20%	<or=10%

Managed Care Organization Quality Improvement Goal Template

Example

Mid-Year Reporting

Goals and Measures of Progress for the 1st (mid-year) Semi-annual Goal Review Meeting:
(measures should be quantifiable whenever feasible and appropriate.)

Examples:

1. *The on-line system for monitoring and self-management of diabetic members is in beta testing with a pre-selected group of diabetic members.*
2. *80% of high-risk diabetics are enrolled in the DM Program.*
3. *Year-to-date, the voluntary rate of membership termination in the DM Program equals 15%.*
4. *QI incentive program specifications have been developed and are undergoing testing with members and PCPs.*
5. *Measured changes in glycemic levels for participants in the DM Program indicate improvement when compared to the prior year scores for continuously enrolled members*

Year-End Reporting

Measures of Progress and Goal Attainment for the 2nd (year-end) Semiannual Goal Review Meeting (measures should be quantifiable whenever feasible and appropriate)

Examples:

1. *The on-line monitoring and self-management system for diabetic members has been implemented and its availability has been communicated to members and providers through multiple modalities of communication.*
2. *90% of high-risk diabetics are enrolled in the DM Program.*
3. *The year-to-date DM program voluntary termination rate equals 10%.*
4. *The quality incentive program specifications have been completed and tested and are ready for January 1 implementation.*
5. *Measured changes in glycemic levels of DM Program participants indicate statistically significant improvement. Final goal measurement will be result from forthcoming HEDIS measurement and will be available in June.*

Appendix E

Section 6.3(G) Performance Improvement Measures

Introduction

Section 6.3(G) of Rule 9-03 requires that each MCO demonstrate performance improvement with respect to several categories of measures developed by applicable national organizations with recognized expertise in quality measures. The Department has identified the following HEDIS[®] and CAHPS[®] measures as applicable to the requirements of this section of the rule. Improvement must be demonstrated on the basis of an individual measure, which can be either a composite or any of its subcomponents. Not all of these measures will be available for evaluation of improvement during every triennial review period due to annual measurement rotation or changes in measure specifications. The list that follows will be updated as new measures are introduced and older measures retired.

For a given triennial review, the Department will base its evaluation on the HEDIS[®] and CAHPS[®] data filings that coincide with the period of time that is the focus of the triennial review. Examples of potential measures are listed below.

HEDIS Access/Availability of Care and Use of Services Measures

- Adults' Access to Preventive/Ambulatory Care
- Children and Adolescents' Access to Ambulatory Care
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Composite
 - Initiation of alcohol and other drug dependence treatment
 - Engagement of alcohol and other drug dependence treatment
- Timeliness of Prenatal Care
- Postpartum Care
- Call Answering Composite
 - Call Abandonment
 - Call Answer Timeliness
- Well-child Visits in the First 15 Months of Life
- Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well Care Visits

6.3 (G) 1. Member service, satisfaction and experience of care CAHPS[®] MCO Administrative Service Measures

- Rate your overall health plan experience
- Getting Needed Care Composite
 - Ease with which to get an appointment with specialists
 - Easy to get the care, tests, or treatment you thought you needed
- Claims Processing Composite
 - Claims processing is timely
 - Claims are processed correctly
- Plan Information on Costs Composite
 - Able to find out how much to pay for a health care service or equipment
 - Able to find out how much to pay for prescription medications

- Health Plan Customer Service Composite
 - Written materials or internet provided the information you needed about how health plan works
 - Customer service gave information or help needed
 - How often did customer service staff treat you with courtesy/respect
 - Health plan forms easy to fill out

6.3 (G) 2. Preventive care

HEDIS[®] Preventive Care Measures

- Adult BMI Screening
- Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents - BMI Percentile
- Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents – Counseling for Nutrition
- Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents – Counseling for physical activity
- Childhood Immunization Status
- Immunizations for Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening Composite
 - Chlamydia screening 16-20
 - Chlamydia screening 21-24
- Colorectal Cancer Screening
- Flu Shot for Adults Ages 50-64
- Medical Assistance with Smoking and Tobacco Use Cessation

6.3 (G) 3. Acute illness care

HEDIS[®] Acute Illness Measures

- Care for Children Composite
 - Appropriate Testing for Children With Pharyngitis
 - Appropriate Treatment for Children With Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Follow Up after Hospitalization for Mental Illness: 30 Days
- Follow Up after Hospitalization for Mental Illness: 7 Days
- Use of Imaging Studies for Lower Back Pain
- Antidepressant Medication Management Composite
 - Effective acute phase treatment
 - Effective continuation phase treatment

6.3 (G) 4. Chronic illness care

HEDIS[®] Chronic Illness Measures

- Caring for People with Asthma
- Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening
- Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Level <100
- Diabetic Composite
 - HbA1c testing
 - Diabetic eye exam
 - Good HbA1c control <8%
 - Poor HbA1c control >9%
 - LDL-C level <100
 - LDL-C screening
 - Monitoring blood pressure control <130/80
 - Monitoring blood pressure control <140/90
 - Monitoring for diabetic nephropathy
- Annual Monitoring for Patients on Persistent Medications Composite
 - Annual monitoring for patients on ACE inhibitors or ARB
 - Annual monitoring for patients on anticonvulsants
 - Annual monitoring for patients on diuretics
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Use of Spirometry Testing in the Assessment of and Diagnosis of COPD

Appendix F

Vermont Regulatory Requirements Addendum

This Vermont Regulatory Requirements Addendum ("Addendum") is made part of the Provider Agreement ("Agreement") entered into between [MANAGED CARE ORGANIZATION NAME] and the health care professional or entity named in the Agreement ("Provider"). This Addendum applies to the covered services rendered to members in Vermont to the extent such covered services are subject to regulation under Vermont laws.

[MANAGED CARE ORGANIZATION NAME], and Provider each agree to be bound by the terms and conditions contained in this Addendum. In the event of a conflict or inconsistency between this Addendum and any term or condition contained in the Agreement, this Addendum shall control, except with regard to health benefit plans outside the scope of this Addendum.

- 1. Member Hold Harmless.** Provider agrees that in no event, including nonpayment or insolvency of [MANAGED CARE ORGANIZATION NAME], or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or a person (other than [MANAGED CARE ORGANIZATION NAME]) acting on behalf of the member for services provided pursuant to the Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the certificate of coverage, or fees for uncovered services delivered on a fee-for-service basis to members.

This Agreement prohibits Provider from requesting payment from a member for any services that have been confirmed by independent external review obtained through the Department of Banking, Insurance, Securities and Health Care Administration pursuant to Vermont law to be medically unnecessary, experimental, investigational or a medically inappropriate off-label use of a drug.

- 2. Continuation of Covered Services Following Termination.** In the event of [MANAGED CARE ORGANIZATION NAME]'s insolvency or other cessation of operations, covered services to a member will continue to be provided through the period for which a premium has been paid to [MANAGED CARE ORGANIZATION NAME] on behalf of the member or until the member's discharge from an inpatient facility, whichever period is greater. Covered services to a member confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the member's continued confinement in the facility is no longer medically necessary. In the event the Agreement is terminated without cause, or has not been renewed without cause, members receiving an ongoing course of treatment from Provider may continue to utilize Provider so long as Provider agrees to abide by [MANAGED CARE ORGANIZATION NAME]'s payment rates, quality of care standards and protocols, and to provide the necessary clinical information to [MANAGED CARE ORGANIZATION NAME], as follows: members with disabling or degenerative conditions shall be allowed to continue to see Provider for sixty (60) days from the date of termination or nonrenewal or until accepted by a provider contracted with [MANAGED CARE ORGANIZATION NAME], whichever is shorter, and women in their second or third trimester of pregnancy shall be allowed to continue to obtain care from Provider until the completion of postpartum care.

- 3.** The provisions in Sections 1 and 2 shall be construed in favor of the member, shall survive the termination of the Agreement regardless of the reason for termination,

including [MANAGED CARE ORGANIZATION NAME]'s insolvency, and shall supersede any oral or written contrary agreement between Provider and a member or a member's representative if the contrary agreement is inconsistent with the "Member Hold Harmless" and "Continuation of Covered Services Following Termination" provisions in Sections 1 and 2.

4. **Notice of Termination.** Either party terminating the Agreement without cause shall provide to the other party advance final written notice in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) days before terminating the Agreement.
5. **Notice of Termination to Members.** [MANAGED CARE ORGANIZATION NAME] shall provide written notice of the termination of Provider at least six (6) weeks prior to the anticipated date of a termination without cause, or on, or if possible, before the date on which the Agreement is terminated by [MANAGED CARE ORGANIZATION NAME] or Provider for cause, to all members <who are patients of [IF PRIMARY CARE PROVIDER]> [OR] <who are seen on a regular basis by Provider [IF SPECIALTY PROVIDER]>. Within five (5) business days of the date Provider either gives or receives notice of termination, either for or without cause, Provider shall supply [MANAGED CARE ORGANIZATION NAME] with a list of his or her patients that are members of [MANAGED CARE ORGANIZATION NAME].
6. **No Transfer of [MANAGED CARE ORGANIZATION NAME]'s Liability.** Nothing in the Agreement shall be construed to contain any clause purporting to transfer to Provider, other than a medical group, by indemnification or otherwise, any liability relating to the activities, actions or omissions of [MANAGED CARE ORGANIZATION NAME].
7. **Disclosure of Contract Provisions.** Nothing in the Agreement shall be construed as prohibiting Provider from disclosing to members or potential members information about the Agreement or the members' health benefit plans that may affect their health or any decision regarding health.
8. **Freedom to Discuss Treatment Options.** Nothing in the Agreement shall be construed as prohibiting Provider from, or penalizing Provider for, discussing treatment options with Members regardless of [MANAGED CARE ORGANIZATION NAME]'s position on the treatment options, or advocating on behalf of members within the utilization review or grievance process established by [MANAGED CARE ORGANIZATION NAME], nor shall it penalize Provider because Provider in good faith reports to state or federal authorities any act or practice by [MANAGED CARE ORGANIZATION NAME] that jeopardizes member health or welfare.
9. **No Incentive to Forego Covered Services.** Nothing in the Agreement shall be construed to offer an inducement to Provider to forego providing medically necessary services to a member or referring a member to such services.
10. **Availability and Confidentiality of Health Records.** Provider shall make health records available as required by law to the appropriate state or federal authorities involved in assessing the quality of care or investigating grievances or complaints of Members, and shall comply with the applicable state and federal laws related to confidentiality of medical or health records.
11. **Credentialing Verification Practices.** [MANAGED CARE ORGANIZATION NAME] completes initial verification of credentials before entering into the Agreement.

[MANAGED CARE ORGANIZATION NAME] will also conduct periodic recredentialing of Provider's credentials at least once every three (3) years. The criteria for credentialing and recredentialing policies and procedures are available to Provider upon written request. All information obtained in the credentialing process shall be kept confidential, except that it shall be subject to review and correction of any erroneous information by Provider. Records and documents relating to Provider's credentialing verification process shall be retained by [MANAGED CARE ORGANIZATION NAME] for at least three (3) years.

Provider shall notify [MANAGED CARE ORGANIZATION NAME] immediately of any changes that would impact Provider's credentialing status or ongoing availability to members, including the status of Provider's license, current level of professional liability coverage, status of hospital privileges, current DEA registration certificate and specialty board certification status as applicable.

Appendix G: Rule H-2011-02, Independent External Review

A link to this rule can be found at the website below:

http://www.bishca.state.vt.us/sites/default/files/H_2011_01_mental_health_review_agents_adopted.pdf