Member rights and responsibilities

In order for Blue Cross and Blue Shield of Vermont (BCBSVT) and The Vermont Health Plan (TVHP) members to get the most from their benefit plan, they must follow certain guidelines, known as our Member Rights and Responsibilities statement. A complete copy of our Member Rights and Responsibilities is available on our website, www.bcbsvt.com/member/member-rights-responsibilities. To request a paper copy, please contact your provider relations consultant.

We want your feedback

As always, we welcome input and feedback regarding our quality program initiatives. For information about participating in quality activities, or to request a description of our quality program and progress on meeting goals, you can reach us at (802) 371-3651 or qualityimprovement@bcbsvt.com.

Referring members to BCBSVT/TVHP case management

BCBSVT designed its case management program as a member-centered, proactive program to identify at-risk members as early as possible. Our case management program utilizes a whole-person approach, addressing medical, mental health, substance use disorder and pharmacy needs at all levels of care and stages of life to help members achieve and maintain health, navigate acute interventions, and live with and manage chronic illness.

Clinicians are trained in cross-disciplinary medical and mental health/substance use disorder (MHSUD) support to create a comprehensive, whole-person personal care plan and help patients with high health complexity overcome clinical and non-clinical barriers to improvement. The program is designed to identify potentially high-cost and high-risk members as early as possible, assess alternative treatment options, assist in stabilizing or improving the member's health care outcomes and manage health care benefits in the most cost-effective manner.

We encourage providers to refer BCBSVT/TVHP members directly into our integrated case management program by calling us toll free at (800) 922-8778, Monday through Friday from 8 a.m. to 4:30 p.m. Our intake triage staff will record the information and complete outreach to the member for enrollment. Members may self-refer to the case management program. Family members and caregivers may also refer members to the program. If we determine that the member has the potential to benefit from case management, we send a welcome packet defining his or her case manager's role and the member's rights and responsibilities in participation. Once the member consents to participate, our case manager completes a comprehensive assessment of the member's condition. The member, case manager and provider then develop a member-specific case management plan of care to support the member's clinical plan of care. The plan includes a member self-management plan, as well as short- and long-term goals and discharge criteria.

Chronic condition management program helps improve clinical outcomes

BCBSVT prevalent and rare chronic condition programs provide personalized condition-specific support for certain prevalent and rare conditions. Prevalent condition management provides local support to members with chronic medical and mental health or substance use disorder issues. Our partner, Accordant Health Services, provides member-focused outreach to those with specific rare and complex conditions. In collaboration with providers, BCSBVT proactively leverages its data and identifies those at risk, reaches out to them for support, and provides access to specialized programs and services.

BCBSVT provides participants with user-friendly and results-oriented resources to help them live longer, healthy lives. Participation is free and voluntary for all eligible members.

The program's care team, comprised of registered nurses, social workers and licensed mental health counselors, provides support to help members follow their providers' treatment plans, and encourages them to take a proactive role in the management of their overall health. This is a covered service and does not require referrals to participate. BCBSVT keeps all member information, such as medical or pharmacy claims needed to administer the program's specialized services, in the strictest confidence. BCBSVT fully complies with all HIPAA regulations.

Every aspect of the program is designed to provide maximum support and benefit to providers and members. Providers and members have access to the following:

Physician resources:

- Care team professionals who work with members to reinforce treatment plans and provide assistance to help them overcome barriers to following their treatment plan and improve clinical outcomes.

Member resources:

- Regular telephone contact from clinicians who review their health status, provide education and support in making lifestyle changes to support health and well-being, and address any barriers to following provider treatment plans.
- Educational mailings and resources to improve members' understanding and management of their condition(s).
- Periodic reminders encouraging members to obtain recommended laboratory tests, screenings and exams
- Periodic reviews of a member's success in following a prescribed, goal-centered treatment plan

The company welcomes any comments and questions providers may have about the program. Please call toll free at (800) 922-8778, anytime Monday through Friday, 8 a.m. to 4:30 p.m.

BCBSVT practitioner availability

BCBSVT annually measures compliance with the practitioner availability standards. We monitor practitioners that serve as primary care providers by specialty and in aggregate. We define the following areas as primary care practices: pediatrics; internal medicine; family practice; general practice; naturopaths; nurse practitioners and geriatrics. BCBSVT also monitors high-volume and high-impact specialties. In 2019, we monitored obstetrics and gynecology (OB/GYN), a high-volume specialty, and

oncology, a high-impact specialty. In addition, we evaluate the availability of mental health and substance use disorder practitioners.

- The practitioner availability standards are:
- Primary Care: Choice of at least two age-appropriate network PCPs, who are accepting new patients within 30 minutes travel time.
- High-Volume Specialty: Choice of at least one obstetrics and gynecology practitioner within 60 minutes travel time.
- High-Impact Specialty: Choice of at least one oncology practitioner within 60 minutes travel time.
- Mental Health - Choice of at least one mental health practitioner within 30 minutes travel time.
- Substance Abuse - Choice of at least one substance abuse practitioner with 30 minutes travel time.

Performance against goal:

In 2019, we monitored the BCBSVT PPO/EPO, BCBSVT HMO/POS and TVHP networks. Each of the networks exceeded our performance goals.

BCBSVT accessibility of services

BCBSVT annually measures compliance with the expected standards for accessing care. We monitor health care practitioners, including mental health substance use disorder (MHSUD) practitioners.

The access standards for practitioners providing medical services are:
- Urgent care within 24 hours, or a timeframe consistent with the medical urgency of the case for urgent care.
- Non-emergency, non-urgent care within 14 days.
- Preventive care (including routine physical examinations) within 90 days.
- Routine laboratory, imaging, general optometry and all other routine services within 30 days.

BCBSVT requires primary care providers, high-volume specialties (obstetrics and gynecology), and high-impact specialties (oncology) to provide 24-hour, seven day a week access to members by means of our on-call or referral system. Practitioners should return any after-hour telephone calls from members regarding urgent problems in a reasonable time, not to exceed two hours of receipt. Please refer to the Accessibility of Services and Provider Administrative Service Standards Policy for acceptable mechanisms of after-hours care.

The access standards for practitioners providing MHSUD services are:
- Care for a non-life threatening emergency within six hours.
- Urgent care within 48 hours.
- Initial visit for routine care within 10 business days.
- Routine follow up visit within seven business days.

BCBSVT expects all MHSUD practitioners to work with patients to develop individualized crisis plans to outline options for crisis care during and after typical office hours. BCBSVT expects these crisis plans to identify opportunities for members to access care from the MHSUD practitioner as a first course of action in the event of a non-life threatening emergency, but BCBSVT also advises all MHSUD practitioners to direct members with a non-life-threatening emergency to go directly to their local

emergency room or to the appropriate emergency services available if the MHSUD practitioner is not available to provide care.

Financial incentives

BCBSVT bases its utilization management (UM) decisions on the appropriateness of care and service, and whether the member has coverage. BCBSVT and its affiliate, The Vermont Health Plan, do not reward practitioners or other individuals for issuing denials of coverage or service care. We also do not offer financial incentives to our UM decision makers for issuing denials or making decisions that result in under-utilization.

We do not make decisions about hiring, promoting or terminating practitioners or other staff based on the likelihood, or perceived likelihood, that they will support denials of benefits.

We base decisions on clinical review criteria

We use nationally recognized health care guidelines, MCG (formerly Milliman Current Edition), and the locally approved health care guidelines developed internally to reflect national and local standards of care.

Our integrated health management department shares the appropriate MCG Optimal Recovery Guidelines with the utilization reviewers from participating facilities and attending providers when questions arise about clinical rationale and application of criteria. Upon request, we make the applicable MCG and internal BCBSVT medical policies available to members and providers. Each of the participating hospitals has a copy of the MCG Inpatient Health Care Guidelines. We review these guidelines on an annual basis to assure relevance with current practice. Providers and members may request a copy of the applicable criteria from the integrated health management department, by phone (800) 922-8778, by fax (802) 371-3491 or mail at BCBSVT/TVHP, P.O. Box 186, Montpelier, Vt., 05601-0186.

You may speak with a reviewer about your denial

BCBSVT and TVHP provide practitioners with the opportunity to discuss utilization review denial decisions based on medical necessity with a Plan physician or pharmacist reviewer. If a provider wants to discuss a medical necessity UM denial with a Plan physician or pharmacist, they can call us toll free at (800) 922-8778, Monday through Friday from 8 a.m. to 4:30 p.m. An administrative coordinator or member of the clinical support staff will schedule a time for the requesting provider to speak with the appropriate reviewer.

Independent, external review available

Members may request an independent external review of the decision by an independent review organization. Members may request external appeals by calling the state of Vermont at (800) 964-1784, or by writing to 89 Main Street, Montpelier, Vt. 05602. The state will determine if the case is appropriate for review.

Clinical practice guidelines

The Plan has adopted nationally recognized guidelines, developed by experts in their field, for preventive health, chronic health conditions and mental health disorders. A list of adopted guidelines is available at www.bcbsvt.com/provider/policies/clinical-practice-guides.

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