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Testimony for House Committee for Healthcare- Payer Administrative Burden

Kelly Champney Lange, UVMHN Network VP Managed Care Contracting

- Current Role (2.5 Years):
  - Oversee all negotiations for Commercial, Medicare Advantage and Managed Care Payers
  - Oversee day-to-day payer escalations: policy disputes, patient access concerns, prior authorization and utilization managements concerns, etc.
  - Oversee value based contracting programs
- Background
  - Juris Doctorate, Western New England University School of Law (2007)
    - Focus on Contracting and Health Care Law
  - Prior Experience: VP of Strategy, Adirondacks ACO (1.5 years); Corporate Director Health Care Reform and Director of Contracting roles, BCBSVT (10 years), Defense Counsel, Ryan Smith and Carbine, Rutland VT (3 years).

Current Payer Policy Environment:

- Number of Payers in VT: More than 20
- Network Volume of Payer Policy Changes: Estimated 2100 policy changes per year (40/week average)
- Current Manual Process:
  - Individual policies identified and "pulled" from payer communications in varying formats (PDF, emails, Hard Copy, online newsletter etc.). These are then manually reviewed, flagged, disseminated to the entire network for detailed review by clinical subject matter experts
  - Payer notices take various forms: Newsletters, paper notices, policy releases, PDFs, emails, websites, flyers, and at times no notice
  - Payer notification lacks standard information (i.e. effective date, change log, redlines, resource support)
  - Payer notifications and policies impact varying locations, multiple lines of business (MA, Medicaid, Commercial), and are released differently by each payer. Resources only allow focus on large payers and larger potential impact areas
  - Payers utilize third party vendors to support policy implementation often creating additional resource requirements to mange, interact and monitor
  - 1 Contracting FTE (with an MBA degree), Provider Billing Teams, Hospital Billing and Underpayments Team
  - Payer payment policies often not focused on patient care or quality but rather what is billed and coded
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Case Study: BCBSVT Cotiviti

- Cotiviti edits implemented in 2023: See BCBSVT policy – Notified November 2022

        - Policy is over 50 pages long with little detail on the editing process/guidance for edits – difficult to review for impacts
        - BCBSVT communication and reporting has been inconsistent
- Not standardized within one payer- BCBSVT applied to commercial and out of state BlueCard claims but not MA or some self insured programs creating inconsistencies within one payer
- The Value Add of Edits is unclear (not denying due to "bad" coding) – Under the current policy we get paid on 65% of the claims we submit records for – and 79% of all claims (denied and processed cleanly)
    - Year over year increase in denials for provider billing only demonstrates almost a 200% increase in BCBSVT denials for claims that are now considered to lack information or include separately billable services
- Unclear what we are supposed to do to avoid denials. Denials lack information to properly understand why revenue is denied requiring a weekly manual report to be provided, which continues to lack sufficient information as to all edits
- Resource allocations have been made to dispute BCBSVT denials: (ex. 2 Contract Analyst FTEs to be redeployed to email medical records on one specific edit (Modifier 59) with the support of 1 Contracting FTE and VP of Managed Care Contracting)
- Obtaining medical records disputing edits requires 10 minutes on average per medical record to retrieve and send in and individual email – Emails expire, and we have to resend if not reviewed
    - Based on current claim volume, If it takes an average of an hour per claim to review the denial, print and fax medical records, and conduct a single follow-up review, a team of six people would each have to work 8 hours a day for 1.32 years and do no other work. For a single person this would take 7.921 years to complete. This is only on UVMMC's current volume.
- BCBSVT response to medical record evidence is slow (ex. Outstanding responses to medical records provided in November 2022) BCBS has 60 days to review and respond; we have examples of claims (47 total) that have reached that 60 day mark with no reaction from BCBS yet
    - Of the 1843 records faxed we have only received a response on 56% of them
    - Delays patient billing and patient understanding of liability or impact to deductibles and benefits
- Delayed Revenue – initial processing time, but then have to add time for billers to work the denial, 60 days for response, if unfavorable then additional time is needed to appeal again and wait longer

Patient and Provider Impact

- Potential barriers to access care
- Increased health system costs
- Provider / workforce frustration