VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: Provider Participation with Vermont Medicaid regarding Standards of Care (SOC)

Issuance Date: September 21, 2023

(Must be reviewed annually)

Applicable Regulations, Guidelines, and AHS Policy:

Federal statute or rule:

- Affordable Care Act of 2010 (ACA)
- CFR §455.106424.502
- Social Security Act Section 1128 B (f)
- 42 CFR §455.106.
- 42 CFR 455 Subpart E. §455.416
- 42 CFR §1002.2.
- 42 CFR §455.416(c)

Vermont statute or rule:

- DVHA rule 7105.2 Provider Responsibility (07/01/1991, 91-31)
- DVHA Rule 7106, “Violations of Provider Responsibility”: 7106 Violations of Provider Responsibility (04/01/1999, 98-11F)

State Plan:

Rules 7105.2 & 7106

Other:

- DVHA General Provider Agreement (GPA)
- DVHA Clinical Service Team Quality-of-Care (QOC) SOP
- Medicaid Quality Management Plan (May 2019)
- Medicaid Provider Enrollment Compendium (MPEC)

Purpose:

To document the process for case referral by the Member Provider Services (MPS) team to the Clinical Services Team (CST) when concerns arise during provider application screenings and when reports about professional standards of care (SOC) are received.

Procedure:

Member and Provider Services (MPS) coordinates case review efforts with the Clinical Services Team (CST) of DVHA, other DVHA units, or AHS departments regarding various cases.

Coordination with these units is required to comply with the Centers for Medicare and Medicaid Services (CMS) screening and validation requirements, state rules, and other health industry standards. MPS is also obligated to refer cases to CST regarding Standard of Care (SOC) issues or other notable concerns that are alleged or documented about an already participating, revalidating or newly enrolling Provider(s).

Subject Matter Experts (SMEs) evaluate care standards in specific situations utilizing professional and industry standards of health care. DVHA staff qualified to do so utilize specific industry standards regarding healthcare services to review and render decisions on cases.

Clinical Service Team
Criteria for routing cases to CST:

- Any Provider, Facility or Group, that is the subject of a malpractice suit settled for $100,000 or more.
- Any Provider, Facility or Group with clinical concerns around any malpractice suit.
- Provider who is the subject of an active Letter of Reprimand or sanction.
- Provider with a New Condition imposed on license.

Applicants are Providers applying for or revalidating their Medicaid participation. These include:

- First-time applicants
- Reenrollments
- Revalidation

Any concerns arising from monthly checks are subject to an SOC review.

All of these applicants are subject to the criteria for routing cases to CST. Applications or revalidations are processed by the fiscal agent.

New applicants who are denied will be notified of their denial via letter. Providers who have been enrolled in the Vermont Medicaid program and are being newly excluded will be reported to CMS if their exclusion is a “for cause” reason.

MPS is responsible for sending any documentation from the CMO regarding a Provider’s enrollment status to the fiscal agent for placement in file via the PMM system.

If a Provider is excluded, MPS is also responsible for sending an exclusion letter to the Provider, as well as documenting the exclusion in the DEX database.

Revision History:

Date	Summary of Revisions
Jan 2020	Draft of SOP
March 2020	Draft to COU Director & CMO for review
April 2021	Draft approved for OMU review
4/21/21	OMU review
4/26/21	OMU draft back to SME for suggested edits
4/27/21	Draft agreed upon for final review by SME and Director.
5/3/22	OMU review. Adjusted template to match current ADA SOP.

Table 1 Revision History