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MEMORANDUM

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FROM: Pat Jones, Director of Health Care Quality Improvement

RE: **Rule H-2009-03 Clarifications**

DATE: April 14, 2010

cc: Michael Bailit, Margaret Houy and Michael Joseph (Bailit Health Purchasing),
Tim Bigelow (BCBSVT), Laurie McGovern (MBH), Dawn Bennett and Doreen
Chambers (BISHCA)

The Department has received a number of questions regarding Rule H-2009-03 during the past couple of months. Questions and the Department's responses are found below:

- 1. When are MCOs required to meet the Section 6.3(D) requirement to establish participation in at least two joint QI goals with one or more managed care organizations?**

Department Response: Section 1.12(E) specifies that if the Department determines that requirements imposed by the new rule for Sections 5.2, 5.3, 5.4, 6.2 and 6.3 "were not in effect prior to the Rule's adoption, each managed care organization shall have one year from the date of adoption to come into compliance with such new requirements." While the language in Section 6.3(D) indicates that MCO participation in such goals was to have been established by January 1, 2010, the Department acknowledges that Section 6.3 (D) was not in effect prior to the adoption date of the new rule on December 17, 2009. Therefore, MCOs have until December 17, 2010 to establish participation in at least two joint goals. The Department expects each MCO to provide documentation of such participation by that date.



2. Are MCOs able to count their joint mental health goal toward the goal requirements outlined in Section 6.4(C)?

Department Response: Section 6.4(C) requires MCOs to establish at least one mental health goal jointly with its MBHO delegate (this was actually previously required by statute, so it is currently effective). This goal cannot be used to satisfy the requirements of Section 6.3(D).

3. Will MBHOs be required to establish participation in two or more joint quality improvement goals with other MCOs (not including the MCO that delegates mental health management to the MBHO)?

Department Response: The Department has decided that for now, due to MBHOs being responsible for a limited number of clinical conditions relative to other MCOs, MBHOs will be required to establish participation in only one joint quality improvement initiative.

4. Regarding direct communication with provider or provider's designee (Section 3.1(E)2):

- **Does this apply to administrative adverse determinations (e.g. - no out-of-network benefits, benefit exhaustion)?**
- **Does this apply to post-service reviews (e.g. - MCO was not notified of admission, discharge has already occurred, and medical record submitted for review)?**

Department Response: Section 3.1(E) 2., relating to UM mechanisms applied to mental health and/or substance abuse benefits, requires MCOs to engage in direct communication with the provider or provider's designee before making an adverse benefit determination, "unless the treating provider or designee has refused or has repeatedly failed to engage in such communication when it has been offered at a time and in a manner reasonably convenient to the provider." Adverse benefit determination is defined in Section 1.4(A) and means "a denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a health benefit plan..." Contractual limitations including no out-of-network benefits or benefit exhaustion are included in this definition. Section 3.1(E)2. applies to all reviews, regardless of whether they are administrative, concurrent, pre-service or post-service.

5. Regarding the requirement to continue authorization of services (Section 3.1(G)3):

- **If the member discharges prior to the completion of all levels of appeal would coverage end upon discharge?**
- **If the member has discharged prior to the request for the independent external review would the independent external review still be expedited?**

Department Response: Section 3.1(G)3. describes an insurer's obligation to continue to provide benefits when an adverse benefit determination is made during the course of a facility stay or other ongoing course of treatment, when an expedited grievance or

independent external review has been requested. The insurer's obligation after discharge would depend upon the circumstances of the discharge; and in particular, whether the treating provider has determined whether it is medically necessary for the treatment to continue without disruption or delay. For example, if a member ended treatment due to concerns about financial liability, and the treating provider believed that additional immediate treatment was medically necessary, it is conceivable that additional coverage would be required and that an independent external review would need to be expedited.

6. **Regarding UR timeframes if a request is not considered urgent (Section 3.2(B)1):**
- **What timeframe does this revert to if the member or treating provider informs the MCO that the request is not urgent? In the past, timeframes for mental health and substance abuse services have differed from timeframes for other health care.**
 - **Would this be the same as 3.2(E) Non-Urgent, Pre-Service Review - Timeframe for Completion and Notification discussed on page 32?**

Department Response: If a pre-service request is not designated as urgent as described in Section 3.2(B)1-4, the timeframe for completion and notification of a non-urgent pre-service review for mental health and substance abuse services or other health care services is specified in Section 3.2(E).

7. **Regarding grievance timeframes if a request is not considered urgent (Section 3.3(B)):**
- **What timeframe does this revert to if the MCO/member/treating provider agrees that it is not medically necessary to expedite the timeframe for a grievance review? In the past, timeframes for mental health and substance abuse services have differed from timeframes for other health care.**
 - **Would this be the same as 3.3(H) First-Level Non-Urgent, Pre-Service Grievance - Timeframe for Completion and Notification on page 39?**

Department Response: If a grievance request has been determined not to be urgent, based on the exceptions in Section 3.3(B), the timeframe for completion and notification of a non-urgent grievance review for mental health and substance abuse services or other health care services is specified in Section 3.3(H).

8. **Rule H-2009-03 requires MCOs to report timeframe information for concurrent utilization review and concurrent grievance decisions. Some MCOs have not been collecting data separately for concurrent reviews and grievances. Are MCOs required to report that information in the July 2010 data filing?**

Department Response: Section 1.12(C) indicates that compliance with Sections 3.2 and 3.3 of the Rule is not required until six months after the adoption of the Rule (June 17, 2010). As a result, MCOs are not required to separate concurrent utilization review and grievance review data from expedited pre-service data for the July 2010 data filing requirements in Sections 6.6(B)7 and 6.6(B)8 of Rule H-2009-03.

Beginning in 2011, the Department has decided to make a change and use the same reporting periods (calendar year) for grievance and utilization review data filings (currently utilization review data is reported by calendar year, and grievance data is reported from July 1 through June 30). For the July 2011 data filing, MCOs will be required to report on grievances and utilization reviews for calendar year 2010. In that filing, MCOs will be required to report separately on concurrent utilization reviews and grievances from July 1, 2010 through December 31, 2010, because the requirement to report on concurrent review timeframes does not take effect until June 17, 2010.

9. What is the grievance reporting period in the July data filing now that the January 15 data filing has been eliminated?

Department Response: For the July 2010 data filing, grievance data should be reported from July 1, 2009 through June 30, 2010. Beginning with the July 2011 data filing, MCOs will be expected to report grievances for the prior calendar year, as noted in the response to Question 8.

10. Can practices using electronic health records (EHRs) be deemed compliant with Section 6.1 in Rule H-2009-03?

Department Response: Section 6.1(B) of Rule H-2009-03 requires that "The managed care organization shall have a system to access and audit the content of clinical records of high-volume primary care providers at least once every three (3) years, to ensure that they are legible, organized, complete and demonstrate compliance with any other clinical record-keeping standards established by the managed care organization..." While well-designed and fully used EHRs would theoretically address these elements, research shows that in Vermont EHRs vary, and physician use of EHRs varies.

We have discussed potential scenarios under which physicians in Vermont might be using EHRs. Each is discussed below and includes the Department's decision on whether EHR use should be considered in evaluating MCO compliance with Section 6.1(B):

- **Blueprint pilot practices using EHRs** - Discussions with Blueprint Director Craig Jones have revealed that Blueprint and VCHIP staff are currently working with the pilot practices to ensure that EHRs contain key data elements and that those data elements are completed by the practices. This effort is integral to the Blueprint evaluation process. As a result, the Department believes that Blueprint pilot practices using EHRs can be considered to comply with the requirement in Section 6.1(B) that their records "are legible, organized, complete and demonstrate compliance with any other clinical record-keeping standards established by the managed care organization" without being audited by the MCO. The Department reserves the right to modify this interpretation in the future.
- **Non-Blueprint practices using EHRs** (regardless of whether they have achieved NCQA Physician Practice Connections (PPC) or PPC-Patient-Centered Medical Home recognition) - In the absence of audits of practices regarding their use of

EHRs, it is difficult to envision how the MCOs could verify whether the records for practices using EHRs meet the Rule H-2009-03 requirements to any greater degree than the records for those practices that don't use EHRs. Consequently, the Department will continue to require MCOs to audit these practices to determine if they meet the requirements of Section 6.1(B).

- 11. Could the MCO audit non-Blueprint practices using EHRs in such a way that the MCO and BISHCA would be satisfied that the EHR is being used effectively, so that the provider could be off the hook for future Medical Record Reviews, as long as the practice's EHR doesn't change?**

Department Response: The Department does not believe that a one-time audit would be sufficient to verify that the EHR is being used effectively, and so would require the "once every three years" audit requirement contained in Rule H-2009-03. The federal government promulgated draft "meaningful use" standards for future EHR use on December 30, 2009. When the standardization is finalized, there may be opportunities to streamline the Rule H-2009-03 requirements. We will do our best to remain informed about the federal efforts, and we would encourage you to do the same.

- 12. NCQA does not require "practitioners who practice exclusively within the inpatient setting and provide care to...[MCO] members only as a result of members being directed to the hospital or another inpatient setting" to be credentialed. Can BISHCA take the same approach?**

Department Response: The Department agrees that Vermont regulation can be consistent with NCQA and not require credentialing of providers who practice exclusively within the inpatient setting as described above. These practitioners might include radiologists, anesthesiologists, pathologists, ER physicians, hospitalists, neonatologists and telemedicine consultants.

- 13. How does the Common Physician Measurement Project interface with Sections 6.3(B)7, 6.3(B)8, and 6.3(D)?**

Department Response: The Common Physician Measurement work has the potential to partially meet the above requirements.

- It involves working with primary care physicians for children. The Department would be willing to consider the selected practices as meeting the requirement for high volume pediatric primary care physicians. However, MCOs would also need to work with high volume adult primary care physicians in order to meet the requirements of the Rule.
- Section 6.3(B)7.a. requires that "provider-specific performance data" include "multiple dimensions of quality" and be compared to "a standard, goal, or MCO norm." As currently envisioned, the Common Measurement project will include multiple dimensions of quality and compare physicians to both the state commercial MCO average and the NCQA Quality Compass 90th percentile rate.

- Section 6.3(B)7 also requires MCOs to review and discuss performance results directly with providers, identify “opportunities for improvement and provider improvement goals”, assess provider performance relative to those goals, and motivate and support high-volume provider efforts to improve. It is not yet clear whether the Common Measurement project will include these activities, so it cannot be considered to meet these requirements at this time.
- Section 6.3(B)8 requires MCOs to “adopt and publish quality standards...; measure and report results to providers; identify providers...that do not meet...standards; take appropriate action to correct deficiencies...; monitor providers to determine where they have implemented corrective action; and take appropriate and significant action when a provider has not implemented corrective action...” The Common Measurement project does not address most of these requirements, with the exception of measuring and reporting results to providers. It is possible that the project could be developed to meet the requirements, but it does not do so at this time.
- Section 6.3(D)1 requires joint quality improvement projects that address the requirements in Sections 6.3(B)7 and 6.3(B)8. There is no question that the Common Measurement project involves joint activities between MCOs. To the extent that the project does not currently address the requirements in Sections 6.3(B)7 and 6.3(B)8, as outlined above, it will not meet the requirements of Section 6.3(D). However, it has the potential to do so.

14. What are the annual notice requirements for members and providers?

Department Response:

Rule 09-03 has two annual member notice requirements.

Section	Content Regarding Member Notification
6.3(B)11	Promote the use of preventive health services by: b. Establishing effective procedures for informing members on at least an annual basis about preventive health services available to them;
6.3(B)12	Inform members in hard copy, on the internet, or in an electronic mailing, at least annually, about health promotion programs available to them, such as smoking cessation courses, nutritional courses, and weight loss programs...

Other required member disclosures are found in Section 2.2 of the Rule; member handbooks, certificates of coverage and provider directories and lists are the vehicles for those disclosures.

MCOs are also required to provide high-volume contracted providers with information about quality standards/quantitative thresholds regarding quality improvement and recertification activities (see Section 6.3), and they are required to give written information about chronic care programs to members and providers (See Section 6.5).

15. Regarding Section 6.6(B):

- **Where the Rule uses the word “indicators,” does it mean results of the indicators?**

Department Response: Yes.

- **When the phrase “for example” occurs, does the Rule mean that the MCO is to provide its own indicators or will the Department define the indicators?**

Department Response: For some areas, the Department will specify the indicators. In other areas, the Department might provide a list of potential indicators from which the MCOs may choose. The Department will continue to annually communicate indicator reporting requirements in advance of the required data filing.

16. In Section 6.3(B)(7)(c), are MCOs required to discuss performance results directly with all high volume providers including those who meet and/or exceed the goal or only those identified as needing improvement in the respective performance measure?

Department Response: Section 6.3(B)7. is the portion of the Rule that requires MCOs to work with providers to continually improve performance over time and across the network (similar to 10.203A3 from Rule 10). To comply with this section, MCOs are required to work with all high volume providers, not just those who do not meet the MCO's published quality standards. Section 6.3(B)8. is the section that requires the MCOs to identify and take appropriate and significant action with providers that do not meet the published quality standards (similar to 10.203A4bv from Rule 10).

17. What is the nature of the oversight that MCOs will need to provide for delegates that have achieved NCQA accreditation for utilization management (UM) and credentialing?

Department Response: To meet a requirement by deeming to an accredited delegate, the MCO must provide the delegate's accreditation report to the Department at the time of the deeming request. If delegates are NCQA-accredited for UM and credentialing, MCOs will not be required to audit delegate UM records or credentialing files as an oversight activity for those requirements for which the Department allows deeming to NCQA. By virtue of the accreditation, MCOs may assume that the delegates are correctly performing NCQA-defined UM and credentialing functions.

Because Rule H-2009-03 includes requirements that are not addressed by the NCQA accreditation standards, MCOs are required as part of their oversight responsibilities to

audit delegate compliance with all Rule H-2009-03-unique requirements (i.e. – those to which the Department does not deem compliance as a result of NCQA accreditation. The Department is in the process of determining which Rule H-2009-03 requirements will be deemed met by virtue of achieving NCQA accreditation. When that process is complete, we will send MCOs a listing of all Rule H-2009-03 requirements for which NCQA deeming will be permitted.

In addition, there are other oversight responsibilities that MCOs retain, regardless of a delegate's NCQA accreditation status. Specifically, Section 1.3(F) of Rule H-2009-03 requires MCOs that delegate activities or functions to maintain effective oversight, which is defined to include:

1. A written description of the delegate's activities and responsibilities, including reporting requirements;
2. Evidence of formal approval of the delegate's program by the managed care organization; and
3. A process by which the managed care organization at least annually evaluates the performance of the delegate and any sub-delegates, including but not limited to a process by which the managed care organization documents, tracks, addresses and resolves complaints from members and providers regarding the delegate's conduct and/or the conduct of any other managed care organization that performs any activities on its behalf.

While requirements 1 and 2 of Section 1.3(F) are self-explanatory, the Department would like to comment on the third requirement. Since MCOs do not need to audit accredited delegates' UM or credentialing activities for deemed requirements, other evaluation processes would need to be used to meet this requirement. Those other processes could include receiving regular (e.g., annual) reports on the number of providers credentialed and the results of the credentialing process. Similarly, regular reports on UM activities and their outcomes would be appropriate, as would results of patient experience surveys that ask about delegate UM activities. Requiring the delegate to maintain NCQA accreditation could also be a component of this requirement.

Similarly, in the event that an MCO is delegating to another Rule H-2009-03-regulated MCO (e.g. – an MBHO), the delegating MCO is responsible for the compliance of their delegated MCO with all Rule H-2009-03 requirements. The Department will include any deficiencies identified in a review of a delegate in the corrective action and enforcement activities for the delegating MCO. In addition, MCOs are strongly encouraged to review the Department's annual data filing report and, if applicable, work with their MBHO delegates to address the areas identified by the Department as opportunities for improvement.

- 18. Will MCOs need to produce a separate (presumably Vermont-specific) audit tool to audit delegate compliance with case management requirements in order to ensure that all Rule H-2009-03 standards are met?**

Department Response: Because Rule 2009-03 includes unique requirements, MCOs will need to develop a separate delegate audit tool to assure that all Rule H-2009-03 requirements are met. A separate audit tool will be needed for Case Management, as well as for some Credentialing and UM activities, because of the Rule H-2009-03-unique requirements in each section.

- 19. Will the Department review draft letters and notices required under Sections 3.2 and 3.3 in advance of their required implementation on June 17, 2010 (see Section 1.12(C))?**

Department Response: The Department will review draft letters and notices; we request that they be submitted by May 15, 2010 in order to ensure review prior to the implementation date of June 17, 2010.

- 20. What is the Department going to call the new rule?**

Department Response: “Rule 9-03” (i.e. “nine-oh-three”).