

Act 203, Section 31

Fair Contracting Standards
Workgroup Report

January 15, 2009

TO

Senator Douglas Racine, Chair, Committee on Health and
Welfare

Rep. Steven Maier, Chair, Committee on Health Care

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Contract Standards Report Act 203, Section 31 (2008)

Executive Summary

Legislative charge

Section 31 of Act 203 of the 2007/2008 legislative session required the Vermont Medical Society to convene a study group in collaboration with the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), the Vermont Association of Hospitals and Health Systems (VAHHS), insurers, practice managers and other interested parties to address fair and transparent contracting standards for providers participating in health insurance plans, categories of coverage, rental networks and most favored nation clauses. Section 31 further required a report to the House Committee on Health Care and the Senate Committee on Health and Welfare on the outcome of the study.¹

The workgroup met from June through December, with four full-group meetings and a number of topic-specific subcommittee meetings and conference calls. Materials were distributed to a list of over 70 interested groups and individuals, representing insurers, health care practitioners, hospitals, practice managers, physician hospital organizations (PHOs), national associations, and state agencies including BISHCA² and OVHA³. Most full group meetings were attended by about 20 participants of the work group.

Although there was a good effort to reach consensus on all parts, two primary areas of disagreement remained at the end of the process. One of these was the inclusion of a private right of action in the enforcement section that the three health insurance plans participating in the process expressed strong reservations about. The other was the all products clause, which concerned MVP Healthcare because of their contracting process and concerned BISHCA due to potential impacts on the practitioner networks and patient access for products with government-set fee schedules such as Catamount. The group also was unable to complete work on amendments proposed by Blue Cross Blue Shield to Section 27 of Act 203, the overpayment recovery section of the law enacted last year.

Problem statement

Preserving a strong health care delivery system in the face of a declining health care workforce is critical to ensure that Vermont will have the ability to address the acute and chronic care needs of an increasingly older Vermont population. Most practitioners, particularly those in small independent practices, have very limited ability to negotiate with health plans around amendments, all-products clauses, reimbursement or other

¹ <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT203.HTM> ;
Section 31

² Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

³ Vermont Office of Vermont Health Access (OVHA) (Medicaid, VHAP, Dr. Dynasaur and SCHIP)

contract terms. Practitioners frequently experience difficulty in obtaining access to information about reimbursement, such as fee schedule amounts or claim editing information. Since patients' coverage changes from time to time, practitioners who wish to continue to see their patients must participate with all plans in Vermont. Because withdrawal is a drastic option exercised rarely, Vermont patients have generally had access to health care practitioners regardless of the plan they find themselves in.

Health care practitioners' level of satisfaction with their interactions with health plans varies considerably from plan to plan, with some plans consistently receiving higher ratings and others lower. BISHCA's 2007 *Evaluation of Managed Care Organization Data Filings* found that provider satisfaction ranged from low to moderate. Key areas of dissatisfaction included the claims payment process, communication with providers, and ease of plans' prior authorization processes. While other states have enacted laws that create more balance in the relationship between practitioners and health plans, until last year Vermont's only statutory protection for health care practitioners was a timely payment law passed a decade ago. Last year in Sections 27 through 30 of Act 203, provisions were added to address overpayment recovery, claim editing and processing, prior authorization and credentialing. A number of other issues, including the contract standard issues were deferred pending the outcome of this study group required by Section 31 of Act 203.

Nationwide, in the past few years, health care practitioners reached class action settlements with national health insurers and many BC/BS plans, addressing physician concerns such as the insurers' failure to provide physicians with information about how they would be paid under plan fee schedules as modified by computerized claim editing, the insurers' failure to follow national coding standards, their failure to make timely payments, and their failure to comply with other contract standards. CIGNA was the only large Vermont plan directly affected by these settlements; although many health care practitioners in Vermont have reported problems similar to those addressed in the settlements. A number of other states have begun to incorporate these protections in their laws.

At the same time, Vermont health care practitioners have experienced the impact of health plan procedures and contract provisions on their practices. Practitioners experience frustration in obtaining payment and complying with plan administrative procedures and requirements. This frustration would be ameliorated by creating increased transparency and clear contract standards applicable to all payers. Practitioners' perception of increasing administrative hassles, cost and frustration impacts the practice environment and has been reported to affect recruitment, retention and decisions relating to early retirement.

Proposed solutions

The attached draft bill creates standards and transparency requirements for health care practitioner relationships with health plans and focuses on the problems identified by Vermont practitioners, members of the Act 203 workgroup, the BISHCA evaluation, and the class-action settlements. The draft bill intends to create a level playing field and a set

of standards for all entities contracting with health care practitioners in Vermont. The group acknowledged throughout the process that the plans participating most actively in the study group process were already meeting a number of the standards being discussed by the group. These plans' support for many of the proposed solutions in the draft was predicated on ensuring that other entities participating in the Vermont market would be required to adhere to the same level of corporate best practices as those followed by the participating plans.

The draft bill includes specific standards for health practitioner contracts with health plans and amendments to these contracts that ensure access to information, including:

- Information including information about reimbursement such as fee schedules and claim editing and bundling procedures,
- Health plan products covered in the contract,
- Term and termination of the contract,
- Contact information for entity responsible for processing payment, and
- Mechanisms to resolve grievances.

Each contract or amendment is required to include a summary sheet that includes material terms and contact information for the contracting entity.

While mutually agreed-on amendments to health care contracts are always preferred, the amendment standards in the draft bill, at a minimum, require 60 days notice of an amendment, and are designed to encourage communication and resolution of concerns. They permit practitioners to object to amendments within the 60-day period, and if the objection is not resolved, either the plan or the practitioner may terminate the contract relationship. During the termination period, the underlying contract terms, not the amendment terms, remain in effect.

The draft bill disallows the use of "most-favored nation" clauses in contracts. These clauses take various forms. One example prohibits practitioners from granting larger discounts to other plans than to the contracting plan. Other examples require practitioners to accept lower payment from one payer if accept lower payment from another or require them to disclose the reimbursement rates they have agreed to with other payers.

The draft bill updates Vermont's timely payment law by reducing the time for payment of uncontested claims from 45 days to 30 day. It regulates the operation of rental networks within Vermont by requiring registration of rental networks with BISHCA, and by requiring disclosure of rental network transactions and termination of the use of the rental network and associated discounts when the original underlying contract is terminated.

Areas of disagreement

The draft bill prohibits the use of "all-products" clauses, contract provisions that require health care practitioners who agree to provide services to patients covered by one insurer product to provide services to patients covered by all other products offered by the same insurer, including products that may include lower reimbursement terms or administrative

terms that health care practitioners do not find acceptable. BISHCA and MVP objected to this prohibition and the disagreement was not resolved.

The draft bill also includes a private right of action that health plans object to, but health care practitioners believe is an important enforcement tool. Practitioners are concerned that because BISHCA's enforcement authority will be limited by the available funds and personnel, it will be insufficient to address all problems. Additionally, if a contract does not track the requirements of the law, a breach of contract action will not be effective to resolve the problem, because the problem will not be a breach of the contract terms. Health plans raised concerns about the potential expense of frivolous lawsuits and believe that BISHCA's enforcement powers, in addition to existing breach of contract actions offer sufficient remedies for practitioners.

Fair and Transparent Contract Standards Report

Problem Statement

Preserving a strong health care delivery system is critical to ensure that Vermont will have the ability to address the health care needs of its population. According to BISHCA's 2005 *Health Resource Allocation Plan* (HRAP), Vermont's 65 and older population is projected to increase almost 50% from 2000 to 2015. The burden of chronic illness in this older population will create additional demands on already-strained resources. At the same time, the HRAP found that Vermont is experiencing workforce shortages and mal-distribution in a number of health care professions.⁴ Consistent with the HRAP's finding, the Department of Health's physician license renewal survey data shows that between 1996 and 2006, access to primary care physician practices declined significantly. In 1996, 92% of Vermont primary care physicians were accepting new patients and 87% were accepting new Medicaid patients. By 2006, only 82% of physicians were accepting new patients and only 71% were accepting new Medicaid patients,⁵ a decline in access to primary care of 10% for all patients and 16% for Medicaid patients.

Ensuring a strong health care delivery system is critical to ensure that Vermont will have the ability to address the acute and chronic care needs of its increasingly older population. Most practitioners, particularly those in small independent practices, have very limited ability to negotiate with health plans around amendments, all-products clauses, reimbursement or other contract terms. Practitioners frequently experience difficulty in obtaining access to information about reimbursement, such as fee schedule amounts or claim editing information. Since patients' coverage changes from time to time, practitioners who wish to continue to see their patients must participate with all plans in Vermont. Because withdrawal is a drastic option exercised rarely, Vermont patients have generally had access to health care practitioners regardless of the plan they find themselves in.

Vermont health care practitioners have experienced the impact of health plans' administrative policies and procedures and health plans' contract provisions on their practices. Practitioners experience frustration in obtaining payment and complying with plans' administrative procedures and requirements. This frustration would be addressed in part by creating increased transparency and clear contract standards applicable to all payers. Practitioners' perception of increasing administrative hassles, cost and frustration impacts the practice environment and has been reported to affect recruitment, retention and decisions relating to early retirement.

⁴ http://www.bishca.state.vt.us/HcaDiv/HRAP_Act53/HRAP_final8105.pdf Executive Summary pages iii-iv

⁵ <http://healthvermont.gov/pubs/documents/phys06bk.PDF>;
<http://healthvermont.gov/pubs/documents/PHYS06pp.pdf>

While other states have enacted laws that create more balance in the relationship between practitioners and health plans, until last year Vermont's only statutory protection for health care practitioners was a timely payment law passed a decade ago. Last year in Sections 27 – 30 of Act 203, provisions were added to address overpayment recovery, claim processing and editing, prior authorization and credentialing.

BISHCA Provider Satisfaction Evaluation

Health care practitioners' level of satisfaction with their interactions with health plans varies considerably from plan to plan, with some plans consistently receiving higher ratings and others lower. The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) annually evaluates provider satisfaction. Seven managed care organizations are subject to BISHCA's oversight and as part of that oversight are required to submit data filings annually to BISHCA: Blue Cross Blue Shield of Vermont/Vermont Health Partnership (BCBS), CIGNA Healthcare (CIGNA), CIGNA Behavioral Health (CBH), Magellan Behavioral Health (MBH), MVP Health Plan (MVP) PrimariLink (PrimariLink), and The Vermont Health Plan (TVHP). BISHCA's *Evaluation of the 2007 Rule 10 Managed Care Organization (MCO) Data Filings*⁶ found that overall "provider satisfaction with the MCOs is in most cases low to moderate with satisfaction varying between 33% and 86%."⁷ Key areas of dissatisfaction identified in the report included the claims payment process, communication with providers, ease of the prior authorization process, and satisfaction with pharmacy management programs. The report found CIGNA's levels of provider satisfaction to be noticeably lower in all areas measured, compared to the other MCOs.⁸

Provider satisfaction rates did not improve markedly from 2006 to 2007; the BISHCA *Evaluation of the 2006 MCO Data Filings* found overall satisfaction in 2006 to range from 43% to 85%. Three of the areas of dissatisfaction identified by the BISHCA evaluation in 2006 persisted in 2007 – claim payment process, prior authorization process, and the pharmacy management programs.⁹

Common Claims Report

Vermont has attempted through its health care reform process to make the relationship between health practitioners and plans simpler and more transparent. Section 55 of Act

⁶

http://www.bishca.state.vt.us/HcaDiv/Data_Reports/Rule10_annual_report/2007rule10_mancare_datafiling_eval.pdf

⁷ Id. at page 5.

⁸ Id at page 150.

⁹

http://www.bishca.state.vt.us/HcaDiv/Data_Reports/Rule10_annual_report/2006Rule10_mancare_datafiling_eval.pdf

191 (2006)¹⁰ created the Common Claims Work Group and charged the group with designing and implementing steps to simplify the claims administration process and lower administrative costs in the health care system. One of the areas addressed by that work group was improving the efficiency of claims administration. A subcommittee was formed that identified the lack of consistency in insurers' claims adjudication rules as causing payment delays, appeals and additional administrative burden and noted that billing for assistant surgeons, modifiers, claims bundling and unbundling were particularly problematic. The subcommittee found that there was a need for increased transparency to ensure that providers can know in advance how claims will be adjudicated and what they will be paid.

In its recommendations, the work group identified transparency as a key component of the group's goal of increasing the efficiency of claims adjudication and recommended adopting a rule patterned on a California rule that requires disclosure of detailed payment policies and rules. The group also recommended improving the process by which insurers notify providers of material changes to claim adjudication rules by ensuring that notice is provided at least 30 days before the change is implemented and by affording affected parties an opportunity to comment on the planned change. Two health plans that participated on the subcommittee, in letters attached to the report, expressed concern about implementing the California rule transparency requirements in Vermont.¹¹ The recommendations of the report were not implemented. The Act 203 contract standards group addressed creating standards and transparency for claim adjudication and reimbursement, but did not recommend implementing the California transparency rule.

Managed Care Settlements

At the national level, in 2001 and 2002, physicians filed class action lawsuits against major health insurers, including CIGNA and a number of BlueCross Blue Shield plans (not Blue Cross Blue Shield of Vermont), to address many of the issues reviewed by the contract standards workgroup. The lawsuits alleged that the insurers

- Improperly denied reimbursement for medically necessary services by
 - Bundling – refusing payment or reducing payment for more than one service per visit;
 - Downcoding – routinely retroactively reducing the code billed by a physician for a service to a lower code;
 - Denying reimbursement for complicated cases that require additional services – identified by modifiers;
 - Using software programs to automatically down code and deny payment; and
 - Denying payments for unrelated services as services that fall within a “global period;”
- Monitored and penalized physicians for high utilization by improperly applying guidelines to deny medically necessary care;

¹⁰ <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.HTM>

¹¹ <http://www.leg.state.vt.us/CommissiononHealthCareReform/Executive%20Summary.FINALVersion.pdf>
pages 8-9; 58-69

- Failed to make payments within time periods required by law and contract;
- Failed to provide physicians with fee schedule and payment information;
- Failed to provide explanation as to failure to reimburse claims in whole or in part; and
- Failed to provide adequate staffing, resulting in extended telephone time to obtain prior authorization.

Approximately nine national insurers entered into class action settlements with health care practitioners that address these and other issues, including access to fee schedules, disclosure of claims payment practices, contract termination without cause, prompt payment claims submission, downcoding, bundling and computerized claim editing, and overpayment recovery.¹² The contract standards group reviewed several of the provisions of these class action settlements, in its effort to address problems similar to those identified in the lawsuits and settlements.

Rental Network

Entities that rent and sell contractual practitioner discounts and networks, often with virtually no disclosure to the health care practitioner, have emerged as an increasing problem in Vermont. While large practices and PHOs are aware of this practice, many smaller groups and solo practitioners are not well-equipped to deal with this issue.

When a health care practitioner contracts with a health insurer and joins the insurer's network, the practitioner often agrees to accept a discounted payment rate in return for the plan directing patients into his or her practice. Over the past ten years, an unregulated secondary discount market has evolved that takes advantage of these discounted rates. A practitioner who decides to contract with a single network preferred provider organization (PPO) may unknowingly end up with dozens of rental network PPOs, as third-party payers. These entities have contracted with the original PPO to gain access to any and all discount agreements that the first PPO has negotiated with the practitioner. Often this access is gained without the practitioner's prior knowledge or permission.

In some cases, the discounting entities remove the contracting step altogether. These entities send what appear to be solicitations for participation in a PPO network, but which are actually treated as "opt out" agreements. If a practitioner fails to "opt out" he or she is considered to be a participant.

In November of 2008, the National Conference of Insurance Legislators (NCOIL) adopted model rental network legislation, designed for enactment by states. The model bill was the outcome of an effort to reach consensus among national organizations representing physicians, networks and insurers including the American Medical Association (AMA) and the American Association of Preferred Provider Organization (AAPPO), and America's Health Insurance Plans (AHIP). The NCOIL model bill is included in Appendix D.

¹² <http://www.hmosettlements.com/index.html>

Although two of the major Vermont health insurers do not engage in this practice, the work group learned from practice managers that approximately 15 entities are engaging in this practice in Vermont. The contract standards group attempted to address these issues by requiring oversight, transparency and standards for these operations in the draft bill.

Study group process

Consistent with the requirements of Section 31 of Act 203, the Vermont Medical Society (VMS) convened the Contract Standards work group by inviting representatives of health care professionals, health care facilities, health insurers, physician hospital organizations, practice managers, and state government to participate in the study. The workgroup met from June through December, with four full-group meetings and a number of topic-specific subcommittee meetings and conference calls. Materials were distributed to a list of over 70 interested groups and individuals, representing insurers, health care practitioners, hospitals, practice managers, physician hospital organizations (PHOs), national associations, and state agencies including BISHCA and OVHA. Most full group meetings were attended by about 20 participants of the work group. Although there was a good effort to reach consensus on all parts, two primary areas of disagreement remained at the end of the process. A list of more than 70 participants who received study group notices, documents and other materials by e-mail is included in Appendix C.

The first meeting of the full work group held on June 20, 2008 and was attended by 26 members of the group representing a broad cross section of health care practitioners, health care facilities, practice managers, insurers, and state agencies. At this meeting, the work group reviewed the legislative charge and the draft legislation introduced to the House Health Care committee in late February of 2008 and flagged a number of substantive and drafting issues for further discussion and research.

Draft legislation addressing contract standards, most favored nation clauses and prompt payment, rental networks and all products clauses was prepared by VMS staff based on legislation from other states and distributed to the e-mail list in August. A subcommittee conference call was held on August 27, 2008 to begin to discuss the draft, focusing on Sections I and II, Definitions and Contract Standards.

The full group met again on September 5, 2008 and continued discussion of the draft. To resolve issues identified by the work group, a subcommittee conference call was held on October 2, 2008 to discuss how to provide access to plans' fee schedule information to health care practitioners.

The next full group meeting on October 3, 2008 focused largely on the timely payment and amendment sections. An enforcement subgroup met by conference call on October 22, 2008 and reached agreement on the BISHCA enforcement provisions and on the arbitration provision, but did not agree on the private right of action.

The final full-group meeting was held on November 14, 2008, to review a new draft bill circulated on October 31, 2008. The group agreed to disagree on several provisions and focused on determining realistic effective dates for the various provisions in the bill. A final conference call was held on December 3, 2008 to address the creation of claim processing and edit standards or transparency.

Throughout the process, members of the work group participated actively and listened to the various perspectives of members the group representing diverse interests. Through its efforts, the group was able to reach consensus on many issues, with some exceptions, including the all-products clause and a private right of action.

Minutes of work group and subcommittee meetings are included in Appendix D.

Summary of Findings and Proposed Legislation

The draft bill included as Appendix B creates standards and transparency requirements for health care practitioners' relationships with health plans that focus on the issues identified by Vermont practitioners, workgroup members, the BISHCA evaluation and the class-action settlements. The draft bill intends to create a level playing field and a set of standards for all entities contracting in Vermont. The work group acknowledged throughout the process that the plans participating most actively in the study group process were already meeting a number of the standards being discussed by the group. These plans' support for many of the proposed solutions in the draft was predicated on ensuring that other entities participating in the Vermont market would be required to adhere to the same level of corporate best practices as those followed by the participating plans.

Section I is the definition section and includes definitions of terms used in the draft such as "contracting entity," "health care contract," "most-favored nation," and "product."

Sections II and III create standards for health practitioner contracts with health plans and amendments to these contracts. The contract standards in Section II address access to:

- Reimbursement information including fee schedules and claim editing and bundling procedures; and
- Information about
 - Health plan products covered in the contract;
 - Term and termination of the contract;
 - Contact information for entity responsible for processing payment; and
 - Mechanisms to resolve grievances.

Access to fee schedule information will be provided on request, including payment amounts for the codes typically used by a provider in the same specialty or the codes actually billed by the requesting provider. The actual fee schedule information would not be required to be included in the contract. Plans could elect to provide this information either electronically or by CD-ROM but providers could request a hard copy instead. Non-participating providers who were actively determining whether to participate in a

plan would have access to fee schedule information, but not to information about edits, modifiers and bundling practices.

The draft bill modifies the requirements for transparency of claim edits included in Section 28 of Act 203. Plans will be able to elect to use the NCCI professional standards as a baseline, or in the alternative could elect to use national specialty society edit standards. Other proprietary edits will continue to be subject to BISHCA's approval, as required by Section 28. Plans will be required to disclose whether they are using NCCI or national specialty society standards and also to disclose their payment percentages for modifiers, on the web-based system required by Section 28 of Act 203.

While mutually agreed-on amendments to health care contracts are always preferred, the amendment standards in Section III of the bill at a minimum require 60 days notice of an amendment, and are designed to encourage communication and resolution of concerns. They permit practitioners to object to amendments within the 60-day period, and if the objection is not resolved, either the plan or the practitioner may terminate the contract relationship. During the termination period, the underlying contract terms, not the amendment terms, remain in effect. Sections II and III also require contracts and amendments to include a summary of material terms and contact information.

Section IV addresses and prohibits the use of "most favored nation" clauses in contracts. These clauses prohibit practitioners from granting larger discounts to another plan than to the contracting plan. They may require practitioners to accept lower payment from one payer if accept lower payment from another or require them to disclose the reimbursement rates they have agreed to with other payers. None of the major Vermont plans use most favored nation clauses in their contracts with health care practitioners, but other plans do use them.

Section V updates the timely payment law by reducing the time for payment of uncontested electronic and paper claims from 45 days to 30 days, and by requiring acknowledgment of electronic claims.

Section VI regulates the operation of rental networks within Vermont by requiring registration of rental networks with BISHCA. Section VI also requires disclosure of rental network transactions and requires termination of the use of network and discounts when the original underlying contract is terminated. Section VI is based on model legislation proposed by national organizations such as the American Medical Association (AMA) and the National Conference of Insurance Legislators (NCOIL) and on legislation adopted by other states including California, Ohio, Florida, Indiana, and Connecticut.

Section VII prohibits the use of "all products" clauses, contract provisions that require health care practitioners who agree to provide services to patients covered by one product, such as a fee-for-service product, to agree to provide services to patients covered by other products, such as HMOs, PPOs or government products, that may include lower reimbursement terms or administrative terms that health care practitioners do not find acceptable.

Section VIII confirms BISHCA's authority to enforce the provisions of the draft bill and clarifies that binding arbitration may be requested by either party to resolve disputes. Section VIII also includes a private right of action that health plans object to, but health care practitioners believe is an important enforcement tool.

Areas of Disagreement

The group was unable to reach consensus on whether to prohibit use of all-products clauses and whether to permit use of a private rights of action. One insurer that contracts by company expressed concern about disallowing all-products clauses since each of its current contracts addresses all of the products offered by that company. Health care practitioners, however, expressed concern that if they accepted one product offered by an insurer, under an all-products clause, they would be required to accept all products, some of which might have reimbursement provisions or administrative provisions that they do not find acceptable. Because failure to permit use of all-products clauses could result in fewer health care providers enrolling in programs with government regulated reduced fee schedules, such as Catamount, BISHCA expressed opposition to prohibiting all-products clauses that applied to government programs.

The group also split on the issue of whether to include a private right of action as an enforcement option. Health care practitioners believe that limiting enforcement options to BISHCA's administrative powers and to breach of contract actions is not sufficient. BISHCA's ability to investigate, order remediation, and levy fines where it finds patterns or practices that violate the law will be limited by the agency's budget, personnel, and priorities. An action for breach of contract would only be meaningful if the contract provisions were consistent with the law. If the contract itself failed to comply with the law, a breach of contract action would not offer relief. Health insurers raised concerns that including a private right of action could cause them to incur unnecessary expense defending frivolous actions and could make them liable for punitive damages which they believe are not available through contract actions. Health plans believe that BISHCA enforcement combined with breach of contract actions offer sufficient enforcement options for practitioners.

Appendices

- A. Text of Act 203 charge
- B. Proposed legislation
- C. List of participants and minutes of meetings
- D. Background information
 - Common Claims Report
 - NCOIL Model Bill
- E. AHIP Letter

Appendix A

Fair contracting standards study work group charge:

Act 203 An Act Relating to Health Care Reform

Sec. 31. FAIR CONTRACTING STANDARDS STUDY

The Vermont medical society, in collaboration with the department of banking, insurance, securities, and health care administration; the Vermont association of hospital and health systems; insurers; practice managers; and other interested parties, shall work to address the following issues and report to the house committee on health care and the senate committee on health and welfare on or before January 15, 2009:

(1) Fair and transparent contracting standards for providers participating in health insurance plans;

(2) Categories of coverage;

(3) Rental networks; and

(4) Most favored nation clauses.

1 **Appendix B**

2
3 **RE-DRAFT 1/2/09**
4 **Health Care Contract Standards**

5
6
7 **Section I Definitions**

8
9 “Affiliate” means any person or entity that has ownership or control of a contracting
10 entity, is owned or controlled by a contracting entity, or is under common ownership or
11 control with a contracting entity.

12
13 “Claim” 18 VSA 9418 (2) – means any claim, bill or request for payment for all or any
14 portion of provided health care services that is submitted by

- 15 • A health care provider or a health care facility pursuant to a contract or agreement
- 16 with a health plan or contracting entity, or
- 17 • A health care provider, health care facility or patient covered by the health plan.

18
19 “Contested claim” 18 VSA 9418 (3) – a claim submitted to a payer, health plan or
20 contracting entity that does not include:

- 21 (1) Sufficient information needed to determine payer liability; or
- 22 (2) Reasonable access to information needed to determine the liability or basis for
- 23 payment of the claim.

24
25 “Correct Coding Initiative” or “CCI” or “National Correct Coding Initiative” or “NCCI”
26 means the Centers for Medicare and Medicaid Services’ (CMS) published list of edits
27 and adjustments that are made to health care providers’ claims submitted for services of
28 supplies provided to patients insured under the federal Medicare program and under other
29 federal insurance programs.

30
31 “Contracting entity” - means any entity that contracts directly or indirectly with a health
32 care professional (A) for the delivery of health care services, or (B) for the selling,
33 leasing, renting, assigning or granting of access to a contract or terms of a contract. For
34 purposes of this section, a health care professional, PHO, health care facility, or stand
35 alone dental plan, is not a contracting entity.

36
37 “Covered entity” or “third party” means an entity that has not contracted directly with a
38 health care provider, but that buys, leases, rents, is assigned or accesses a health care
39 contract or the terms of a health care contract to gain access to a provider network
40 contract, that is responsible for (A) the payment or coordination of health care services,
41 or (B) for the establishment or extension of health care provider networks.

42
43 “Direct notification” means a written or electronic communication from a contracting
44 entity to a provider documenting third party access to a provider network.

1
2 “Edit” or “editing” means a practice or procedure pursuant to which one or more
3 adjustments are made to CPT® Codes or HCPCS Level II Codes included in a claim that
4 result in

- 5 • Payment being made on based on some, but not all, of the CPT® Codes or
6 HCPCS Level II Codes originally billed by a participating health care
7 provider,
- 8 • Payment being made based on different CPT® Codes or HCPCS Level II
9 Codes than those originally billed by a participating health care provider,
- 10 • Payment for one or more of the CPT® Codes or HCPCS Level II Codes
11 included in the claim originally billed by a participating health care
12 provider being reduced by application of payer’s editing software such as
13 multiple procedure logic software,
- 14 • Payment for one or more of the CPT® Codes or HCPCS Level II Codes
15 being denied,
- 16 • A reduced payment as a result of services provided to an enrollee that are
17 claimed under more than one procedure code on the same service date, or
18 • Any combination of the above.

19
20 “Enrollee” means any person eligible for health care benefits under a health benefit plan,
21 including an eligible recipient of Medicaid and includes all of the following terms:
22 enrollee, subscriber, member, insured, dependent, covered individual, and beneficiary.
23

24 “Health care contract,” “provider network contract” or “contract” means a contract
25 entered into, amended, or renewed between a contracting entity or health plan and a
26 health care provider specifying the rights and responsibilities of the contracting entity and
27 provider for the delivery of health care services to enrollees including, primary care
28 health services, preventive health services, chronic care services, specialty health care
29 services.
30

31 “Health care provider” or “provider” means any physician, or other health care
32 professional that contracts with a contracting entity or health plan to provide health care
33 services, and includes any physician group or health care provider group, physician
34 network, independent practice association, physician organization or physician hospital
35 organization, that is acting exclusively as an administrator on behalf of a health care
36 provider to facilitate the health care practitioner’s participation in health care contracts. A
37 “health care provider” includes a hospital, but does not include a pharmacist, a pharmacy,
38 a nursing home, or a health care practitioner organization or physician-hospital
39 organization that leases the health care practitioner organization’s or physician-hospital
40 organization’s network to a third party or contracts directly with employers or health and
41 welfare funds.
42

43 “Health Plan” means a health insurer, disability insurer, health maintenance organization,
44 or medical or hospital service corporation, workers’ compensation plan for a property and
45 casualty insurer licensed in Vermont, a state-financed health insurance program or any
46 self-insurance plan. “Health plan” also includes a health plan that requires its medical

1 groups, independent practice associations, or other independent contractors to pay claims
2 for the provision of services.

3
4 “Most Favored Nation” means a provision in a health care contract that

- 5 • Prohibits, or grants a contracting entity an option to prohibit, a participating
6 provider, who contracts with another contracting entity, from accepting lower
7 payment for the provision of health care services than the payment specified in
8 the first contracting entity’s contract;
- 9 • Requires, or grants a contracting entity an option to require, the participating
10 provider to accept a lower payment in the event the participating provider agrees
11 to provide health care services for any other contracting entity at a lower price;
- 12 • Requires, or grants a contracting entity an option to require, termination or
13 renegotiation of the existing health care contract in the event the participating
14 provider agrees to provide health care services for any other contracting entity at a
15 lower price;
- 16 • Requires the participating provider to disclose the participating provider’s
17 contractual reimbursement rates with other contracting entities.

18
19 “Participating Health Care Provider – means a health care provider that has a health care
20 contract with a contracting entity and is entitled to reimbursement for health care services
21 rendered to an enrollee under the health care contract. A “participating health care
22 provider” includes a hospital, but does not include a pharmacist, a pharmacy, a nursing
23 home, or a health care practitioner organization or physician-hospital organization that
24 leases the health care practitioner organization’s or physician-hospital organization’s
25 network to a third party or contracts directly with employers or health and welfare funds.

26
27 “Payer” – means any person or entity that assumes the financial risk for the payment of
28 claims under a health care contract or the reimbursement for health care services rendered
29 to an enrollee by a participating provider under the health care contract. The term
30 “payer” does not include entities such as reinsurers that do not directly pay claims or act
31 as contracting entities.

32
33 “Procedure Codes” – includes the American Medical Association’s current procedural
34 terminology codes (CPT®), the Healthcare Common Procedure Coding System Level II
35 Codes (HCPCS), the American Society of Anesthesiologists’ (ASA) current procedural
36 terminology, and the American Dental Association’s current dental terminology.

37
38 “Product” means one of the following types of categories of coverage for which a
39 participating provider may be obligated to provide health care services pursuant to a
40 health care contract:

- 41 ○ Health maintenance organization,
- 42 ○ Preferred provider organization,
- 43 ○ Fee for service or indemnity plan,
- 44 ○ Medicare Advantage HMO plan
- 45 ○ Medicare Advantage private fee-for-service plan,
- 46 ○ Medicare Advantage special needs plan,

- 1 ○ Medicare Advantage PPO,
- 2 ○ Medicare supplement plan,
- 3 ○ Workers compensation plan,
- 4 ○ Medicaid, VHAP, Dr. Dynasaur,
- 5 ○ SCHIP,
- 6 ○ Catamount Health or,
- 7 ○ Any other commercial health coverage plan or product.

8
9 **Section II Fair Contract Standards**

10
11 **(A)** Each contracting entity shall provide and each health care contract shall obligate the
12 contracting entity to provide participating health care providers with the following
13 information:

14
15 **(1)** Information sufficient for the participating provider to determine the compensation or
16 payment terms for health care services, including all of the following:

- 17
- 18 **(a)** The manner of payment, such as fee-for-service, capitation, case rate or
19 risk;
- 20 **(b)** On request, the fee for service dollar amount allowable for each CPT®
21 Code for those CPT ® Codes and that a provider in the same specialty
22 typically uses or that the requesting provider actually bills. Fee schedule
23 information may be provided by CD-ROM or electronically, at the election of
24 the contracting entity, but a provider may elect to receive a hard copy of the
25 fee schedule information instead of the CD-ROM or electronic version.
- 26
- 27 **(c)** A clearly understandable, readily available mechanism, such as a specific
28 web site address, includes the following information:
 - 29 i. The name of the commercially available claims editing software
30 product that the health plan, contracting entity, covered entity, or
31 payer utilizes;
 - 32 ii. The standard or standards from subsection (c) of Section 9418a
33 that the entity uses for claim edits;
 - 34 iii. Payment percentages for modifiers; and
 - 35 iv. Any significant proprietary edits, as determined by the health plan,
36 contracting entity, covered entity, or payer, added to the claims
37 software product, which are made at the request of the health plan,
38 contracting entity, covered entity, or payer, and have been
39 approved by the Commissioner pursuant to subsection (b) or (c) of
40 Section 9418a.

41
42 **(2)** Contracting entities shall provide the information described in subsections **(A)(1)(a)**
43 and **(b)** of this section to health care providers who are actively engaged in the process of
44 determining whether to become a participating provider in the contracting entity's
45 network.

1 (3) Changes to the manner of payment, to payment edits, or to the fee for service dollar
2 amounts allowable for CPT® Codes shall be considered contract amendments and shall
3 be subject to the contract amendment requirements in Section III, except as otherwise
4 provided in Section III (C)(2).

5
6 (4) Contracting entities may require health care providers to execute written
7 confidentiality agreements with respect to fee schedule and claim edit information
8 received from contracting entities.

9
10 (5) Each health care contract shall include the following information:

11 (a) Any product, company, or network for which the participating provider has agreed to
12 provide services;

13 (b) For each product or network, reimbursement terms and methodologies, unless the
14 terms are identical for multiple products or networks;

15 (c) The term of the health care contract;

16 (d) Termination notice period and reasons for termination;

17 (e) Language that identifies the contracting entity or payer responsible for the processing
18 of the participating provider's compensation or payment, including contact information,
19 including phone, fax and e-mail. This requirement may be satisfied by providing a
20 specific web address that contains the necessary information.

21 (f) Any internal mechanism provided by the contracting entity to resolve disputes
22 concerning the interpretation or application of the terms and conditions of the contract. A
23 contracting entity may satisfy this requirement by providing a clearly understandable,
24 readily available mechanism, such as a specific web site address or an appendix, that
25 allows a participating provider to determine the procedures for the internal mechanism to
26 resolve those disputes.

27 (g) A list of addenda, if any, to the contract.

28
29 (6) Effective dates:

30
31 (A) (1) through (4), with the exception of (A)(1)(c):

- 32 • Contracting entities shall provide the information required in (1) through (3) after
33 the effective date of the law.
- 34 • Contracts shall obligate contracting entities to provide the information in (A)(1)
35 through (4), with the exception of (A)(1)(c), on request within 60 days, and
36 otherwise within 180 days.

37 (A)(1)(c) –no later than 12 months after the effective date of this law.

38
39 (A)(5) Effective date of law.

40
41 (B)(1) Each contracting entity shall include a summary disclosure form with a health care
42 contract that includes all of the information specified in subsection (A) of this section.
43 The information in the summary disclosure form shall refer to the location in the health
44 care contract, whether a page number, section of the contract, appendix, or other
45 identifiable location, that specifies the provisions in the contract to which the information
46 in the form refers.

- 1
2 (2) The summary disclosure form shall include all of the following statements:
3 (a) That the form is a guide to the health care contract and that the terms and
4 conditions of the health care contract constitute the contract rights of the parties;
5 (b) That reading the form is not a substitute for reading the entire health care contract;
6 (c) That by signing the health care contract, the participating provider will be bound
7 by the contract's terms and conditions;
8 (d) That the terms and conditions of the health care contract may be amended
9 pursuant to (Section III) below and the participating provider is encouraged to
10 carefully read any proposed amendments sent after execution of the contract;
11 (e) That nothing in the summary disclosure form creates any additional rights or
12 causes of action in favor of either party.
13

14 (3) No contracting entity that includes any information in the summary disclosure form
15 with the reasonable belief that the information is truthful or accurate shall be subject to a
16 civil action for damages or to binding arbitration based on information included in the
17 summary disclosure form. Inclusion of intentional misstatements or intentional
18 misrepresentations in the summary disclosure form shall considered a violation of this
19 chapter subject to enforcement under Section VIII. Subsection (B)(3) of this section does
20 not impair or affect any power of the department of banking, insurance, securities and
21 health care administration to enforce any applicable law.
22

23 (4) The summary disclosure form described in subsections (B)(1) and (2) of this section
24 shall be in substantially the following form:
25

26 "SUMMARY DISCLOSURE FORM

- 27 (1) Compensation terms
28 (a) Manner of payment
29 [] Fee for service
30 [] Capitation
31 [] Risk
32 [] Other See
33 (b) Reimbursement schedule available at
34 (c) Claim edit information available at
35 (2) List of products or networks covered by this contract
36 []
37 []
38 []
39 []
40 []
41 (3) Term of this contract
42 (4) Termination Notice period
43 (5) Contracting entity or payer responsible for processing payment available at
44 (6) Internal mechanism for resolving disputes regarding contract terms available at
45
46 (7) Addenda to contract

1	Title	Subject
2	(a)	
3	(b)	
4	(c)	
5	(d)	
6	(8)	Telephone number to access a readily available mechanism, such as a specific web
7		site address, to allow a participating provider to receive the information in (1) through (6)
8		from the payer
9	(9)	Rental Network information required by Section VI (B)(2) including:
10	(a)	A statement that a purpose of the contract is to rent or lease the provider network to
11		third parties;
12	(b)	A statement that state law applies to such rental or lease and citation or link to the
13		law;
14	(c)	A statement that rental network rights terminate when the contract terminates
15	(d)	A statement that a rental network must comply with the terms of the contract,
16	(e)	A statement that a contracting entity must maintain a web page that lists the name and
17		contact information rental networks associated with the contract, including entities
18		responsible for payment;
19	(f)	A statement that rental networks must be identified on member or subscriber
20		identification cards, and remittance advices, and
21	(g)	A statement that a provider who believes a rental network has not complied with the
22		law may file a complaint with the Vermont Department of Banking, Insurance, Securities
23		and Health Care Administration, including contact information.

24
25 **IMPORTANT INFORMATION - PLEASE READ CAREFULLY**

26 The information provided in this Summary Disclosure Form is a guide to the attached
27 Health Care Contract. The terms and conditions of the attached Health Care Contract
28 constitute the contract rights of the parties.

29
30 Reading this Summary Disclosure Form is not a substitute for reading the entire Health
31 Care Contract. When you sign the Health Care Contract, you will be bound by its terms
32 and conditions. These terms and conditions may be amended over time pursuant to
33 (Section III). You are encouraged to read any proposed amendments that are sent to you
34 after execution of the Health Care Contract.

35
36 Nothing in this Summary Disclosure Form creates any additional rights or causes of
37 action in favor of either party."

38
39 **Effective dates for summary disclosure form:**

40 (C) On request, contracting entities shall provide the summary disclosure form required
41 by subsection (B) of this section within 60 days of the request.

42 (D) The summary disclosure form required by subsection (B) of this section shall be
43 included in all contracts which are entered or renewed after the effective date of this law
44 and shall be provided for all other existing contracts no later than 5 years after the
45 effective date of this law;

46

1 (E) When a contracting entity presents a proposed health care contract for consideration
2 by a provider, the contracting entity shall provide in writing or make reasonably available
3 the information required in subsection (A)(1) of this section.

4
5 (F) The contracting entity shall identify any utilization management, quality
6 improvement, “pay for performance,” “provider profiling,” price/quality transparency
7 program,” or a similar program that the contracting entity uses to review, monitor,
8 evaluate, or assess the services provided pursuant to a health care contract. The
9 contracting entity shall disclose the policies, procedures, or guidelines of such a program
10 applicable to a participating provider upon request by the participating provider within
11 fourteen days after the date of the request.

12
13 (G) The requirements of subsection (C) of this section do not prohibit a contracting entity
14 from requiring a reasonable confidentiality agreement between the provider and the
15 contracting entity regarding the terms of the proposed health care contract. If either party
16 violates the confidentiality agreement, a party to the confidentiality agreement may bring
17 a civil action to enjoin the other party from continuing any act that is in violation of the
18 confidentiality agreement, to recover damages, to terminate the contract, or to obtain any
19 combination of relief.

20
21 **Sec. III Contract Amendments.**

22
23 (A) A health care contract may be amended by mutual agreement of the parties,

24
25 (B) Absent mutual agreement of the parties, an amendment to a health care contract shall
26 occur only if the following conditions are met:

27
28 (1) The contracting entity provides to the participating provider the amendment in writing
29 and notice of the amendment not later than sixty days prior to the effective date of the
30 amendment. The notice shall be conspicuously entitled "Notice of Amendment to
31 Contract" and shall include a summary of the amendment as described in subsection
32 (B)(7) of this section.

33
34 (2) If within sixty days after receiving the amendment, notice and summary described in
35 subsection (B)(1) of this section, the participating provider objects in writing to the
36 amendment, and there is no resolution of the objection within 60 days, either party may
37 terminate the contract upon written notice of termination provided to the other party.
38 Termination shall become effective in the time period specified in the provider contract.
39 If no termination period is specified in the provider contract, the termination shall
40 become effective 90 days after the notice of termination is provided. The terms of the
41 underlying contract, not the amendment, remain in effect through the termination period.

42
43 (3) If the participating provider does not object to the amendment in the manner
44 described in subsection (B)(2) of this section, the amendment shall be effective as
45 specified in the notice described in subsection (B)(1) of this section.

1 (4) The 60-day notice period may be extended by mutual agreement of the parties.
2

3 (5) If the amendment is the addition of a new product and the health care provider objects
4 to the amendment, the addition shall not be effective as to the health care provider, and
5 the objection shall not be a basis upon which the contracting entity may terminate the
6 contract.
7

8 (6) The notice of amendment shall include a summary cover sheet that shall include the
9 following information:

- 10 a. Brief explanation of the amendment,
- 11 b. Date amendment will become effective,
- 12 c. Notice of right to object in writing to amendment,
- 13 d. Time for objection,
- 14 e. Where to send objection,
- 15 f. Who to call to discuss the amendment for further information or to resolve
16 objection,
- 17 g. Effect of objection,
- 18 h. Right to terminate contract if objection is not resolved,
- 19 i. Time period for termination, and
- 20 j. Where to send notice of termination.

21
22 (C)(1) Subsection (B) of this section does not apply if the delay caused by compliance
23 with the 60-day notice period in that subsection could result in imminent harm to an
24 enrollee, if the amendment of a health care contract is required by a state or federal law,
25 rule, or regulation that includes an effective date for the amendment, or if the provider
26 affirmatively accepts the amendment in writing and agrees to an earlier effective date
27 than otherwise required by subsection (B)(1) of this section.
28

29 (2) Subsection B of this section does not apply under any of the following circumstances:

- 30 (a) The participating provider's payment or compensation is based on the current
31 Medicaid or Medicare physician reimbursement schedule, and the change in
32 payment or compensation results solely from a change in that physician
33 reimbursement schedule.
- 34 (b) A routine change or update of the health care contract is made in response to
35 any addition, deletion, or revision of any service code, procedure code, or
36 reporting code, or a pricing change is made by any third party source.
37

38 For purposes of subsection (C)(2)(b) of this section:

- 39 (i) "Service code, procedure code, or reporting code" means the current
40 procedural terminology (CPT), current dental terminology (CDT), the
41 healthcare common procedure coding system (HCPCS), the international
42 classification of diseases (ICD), or the drug topics Red Book average
43 wholesale price (AWP).
- 44 (ii) "Third party source" means the American Medical Association (AMA),
45 the American Society of Anesthesiologists (ASA), the American Dental
46 Association, the Centers for Medicare and Medicaid Services (CMS), the

1 national center for health statistics, the department of health and human
2 services office of the inspector general, the Vermont department of
3 banking, insurance, securities and health care administration or the
4 Vermont agency of human services.
5

6 **(D)** Notwithstanding subsections (A), (B) and (C) of this section, a health care contract
7 may be amended by operation of law as required by any applicable state or federal law,
8 rule, or regulation.
9

10 **(E)** Subsection (B) of this section shall not apply to amendments of health care contracts
11 with hospitals.
12

13 **Sec. IV Most Favored Nation Clause**

14
15 No contracting entity shall do any of the following:
16

- 17 (1) Offer to a provider or hospital a health care contract that includes a most
18 favored nation clause;
- 19 (2) Enter into a health care contract with a provider or hospital that includes a
20 most favored nation clause;
- 21 (3) Amend an existing health care contract previously entered into with a provider
22 or hospital to include a most favored nation clause.
23

24 Contracting entities shall comply with this section no later than 180 days after the
25 effective date of this law.
26

27 **Sec. V – Amendments to 18 V.S.A. 9418 (Prompt Payment)**

28
29 (b) Within 30 calendar days of receipt of a claim that is not contested, a health plan,
30 contracting entity, or payer shall remit payment for the claim.
31

32 (c) A health plan, contracting entity or payer shall acknowledge receipt of an electronic
33 claim to the submitting party within 24 hours after the beginning of the next business day
34 after receipt of the claim. For purposes of this section the term “submitting party” means
35 a health care provider submitting a claim to a contracting entity, health plan or payer or a
36 clearinghouse submitting a claim on behalf of a health care provider to a contracting
37 entity, health plan or payer.
38

39 (d) If additional information is needed by health plan or payer to evaluate or validate any
40 claim for payment, the contracting entity, health plan or payer shall request additional
41 information in writing within 30 calendar days of receipt of a claim. The notice shall
42 specify in detail the information needed to evaluate or validate the claim.
43

44 (e) For a claim that is contested because the health plan, contracting entity or payer was
45 not provided with sufficient information to determine liability for payment and for which
46 written notice has been provided as required by subdivision (d) of this section, the health

1 plan, contracting entity or payer shall have 30 days after receipt of the additional
2 information requested in the written notice to process the claim and remit payment.

3
4 (f) Interest shall accrue on a claim at the rate of 12 percent per annum calculated as
5 follows:

- 6 (1) For a claim that is not contested, from the 31st calendar day after the date the
7 claim is received by the health plan, contracting entity or payer.
- 8 (2) For an electronic claim that is contested, for which acknowledgment of receipt of
9 claim and notice of additional information needed was provided as required by
10 subsections (c) and (d) of this section, from the 31st calendar day after the date
11 that the requested additional information is received.
- 12 (3) For a non-electronic claim that is contested, for which notice of additional
13 information needed was provided as required by subsection (d) of this section,
14 from the 31st calendar day after the date that the requested additional information
15 is received.
- 16 (4) For an electronic claim that is contested for which acknowledgment of receipt or
17 notice of additional information needed was not provided as required by
18 subsections (c) or (d) of this section or for which acknowledgment or notice was
19 provided later than the time periods required by subsections (c) or (d) of this
20 section, from the 31st calendar day after the date the original claim was received
21 by the health plan or payer.
- 22 (5) For a non-electronic claim for which notice of additional information needed was
23 not provided as required by this subsection (d) of this section or for which notice
24 of additional information needed was provided later than the time period required
25 by subsection (d) of this section, from the 31st day after the date the original claim
26 was received by the health plan, contracting entity or payer.
- 27 (6) For a claim that was denied, from the first calendar day after the 15-day period
28 following the date of a final arbitration award, judgment or administrative order
29 that found a health plan, contracting entity or payer to be liable for payment of the
30 claim.

31
32 (??) Health plans, contracting entities and payers shall comply with amendments to
33 subsections (b), (c), (d), (e) and (f) of this section no later than 12 months after the
34 effective date of this law.

35 36 **VI Rental network provisions**

37 38 Registration and Licensure.

39
40 (A) Registration. The Commissioner of Banking, Insurance, Securities and Health Care
41 Administration shall establish a registration process for all contracting entities, not
42 otherwise licensed or registered by the Department, and shall have jurisdiction to oversee
43 compliance of contracting entities and covered entities with the provisions of this
44 subchapter. The Commissioner may collect a reasonable fee for the purpose of
45 administering the registration process.

1 **(B)** A contracting entity's health care provider contract shall:
2

3 (1) State that entities that are not authorized by subsection (C)(1) of this section may not
4 apply or transfer rights under a health care contract, or the terms of a health care contract
5 including a health care provider's reimbursement rate under an agreement with a
6 contracting entity;
7

8 (2) State the following in clear terms in the body of the contract or amendment and in the
9 summary disclosure form required by Section II (B)(4) or Section III (B) (6) of this
10 subchapter, if the contract authorizes renting, leasing or otherwise providing access to the
11 provider's services:

12 (a) That a purpose of the contract or amendment is to rent or lease the provider panel
13 to other preferred provider networks, payers and other covered entities;

14 (b) That state laws and regulations applicable to such rental, lease, or other access
15 will apply to the contract or amendment.

16 (c) That health care providers who believe that the contract or amendment terms are
17 being inappropriately applied will have access to the enforcement process
18 identified in this subchapter and all applicable state remedies;
19

20 (3) Ensure that all covered entities to which the contracting entity has sold, rented,
21 assigned or otherwise given access to the health care provider's discounted rate comply
22 with all terms of the health care contract, including all requirements to encourage access
23 to the contracted health care provider, and requirements to pay the health care provider
24 pursuant to the rates of payment and methodology set forth in that contract without
25 further reduction;
26

27 (4) Require the contracting entity to obligate any covered entity through contract, to not
28 further sell, rent or give its right to access the health care provider's discounted rate to
29 any other entity, unless such entity is specifically approved by the contracting entity and
30 complies with all requirements of this subchapter;
31

32 (5) Require that upon termination of the contracting entity's health care provider contract,
33 the contracting entity must notify each covered entity that it must cease taking the health
34 care provider's discounted rate or exercising any other contractual right immediately.
35

36 **(C)(1)** No contracting entity shall sell, lease, rent, or give a third party access to the
37 contracting entity's rights to a participating provider's services pursuant to the contracting
38 entity's health care contract with the participating provider unless one of the following
39 applies:
40

41 (a) The covered entity accessing the participating provider's services under the health care
42 contract is an employer or other entity providing coverage for health care services to its
43 employees or members, and that employer or entity has a contract with the contracting
44 entity or its affiliate for the administration or processing of claims for payment for
45 services provided pursuant to the health care contract with the participating provider.
46

1 (b) The covered entity accessing the participating provider's services under the health
2 care contract either is an affiliate or subsidiary of the contracting entity or is providing
3 administrative services to, or receiving administrative services from, the contracting
4 entity or an affiliate or subsidiary of the contracting entity.
5

6 (d) The health care contract expressly states that it applies to network rental arrangements
7 and further states that one purpose of the contract is selling, renting, or giving the
8 contracting entity's rights under the health care contract, and the covered entity accessing
9 the participating provider's services is any of the following:
10

11 (i) A payer or a third-party administrator or other entity responsible for administering
12 claims on behalf of the payer;
13

14 (ii) A covered entity that receives access to the participating provider's services pursuant
15 to an arrangement with the contracting entity, provided that the covered entity complies
16 with all of the terms, conditions, and affirmative obligations to which the original
17 contracting entity is bound under its contract with the participating provider, including,
18 but not limited to, obligations concerning patient steerage and the prompt payment
19 requirements of Section V of this subchapter, compliance with state and federal laws, and
20 reimbursement terms specified by the participating providers contract with the
21 contracting entity.
22

23 (iii) An entity that is engaged in the business of providing electronic claims transport
24 between the contracting entity and the payer or third-party administrator and complies
25 with all of the applicable terms, conditions, and affirmative obligations of the contracting
26 entity's contract with the participating provider including, but not limited to, obligations
27 concerning patient steerage and the prompt payment requirements of Section V of this
28 subchapter, compliance with state and federal laws, and reimbursement terms specified
29 by the participating providers contract with the contracting entity.
30

31 **(C)(2)** The contracting entity that sells, leases, rents, gives or otherwise grants access to
32 the contracting entity's rights to the participating provider's services pursuant to the
33 contracting entity's health care contract with the participating provider as provided in this
34 section shall do the following:
35

36 (a) Maintain a web page that contains a listing of covered entities described in
37 subsections (C)(1)(b) and (c) of this section with whom a contracting entity contracts for
38 the purpose of selling, renting, or giving the contracting entity's rights to the services of
39 participating providers that is updated at least monthly and is accessible to all
40 participating providers, or maintain a toll-free telephone number accessible to all
41 participating providers by means of which participating providers may access the same
42 listing of third parties;
43

44 (b) Where the contracting entity or covered entity issues member or subscriber
45 identification cards, the cards shall, in a clear and legible manner, identify the entity
46 responsible for paying claims and the contracting entity, whose contracts with the health

1 care providers control the reimbursement for claims pursuant to the subscriber contract;
2 and

3
4 (c) Require that any covered entity accessing the participating provider's services through
5 the participating provider's health care contract with a contracting entity is obligated to
6 comply with all of the applicable terms and conditions of the contract, including, but not
7 limited to, the products for which the participating provider has agreed to provide
8 services, except that a payer receiving administrative services from the contracting entity
9 or its affiliate shall be solely responsible for payment to the participating provider under
10 the direct and specific oversight of the contracting entity, including accuracy of
11 reimbursement and problem resolution. Participating providers may balance bill patients
12 if a covered entity does not pay in accordance with the reimbursement terms of the
13 contracting entity.

14
15 (C)(3) Information provided to health care providers by contracting entities, covered
16 entities and their agents, including eligibility verification information, prior authorization
17 information, or payment information, shall be binding on all contracting entities, covered
18 entities, their affiliates and their agents.

19
20 (4) Each contracting entity or covered entity shall include in each response to an
21 eligibility verification request the name of the contracting entity through which the
22 reimbursement for the claim will be made.

23
24 (5) On and after January 1, 2010, all remittance advices, whether written or electronic,
25 shall clearly identify the following:

26 (a) The name of the covered entity responsible for payment to the health care provider,
27 and

28 (b) The name of the contracting entity through which the payment rate and any discounts
29 are claimed.

30
31 (6) Subject to any applicable continuity of care requirements,¹ agreements or contractual
32 provisions with a health care provider, a covered entity's right to exercise a contracting
33 entity's rights and responsibilities under a contract with a health care provider shall
34 terminate on the date such contracting entity's contract with such participating health care
35 provider is terminated.

36
37 (7) A contracting entity shall establish a process for participating health care providers to
38 use to communicate violations of this section. On receipt of information from a
39 participating health care provider that a covered entity is not complying with the terms of
40 the underlying contract, has violated this section, has failed to comply with timely
41 payment requirements, has further rented, sold or given its right to a physician's
42 discounted rates to other entities in violation of subsection (B)(4) of the section, or has
43 continued to exercise contract rights and discount after termination of the contracting
44 entity's contract with participating provider, within 30 days, the contracting entity shall
45 do at least one of the following:

¹ Vermont Board of Medical Practice Policy on Termination of Patients; BISHCA Rule 10

- 1 (a) Ensure that the covered entity corrects the violation, complies with the
2 terms of the underlying contract and causes correct payment to be
3 made, or
4 (b) Terminate the contracting entity's arrangement with the covered
5 entity.
6

7 **(D)** Contracting entities and covered entities shall comply with this section no later than
8 180 days after the effective date of this law.
9

10 **(E)** This section shall not apply in circumstances where access to the provider network is
11 granted to an entity operating under the same brand licensee program as the contracting
12 entity.
13

14 **VII All product clauses**

15
16 **(A)(1)** No contracting entity shall require, as a condition of contracting with the
17 contracting entity, that a participating provider provide services for all of the products
18 offered by the contracting entity.
19

20 **(2)** Subsection **(A)(1)** of this section shall not be construed to do any of the following:

- 21 **(a)** Prohibit any participating provider from voluntarily accepting an offer by a
22 contracting entity to provide health care services under all of the contracting entity's
23 products;
24 **(b)** Prohibit any contracting entity from offering any financial incentive or other form of
25 consideration specified in the health care contract for a participating provider to provide
26 health care services under all of the contracting entity's products;
27

28 **(3)(a)** Notwithstanding subsection **(A)(2)** of this section, no contracting entity shall
29 require, as a condition of contracting with the contracting entity, that the participating
30 provider accept any future product offering that the contracting entity makes.
31

32 **(4)** If a participating provider refuses to accept any future product offering that the
33 contracting entity makes, the addition of the future product shall not be effective as to the
34 health care provider, and the refusal shall not be a basis upon which the contracting entity
35 may terminate the contract.
36

37 **(B)** A participating provider may decline to participate in products on an annual basis and
38 at any time a new product is introduced.
39

40 **(C)** This section shall apply to all contracts entered or renewed after the effective date of
41 this law and shall apply to all other existing contracts no later than 5 years after the
42 effective date of this law.
43

44 **Sec. VIII – Enforcement**

45

- 1 (A) In addition to any other remedy provided by law, the commissioner shall have the
2 power to examine and investigate any health plan, contracting entity, covered
3 entity, or payer to determine if the health plan, contracting entity, covered entity or
4 payer has violated the provisions of this subchapter.
5
- 6 (B) If the commissioner finds that a health plan, contracting entity, covered entity or
7 payer has violated this subchapter, the commissioner may order the health plan,
8 contracting entity, covered entity, or payer to cease and desist from further
9 violations and may order the health plan, contracting entity, covered entity, or
10 payer to remediate the violation.
11
- 12 (C) If the commissioner finds that a health plan, contracting entity, covered entity or
13 payer has engaged in a pattern or practice of violating this subchapter the
14 commissioner may impose an administrative penalty against the health plan,
15 contracting entity, covered entity, or payer of no more than \$500.00 for each
16 violation. In determining the amount of penalty to be assessed, the commissioner
17 shall consider the following factors:
18 (1) The appropriateness of the penalty with respect to the financial resources and
19 good faith of the health plan, contracting entity, covered entity, or payer.
20 (2) The gravity of the violation or practice.
21 (3) The history of previous violations or practices of a similar nature.
22 (4) The economic benefit derived by the health plan, contracting entity, covered
23 entity, or payer and the economic impact on the health care facility or health care
24 provider resulting from the violation.
25 (5) Any other relevant factors. ²
26
- 27 (D) This subchapter may also be enforced by a health care provider under contract
28 with a health plan or contracting entity through a private cause of action in a court
29 of competent jurisdiction for damages and for injunctive relief to enjoin, restrain
30 or prevent a violation of this subchapter. The court may award costs and
31 reasonable attorney's fees to the health care provider who prevails in an action
32 under this section.
33
- 34 (E) Any dispute arising out of or relating to the provisions of this subchapter shall, at
35 the option of either party, be settled by arbitration in accordance with the rules or
36 procedures of a mutually agreed upon alternative dispute resolution forum such as
37 the American Arbitration Association, or the American Health Lawyers
38 Association. Judgment upon the arbitrator's award may be entered in any court
39 having jurisdiction and the arbitrator's award shall be binding on both parties.
40
- 41 (F) Nothing in this subchapter shall be construed to prohibit a health plan, contracting
42 entity, covered entity, or payer from applying payment policies that are consistent
43 with applicable federal or state laws and regulations, or to relieve a health plan,
44 contracting entity, covered entity, or payer from complying with payment
45 standards established by federal or state laws and regulations, including rules

² (18 V.S.A. Section 9418 (i))

1 adopted by the commissioner pursuant to section 9408 of this title, relating to
2 claims administration and adjudication standards, and rules adopted by the
3 commissioner pursuant to section 9414 of this title and section 4088f of Title 8,
4 relating to pay for performance or other payment methodology standards.³
5

6 **Amendment to 18 V.S.A. § 9412 Enforcement**
7

8 (a) In order to carry out the duties under this chapter, the commissioner, in addition to the
9 powers provided in Chapter 1 of Title 8 V.S.A. may examine the books, accounts and
10 papers of health insurers, health care providers, health care facilities, health plans,
11 contracting entities, covered entities, and payers and may administer oaths and may issue
12 subpoenas to a person to appear and testify or to produce documents or things.⁴
13

14 (b) In addition to any other power or duty authorized by law, the commissioner shall in
15 the case of health insurers, enforce a violation of a provision of this subchapter, or a rule
16 adopted pursuant to a provision of this subchapter, as a violation of a requirement of Title
17 8 relating to health insurers.⁵
18

19 **§ 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO**
20 **CODING RULES**
21

22 ...

23 (b) Health plans, contracting entities, covered entities, and payers shall accept and
24 initiate the processing of all health care claims submitted by a health care provider
25 pursuant to and consistent with the current version of the American Medical
26 Association's current procedural terminology (CPT) codes, reporting guidelines and
27 conventions; the Centers for Medicare and Medicaid Services health care common
28 procedure coding system (HCPCS); American Society of Anesthesiologists (ASA),
29 the National Correct Coding Initiative (NCCI); the National Council for Prescription
30 Drug Programs coding; or other appropriate standards, guidelines, or conventions
31 approved by the commissioner.

32 (c) When editing claims, health plans, contracting entities, covered entities and
33 payers shall adhere to the following edit standards, except as provided in
34 subsection (d) of this section,
35

- 36 i. The Current Procedural Terminology Codes (CPT), the Health
37 Care Common Procedure Coding System (HCPCS) and National
38 Correct Coding Initiative (NCCI);
- 39 ii. National specialty society edit standards; or
- 40 iii. Other appropriate edit standards, guidelines or conventions
41 approved by the Commissioner.
42

³ Act 203, Sections 27, 28, 29.

⁴ 18 V.S.A. § 9412 (a)

⁵ 18 V.S.A. § 9412 (b)

- 1 (d) Adherence to the edit standards in subsection (c)(i) or (c)(ii) of this section is not
2 required
- 3 i. when necessary to comply with state or federal law or coverage
4 mandates, or
- 5 ii. for services not addressed by NCCI standards or national specialty
6 society edit standards,
- 7 (e) Health plans, contracting entities, covered entities and payers may use edits that
8 are less restrictive for providers than NCCI or national specialty society edit
9 standards.
- 10 (f) Nothing in this section shall preclude a health plan contracting entity, covered
11 entity, or payer from determining that any such claim is not eligible for payment
12 in full or in part, based on a determination that:
- 13 (1) The claim is contested as defined in subdivision 9418(a)(3) of this title;
- 14 (2) The service provided is not a covered benefit under the contract, including a
15 determination that such service is not medically necessary or is experimental or
16 investigational;
- 17 (3) The enrollee did not obtain a referral, prior authorization, or precertification,
18 or satisfy any other condition precedent to receiving covered benefits from the
19 health care provider;
- 20 (4) The covered benefit exceeds the benefit limits of the contract;
- 21 (5) The person is not eligible for coverage or is otherwise not compliant with the
22 terms and conditions of his or her coverage agreement;
- 23 (6) The health plan has a reasonable belief that fraud or other intentional
24 misconduct has occurred; or
- 25 (7) The health plan contracting entity, covered entity, or payer determines
26 through coordination of benefits that another health entity is liable for the claim.
- 27
- 28 (g) Nothing in this section shall be deemed to require a health plan, contracting
29 entity, covered entity, or payer to pay or reimburse a claim, in full or in part, or to
30 dictate the amount of a claim to be paid by a health plan, contracting entity,
31 covered entity, or payer to a health care provider.
- 32
- 33 (h) No health plan, contracting entity, covered entity, or payer shall automatically
34 reassign or reduce the code level of evaluation and management codes billed for
35 covered services (downcoding), except that a health plan, contracting entity,
36 covered entity, or payer may reassign a new patient visit code to an established
37 patient visit code based solely on CPT codes, CPT guidelines, and CPT
38 conventions.
- 39
- 40 (i) Notwithstanding the provisions of subsection (f) of this section, and other than the
41 edits contained in the conventions in subsections (b) and (c) of this section, health
42 plans, contracting entities, covered entities, and payers shall continue to have the
43 right to deny, pend, or adjust claims for covered services on other bases and shall
44 have the right to reassign or reduce the code level for selected claims for covered
45 services based on a review of the clinical information provided at the time the
46 service was rendered for the particular claim or a review of the information

1 derived from a health plan's fraud or abuse billing detection programs that create
2 a reasonable belief of fraudulent or abusive billing practices, provided that the
3 decision to reassign or reduce is based primarily on a review of clinical
4 information.
5

6 (j) Every health plan, contracting entity, covered entity, or payer shall publish on its
7 provider website and in its provider newsletter:

- 8
- 9 i. The name of the commercially available claims editing software
10 product that the health plan, contracting entity, covered entity, or
11 payer utilizes;
 - 12 ii. The standard or standards from subsection (c) that the entity uses
13 for claim edits;
 - 14 iii. The payment percentages for modifiers; and
 - 15 iv. Any significant proprietary edits, as determined by the health plan,
16 contracting entity, covered entity, or payer, added to the claims
17 software product which are made at the request of the health plan,
18 contracting entity, covered entity, or payer, and have been
19 approved by the Commissioner pursuant to subsection (b) or (c) of
20 this Section; and

21

22 (k) Upon written request, the health plan, contracting entity, covered entity, or payer
23 shall also directly provide the information in subsection (j) of this section to a
24 health care provider who is a participating member in the health plan contracting
25 entity, covered entity, or payer's provider network.
26

Appendix C

List of contract standards work group participants

Meeting minutes

- June 20, 2008
- August 27, 2008
- September 5, 2008
- October 2, 2008 – Fee schedule subgroup
- October 3, 2008
- October 10, 2008 – Complete claim, effective date, claim processing subgroup
- October 22, 2008 – Enforcement subgroup
- November 14, 2008
- December 3, 2008 – Claim edit subgroup

Madeleine Mongan

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Contracting Standards Study Group
June 20, 2008
1:30 p.m.
BISHCA 3rd Floor Conference Room

Attendees:

Jon Aselin, COO, Primary Care Health Partners
Stephanie Beck, Provider Relations, OVHA
Gretchen Begnoche – Vermont Managed Care (VMC)
Pamela Biron, Director Reimbursement Programs, BC/BS of Vermont
Kathryn Callaghan – Director Employee Benefits, State of Vermont Administrative Services Division
Linda Cohen – Dinse, Knapp & McAndrew
Andrew Garland, Director, Provider Contracting, BC/BS of Vermont
Martita Giard – Director, Network Development, VMC, Inc.
Mary Gover – OVHA
Susan Gretkowski – MVP Health Care
Paul Harrington – VMS
Michelle Heezen – Director of Finance CVMC
Rebecca Heintz – Assistant General Counsel, BISHCA
Jeanne Kennedy – JB Kennedy Associates, LLC – CIGNA
Jill McDermott – William Shouldice & Associates
Lou McLaren – MVP Health Care
Jimmy Mauro – Reimbursement Consultant – BC/BS of Vermont
Madeleine Mongan - VMS
Jill Olson – VAHHS
Erin Orser – Contracting Counsel, BC/BS of Vermont
Brian Quigley – AHIP
Derek Raynes – Contracting FAHC
Sarah Rugnetta - BISHCA
Beth Wennar- Rosenberg, HealthInova, Bennington
Elizabeth Schumacher - AMA
Charles Storrow – Kimbell, Sherman & Ellis, America’s Health Insurance Plans (AHIP)

Madeleine Mongan convened the meeting at 1:30 p.m. After introductions, the group reviewed the legislative charge to the committee in Section 31 of Act 203 (H. 887).

The next agenda item was a review of the provisions in Section 4 (Fair Standards for Provider Contracts with Insurers) and Section 6 (Minimum Standards) of the legislative council draft dated February 29, 2008, of the 2008 Health Care Reform Bill, presented to the House Health Care Committee. In its review of the draft, the group identified some issues needing further discussion.

Substantive issues flagged for further research and discussion include

- Notice of “material changes” to contracts and the associated 90-day notice period;

- Contract amendment becoming effective automatically if contracting professional fails to notify insurer in writing within time period, for example 30 days;
- Access to full fee schedule or certain codes only, manner of access (or example, electronic access), and timing of access including access to fee schedules prior to signing a contract,
- Clear identification of sources of payment edits;
- Clarity of reimbursement methodology, for example an insurer may reimburse at 130% of Medicare in aggregate, but reimbursement may vary by code making it difficult for practitioners to determine what they will be paid;
- Rental networks or silent PPOs;
- Prompt payment;
- Category of coverage or all-products clauses, clauses requiring a contracting practitioner to take any patients with category of coverage at the insurer's option, such as commercial fee for service, HMO, PPO, Catamount, workers compensation, Medicare Advantage; and
- Health care practitioner ranking and tiering methodology, for example the settlements health insurers entered with the New York Attorney General.

To provide an opportunity for further discussion of these issues, two conference calls will be scheduled prior to the September meeting to address:

- Fair and transparent contracting including most-favored-nation clauses, material change, disclosure of fee schedules and prompt payment; and
- Rental network and category of coverage issues.

Suggested draft language, including language based on work underway in other states, will be circulated to the group to review prior to the conference calls.

Drafting issues to be resolved include defining "category of coverage," clarifying references to insurers, health plans, third-party payers and contracting entities, and adding AHLA as arbitration association. BISHCA Rule 10 permits termination without cause after at least 60-day notice; February 29, 2008 draft required 90 days based on law from Colorado.

The Office of Vermont Health Access has agreed to participate in the contracting standards group and to apprise the group of federal law barriers to contracting and reimbursement standards and standards that OVHA could adopt.

The group discussed the physician ranking settlement developed by the Attorney General in New York and reviewed a summary of the terms of that agreement. With respect to physician ranking and tiering, a subgroup, led by Paul Harrington from VMS and Lou McClaren from MVP will review current work under way, including the Blueprint, to avoid duplication and make recommendations to the study group.

The meeting adjourned at 2:50. Thanks to all participants.

Future meeting dates:

September 5 10:00 a.m. – noon;
October 3 10:00 a.m. – noon; and
November 14 10:00 a.m. – noon.

These meetings will take place at the BISHCA third floor conference room, Montpelier, VT. Telephone participation will be available.

Questions or comments should be directed to Madeleine Mongan or Paul Harrington at the Vermont Medical Society:

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Minutes
Contract Standards Committee Conference Call
August 27, 2008
2:00 pm to 3:30 pm

Participants:

Jon Aselin, Primary Care Health Partners (PCHP)
Gretchen Begnoche – Vermont Managed Care (VMC)
Pamela Biron, BC/BS of Vermont
Linda Cohen – Dinse, Knapp & McAndrew
Andrew Garland, BC/BS of Vermont
Martita Giard –VMC
Mary Gover – OVHA
Susan Gretkowski – representing MVP Health Care
Martha Halnon - PCHP
Paul Harrington – VMS
Michelle Heezen –CVMC
Jackie Hughes – Kimbell, Sherman & Ellis
Lou McLaren – MVP Health Care
Madeleine Mongan - VMS
Erin Orser – BC/BS of Vermont
Brian Quigley – America’s Health Insurance Plans (AHIP)
Derek Raynes – Contracting, FAHC
Sarah Rugnetta - BISHCA
Charles Storrow – Kimbell, Sherman & Ellis, representing AHIP

Madeleine Mongan, VMS convened the meeting at 2:00 p.m and reviewed the contract standards committee process. A draft of a contract standards bill introduced in the legislature in February 2008 was discussed at the June 20 meeting of the group. Issues identified by participants in going through that draft at the meeting were reflected in the minutes circulated by e-mail on July 10. Legislation enacted in other states and managed care class action settlements addressing contract standards, rental networks, prompt payment, most favored nation clauses and all products clauses were reviewed by VMS staff and two discussion drafts were prepared and circulated by e-mail for comment. The first, distributed on August 13, 2008 addressed contract standards, most favored nation clauses and prompt payment. The second, distributed on August 22, 2008 addressed rental networks and all products clauses.

Ms. Mongan acknowledged that Vermont health plans are meeting many or most of the standards being discussed already and are not the target of the draft legislation. The contracting environment has changed, however and health care practitioners may receive contracts from out-of-state entities they are unfamiliar with that include onerous terms and conditions.

Susan Gretkowski, who represents MVP, asked about the process going forward and whether the final draft would be a VMS draft or a consensus draft. VMS staff responded that the task of the committee is to prepare recommendations and draft legislation with respect to contract standards to present to the legislature in January. While every effort will be made to reach consensus, it may not be possible to achieve consensus on all issues. The report submitted to the legislature will identify issues where consensus was reached as well as those issues where consensus could not be reached.

The group went through the working draft of the contract standards draft and discussed the following issues. The comments below also include written and oral comments received by VMS staff outside of the conference call.

Section I Definitions:

“Contracting entity” – MVP questioned how responsibilities could be shared between PHOs and health plans or contracting entities. In some cases MVP passes through some contract requirements to PHOs who in turn provide information to individual practitioners. Section II(A)(1)(c) on page 4 is an example of a provision where this issue may come up and needs to be clarified. Hospitals most likely will not be included as contracting entities.

“Contest” Should the term “clean claim” be substituted for “contested claim?” BC/BS will send a definition of “clean claim,” for the group to consider.

“Edit” – this term may need more clarity to ensure that it covers modifiers and bundling. It is used in two places in the draft – first on page 4 in Section II (A)(1)(b)(ii) which requires contracting entities that are unable to comply with requirements in subsections (a)(ii) and (iii) to provide the identity of any internal processing edits, including the publisher, product name, version and version update of any editing software. The term “edit” is also used on page 5 where the identity of internal processing edits is one of the listed elements of the summary disclosure form.

“Enrollee” add “dependent” to the list at the end of the definition.

“Health care provider” VMS met with VAHHS to determine whether hospitals should be included or excluded. It is likely that hospitals will not wish to be included in Section II (contract standards) or Section VIII (all products clauses). They are included in the current prompt payment law and enforcement sections will remain included in these sections. VAHHS is investigating whether other sections such as rental networks, and most-favored-nation should apply to hospitals.

“Health plan” – This definition generally tracks a definition in the Vermont prompt payment statute 9418(a)(1), but state-financed health insurance programs and self-insurance plans were added. Susan Gretkowski and Brian Quigley (AHIP) raised concerns about the inclusion of workers’ compensation plans and disability insurers in the contract standards provisions.

“Material amendment” - health plans expressed concern that sorting material amendments from other amendments and applying different standards to them could be difficult to implement. The group agreed to consider deleting this definition and to review Section III on amendments to see whether that section should apply to all contract amendments.

“Participating health care provider” – the exclusions from the definition of health care provider should be included in this definition as well, if both definitions are needed.

“Payer” – this term should be clarified so that it does not apply to payers such as re-insurers who, although they assume financial risk, do not pay claims directly to health care providers or act as contracting entities.

“Procedure codes” – the American Society of Anesthesiologists should be added to address anesthesia codes.

“Product” – Add Medicare Advantage PPO. Brian Quigley questioned whether Medicare supplement plans should be included on this list. Further discussion of the definition of product will be deferred to the discussion of the All Products Clause in Section VIII of the draft circulated on 8/22.

Section II – Fair Contract Standards

(A)(1)(a)(i) – Manner of payment – add “case rate” and clarify that if reimbursement methods and rates differ for different products, they should be disclosed for each product or network.

(A)(1)(a)(ii) – Change “fee schedule” to “reimbursement schedule” wherever it occurs.

There was considerable discussion around provision of the entire fee schedule as opposed to the provision of certain codes or the provision of certain codes and the complete fee schedule only on request. A question was raised about whether this would apply to hospital outpatient reimbursement like DRGs, bundled payments, case rates and hybrid payments that may include procedure codes, facility fees and technical fees. VMS will discuss this with VAHHS. At least one group member recommended that fee schedules should be made available at no cost to the provider. Providers support having access to fee schedules on a secure website in a usable format, such as Excel so that they can analyze the information. Participating providers would have secure log-ons and passwords. In addition to the limits on sharing reimbursement information imposed by antitrust law, plan contracts could require that this information be kept confidential and not shared with others.

Including the fee schedule information in the contract itself was a major concern to health plans, because it would mean that multiple pages of fee schedule information that is subject to change would be required to be part of the contract. The group discussed whether the draft could instead require that the contract oblige the health plan to provide

this information to providers, but not require the health plan to include it in the contract itself.

A subgroup will work on this issue including representatives of Blue Cross/Blue Shield, MVP, VMC and PCHP. Others are welcome to participate as well. Please let VMS know if you are interested in participating in this discussion.

(A)(1)(c) Delete “by telephone.” Ensure that contracting entities such as health plans can delegate these responsibilities to PHOs. Ensure that remote payers like reinsurers are not required to provide this information to providers.

(A)(2) – Discussion of the requirement to include a list of products in the contract was deferred to the “all products clause” discussion. MVP for example contracts by MVP company and all products offered by the company are included in the contract. VMS questioned how to handle different products such as Catamount that have lower reimbursement.

Committee members recommended adding a new subsection (A)(4) Termination notice period and reasons for termination; and renumbering the remaining subsections

II (B) – Summary disclosure form – Concerns included whether having the summary form would discourage providers from reading the contract itself, whether the list of information to include on the form was too prescriptive or whether the introductory information was insulting to providers and whether the purpose achieved by having a summary disclosure form or executive summary could be achieved by some other means such as a table of contents.

II (D) - A question was raised about whether there would be consequences for failure to disclose policies and procedures within 14 days, what those consequences would be and whether health plans would be required to track their disclosure times.

II (E) – Discussion about the need for reciprocity of the confidentiality agreement provision. Some plans did not feel that reciprocity was needed; providers preferred having reciprocity.

Section III - Amendment

Section III – Comments received by VMS outside of the conference call recommended changing the time limits for notice of a non-material amendment from 15 days to 30 days; changing the time limit for objection to a material amendment from 15 days to 30 days and permitting either party to terminate the contract not later than 30 days prior to the effective date of the material amendment (instead of 60 days before the effective date).

Section IV – Most Favored Nation

MVP questioned whether this was an issue was designed to address a problem that was occurring in Vermont or whether the provision was included as a preventive measure. Paul Harrington responded that this was something that health care providers were seeing in Vermont in their dealings with health plans and contracting entities from other states.

Section V – Prompt Payment

Plans expressed some concern about changing the prompt payment time frame from 45 to 15 days. Even though most claims are paid in that time period, there are times when backlogs occur, which may result from changing computer systems, or changing regulatory requirements such as HIPAA or NPI. VMS staff explained that the Vermont prompt payment law was originally enacted in 1998 and since that time two things have happened. Electronic claim submission has become almost universal and many other states have enacted laws that are stronger than Vermont's law.

Plans also expressed concern about the mandated interest penalty on late payments which can result in a provider receiving a check for \$.05 of interest that costs the plan \$5.00 or more to send.

Plans noted that in the future they may wish to look into a reciprocal or at least shorter requirement for submission of claims by providers, which would help plans have a more predictable and consistent cash flow. Most plan contracts now allow providers 180 days to submit claims.

Section VI – Enforcement

The starting point for this section was the amended enforcement language included in Act 203, Sections 27, 28 and 29. This language is generally restated in subsections (B) and (D) of Section VI. In addition to health plans, these enforcement provisions would apply to "contracting entities." Subsection A of this section authorizes the commissioner of BISHCA to examine and investigate health plans and contracting entities with respect to violations of the subchapter. Subsection (C) creates a private right of action for health care providers and authorizes recovery of costs and attorney's fees. Sarah Rugnetta reported that BISHCA is reviewing the enforcement language and will provide input to the committee.

The draft also includes violations of this subchapter (contract standards, most favored nation, prompt payment, rental network, all products, overpayment recovery, prior authorization, and claim processing standards) on the list of unfair claim settlement practices for insurers in 8 V.S.A. § 4724.

Section VII – Rental Networks

Vermont health plans want to ensure that the rental network provisions do not apply to their branded products and affiliates.

Section VIII – All products clauses

MVP is concerned about this provision since each MVP company contracts with providers and each contract addresses all the products that company offers. VMS staff asked about Catamount, and other products with differing types and levels of reimbursement. Discussion deferred to next meeting.

Other Issues:

Effective date – Some plans use evergreen contracts that renew year after year, unless they are terminated or amended. Most providers would re-contract with a plan within a 3 to 5-year period. Plans need time to phase in the new requirements to their existing provider contracts.

Please send comments and language suggestions by e-mail on either draft as soon as possible.

Next meeting:

Friday, September 5, 2008 1-4 pm BISHCA 3rd floor conference room

Future meetings:

Friday October 3, 2008	1:30 p.m. to 3:30 p.m.
Friday, November 14, 2008	1:30 p.m. to 3:30 p.m.

Please note that all meetings are scheduled for the afternoon.

**Contract Standards Workgroup
Meeting Notes
September 5, 2008
1:00 pm
BISHCA Conference Room**

Participants:

Jon Aselin, Primary Care Health Partners (PCHP)
Gretchen Begnoche – Vermont Managed Care (VMC)
Andrew Garland, BC/BS of Vermont
Martita Giard –VMC
Susan Gretkowski – representing MVP Health Care
Martha Halnon - PCHP
Paul Harrington – VMS
Michelle Heezen –CVMC
Rebecca Heintz – BISHCA
Jackie Hughes – Kimbell, Sherman & Ellis representing BC/BS
Jeanne Kennedy – CIGNA
Mary Lacillade –state workers’ compensation plan
Lou McLaren – MVP Health Care
Madeleine Mongan - VMS
Erin Orser – BC/BS of Vermont
Anthony Otis – Vermont Pharmacists, Chiropractors
Brian Quigley – America’s Health Insurance Plans (AHIP)
Derek Raynes – Contracting, FAHC
Sarah Rugnetta - BISHCA
Charles Storrow – Kimbell, Sherman & Ellis, representing AHIP
Peter Taylor – Vermont State Dental Society

The group commenced discussion at 1:00 pm. and reviewed the minutes of the contract standards conference call on August 27, 2008. Jeanne Kennedy will be added to the participant list for that call. Madeleine noted that the minutes reflected the discussion on the call, but also referenced comments received outside of the meeting itself.

Section III – Amendment

The group picked up by discussing Section III – Amendments. Concern was expressed about categorizing amendments as “material” and “non-material,” – the approach taken by the two states – Ohio and Colorado – that have enacted contract standard laws so far. In those states, material amendments included amendments that affected reimbursement, or significantly affected administrative responsibilities for providers.

Plan representatives would prefer to maintain their current practice of giving providers 30-days notice of all amendments. The plan amendments automatically go into effect if the provider does not object in writing within the 30 days. Providers prefer to have all amendments to contracts agreed on by both parties, and are concerned about amendments become effective automatically. Depending on who opens the mail, providers may only become aware of the amendment after the time to object has expired. From the provider perspective, the 30-day time period is too short. Plans will investigate longer periods of time. Providers could automatically object to all amendments, which would stop the time clock on automatic adoption of the amendment and allow for discussion and consideration of amendments, an approach, if universally adopted, this practice would create difficulty for plans, and would be time-consuming for providers as well. Plans will investigate alternatives. Using the “material amendment” concept may be the most feasible middle ground, although not ideal.

Section IV – Most Favored Nation

The group did not have a problem with this section as drafted. VMS will coordinate with VAHHS.

Section V Prompt Payment

The group’s discussion clustered around requiring payment in 15 days for electronic claims and in 30 days for written claims. Plans expressed concern about changing from the current 45-day period, will look into how this change would affect them and the possible need to phase in such a change in payment deadlines.

The 30 day and 15 day periods for paper and electronic claims are consistent with the BC/BS and CIGNA class action settlements.

- Plan required to issue check for complete claims within 30 days (Plan had 9 months to implement)
- Plan required to issue check for complete claims submitted electronically within 15 days (Plan had 1 year to implement)

The 30-day and 15-day periods also are consistent the time frames for Medicare Part A & B electronic and paper claims in a CMS rule forwarded to the group by Brian Quigley.

Timely payment provisions from the BC and CIGNA settlements are included as Appendices A and B to these meeting notes.

BC/BS offered its definition of “Complete claim” for the group to consider:

“Complete claim”– A request for payment submitted by Provider on a CMS-1500 or UB-04 or their successor forms, or other industry-standard billing form, to a payer which is accurate and provides that information necessary for proper adjudication (including but not limited to: Provider name, Provider address, Provider tax identification number, National Provider Identifier, employer (account) identification number, insured name, insured certificate number, patient

name, patient date of birth, other insurance, date(s) of service, ICD-9-CM diagnostic codes, procedure description CPT-4 code(s), HCPCS code(s), amount charged), which does not unduly require medical records or other information, and as to which there is no substantial issue regarding the payor's responsibility for payment. A substantial issue may include, but should not be limited to, an issue related to subrogation, coordination of benefits, other third party recovery or other suspense condition.

MVP prefers to use the term "compliant claim," and to incorporate the HIPAA standards for claims for when standard transactions are submitted electronically.

Plans expressed concern that written acknowledgement of the receipt of written claims could be problematic. BC/BS acknowledges electronic claims within 24 hours. MVP acknowledges receipt of HIPAA compliant claims within 24 hours or the next business day, in the case of claims received on weekends and holidays.

MVP raised the issue of how to address intermediaries like McKesson or Web-MD who pay claims for smaller practices. VMS will work with VMC to redraft the language to address the intermediary issue.

MVP also pointed out the need for our draft to be consistent with the 2002 Department of Labor Claims rule. Although the DOL rule pertains to ERISA plans, plans apply it to all their processes for consistency, not just to their self-insured business. Susan Gretkowski and Lou McClaren will provide the group with the pertinent parts of the DOL 2002 Claims rule and proposed language to use in the draft.

The group discussed different approaches to address interest payments on late paid claims. Current law requires automatic payment of interest, which can result in administrative expense for plans. While BISHCA has ordered that interest be paid with the late payment in one case, plans would do not support this concept as a solution. Brian Quigley from AHIP circulated a CMS rule to the group that exempted plans from paying interest if 95% of their claims were paid on time. Batching claims for purposes of interest payments was also discussed. Plans will propose solutions to the group.

Section VI Enforcement

MVP objected to both the private right of action and BISHCA enforcement under the fair trade practices unfair competition laws. MVP would like the private right of action to be reciprocal, if it is included, but would prefer not to have a private right of action at all. AHIP questioned the need for a private right of action if enforcement was available under the prompt payment law and under the unfair competition law. This may be an area where consensus is not possible.

Section VII Rental Network

The group discussed rental networks. MVP asked whether this was a problem in Vermont as neither MVP nor Blue Cross engage in this practice. Madeleine provided a list of rental networks operating in Vermont, which included CIGNA, Vermont Managed Care (VMC) is aware of at least one other rental network and will provide this information to the group. Gretchen Begnoche from VMC explained how the rental network process works and how it unfairly affects physicians. Madeleine reviewed the 5 points of agreement on rental network regulation that were reached nationally by representatives of insurers, provider network and organized medicine, including AHIP. Madeleine also mentioned that some states were looking into registering rental networks through their departments of insurance, but that this had not been discussed with BISHCA. Brian Quigley explained AHIP's involvement in reaching consensus on the 5 points of agreement and also said that model legislation was being drafted for review by NCOIL. Madeleine asked participants to submit any specific language suggestions they have on this section.

VIII All Products Clauses

MVP and BISHCA object to this provision, and the group discussed alternatives. The problem is that providers are concerned about products with lower fees, such as government programs, or products with different payment structures or administrative requirements such as HMOs.

The group will consider how to permit employers and insurers to maintain benefit design variability without requiring providers to accept government products or products with externally imposed fee schedules.

Miscellaneous

The group considered whether the contract standards draft should apply to self-insured plans. The Ohio law that many of the provisions in the draft are based on did apply to self-insured plans and there are ERISA opinions that support this position. Andrew Garland (BC/BS) pointed out that smaller employers might find it burdensome to comply with the contract standards.

Next steps

Deciding the length of the notice period and process for amendments to contracts and finalizing decision on "material amendment;"

Resolving how to take clearinghouses into account in the prompt payment – complete/compliant claim equation;

Considering interest payment alternatives that create less administrative burden;

The reimbursement schedule group will discuss by e-mail how to provide fee schedule information to participating health care providers and providers who are considering joining a network.

The contract standards group adjourned at 3:00 p.m.

Next meetings:

Friday, October 3, 2008 1:30 pm to 3:30 pm BISHCA 3rd floor conference room

Friday, November 14, 2008 1:30 pm to 3:30 pm BISHCA 3rd floor conference room

Dial in number: 1 (800) 377-8846. Pass code: 54096025#

Location for all meetings: BISHCA 3rd floor conference room.

Appendix A
Timely Payment and Interest provisions
BC/BS Settlement Agreement:

7.18 Timelines for Processing and Payment of Complete Claims

(a) Beginning not later than nine (9) months after the Final Order Date, each Blue Plan shall direct the issuance of a check or an electronic funds transfer in payment for Complete Claims for Covered Services within thirty (30) calendar days following the later of the Blue Plan's receipt of such claim or the date on which the Blue Plan is in receipt of all information needed and in a format required for such claim to constitute a Complete Claim and is in receipt of all documentation which may be requested by a Blue Plan consistent with this Agreement and which is reasonably needed by the Blue Plan: (i) to determine that such claim does not contain any material defect or error; or (ii) to make a payment determination. Beginning one (1) year following the Effective Date, each Blue Plan shall direct the issuance of a check or an electronic funds transfer in payment for Complete Claims for Covered Services that are submitted electronically by Physicians within fifteen (15) business days following the later of the Blue Plan's receipt of such claim or the date on which the Blue Plan is in receipt of all information needed and in a format required for such claim to constitute a Complete Claim and is in receipt of all documentation which may be requested by a Blue Plan consistent with this Agreement and which is reasonably needed by the Blue Plan: (i) to determine that such claim does not contain any material defect or error; or (ii) to make a payment determination. If direction for the issuance of payment for Complete Claims for Covered Services is not made within the time periods specified in this § 7.18(a), the Blue Plan shall pay interest pursuant to § 7.18(b). For purposes of this § 7.18, where a state provides a definition of "clean claim" or "complete claim" which varies from the definition of Complete Claim provided herein, such definition shall be substituted for the definition of "Complete Claim" herein.

(b) For each Complete Claim with respect to which a Blue Plan has directed the issuance of a check or the electronic funds transfer later than the applicable period specified in § 7.18(a), the Blue Plan shall pay interest at the rate of eight percent (8%) per annum on the balance due on each such claim computed from the sixteenth (16th) business day or the thirty-first (31st) calendar day (as appropriate based on the circumstances described in § 7.18(a)) up to the date on which the Blue Plan directs the issuance of the check or the electronic funds transfer for payment of such Complete Claim; provided that to the extent that payment is made later than the period specified by applicable law or regulation, the Blue Plan shall pay interest at any rate specified by such law or regulation in lieu of the interest payment otherwise contemplated by this sentence. Interest paid pursuant to this § 7.18(b) shall, at the Blue Plan's election, either be included in the claim payment check or wire transfer or be remitted periodically (but at least quarterly) in a separate check or wire transfer along with a report detailing the claims for which interest is being paid.

(c) No Blue Plan shall have an obligation to make any interest payment pursuant to § 7.18(b) (i) with respect to any Complete Claim if, within thirty (30) days of the submission of an original claim, a duplicate claim is submitted while adjudication of the original claim is still in process; (ii) to any Participating Physician who balance bills a Plan Member in violation of such Participating Physician's agreement(s) with the Blue Plan; (iii) with respect to any time period during which a Force Majeure, as defined in § 7.32 of this Agreement, prevents adjudication of claims; or (iv) where payment is made to a Plan Member.

(d) Each Blue Plan shall affix to or on paper claims for Covered Services, or otherwise maintain a system for determining, the date such claims are received by the Blue Plan. Each Blue Plan shall send an electronic acknowledgement of claims for Covered Services submitted electronically identifying the date such claims are received by the Blue Plan. If a Blue Plan determines that there is any defect or error in a claim that prevents the claim from entering the Blue Plan's adjudication system, it shall provide notice within ten (10) days of receipt of such claim. Nothing contained in this § 7.18 is intended or shall be construed to alter a Blue Plan's ability to request Clinical Information consistent with the provisions of § 7.8(d)(ii) or any other provision of this Agreement.

(e) Notwithstanding anything in the Agreement to the contrary, the requirements of § 7.18 shall not apply to (i) claims for Covered Services that are processed under the BlueCard Program or any similar national account delivery program governed by the BCBSA (including but not limited to NASCO-to-NASCO arrangements) in which the Blue Plan participates but is not solely responsible for the processing and payment of the claim, and/or (ii) claims for Covered Services under a program offered or sponsored by any state or federal governmental entity other than in its capacity as an employer.

http://www.hmosettlements.com/settlements/bluecross/Thomas%20-%20Amended%20Settlement%20Agreement%20_Joinder%20of%20IBC_.pdf

Appendix B
Timely Payment and Interest Provisions
CIGNA Settlement

7.1.8 Payment of Simple Interest on Certain Claims.

a. Through the use of two new claims platforms described in Section 7.1 of this Agreement, CIGNA HealthCare has increased its ability to auto-adjudicate claims and to receive claims electronically. The level of claims submitted electronically has also increased. At present, approximately 60% of the claims handled on one new system are submitted electronically and approximately 70% are submitted electronically on the other. The new systems are presently processing for payment approximately 90% of the number of fee for service claims that include the information set forth in Section 7.17.b within fourteen (14) calendar days of receipt. Every claim-received by CIGNA HealthCare is and at least until the Termination Date will be logged with a receipt date whether the claim is received on paper or electronically. CIGNA HealthCare will continue to pursue initiatives designed to improve the timeliness of claim processing and shall attempt to include in its contracts with each clearinghouse a requirement that each such clearinghouse transmit claims to CIGNA HealthCare within twenty four (24) hours after such clearinghouse's receipt thereof.

b. CIGNA HealthCare shall pay simple interest of six percent (6%) per annum on the balance due on all claims submitted by Class Members that are processed and finalized for payment more than thirty (30) calendar days following the submission of all information necessary to make the claim consistent with Section 7.17.b of this Agreement. Beginning one year following Final Approval, for claims processed on either of the new systems referenced above, CIGNA HealthCare shall pay simple interest of six percent (6%) per annum on the balance due on all claims submitted electronically by Class Members that are processed and finalized for payment more than fifteen (15) Business Days following the submission of all information necessary to make the claim consistent with Section 7.17.b of this Agreement. Notwithstanding the foregoing, if CIGNA HealthCare determines that an applicable state law or regulation requires interest to be computed and paid at a different interest rate, CIGNA HealthCare shall observe the requirements of that state law or regulation. Under this provision, simple interest shall be computed from the sixteenth (16th) or the thirty-first (31st) day (as appropriate based on the circumstances described above) after CIGNA HealthCare receives the information necessary to make the claim consistent with Section 7.17.b to the date on which the claim is processed by CIGNA HealthCare and placed in line for payment. Interest so computed shall, at CIGNA HealthCare's election, either be included in the claim payment check or wire transfer or be remitted in a separate check or wire transfer. Notwithstanding the terms of this subparagraph, CIGNA HealthCare shall have no obligation to make any interest payment on any such claim as to which (i) the Class Member, within thirty (30) days of the submission of an original claim, submits a duplicate claim while the original claim is still being processed; or (ii) the Class Member violates the terms of his, her or its contract with CIGNA HealthCare by inappropriately billing a CIGNA HealthCare Member for the balance due from CIGNA HealthCare. In addition, with respect to

interest payments that total less than One Dollar (\$1.00) on any single claim ("de minimis interest"), CIGNA HealthCare may, at its sole option, either (i) pay such amounts in the same manner as any other interest payment under this paragraph, or (ii) if it determines that it cannot practically pay using option (i), calculate the total dollar amount of de minimis interest for each year during the period for which this section 7.18 applies, and pay such amount to the Foundation. If CIGNA HealthCare elects the approach described in subsection (ii) in the preceding sentence, the calculation of de minimis interest will be determined by a claim audit based on statistically valid claim audit procedures and will include interest on the de minimis interest for the preceding year, which interest of six percent (6%) per annum will be calculated on a reasonable basis. CIGNA HealthCare will provide the audits to Notice Counsel.

<http://www.hmosettlements.com/settlements/cigna/CIGNASettlementAgreement2.pdf>

**Fee schedule subgroup
Contract Standards Committee
Conference call
October 2, 2008
10:30 a.m. to 12:00 p.m.**

Participants:

Anthony Otis, Delta Dental
Pam Biron, BC/BS
Jo-Ann Beaudin, Otter Valley
Susan Gretkowski, MMR for MVP
Brenda Hornbuckle-Davis, Magellan
Jon Asselin, PCHP
Martha Halnon, PCHP
Gretchen Begnoche, VMC
Rebecca Heintz, BISHCA
Lou McClaren, MVP
Erin Orser, BC/BS
Andrew Garland, BC/BS
Brian Quigley, AHIP
Rebecca Bowen, CVPHO
Madeleine Mongan, VMS

Issues discussed included:

Access to fee schedule information. The group reviewed the settlement language from the BC/BS class action settlement and proposed to require access to fee schedule information on request, including codes typically used by a provider in the same specialty or codes actually billed by the requesting provider. Plans could elect to provide this information either electronically or by CD-ROM but providers could request a hard copy instead.

Access to information that allows providers to determine the effect of procedure codes, edits, modifiers and bundling on reimbursement, payment or compensation before a service is provided or a claim is submitted. The group discussed this subject at length. CIGNA currently provides this information, but as a national plan, a \$1 million increase in IT infrastructure for CIGNA would only result in a very small increase in PMPM. Smaller plans could see a significantly higher PMPM premium increase, with a similar investment. Both MVP and BC/BS are currently working on providing this information to providers, but need additional time to phase in a change like this. The phrase "as soon as reasonably practicable" concerns MVP, and plans will work with VMS on finding a more specific but reasonable time period for the phase-in.

Access by providers who are actively involved in determining whether to become a participating provider. The group decided to permit these non-participating providers to

have access to fee schedule information, but not to information about edits, modifiers and bundling practices of contracting entities at this time.

MVP will work with VMS to determine if this draft can be adjusted to ensure consistency with the new BISHCA Price and Quality rule.

Pam Biron (BC/BS) will circulate the report from the “Common Claim” subgroup that examined issues relevant to fee schedules, modifiers, bundling, etc.

Provider representatives will look at the claim processing language that passed in Vermont last year and determine if any further revisions are necessary to move in the direction of standardizing coding consistent with NCCI, CPT, etc. Jon Asselin (PCHP) noted the detailed information about coding standards and use of modifiers included in the BC/BS settlement.

Thanks to all for participating.

**Contract Standards Workgroup
Meeting Notes
October 3, 2008
1:30 pm – 3:00 pm
BISHCA 3rd Floor Conference Room**

Participants:

Jon Aselin, Primary Care Health Partners (PCHP)
Jo-Ann Beaudin, Otter Creek Associates
Gretchen Begnoche – Vermont Managed Care (VMC)
Pam Biron, BC/BS of Vermont
Andrew Garland, BC/BS of Vermont
Martita Giard –VMC
Mary Gover, OVHA
Susan Gretkowski – representing MVP Health Care
Martha Halnon - PCHP
Paul Harrington – VMS
Rebecca Heintz – BISHCA
Brenda Hornbuckle-Davis, Magellan
Jeanne Kennedy – CIGNA
Mary Lacillade –state workers’ compensation plan
Madeleine Mongan - VMS
Erin Orser – BC/BS of Vermont
Robert Penny, M.D., PCHP
Brian Quigley – America’s Health Insurance Plans (AHIP)
Derek Raynes – FAHC
Charles Storrow – Kimbell, Sherman & Ellis, representing AHIP
May Trimmell, Magellan
Beth Wennar, Healthnova

The group began its discussion at 1:30 p.m., reviewed the minutes of the contract standards meeting on October 3, 2008 and went through the following agenda issues for discussion and decision.

1. Definition of complete, clean, or compliant claim

Andrew Garland of Blue Cross will convene a subgroup to finalize language for a definition of complete claim (or clean claim or compliant claim) that includes electronic claims that meet the HIPAA standards. A possible starting point for discussion is the BC definition circulated with the minutes of the 9/5/08 meeting, or the definition of “complete claim” from the managed care settlements. The subgroup will include representatives of MVP, PCHP, VMC, VMS and FAHC. The goal will be to have a proposed definition by 10/17/08.

2. Timely payment

While no party prefers the change to a 30-day prompt payment period, (providers prefer the 15-day period for electronic claims used in New Hampshire and payers prefer the 45-day period in current law) the group generally agreed to a 30-day time period for payment of both electronic and paper claims.

The group discussed using an interest methodology similar to the one used by CMS where Medicare plans are not liable for interest if 95% of their claims are paid within the specified time frame. While both providers and plans understand the advantages of this model, accountability would be difficult for a regulator to ensure. Plans will investigate how this works with the private Medicare Advantage plans, to see if a similar model could be applied in Vermont. Unless this can be resolved, the group will stick with the interest methodology in current law, acknowledging that it is administratively burdensome and less than ideal. Electronic claims will be acknowledged within one working day 24 hours. Paper claims will not be subject to an acknowledgment requirement, but plans will notify providers within the 30-day period if additional information is needed to process a claim. Plans will have 12 months to phase in timely payment changes.

3. Amendment

The amendment provisions will apply to all amendments, and the reference to “material amendment” will be deleted. An amendment cover sheet will be required to include basic information such as the subject of the amendment, the time period to object, plan contact to discuss amendment, address for objections, and termination provisions. Plans will provide 60 days notice of amendments. Providers will have 60 days to object and to attempt to resolve concerns with the plan. If resolution is not possible and if providers initiate termination within the 60-day period, the old contract will remain in effect through the termination period specified in the provider contracts. Termination will not be automatic. Plans and providers may mutually agree to extend the 60 days to work out issues or may mutually agree to modify the amendment or the contract. With respect to all products clauses, if a provider objects, the clause will not become effective and termination will not be required. **Note: PCHP to take the lead to work with plans on design of the amendment cover sheet by October 17 ?**

4. All-products clauses

The group is split on this issue. Providers prefer to be able to select products to participate in based on reimbursement, and administrative procedures. MVP’s business model groups products with the exception of government payers and plans such as Catamount with government fee schedules. Various options were discussed such as separating out products by reimbursement type, by government payers, by government fee schedule, but agreement was not reached.

5. Enforcement

The group discussed expanding the unfair insurance practices law in Title 8 to authorize BISHCA to enforce the contract standards subchapter. This law typically

designed to protect consumers. A subgroup will look into ensuring that BISHCA has the power to enforce the standards, but it is likely that the enforcement provisions will end up in Title 18 instead of Title 8.

The group also discussed the private right of action and arbitration clause. Brian Quigley from AHIP explained that providers already have a contract enforcement action to address breach of their participation contracts. In his experience in other states, the private right of action has created a tort claim triggering punitive damages.

Another question is how the arbitration provision will interact with the private right of action. The group agreed that either party should be able to choose to proceed to arbitration but did not decide whether the arbitrator's decision should be binding.

Madeleine will convene a subgroup on enforcement. Rebecca Heintz, Erin Orser, Linda Cohen and Susan Gretkowski agreed to participate. Please let Madeleine know if you would like to be added to this group.

6. Fee schedule access

The fee schedule access group met by conference call on Thursday, October 2, 2008. The group decided that plans would make certain fee schedule information available on request. Plans could choose to provide this information in CD-ROM or electronic format. Providers could instead request to receive a hard copy. Providers may request fees for codes that a provider in the same specialty typically bills or for codes that the requesting provider actually bills.

With respect to creating transparency as to the effect of procedure codes, edits, modifiers and bundling practices on compensation, several proposals were discussed.

- Requiring transparency “as soon as is reasonably practicable”,
- Requiring transparency by a date certain that would fit with plans’ IT work plans;
- Requiring transparency with a soft timeline and regular progress reports;
- Setting a coding standard – two options were discussed
 - Tracking the standards in the managed care settlements
 - Using NCCI as a standard (The workers compensation model act takes this direction and uses the language “Treatment coding conforms to the criteria of the National Correct Coding Initiative.”)

Further discussion is needed on this topic. Pam Biron will circulate the Common Claims Report, since a subgroup of the Common Claims group that she participated in looked at this issue. It was suggested that this topic be addressed by the subcommittee that is addressing the definition of “complete claim” since the same parties would be interested in both topics. Madeleine will explore with Blue Cross their ability/willingness to undertake this. It is unlikely that this issue will be resolved by October 17 and a longer time frame may be needed.

While the fee schedule information will be made available to providers who are actively engaged in determining whether to participate in a plan network, the edit information would only be available to participating providers. This was a compromise position on the part of providers who would prefer this information to be available before participation contracts are signed.

7. Scope – ERISA

Group members requested more information about the scope of the application of the contract standard provisions and whether they will apply to health insurers licensed in Vermont and self-insured plans. This topic will be added to the enforcement subcommittee work list.

8. Effective date

Input is needed from the plans about how to apply these provisions to existing contracts. It was suggested that this topic be added to the “complete claim” group and Madeleine will discuss this with Blue Cross.

Next steps.

Based on the information above, information received at earlier meetings, and information to be worked on by subgroups, the goal is to have a new draft and an outline of the legislative report before the next meeting in November.

The group adjourned at 3:00 p.m. Thanks to all participants.

Next meeting:

Date: Friday, November 14, 2008 1:30 pm to 3:30 pm

Location: BISHCA 3rd floor conference room.

Dial in number: 1 (800) 377-8846. Pass code: 54096025#

**Contract Standards Sub-group on complete claims, effective date, claim processing
Conference Call
October 10, 2008
8 am to 10 am**

Participants:

Andrew Garland, BC/BS
Lou McLaren, MVP
Susan Gretkowski, MMR representing MVP
Gretchen Begnoche, VMC
Jon Asselin, PCHP
Madeleine Mongan, VMS

Andrew Garland from BC/BS convened the group by conference call to discuss the definition of complete claim, to consider establishing effective dates for legislation and to discuss claim processing and adjudication standards and transparency.

Definition of clean claim

After reviewing and discussing the BC/BS definition of “complete claim,” and the provisions of the managed care settlement addressing payment of paper and electronic claims, the group decided to retain the definitions in the current Vermont prompt payment law for “claim” and “contested claim.” The current definitions allow for payer flexibility, but since HIPAA has set standards for electronic transactions, there will be a level of uniformity.

Lou McLaren (MVP) raised the issue of clearinghouses that submit claims that do not meet plan standards for payment. The notice that the claim is contested and that more information is needed to process the claim goes to the clearinghouse, not the providers. After discussion, the subgroup determined that this issue should be addressed through providers’ contracts with their clearinghouses and through education of provider groups and practice manager groups such as VMGMA.

Instead of defining “claimant,” the draft uses the term “submitting party,” which should resolve the clearinghouse issue.

Effective dates

Andrew Garland recommended setting different effective dates for different sections of the draft, and the subgroup agreed. Some provisions can go into effect when the law becomes effective on July 1, 2009, assuming it passes this session, but plans will need time to amend their provider contracts or business process or technology to implement other provisions. Preliminarily the group discussed the following provisions:

- Contract summary disclosure form – when contract is renewed, or redone
- Amendment disclosure form – in connection with amendments after the effective date of the law

- Access to fee schedule and compensation information
 - General access to information by request - this should be drafted as a separate provision, not just as a contract standard
 - Some compensation information will be included in contracts and plans should have time for amendments to their contracts
- Most favored nation – this section prohibits the use of these clauses in contracts; time will be needed for plans to prepare and distribute contract amendments. The group recommended having this provision become effective 90 days after the effective date of the law.
- Other issues:
 - Prompt payment change from 45 days to 30 days.
 - All-products clauses – may require a contract amendment
 - Rental network provisions – may require a contract amendment

Plan representatives to check and get back to subgroup with recommendations for effective dates on various sections.

Madeleine will draft proposed language addressing the requirement to provide fee schedule information as opposed to compensation information required to be included in provider contracts.

Claim Processing – Standards and Transparency

The group discussed the pros and cons of developing a system that would enable providers to determine what the claim editing protocols are, how a particular claim would be paid, including a dollar amount. Developing this type of system would be very expensive in a period when all investments are suffering.

Lou McLaren discussed the report of the Common Claims Work Group, which Pam Biron of BC/BS had circulated (link below). A subgroup of the Common Claims Work Group on “Improving the Efficiency of Claims Adjudication,” was initially convened to evaluate the feasibility of requiring use of the National Correct Coding Initiative (NCCI) edits to adjudicate physician claims¹. The subgroup recommended adopting a rule similar to the California Department of Managed Health Care Rules § 1300.71 (o) (link below) requiring disclosure of payment policies with respect to multiple services and multiple procedures (bundling), coding changes, assistant surgeons, administration of immunizations and recognition of CPT modifiers.

Our contract standards subgroup will research this topic further and share information by e-mail. The possibility of continuing a working group next year was raised.

¹ The workers’ compensation claim payment group is drafting timely payment provision for workers’ comp claims that will use NCCI as a standard for timely payment. See the Model Act attached below. (Paul brought this to my attention – we did not discuss it this morning.)

Thanks to Andrew Garland for leading this subgroup, to Blue Cross for hosting the call, and to all participants.

Background information:

- Common Claims Report (See pages 58 to 69 for the report of the subgroup on “Improving the Efficiency of Claims Adjudication”)
http://hcr.vermont.gov/sites/hcr/files/pdfs/HCR-Common_Claims_Final_Report_0.pdf

- Workers’ Compensation Model Act law (attachment below at page 10, section B (4):
“...a bill will be considered adequate for the determination of timely payment ..., provided it meets all of the following criteria: (4) Treatment coding conforms to the criteria of the National Correct Coding Initiative, unless superceded by state exceptions or modifications.”

Electronic Medical
Billing for WC.pdf

- Link to California Department of Managed Health Care Rules cited in Common Claims Report see pages 21 – 23.

<https://www.msophs.com/ab1455/finaltext/final%20text.PDF>

**Contract Standards
Enforcement Subgroup Conference Call
Meeting Notes
October 22, 2008
9:30 am to 10:30 am**

Participants:

Susan Gretkowski, MMR on behalf of MVP
Erin Orser, BC/BS
Eileen Elliott, Shems, Dunkiel & Kassel
Martita Giard, VMC
Jon Asselin, PCHP
Linda Cohen, Dinse, Knapp & McAndrew
Rebecca Heintz, BISHCA
Madeleine Mongan, VMS

The group convened at 9:30 am and began a discussion of a redraft of the enforcement provisions.

Registration

The group reviewed a proposal that BISHCA establish a registration process for contracting entities or covered entities that are operating in Vermont. BISHCA has recently adopted rules that address registration of PBMs and TPAs, which should be reviewed by this group. http://www.bishca.state.vt.us/HcaDiv/RegsBulls/hcaregs/REG_H-2008-01.pdf

BISHCA requested information about the number of companies operating in Vermont. Based on information from the AMA and from Vermont, it appears that about 15 companies are contracting with providers in Vermont. BISHCA will discuss this issue internally, but the small number of companies involved is helpful from a cost and administration perspective. BISHCA will also consider whether a registration fee will be needed and the amount of the fee.

BISHCA Enforcement Provisions

At the last full group meeting, MVP and others had raised some concern about expanding the unfair insurance claim settlement practices section in Title 8 to include violations of the contracting standards subchapter in Title 18 that we are drafting. BISHCA and the group proposed at the October 3 full group meeting to examine the powers that BISHCA has currently in Title 18 and to modify those as necessary in Title 18 instead of expanding into Title 8.

The redraft deletes the modification to the unfair insurance claim settlement practices law in Title 8. In Title 18, Section 9412 (a) currently authorizes BISHCA to administer oaths, issue subpoenas and examine documents of health insurers, health care providers and health care facilities to carry out the duties of Chapter 221 of Title 18 (Health Care Administration). The contract standards subchapter will be part of this chapter. This

section - §9412 (a) - will be amended to apply to contracting entities, covered entities and payers as well as health plans and health insurers.

Sections 27, 28 and 29 of Act 203 (2008) authorize the Commissioner to order health plans to remediate violations and to cease and desist from further violations, when the Commissioner has identified a pattern or practice of violating the timely payment, prior authorization, overpayment recovery and claim processing laws. The redraft will extend the powers created in Act 203 to the new sections we are drafting – contract standards and amendments, most favored nation, rental networks and all products clauses. The redraft also permits the Commissioner to order health plans to remediate violations or cease and desist from further violations in cases where there has not been a finding of a pattern or practice of violations.

Finally, if there is a “pattern or practice” of violations, the Commissioner has the authority to fine health plans. This section will be amended to apply to contracting entities, covered entities and payers, and to apply to violations of the new sections of the contracting standards subchapter.

Private Right of Action

Both BC/BS and MVP expressed serious reservations about including a private right of action in the draft, stating that a contract enforcement action is currently available to address breach of contract. They are concerned that if there is a private right of action, resources could be wasted on resolving minor issues in court. BC/BSVT’s preference is for BISHCA to have sole enforcement power and for providers to file a breach of contract claim if they feel they are entitled to damages.

Linda Cohen and Eileen Elliott pointed out, on behalf of providers they work with, that if the contracts themselves fail to comply with the law, a breach of contract action might not be sufficient, without a private right of action authorizing enforcement of the law. They also expressed concern that BISHCA will not have sufficient staffing or resources to address all problems, and providers will be left without remedies. In current law, a private right of action for injunctive relief is available to consumers and providers with respect to enforcement of violations of the certificate of need law. 18 V.S.A. § 9445 (a)(3).

To date this is an issue where providers and plans have agreed to disagree, although a number of members of the group expressed a willingness to continue to see if a compromise is possible.

Some possible issues to look at are whether to limit the private right of action to injunctive relief or actual damages, whether to require each party to bear its own attorneys’ fees and whether to include a pre-requisite to filing suit, such as filing a complaint with BISHCA. Providers articulated the rationale for allowing the court to award attorneys’ fees to health care providers who prevail. The fees and costs required to bring the action could be far greater than the award, creating a disincentive for providers to bring an action.

Arbitration

There is an arbitration requirement in the current timely payment law, which the redraft expands to cover the contract standards subchapter. The group discussed the parameters of the arbitration provision and decided that either party should be able to request arbitration. The arbitration would be conducted according to the rules and procedures of a mutually agreed on alternative dispute resolution forum such as the American Arbitration Association or the American Health Lawyers Association, and the arbitrator's award would be binding on both parties.

Thanks to all for participating.

**Contract Standards Workgroup
Meeting Notes
November 14, 2008
1:30 pm – 3:00 pm
BISHCA 3rd Floor Conference Room**

Participants:

Jon Aselin, Primary Care Health Partners (PCHP)
Gretchen Begnoche – Vermont Managed Care (VMC)
Pam Biron, BC/BS of Vermont
Becky Bowen, CVPHO
Linda Cohen, FAHC
David Cote
Lucie Garand, representing Springfield Hospital
Andrew Garland, BC/BS of Vermont
Susan Gretkowski – representing MVP Health Care
Martha Halnon - PCHP
Paul Harrington – VMS
Rebecca Heintz – BISHCA
Jeanne Kennedy – CIGNA
Madeleine Mongan - VMS
Erin Orser – BC/BS of Vermont
Anthony Otis, Osteopaths, Chiropractors
Robert Penny, M.D., PCHP
Charles Storrow – Kimbell, Sherman & Ellis, representing AHIP
Katie Wade, CIGNA

The group began its discussion at 1:30 p.m., reviewed the minutes of the contract standards meeting on October 3, 2008, the minutes of subgroup meetings on October 2, 2008 (fee schedule), October 10, 2008 (effective dates/claim processing) and October 22, 2008 (enforcement) and proceeded to address the following agenda issues.

1. Claim Edits – transparency or standards

A conference call for the claim processing/edits subgroup will be scheduled (December 3) to discuss how best to address transparency or standards for claims processing and edits in the draft. MVP raised a concern that their vendor did not offer software that would meet the transparency requirements on page 5 of the draft. Changing vendors would be a huge and expensive undertaking.

Katie Wade from CIGNA clarified that their software would provide dollar amounts for most claims. With respect to global periods and some modifiers, exact amounts might not be available, but providers would be able to come fairly close.

2. All Products Clauses

This is an area where the group members have decided to agree to disagree. Providers believe that these clauses make it difficult to attract and retain physicians at a time when we have major problems with workforce, because they have no choice but to take or leave various products offered by a plan. Providers would encourage payers to offer incentives to encourage providers to participate in all products. Becky Bowen noted that requiring providers to participate in all products could result in providers resigning from all products. Chuck Storrow (AHIP) questioned whether the all products clause would result in cherry picking and lead to network adequacy problems. Susan Gretkowski (MVP) queried whether an all products clause would fit into an accountable care organization structure. BISHCA will not take a position if government programs are carved out.

3. Enforcement – Private Right of Action

Again, plans and providers have agreed to disagree about whether a private right of action should be included in the draft, although consensus was reached on the other enforcement provisions.

4. Effective Dates

The group went through the various provisions and agreed as follows:

Section II Contract Standards (A) (1) and (2), with the exception of (A)(1)(a)(iii) which will have its own effective date.

- Contracting entities will provide the information required in (1) and (2) when the law becomes effective.
- Contracts will be amended to obligate contracting entities to provide the information in (1) and (2) on request within 60 days, and otherwise within 180 days.

Section II Contract Standards (B) summary disclosure

- Contracting entities will provide summary disclosure forms on request within 60 days
- Otherwise, contracting entities will provide summary disclosures as contracts renew, but not later than 5 years after the effective date of the law

Section III – Amendments

- Applies to any amendment after the effective date of the law

Section IV – Most favored nation

- Effective 180 days after effective date of the law

Section V – Prompt payment

- Changes will become effective one year after effective date of law

Section VI – Rental network

- Effective 180 days after effective date of law

Section VII – All products clauses

- For existing contracts – as contracts renew, but not later than 5 years after the effective date of law
- For future product offerings –effective date of law.

5. Registration of rental network entities

The National Conference of Insurance Legislators (NCOIL) will be considering a model rental network bill at its next meeting in mid November. The draft model bill requires registration of rental network entities. BISHCA is concerned that the definition of rental network not be so broad that it will require registration of a large number of entities. BISHCA is comfortable with creating a registration process for the approximately 15 rental network entities reported to be operating in Vermont. VMS will meet with Rebecca Heintz to review and, if necessary, redraft the definition of contracting entity.

6. Overpayment recovery issues

BlueCross explained its interest in amending the overpayment recovery law (Section 27 of Act 203) passed last year that limits overpayment recovery to one year and requires plans to provide specific notice of overpayment recovery to providers. Blue Cross is concerned that Act 203 would require them to send out thousands of notices every year for routine recoveries, such as duplicate payments, resulting in significant unnecessary expense for the plan

Since the overpayment recovery provision in Act 203 was based on a Maine law, VMS recommended that Blue Cross talk to colleagues in Maine about how this provision has been implemented there and also suggested that Blue Cross review the overpayment recovery provision in the Blue Cross class action settlement. Blue Cross will draft proposed language on this issue for the group to review by e-mail.

7. Inclusion of hospitals

VAHHS is reviewing the draft and discussing it with their board and counsel. Similarly, Springfield Hospital is reviewing this draft. VAHHS and Springfield Hospital will let VMS know whether they want to be included in or excluded from the various provisions of the draft.

Next steps.

After the conference call on claim processing, (December 3), VMS will revise the draft and circulate it to the group. VMS will also draft a legislative report and circulate it by e-mail for comment.

The group adjourned at 3:00 p.m. Thanks to all participants.

Meeting Notes
Fee schedule and claim edit subcommittee call
Wednesday December 3, 2008
2:30 pm to 3:30 pm

Participants:

Jon Asselin
Gretchen Begnoche
Pam Biron
Andrew Garland
Martita Giard
Susan Gretkowski
Lou McClaren
Madeleine Mongan
Erin Orser

The group convened by conference call at 2:30 and began with a discussion of how to provide contracting health care professionals with the claim editing information they need to determine how they will be paid. The first topic discussed was using NCCI as a baseline standard for claim edits.

Disclosure and/or standards for claim edits

Pam Biron suggested clarifying the intention to require use of **NCCI professional standards**, and there was some discussion of whether institutional standards should be included as well, if the hospitals wish. Madeleine has informed Jill Olson at VAHHS of this issue.

After discussion, Madeleine will draft the proposal discussed by the group, which will require use of the current version of the NCCI professional standards where applicable, or in the alternative use of the current version of edits of a national specialty society. Plans will be able to select whether to use NCCI or national specialty society edits. All other proprietary edits will be subject to BISHCA approval consistent with the requirement in current law under 18 V.S.A. § 9418a (g).

Plans would disclose whether they were using edits based on NCCI professional standards or national specialty society edit standards on a web-based system as described in § 9418a (g).

Plans will disclose their payment percentages for modifiers on a web-based system as described in § 9418a (g).

Exceptions to the requirement to use NCCI standards or *national specialty society standards* will include

- State mandates
- Services not covered by Medicare and thus not addressed by NCCI

- NCCI will set a floor; however, plans will have the option to use edits that are less restrictive for providers than NCCI

The group still needs to agree on an **effective date** for developing access to and compliance with edit standards including NCCI/national specialty society standards and the disclosure of payment percentages for modifiers.

Discussion of access to fee schedule information.

Pam Biron from BCBS recommended that **HPSC codes** be added to CPT codes, and the group concurred. She also recommended that health plans have the ability to limit the number of codes they give to practitioners to 100 codes – for example the top 100 primary care codes and the top 100 specialty codes. Martita suggested that the top 100 codes would have to be specialty-specific, otherwise smaller specialty groups might only get information about 2 or 3 of their codes. BCBS provides the full fee schedule on request. MVP prefers to provide the limited number of codes and MVP does not want to provide the full fee schedule. Madeleine's belief was that the group had agreed to the following disclosure system reflected in the October 30 redraft:

(A) Each contracting entity shall provide and each health care contract shall obligate the contracting entity to provide participating health care providers with the following information:

(1) Information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following:

- (a) The manner of payment, such as fee-for-service, capitation, case rate or risk;*
- (b) On request, the fee for service dollar amount allowable for each CPT® Code for those CPT® Codes that a provider in the same specialty typically uses or that the requesting provider actually bills. Fee schedule information may be provided by CD-ROM or electronically, at the election of the contracting entity, but a provider may elect to receive a hard copy of the fee schedule information instead of the CD-ROM or electronic version.*

NOTE: Since the call on 12/3, Madeleine reviewed the minutes and drafts. This language above was included in the 10/30 draft and in concept was proposed at the 10/2 meeting of the fee schedule subgroup. The proposal was also reviewed, discussed, agreed to, and reflected in the minutes of the 10/3 full group meeting. None of the minutes reflect any agreement to limit the number of codes provided to 100. The draft will therefore, remain as it is above, but discussions will continue to attempt to clarify this issue.

Appendix D

Background Information

- Common Claims Report – Improving the Efficiency of Claims Adjudication
January 15, 2008
- National Conference of Insurance Legislators (NCOIL) Rental Network Contract Arrangements Model Act, Adopted by NCOIL Executive Committee on
November 23, 2008

January 15, 2008

Common Claims Work Group Final Report

**Common Claims Work Group
Final Report**

TO

THE COMMISSION ON HEALTH CARE REFORM

January 15, 2008

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Executive Summary

The Common Claims Work Group was created by H.861, Section 55 to design, recommend and implement steps to achieve the following goals:

- 1) Simplifying the administrative process for consumers, health care providers, and others so the process is more understandable and less time consuming.
- 2) Lowering the administrative cost in the health care financing system.

As outlined in Section 55 of H.861 (Appendix A) the work group that convened consisted of (Appendix B):

- 1) Two representatives selected by the Vermont Association of Hospitals and Health Systems.
- 2) Two representatives selected by the Vermont Medical Society.
- 3) One representative from each of the three largest health care insurers
- 4) The Director of the Office of Health Access or designee
- 5) Two representatives of the business groups appointed by the Governor
- 6) The health care ombudsman or designee
- 7) One representative for consumers appointed by the Governor
- 8) The Commissioner of Banking, Insurance, Securities and Health Care Administration or designee.

The first meeting of the work group took place on July 1, 2006 at which time Thomas Huebner was appointed Chair of the Common Claims and Procedures Work Group. Over the next two meetings, the work group developed a comprehensive seven-point work plan to be submitted by the September 1, 2006 deadline, as outlined by Section 55 of the Act. The work group has met monthly, with subcommittees meeting more frequently to focus on the details of each plan. You will find detailed backup from each group in their sections.

The work plan, outlined in Appendix C, focused on the following seven areas:

- I. Standardization of Member Identification Card and Maximization of Electronic Transactions
- II. Simplification of Explanation of Benefits and Patient Bills
- III. Prior Authorization Pilot
- IV. Credentialing
- V. Improving the Efficiency of Claims Adjudication
- VI. Simplification of Workers Compensation Claims Adjudication
- VII. Revise work plan tasks as needed to meet the intent of the Act.

Goals and Recommendations

I. Standardization of Member Identification Cards and Maximization of Electronic Transactions

Purpose:

Primary purpose: To identify and evaluate opportunities that exist in the current electronic data sets transactions

Secondary purpose: To improve the patient and provider interaction by examining opportunities available through standardizing member identification cards.

A. Standardization of Electronic Claims Transactions

Goals:

1. Evaluate best-in-class operations that are used to increase electronic transactions while containing costs.
2. Evaluate the utilization of 837 file attachments used to capture and pass coordination of benefits information to Payers. Determine how highly used this information is and identify opportunities to replicate the functionality.
 - The subcommittee recommends that the Commissioner of Banking, Insurance, Securities and Health Care Administration develop an ongoing collaborative process, similar to that used by UHIN, to aggressively seek electronic solutions to improve efficiency, reduce costs, and improve timeliness of electronic transmissions. A key to success of this recommendation is to develop a business model that allows for collaboration prior to moving an idea through the rulemaking process. A collaborative process that encourages best practices would allow BISHCA to successfully implement rules that make good business sense.

B. Develop Consumer Tools to Track Out-of-Pocket Cost

Goal:

To promote price transparency and enhance patient knowledge of out-of-pocket costs.

Recommendation:

The subcommittee has reviewed CIGNA Healthcare's "HealthePass" model for providing patient account information to its beneficiaries.

- After reviewing the tool, the subcommittee recommends that BISHCA, in coordination with the Act 191 pricing transparency process, consider this as a potential option in enhancing patient awareness. These opportunities need to be considered in conjunction with a review of the implementation cost.

C. Member Identification Cards

Goals:

1. Improve the provider interaction with the member by supplying key information needed to efficiently process health insurance claims.
2. Evaluate the available technology that would support simplified and enhanced payment processes, help patients anticipate and manage their health care costs, shorten provider revenue cycles, and help address patient delinquency.
3. Improve efficiencies of front-line staff in hospital facilities and professional physician offices by providing key insurance information up front and reducing the rework related to claims submissions.
4. Reduce call volume to payers by providing information required to collect copays, determine effective dates of coverage and complete claim processing on the member identification card.
5. Reduce contacts to Human Resource departments by providing member out-of-pocket costs on the identification card.
6. Recommend a common dataset for member identification cards to allow for ease of use.

Recommendation:

Based on the information collected, having key elements on the Identification cards would benefit the provider community through enhancing interaction with the patients, reduction of claims rejections, and increased efficiency of claims processing. It does not appear as necessary to mandate a member identification card layout as it does to require key data to be available. Based on the information reviewed, this requirement would have to be applied to all carriers doing business in the State of Vermont. At this time, all but one carrier on the workgroup had the majority of desired information on the member identification card.

- The subcommittee recommends that the following information be required on member identification cards by 2010. Payers would begin replacing cards during 2009, upon the group renewal to reduce disruption, with a requirement that the full replacement be complete by January 30, 2010.

1. Copay of Services
2. Subscriber ID
3. Primary Care Physician
4. Effective Date of Policy
5. Subscriber Name (even on dependent cards)
6. Billing Address
7. Group or Account Number
8. Subscriber Date of Birth - On all cards
9. Dependent Member Code

II. Simplification of Explanation of Benefits (EOB) and Patient Bills

Purpose:

To develop a methodology to provide clear billing information to patients.

Goal:

To produce consistent, consumer-friendly, and understandable explanations of benefits and hospital and physician office billing statements.

Recommendations:

- Adopt the attached Explanation of Benefits terms, definition, and format as the standard to be followed by all health insurance payers doing business in the State of Vermont. Carriers may add additional explanatory text if they determine a need. Begin implementation within one year and complete implementation within two years of acceptance of this report.
- Adopt the attached hospital patient statement, which is modeled after the Patient-Friendly Billing Project, and require that all hospitals in the State of Vermont use this model. Begin implementation within one year and complete implementation within two years of acceptance of this report.
- Adopt the attached physician office statement, which is modeled after the Patient-Friendly Billing Project, and require that physician offices with five (5) or more providers use this model, beginning implementation within one year and completing implementation within two years of acceptance of this report.

III. Prior Authorization Pilot

Purpose:

To review and determine if there are options for streamlining the administrative process for acquiring prior authorization approval.

Goal:

To eliminate unnecessary administrative steps and expenditures in the prior authorization approval process.

Recommendation:

Due to the success of a pilot program between Cigna and Rutland Regional Medical Center, the workgroup feels that developing a web-based prior approval process would save time and costs for physicians, facilities, and health plans.

- Require that each health plan develop a web-based prior approval process within one year of acceptance of this report.
- Require that each health plan transfer information between their utilization management and claims adjudication systems within 72 hours of the

authorization. This process should be in place within six months of acceptance of this report.

IV. Credentialing

Purpose:

To identify and evaluate opportunities for simplifying and streamlining the credentialing process.

Goals:

1. To ensure the successful implementation of the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Datasource.
2. To establish uniform time periods for organizations to act on completed credentialing applications
3. To eliminate variation between payors related to billing for physician assistants and advanced nurse practitioners.

Recommendations:

ACTIVITY 1. CAQH Universal Credentialing Datasource.

During implementation the BISHCA received questions from practitioners regarding the security of the CAQH system, and in particular the requirement to provide social security numbers when completing the credentialing application. Information is available on both the BISHCA and CAQH websites that outlines system security features to ensure the confidentiality of provider information. The online CAQH credentialing application requires practitioner social security numbers because information needed for credentialing may only be available by social security number. However, CAQH does accept the new National Provider Identifier (NPI) required by the Centers for Medicare and Medicaid Services and the Health Insurance Portability and Accountability Act (HIPAA). Currently all practitioners should have a NPI number, however, its full use has been delayed until May 2008. Until that time, CAHQ will continue to require social security numbers on the online credentialing application. Practitioners using the hard copy version of the form can check with insurers and/or hospitals to see if the social security number can be omitted. BISHCA should continue to request that CAQH end their practice of requiring the use of social security numbers.

ACTIVITY 2. Establish Uniform Periods for Organizations to Act on Completed Credentialing Applications.

All Sponsors should work together to develop a reporting process to measure success in meeting the voluntary 60-calendar day processing goal, as well as other efforts to streamline, coordinate, and improve physician credentialing and re-credentialing processes.

ACTIVITY 3. Eliminate the Variation Among Payers Relating to Billing for Physician Assistants and Advanced Nurse Practitioners

Health insurance companies have different rules regarding the ability of physician assistants and nurse practitioners to bill for health care services, which adds to the administrative burden for practices.

As shown on the attached table entitled: Questionnaire on Billing for Services of Physician Assistants and Advanced Nurse Practitioners, BCBSVT and MVP allow for the direct billing of services provided by physician assistants and advanced nurse practitioners with a note indicating that the PA/ANP provided the service.

To reduce the administrative burden for practices, it is recommended that CIGNA and OVHA adopt policies similar that of BCBSVT and MVP and allow for the direct billing of services provided by physician assistants and advanced nurse practitioners.

V. Improving the Efficiency of Claims Adjudication

Purpose:

To review and determine options for simplifying the claims adjudication administrative process. Representatives from physician offices and hospital billing departments were concerned that different insurance companies have different claim adjudication rules. The lack of consistency causes payment delays, appeals, and additional administrative burden for providers and payers.

Goal:

To eliminate unnecessary administrative steps for claims processing with emphasis on requiring insurers to provide the appropriate level of information related to claims processing rules.

Recommendation:

Over the course of the past year, the subcommittee has considered a number of different approaches to achieve the goal of increased efficiency of claims adjudication. Improving efficiency will be beneficial to four principal stakeholders - providers, payers, employer groups, and patients. The subcommittee endorses increased transparency as a key driver towards achievement of this goal.

- Adopt a rule patterned on the California Department of Managed Health Care Rules §1300.71. These Rules call for disclosing detailed payment policies and rules used to adjudicate claims, and requires methodologies to be consistent with standards accepted by nationally-recognized organizations, federal regulatory bodies and major credentialing organizations. The subject matter covered by these Rules paralleled much of the subcommittee's discussion over the past year, and the members felt that if Vermont commercial payers adhered to these rules, physicians and hospitals would gain a much greater understanding of rules used to adjudicate claims.

Although several payers were concerned about certain elements of the California Managed Health Care Rules (see Attachments 2-4), subcommittee members recommend that Vermont consider the adoption of a rule patterned on the California Department of Managed Health Care Rules §1300.71 with input into rulemaking from the provider and payer communities.

- Improved Notification - We recommend that payers improve the process by which they notify providers of material changes to claim adjudication rules. Characteristics of an improved process include:
 - a. Notification should be made a minimum of 30 days in advance of the implementation date.
 - b. The method of notification should be designed to reach the affected parties.
 - c. Parties affected by the change should have an opportunity to comment on the planned change.

VI. Simplification of Workers' Compensation Claims Adjudication

Purpose:

To review and determine options for simplifying the claims adjudication administrative process for Workers' Compensation claims.

Goal:

To explore means to simplify the process for workers' compensation claims filing, processing and payment.

Recommendations:

We recommend that the following steps be taken to minimize costs and maximize the funding capacity of the workers' compensation program:

- Adopt the attached recommendation (Attachment F) for an amendment to Title 18 and 21 to include:
 - 1.) Initial complaints may be made to BISHCA by parties other than DOL, including other providers.
 - 2.) Require automatic interest paid to providers for lack of timely payments in alignment with medical and disability claims
 - 3.) Authorize the DOL to track carrier protocols for claims receipt, claims processing and claims paid, including an online claims status review option for providers;
 - 4.) Enable the DOL to have bill back authority for costs incurred in investigations of the WC carriers;
 - 5.) Insure that penalties assessed against workers' compensation carriers be deposited into a DOL administration fund to pay for tracking and enforcement activities within the division.

Timeframe: July 2008

Instead of requiring employers to file FROI (first report of injury) with the WCSD (workers compensation safety division) and report injury to carrier, we recommend that the process be streamlined and require employers to file FROI with carriers within 72 hours so that carriers can electronically file ALL FROI to the WCSD, as required by law. This would result in one copy of the FROI at the WCSD and would be received electronically creating less delay in entering into the WCSD tracking system and less entry errors to be dealt with by the Division staff.

Timeframe: March 2008

- Since the data entry staff responsibility would be greatly reduced with electronic submission of the majority of FROI, some of the four entry level staff would be freed up to monitor and track complaints about timely payments. These complaints, once verified with the provider and the carrier, would be forwarded to BISHCA for enforcement of timely payments.

Timeframe: March 2008

- Eliminate the “Pattern of Practice” requirement due to the nature of the volume of claims from an individual provider. If this is not possible, require the DOL to provide their own longitudinal study of carriers (over time) who repeatedly delay payment or wrongly deny payment across multiple provider groups, for purposes of creating an internal study of whether there is a patterned practice requiring review.

Timeframe: July 2008

- It is our recommendation that the Legislature should carefully monitor the implementation of the Texas law, which will take effect January 1, 2008, that requires electronic claims filing from the providers to the workers’ compensation carriers. Added benefits to electronic filing include electronic records of claims transmissions and the savings of significant material costs involved with copying and mailing documents.

Timeframe: February - June 2008

- It is our recommendation that the Legislature review cost savings estimated in Attachment G for analysis of the time spent by employer, physician office staff, hospital staff, WC carriers and WCSD. With these savings of time and associated costs, we believe that modifications to the existing systems would more than pay for themselves in a very short time period.

IMPROVING THE EFFICIENCY OF CLAIMS ADJUDICATION

Common Claims and Administrative Simplification (Act 191, Sec. 55)

Subcommittee Members

David Jillson, Chair, Associates in Orthopaedic Surgery

Cherie Bergeron, EDS

Pam Biron, Blue Cross Blue Shield of Vermont

Kathy Bonanno, MVP

Mickey Gleeson, MVP

Lauren Parker, MBA Resources

Kathy Peterson, Rutland Regional Medical Center

Jason Soukup, Cigna

Why was the Subcommittee formed?

Representatives from physician offices and hospital billing departments were concerned that different insurance companies have different claim adjudication rules. The lack of consistency causes payment delays, appeals, and additional administrative burden for providers and payers.

1. Initial Goal:

Evaluate the feasibility of requiring payers to use National Correct Coding Initiative (NCCI) edits to adjudicate physician claims.

Initial Tasks:

1. Determine which payers use NCCI edits.
2. Evaluate information technology issues that may inhibit adoption of NCCI edits.
3. Determine cost of conversion to NCCI edits.
4. Determine feasibility of requiring small payers to use NCCI edits.

Payer response: Payer representatives stated that claims auditing software systems have a claims edit foundation based on the NCCI claims edits, and these systems can then be supplemented by both the software vendor and payers using different industry edits because NCCI is based on Medicare guidelines. Payers then may add customization to support state mandates and proprietary payer specific medical management, business and policy practices. Therefore, the majority of services are adjudicated in a relatively uniform methodology across various payers. However, a subset of claims is adjudicated under varying methodologies by payers because they are based on these customized proprietary payer specific rules. It is this subset that is problematic for providers.

2. Types of Inconsistencies That Cause Adjudication Problems.

Based on the Subcommittee's findings with regard to the evaluation and use of NCCI edits by all payers the Subcommittee agreed that we should focus on remedying some common inconsistencies that can cause payment delays, appeals, and additional administrative burden for providers and payers. Significant issues identified by provider representatives were:

- **Bill Type** is a field on a facility (e.g. hospital) claim that is used to indicate what type of claim is being submitted - 1st inpatient claim, subsequent inpatient claim, replacement claim, etc. If a payer ignores or cannot accept Bill Type, then the claim may be rejected as a duplicate.

Status: Current industry standard “Bill Types” can now be accepted by all payers.

- **Assistant Surgeons** are sometimes used to help the primary surgeon during more complex procedures.

Identified Issue: Medicare publishes a list of procedures where an assistant surgeon is permitted, but commercial payers’ business rules with regard to assistant surgeons are not uniform and are not always aligned with Medicare.

- **Modifiers** are standardized codes developed by the American Medical Association, and are recognized by Medicare and many commercial payers. Modifiers are often used to provide additional information about the procedures that were billed.

Identified Issue: Payers do not accept, recognize, or act on all industry standard modifiers when submitted by providers. Payers often 1) ask for chart notes when a modifier is used, 2) deny the claim, or 3) simply do not pay the procedure with modifier. Commercial payers’ business rules with regard to modifiers and adjudication of modifiers are not uniform and are not always aligned with Medicare.

- **Claims Bundling/Unbundling** is the term used when a provider lists several similar procedures that were performed on the same date of service. For example, a surgeon should not report closing the wound and suturing in addition to reporting a total hip replacement, because the hip replacement code includes suturing.

Identified Issue: The Medicare program developed NCCI edits to ensure the most comprehensive groups of codes are billed rather than the component parts, and to check for mutually exclusive code pairs. However, because many commercial payers have customized some of their claims adjudication methodologies based on proprietary payer specific medical management, business and policy practices, the claim may be denied. Commercial payers’ business rules with regard to claims bundling/unbundling are not uniform and not always aligned with Medicare.

Payer response: Three of these topics: assistant surgeons, modifiers and claims bundling / unbundling fall within proprietary payer specific medical management, business and policy practices. The Subcommittee would need to present a clear business rationale including cost benefit analysis to support any recommendations about these topics.

3. Disclosure of Claims Adjudication Rules/Policies:

The Subcommittee discussed the value of having payers disclose their claims adjudication rules so that providers know in advance how claims will be adjudicated.

Payer responses:

- MVP reported that as a result of New York law, all payers licensed in NY must disclose commercial software used by the Plan to accept and edit claims. The Plan must describe Plan edits in sufficient detail to enable contracted providers to understand modifications made to their software. MVP applies this practice to Vermont providers as well.
- Cigna reported its transparency initiatives and capabilities. Currently, CIGNA utilizes a web-based transparency tool. A contracted provider (either physician or hospital) can enter proposed CPT codes to be billed into the web site, and the program will show how the codes would be adjudicated.
- BCBSVT reported that the Plan maintains and updates regularly a Professional Provider Manual which has a section specific to general claim information regarding claims submission and reimbursement guidelines. Within the manual the Plan discloses what claims auditing software system is utilized by the Plan. The Plan has a provider notification process in place in the event that guidelines are changed. BCBSVT's claims auditing software system is scheduled to be upgraded and enhanced to include a transparency tool by which a contracted provider (either physician or hospital) can enter proposed codes to be billed, into our web site and the program will show what editing will occur.

On 7/23/07 the Subcommittee agreed to amend its workplan to add some additional tasks.

1. Survey the activity of other states to determine if other approaches may be adopted.
 2. Consider recommending a notification process when claim adjudication rules have changed.
 3. Consider recommending a process to educate providers on the various claims adjudication rules used by payers.
- Regarding the first task, the Subcommittee reviewed "Select State Efforts to Regulate Issues Related to Disclosure of Claims Payment Practices" prepared by the McKesson Corp. Information from 4 states was presented: Texas, North Carolina, California and Minnesota. Provider representatives agreed that the summary of rules adopted by California were thorough and well-worded (see Attachment 1). Payer representatives agreed to review the language and report whether any elements were objectionable. Cigna stated that the language was acceptable. Blue Cross, MVP, and the Office of Vermont Health Access all made comments on the language, and their reports are attached as Attachments 2-4.
 - Task 2 - Payer representatives have communicated that they all have contractual notification processes in place. Provider representatives identified the need to ensure the following:
 1. Notifications are timely, clear and concise.

2. Payers follow what they have communicated.
3. Payers regularly “*check*” the effectiveness of the methods of delivery (e.g., mailings, fliers, news letters, provider manuals, web, etc.)
4. Payers regularly “*check*” the effectiveness of the notification lead time to providers (e.g., is it sufficient? should the notification lead time be longer, etc.)

As a result of a recent issue in the state regarding processing changes by a payer which weren't clearly communicated and caused thousands of denied claims at all hospitals in the state, the Subcommittee recommended that:

Notification of changes to claims processing should be clearly stated and sent in multiple ways. This includes, e-mail, a direct letter detailing the change as well as putting the information in their monthly newsletter/bulletin. The notification should be mailed to the patient accounting department directly. The notification should be at least 30 days in advance of the change and should give the providers an opportunity and avenue to comment and get clarification if needed.

- With respect to task 3, provider representatives believe that there is a role for enhanced provider education. Because claims adjudication rules are complex and vary from payer to payer, provider representatives feel there is a need for an independent organization that has access to the specific payer rules, and can educate providers on how best to submit clean claims for services rendered. Payer representatives were not in favor of establishing an organization to educate providers on claims adjudication rules for the following reasons:
 1. Commercial Plans were not willing to share information on claims adjudication rules with an entity that was not a contracted provider.
 2. Payers represented that their Provider Relations departments conduct outreach and education to providers, and were concerned that another entity would create duplication and add administrative costs.

The provider community will pursue this initiative independently.

Recommendations: Over the course of the past year, the Subcommittee has considered a number of different approaches to achieve the goal of increased efficiency of claims adjudication. We believe that improving efficiency will be beneficial to four principal stakeholders - providers, payers, employer groups and patients. The Subcommittee endorses increased transparency as a key component to this goal.

- Adopt a rule patterned on the California Department of Managed Health Care Rules §1300.71. These Rules call for disclosing detailed payment policies and rules used to adjudicate claims, and requires methodologies to be consistent with standards accepted by nationally recognized organizations, federal regulatory bodies and major credentialing organizations. The subject matter covered by these Rules paralleled much of the subcommittee's discussion over the past year, and the members felt that if Vermont commercial payers adhered to these rules, physicians and hospitals would gain a much greater understanding of rules used to adjudicate claims.

Although several payers were concerned about certain elements of the California Managed Health Care Rules (see Attachments 2-4), Subcommittee members recommend that Vermont consider the adoption of a rule patterned on the California Department of Managed Health Care Rules §1300.71 with input into rulemaking from the provider and payer communities.

- Improved Notification - We recommend that payers improve the process by which they notify providers of material changes to claim adjudication rules. Characteristics of an improved process include:
 - a) Notification should be made a minimum of 30 days in advance of the implementation date.
 - b) The method of notification should be designed to reach the affected parties.
 - c) Parties affected by the change should have an opportunity to comment on the planned change.

Attachment 1.

California Department of Managed Health Care Rules §1300.71

“... (o) Fee Schedules and Other Required Information. On or before January 1, 2004, (unless the plan and/or the plan's capitated provider confirms in writing that current information is in the contracted provider's possession), initially upon contracting, annually thereafter on or before the contract anniversary date, and in addition upon the contracted provider's written request, the plan and the plan's capitated provider shall disclose to contracting providers the following information in an electronic format:

(1) The complete fee schedule for the contracting provider consistent with the disclosures specified in section **1300.75.4.1(b)***; and

(2) The detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims, which shall, unless otherwise prohibited by state law:

(A) when available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations;

(B) clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and

(C) at a minimum, clearly and accurately state the policies regarding the following: (i) consolidation of multiple services or charges, and payment adjustments due to coding changes, (ii) reimbursement for multiple procedures, (iii) reimbursement for assistant surgeons, (iv) reimbursement for the administration of immunizations and injectable medications, and (v) recognition of CPT modifiers.

The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented processes, so that a reasonable person with sufficient training, experience and competence in claims processing can determine the payment to be made according to the terms of the contract....”

*1300.75.4.1. Risk Arrangement Disclosure

(b) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-sharing arrangement between a plan and an organization shall require the plan to disclose, on or before October 1, 2001, and annually thereafter on the contract anniversary date, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, and further specify the Medicare RBRVS year if RBRVS is the methodology used for fee schedule development. For any proprietary fee schedule, the

contract must include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

Attachment 2.**MEMORANDUM**

TO: Claims Adjudication Sub-Committee of the Common Claims Committee

FROM: BCBSVT

DATE: September 27, 2007

SUBJ: California Department of Managed Health Care Rules § 1300.71

This memo is to provide a formal response to the Claims Adjudication Sub-Committee's request that payers review and respond to the California Department of Managed Health Care Rules § 1300.71 language and report whether any elements were objectionable. The Plan will comment more fully upon the development of such a rule in the future.

BCBSVT has reviewed the language and our comments and/concerns are noted within the following categories:

- Antitrust
- Protection of Proprietary Information
- Cost
- Rule Language (Clear & Concise)

Antitrust

We recognize that access to accurate information is vital to the efficiency of any claims adjudication process. We are concerned however with any requirement that could promote anti-competitive behavior with the information that is required to be disclosed. We believe such uses or disclosures have the potential to run afoul of the Statements of Antitrust Enforcement in Health Care¹ numbers 5 and 6 published by the Federal Trade Commission (FTC) and the Department of Justice (DOJ). We encourage the working group to include safeguards in any proposal that would prohibit the anti-competitive use or dissemination of fee and fee related information. We think it should make clear that disclosure is not required if such disclosure would violate state or federal law.

Protection of Proprietary Information

Fee and fee related information that is required to be disclosed under the California Managed Health Care Rule § 1300.71 appears to include proprietary information. We don't think the California rule goes far enough in recognizing that fact. The working group should incorporate safeguards against any further use of this information by providers for any purpose other than handling claims.

¹ <http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm>

Cost

To fully comply with this type of rule could require significant investment by a payer to include both upfront investments and continued investment to maintain compliance. This is difficult to quantify at this point as the California rule is not at a granular level to assess/establish investment and resource requirements. The working group should keep in mind and consider the potential cost to payers to comply with and maintain administration of a rule such as this as part of the rule development process. Once a draft rule is developed and the detailed requirements are fleshed out payers will then be in a better position to review and respond on investment, resources and their capability to comply.

Rule Language

The language within the California rule is fairly vague and could be left to different interpretation by the various payers impacted. If a rule was to be established and implemented in Vermont it would need to be clear and concise to ensure it was administered and interpreted consistently by all payers.

In conclusion, it should be noted that there are provisions based on BCBSVT's interpretation of the California Department of Managed Health Care Rules § 1300.71 that the Plan cannot administer for example 1300.71 (B) and areas where the Plan has made business decisions and believe what we are presently administering is sufficient for example 1300.71 (A).

California Department of Managed Health Care Rules § 1300.71		
(A)	when available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations;	Professional/Facility: The Plan's directive is to be consistent with industry practices with regard to coding and standards (e.g., CPT-4, HCPC Level II, UB-04 and other industry standards). When we are not aligned with the industry practice (non-standard coding methodologies) we communicate via a provider notification.
(B)	clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and	Based on the Plan's interpretation of the California Department of Managed Health Care Rules § 1300.71 the Plan cannot administer

BCBSVT would request the Department to give all payers an opportunity to provided feedback and input as part of the rule development process if a rule of this type is pursued in the future.

Attachment 3.

To: COMMON CLAIMS COMMITTEE
Claims Adjudication Subcommittee
From: William Little, Vice President, MVP Health Care
Re: Response to committee recommendations for requirement that VT payers adhere to the requirements specified under the California Department of Managed Care Rules
Date: 10/5/2007

MVP is appreciative of the work this subcommittee has undertaken and its mission to offer to the legislature innovative ideas on how to reduce the administrative burden of running a practice.

The specific language in the California Rule 1300.71 regarding fee schedule disclosure is unacceptable to MVP. A health plan's fee schedule is proprietary and should not be subject to public disclosure primarily because doing so would promote artificial price increases through anti-competitive behavior. Indeed, the statements of Antitrust Enforcement in Health Care numbers 5 and 6 published by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) prohibit such disclosures to prevent anti-competitive conduct in the health care market. We cannot support any proposal that would violate federal authority and which could artificially increase the cost of health care in Vermont.

The disclosure of fee schedules could also cause anti-competitive conduct among the health plans, causing an artificial decrease in health care costs. MVP is often told we are "one of the better payers", but if I discovered my competitors were reimbursing at a lower rate and providers were agreeing to it I'd be inclined to renegotiate contracts for the lower rates. I would have an obligation to do so on behalf of all Vermont MVP rate payers -- businesses and individuals.

While we do not expect providers to contract with the plan without first knowing how they will be paid, we have never had to disclose our entire fee schedule to meet their need for information prior to joining our network. We typically provide a small sample of reimbursement rates, which give them a good sense of how we compare to other payers. For certain specialties, in specific geographic areas we have modified our standard schedule in order to be competitive and contract with the provider.

Other aspects of the California legislation are also objectionable because they are typically issues that are most appropriately addressed on a case-by-case basis in each contract to meet the specific business needs of the providers and the plans, and communication around those needs flows freely between MVP and providers. The MVP Provider Manual, provider website, regular newsletters and provider relations team ensure providers are fully informed prior to and during their affiliation with MVP. MVP does not think it is in the best interests of the health care delivery system for the legislature to negotiate specific contract terms between MVP and Vermont providers.

Attachment 4.**Memorandum**

To: Nancy E. Clermont
From: John B. Dick
Date: March 7, 2008
Re: Common Claims Request

I have reviewed the California language as proposed. I find it quite difficult to analyze because it lacks precision on how Vermont would apply the ideas in the California rules. Nevertheless, I have the following comments.

OVHA does not formally contract with any provider. Most providers enroll in our program and agree in advance that if they submit a claim for services rendered to accept our “payment” (including denials) as payment in full. Will the Vermont requirement be limited to those that contract? Will it apply to all providers that we pay, such as Vermont public school districts, SRS, etc?

A “complete fee schedule” is quite a vague term to implement. (The California definition in the statute was not provided.) If it were interpreted to mean our CPT and DME fee schedules as published today on the EDS web site, compliance might be easy. If that is not “complete”, then it would be very difficult for us to be more comprehensive. There are a number of codes for which we pay different providers a different amount. Some code modifiers change payment. How would that be managed? There are a number of codes that do not have a price on file such as the miscellaneous (xxx99) codes which we often pay per invoice cost or other calculated amounts. Some codes have provider specific payments. The ease, or difficulty, of this requirement depends on the details as applied in Vermont. I think we have extracted as many procedure code fees from our system as we can. Going beyond our current disclosures will demand more system capacity than now exists.

The request for “detailed payment policies and rules” might be met today with our current text in the Provider Manuals, or it could be interpreted to be asking for much more than is on hand. I do not understand what is meant by “non-standard coding methodologies used to adjudicate claims”. The last paragraph suggests an answer. If taken literally, it would insist that we disclose enough information to enable any provider to calculate expected payment for every services or items provided to Medicaid. If this is the intent, we are a long way from that today. This would be a significant undertaking that would demand many resources that are not yet planned. OVHA over the last 10 years has tried to dedicate time and energy to get us to where we are today. We continue to make improvements in our manuals to help clarify our payment policies and claims processing requirements, but we have never tried to cover all possible cases. If this is the intent, would we also have to describe how we pay when we are the secondary payer, the tertiary, etc?

The excerpt also suggests when it says "... for the contracting provider" that the materials would have to be organized on a provider specific basis, such as physician policy, psychologist, hospital, etc. This is very different from our current method where we have the general rules in the Provider Manual for all providers and then additional Manuals organized by claim type, (1500 and UB). Reorganizing these instructions by provider type would demand a huge rewrite of our current manuals. But the California language seems to demand much more than we currently have in writing.

We will have to see many more details filled in before we could begin to clearly estimate if we could comply or not. If the last paragraph sets out Vermont's desired outcome as the ability to forecast claim payment, I think our current materials fall far short of that mark. Consider how would we comply with this for hospital inpatient care paid on a DRG basis? It would be more complex to describe the rules for APCs payment for outpatient care. Most hospitals have the software to make these forecasts with a high degree of accuracy. How would publishing fee schedules and payment rules add value to the current capacity?

Much more is needed before we could determine our ability to meet the objectives.

Cc: File

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National Conference of Insurance Legislators

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NATIONAL CONFERENCE OF INSURANCE LEGISLATORS RENTAL NETWORK CONTRACT ARRANGEMENTS MODEL ACT

Adopted by the NCOIL Executive Committee on November 23, 2008, and by the Health, Long-Term Care, and Health Retirement Issues Committee on November 21, 2008.

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Section I. Definitions

For purposes of this Act, the following definitions shall apply:

- A. "Contracting entity" means any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business.
- B. "Covered individual" means an individual who is covered under a health insurance plan.
- C. "Direct notification" is a written or electronic communication from a contracting entity to a provider documenting third party access to a provider network.
- D. "Health care services" means services for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.
- E.
 1. "Health insurance plan" means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.
 2. "Health insurance plan" shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage similar to the foregoing as specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; dental or vision benefits; benefits for long-term care, nursing home care, home health care, or community-based

care; specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or such other similar, limited benefits as are specified in regulations; Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or other similar limited benefit supplemental coverages.

- F. 1. "Provider" means a physician, a physician organization, or a physician hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts.
- 2. "Provider" does not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.
- G. "Provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and provider for the delivery of and payment for health care services to covered individuals.
- H. "Third party" means an organization that enters into a contract with a contracting entity or with another third party to gain access to a provider network contract.

Section II. Scope

- A. This Act does not apply to provider network contracts for services provided to Medicaid, Medicare, or State Children's Health Insurance Program (SCHIP) beneficiaries.
- B. This Act does not apply in circumstances where access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity.
- C. This Act does not apply to a contract between a contracting entity and a discount medical plan organization.

Drafting Note:

Each state will determine whether this legislation should apply to self-funded employer-sponsored health insurance plans and/or third-party administrators operating on their behalf (as regulated under the Employee Retirement Income Security Act of 1974 [ERISA]).

Section III. Registration

- A. Any person that commences business as a contracting entity shall register with the (*Appropriate State Agency*) within 30 days of commencing business in this State unless such person is licensed by the (*Appropriate State Agency*) as an insurer. Upon passage of this Act, each person, not licensed by the (*Appropriate State Agency*) as a contracting entity shall register with the (*Appropriate State Agency*) within 90 days of the effective date of this Act.
 - 1. Registration shall consist of the submission of the following information:
 - (a) the official name of the contracting entity, including any d/b/a designations used in this state;
 - (b) the mailing address and main telephone number for the contracting entity's main headquarters; and

- (c) the name and telephone number of the contracting entity's representative who shall serve as the primary contact with the Department.
2. The information required by this Section shall be submitted in written or electronic format, as prescribed by the (*Appropriate State Agency*).
3. The (*Appropriate State Agency*) may collect a reasonable fee for the purpose of administering the registration process.

Section IV. Contracting Entity Rights and Responsibilities

- A. A contracting entity may not grant access to a provider's health care services and contractual discounts pursuant to a provider network contract unless:
 1. the provider network contract specifically states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity; and
 2. the third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.
- B. A contracting entity that grants access to a provider's health care services and contractual discounts pursuant to a provider network contract shall:
 1. identify and provide to the provider, upon request at the time a provider network contract is entered into with a provider, a written or electronic list of all third parties known at the time of contracting, to which the contracting entity has or will grant access to the provider's health care services and contractual discounts pursuant to a provider network contract;
 2. maintain an internet website or other readily available mechanism, such as a toll-free telephone number, through which a provider may obtain a listing, updated at least every 90 days, of the third parties to which the contracting entity or another third party has executed contracts to grant access to such provider's health care services and contractual discounts pursuant to a provider network contract;
 3. provide the third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract;
 4. require that the third party who contracts with the contracting entity to gain access to the provider network contract identify the source of the contractual discount taken by the third party on each remittance advice (RA) or explanation of payment (EOP) form furnished to a health care provider when such discount is pursuant to the contracting entity's provider network contract; and
 5.
 - (a) notify the third party who contracts with the contracting entity to gain access to the provider network contract of the termination of the provider network contract no later than (*insert number*) days prior to the effective date of the final termination of the provider network contract; and
 - (b) require those that are by contract eligible to claim the right to access a

provider's discounted rate to cease claiming entitlement to those rates or other contracted rights or obligations for services rendered after termination of the provider network contract.

- (c) The notice required under subsection IV(B)(5)(a) can be provided through any reasonable means, including but not limited to: written notice, electronic communication, or an update to electronic database or other provider listing.

- C. Subject to any applicable continuity of care requirements, agreements, or contractual provisions:
 - 1. a third party's right to access a provider's health care services and contractual discounts pursuant to a provider network contract shall terminate on the date the provider network contract is terminated;
 - 2. claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and
 - 3. claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, are eligible for processing and payment in accordance with the provider network contract.
- D.
 - 1. All information made available to provider in accordance with the requirements of this Act shall be confidential and shall not be disclosed to any person or entity not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity.
 - 2. Nothing contained in this Act shall be construed to prohibit a contracting entity from requiring the provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's direct practice management or billing activities.

Section V. Third Party Rights and Responsibilities

- A. A third party, having itself been granted access to a provider's health care services and contractual discounts pursuant to a provider network contract, that subsequently grants access to another third party is obligated to comply with the rights and responsibilities imposed on contracting entities under Sections IV and VI of this Act.
- B. A third party that enters into a contract with another third party to access a provider's health care services and contractual discounts pursuant a provider network contract is obligated to comply with the rights and responsibilities imposed on third parties under Section V of this Act.
- C.
 - 1. A third party will inform the contracting entity and providers under the contracting entity's provider network contract of the location of a website, toll-free number, or other readily available mechanism, to identify the name of the person or entity to which the third party subsequently grants access to the provider's health care services and contractual discounts pursuant to the provider network contract.
 - 2. The website will be updated on a routine basis as additional persons or entities are granted access. The website shall be updated to reflect all current persons and entities with access every 90 days. Upon request, a contracting entity shall make access information available to a provider via telephone or through direct notification.

Section VI. Unauthorized Access to Provider Network Contracts

- A. It is an unfair insurance practice for the purposes of (*insert applicable reference to state insurance code unfair trade practices section*) to knowingly access or utilize a provider's contractual discount pursuant to a provider network contract without a contractual relationship with the provider, contracting entity, or third party, as specified in this Act.
- B. Contracting entities and third parties are obligated to comply with Sections IV(B)(2) or V(C)(1) and (2) concerning the services referenced on a remittance advice (RA) or explanation of payment (EOP). A provider may refuse the discount taken on the RA or EOP if the discount is taken without a contractual basis or in violation of these sections. However, an error in the RA or EOP may be corrected within 30 days following notice by the provider.
- C. A contracting entity may not lease, rent, or otherwise grant to a third party, access to a provider network contract unless the third party accessing the health care contract is:
 - 1. a payer or third party administrator or another entity that administers or processes claims on behalf of the payer;
 - 2. a preferred provider organization or preferred provider network, including a physician organization or physician-hospital organization; or
 - 3. an entity engaged in the electronic claims transport between the contracting entity and the payer that does not provide access to the provider's services and discount to any other third party.

Section VII. Enforcement

Enforcement of this model will follow that of (*insert applicable reference to state insurance code unfair trade practices section*).

Section VIII. Effective Date

This Act shall be effective (*insert date*).

Appendix E

America's Health Insurance Plans Letter (1/9/09)

16 State Street, Suite 8
Montpelier, Vermont 05602-2903
802 229 4900
802 229 5110
kse@ksey.com
www.kse.com

January 9, 2009

Madeleine Mongan, Deputy
Executive Vice President
Vermont Medical Society
134 Main Street
P.O. Box 1457
Montpelier, VT 05601

RE: Contract Standards Legislation

Dear Madeleine:

I am writing to you on behalf of our client, America's Health Insurance Plans (AHIP). AHIP is a national trade association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. AHIP members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. The purpose of this letter is to provide you with AHIP's comments on the draft legislation (01/02/09 version) you have prepared as a result of and in connection with the meetings of the Act 203 contract standards workgroup.

At the outset I want to express our gratitude for your hard work in getting a proposal on the table. While AHIP disagrees with a number of the positions taken in the draft legislation, it recognizes that the issues under consideration are issues that reasonable people can reasonably disagree over. We sincerely appreciate your leadership in this matter.

AHIP's members are committed to providing Vermont consumers affordable, quality health care. AHIP is concerned that the draft measure will inhibit efforts to develop innovative approaches to increase the quality and affordability of health care coverage for consumers by rewarding physicians who deliver high quality and cost-effective care. Moreover, it will threaten the viability of health care networks and severely disrupt the collaborative efforts of payers and physicians on a range of important initiatives, all of which seek to provide consumers with affordable quality health care while reducing administrative burdens.

AHIP offers the following concerns on various provisions of the proposed legislation. While not exhaustive of all of the concerns, they highlight provisions particularly important to AHIP members.

Contracts Through Legislation

AHIP is concerned with the general public policy matter of legislating contract terms in specific industries among sophisticated interested parties. Provisions of the draft bill clearly establish terms for health care providers that will limit the ability of insurers to obtain the most cost effective agreements as they administer health benefit plans. The imbalance codified by the draft bill will substantially disrupt the bargaining process in which employers, health insurance plans, and third-party administrators seek to procure health care coverage for consumers. The ability of private parties to contract freely is a vital part of a market economy. Those running their businesses, not government, should decide on the terms and conditions of private contracts. Moreover, creating mandatory contract provisions could stand in the way of innovations in health care delivery by stifling new designs and models to enhance patient safety and care.

In order to avoid the significant and unintended consequences to the health care market place and, in turn, for consumers, contracting entities and health care providers need to be able to freely negotiate contract terms in the most innovative and cost effective ways possible. In recent years, the health insurance industry has voluntarily undertaken major initiatives to improve processes and enhance efficiency to reduce administrative burdens. One example is the Council for Affordable Quality Health Care (CAQH), working with other stakeholders – such as the American Medical Association, American Academy of Family Physicians, American College of Physicians, and the Medical Group Management Association – has launched broad initiatives to promote quality interactions between plans, providers, and other stakeholders; and to reduce costs and administrative burdens associated with health care administration. This proposed legislation could prohibit the implementation of the successful work achieved to date, as well as inhibit the future development of operational efficiencies for health plans and providers.

Definitions

AHIP suggests that the definition of “Participating Health Care Provider” be revised as follows:

“Participating Health Care Provider” – means a health care provider that has a health care contract with a contracting entity and is entitled to reimbursement for covered health care services rendered to an enrollee under the health care contract.

The purpose of the proposed revision is to clarify that a participating health care provider is entitled to reimbursement from a health plan only if the health care services provided are covered under the insured’s health insurance contract. This revision should be considered in the context of sections 27 and 29 of Act 203, which limit retrospective denials of claims and require payment for claims that were subject to and received prior authorization.

AHIP also offers the following amendments to the definition of “Contracting entity” to ensure the use of the terms otherwise defined in the proposed legislation:

“Contracting entity” -- means any entity that contracts directly or indirectly with a health care provider professional (A) for the delivery of health care services, or (B) for the selling, leasing, renting, assigning, or granting of access to a contract or terms of a contract. For purposes of this section, a health care provider professional, PHO, health care facility, or stand alone dental plan is not a contracting entity.

Contract Amendments & All Products Clauses

AHIP questions the different treatment afforded to contract amendments under Section III(A)(2) and (A)(5) as it is unclear why one particular contractual provision -- in this “all products” clauses -- receive special treatment and status. We respectfully suggest that these clauses should be subject to the same process as other amendments to the contract, providing health care providers the same opportunity to review and object to the proposed amendment.

In addition, AHIP opposes the proposed prohibition of “all products” clauses. These clauses are intended to ensure that there is an adequate provider network for all of a health plan’s products and also ensures that consumers in government programs have access to the same broad network of providers as all other insureds in the commercial market.

Rental Networks

AHIP supports enhancing transparency in the provider contracting process. Information must be made available to physicians for the purpose of determining the relationship among physicians, preferred provider networks, and the entities processing claims (e.g., health insurance plans or their agents, such as third-party administrators). This can be accomplished through several different means, including but not limited to: 1) network identifiers on materials provided to enrollees, 2) pre-service notification (e.g. websites or toll-free telephone numbers), and 3) post-service notification (e.g. remittance advice or explanation of payment form). Information identifying the physicians in the enrollee’s network must also be made available to inform patients who access the physicians’ services.

AHIP members are concerned, however, with the specific rental network provisions in the proposed draft, including, but not limited to:

- the failure to exclude self-funded employer-sponsored health benefit plans that are regulated under the Employee Retirement Income Security Act of 1974 (ERISA);
- the requirement that a contracting entity provide prior approval of the rental, lease, or other grant of access to the health care contract by a covered entity to another third party when the underlying contract allows for this activity;
- the creation of a private right of action to enforce the new statutory and regulatory obligations;
- the allowance for participating providers to balance bill the consumer when the covered entity does not pay in accordance with the reimbursement terms of the contract -- which

could include situations when unintentional mistakes or errors occur that would be resolved if they were brought to the covered entity's attention:

- the establishment of a new – and duplicative – provider complaint and appeal process;
- the failure to incorporate a reference in the termination provision outlined in subsection (B)(5) to continuity of care requirements; and
- the failure to extend an obligation on payers and third-party administrators under subsection (C)(1)(d)(i) to comply with the underlying terms of the health care contract with the provider, state prompt payment requirements and other similar obligations that are imposed on covered entities.

Enforcement

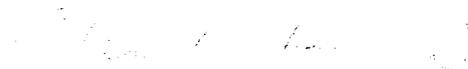
AHIP opposes the creation of a private right of action as an additional means of enforcing the provisions of the proposed legislation. We respectfully note that the relationship between a provider and a health plan should be governed by the contract between them, and the common law rules that pertain to contracts. For instance, a contract provision that violates a statute is generally considered to be unenforceable and void. *See* 17A Am Jur 2d *Contracts* § 229. In addition, if a health plan breaches the terms of a contract or otherwise violates the common law rules that pertain to contracts, the provider can maintain an action against the health plan.

AHIP also is concerned about the inequitable treatment of the parties with respect to recovering costs and reasonable attorney fees. The general rule in the United States is that each party is to bear its costs and attorney's fees regardless of the outcome of the case. If there is to be a cost and attorney's fees provision then it should not be one-sided and only allow the provider to recover its attorney's fees if the provider prevails. Rather, any such provision should provide that a court may award costs and reasonable attorney's fees to the prevailing party.

AHIP hopes the provider community in Vermont and in all states will work collaboratively with members of the insurance industry, employers, and other stakeholders to continue to improve processes and achieve efficiencies in the health care system. We do not believe that this proposal helps advance this goal. All interested parties need to focus their resources, time, and energy on efforts that control the cost of health care, expand access to care, and improve the quality of care for Americans.

We thank you for the opportunity to provide our views on these very important issues.

Sincerely,



Charles F. Storrow