VERMONT

DEPARTMENT OF FINANCIAL REGULATION

Act No. 183 (2022) Report:

Prior Authorizations; Administrative Cost Reduction

February 15, 2023

Submitted by
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Introduction and Background

Section 36 of Act 183 of 2022, *an act relating to economic and workforce development*, requires the Department of Financial Regulation (DFR or Department) to explore the feasibility of requiring health insurers and their prior authorization (PA) vendors to access clinical data from the Vermont Health Information Exchange (VHIE) whenever possible to support PA requests in situations in which such a request cannot be automated. Act 183 further requires DFR to direct health insurers to provide PA information to the Department in a format required by the Department in order to identify opportunities to align and streamline PA request processes. Finally, Act 183 requires DFR to share its findings and recommendations with the Green Mountain Care Board (GMCB) and collaborate with GMCB to provide recommendations to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance regarding statutory changes necessary to align and streamline PA processes and requirements across health insurers.

The first component of this report stems from DFR's previous PA report, mandated under Act 140 of 2020.[1] In that report, DFR described the real-time decision support tools in provider electronic health record (EHR) systems to support insurer PA requests, commonly referred to as "touchless" PA. As part of that report, the Department explored the possibility of integrating insurer PA systems with the Vermont Health Information Exchange (VHIE). All Vermont hospitals and Federally Qualified Health Centers, 174 hospital-owned specialty and primary care practices, 31 independent practices, and several other providers submit data through Vermont Information Technology Leaders (VITL) to the VHIE in accordance with Vermont's State Health IT Plan.[2] DFR concluded that it would be possible to "provide clinical data needed to make a prior authorization determination when an immediate answer could not be given[,]" but it would not be possible for the VHIE to support "touchless" PA as it is currently configured to operate. In this report, the Department will more fully address the feasibility of using clinical data in the VHIE to support PA requests.

The second component of this report derives from earlier work performed by the GMCB under Act 140 to "evaluate opportunities for and obstacles to aligning and reducing PA requirements under the All-Payer Model as an incentive to increase scale, as well as potential opportunities to waive additional Medicare administrative requirements in the future."[3] The GMCB found that although approximately 96% of service-based PAs are ultimately approved, PA requirements are not aligned across payers, which contributes to healthcare providers' administrative burden.

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[1] *See* Department of Financial Regulation, Report, Opportunities to Increase the Use of Real-Time Decision Support Tools Embedded in Electronic Health Records to Complete Prior Authorization Requests for Imaging and Pharmacy Services (Jan. 15, 2022), *available at* https://dfr.vermont.gov/sites/finreg/files/doc_library/dfr-legislative-report-act140-electronic-prior-authorization.pdf.

[2] The State Health IT Plan, which is approved by the Green Mountain Care Board is available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/2020HIEPlanUpdate_Resubmission_DVHA_Rec20201201.pdf;

[3] *See* Green Mountain Care Board, Report, Opportunities for and Obstacles to Aligning and Reducing Prior Authorizations under the All-Payer ACO Model (Jan. 14, 2022), *available at* https://legislature.vermont.gov/assets/Legislative-Reports/GMCB-Act-140-of-2020-Sec.-10-Report-Submitted-01.14.2022.pdf.

Consequently, GMCB identified understanding alignment, cost and risk associated with PA processes as areas of further studies that would benefit from additional stakeholder engagement. GMCB noted, however, that it did not have the regulatory authority to require insurers to provide information about their PA requirements in a uniform format to facilitate analysis.

DFR would like to extend its thanks to Tom Weigel, MD and Josh Plavin, MD at Blue Cross Blue Shield of Vermont, Jordan Estey and Barbara Storti at MVP Health Care (MVP), Jason Williams at the University of Vermont Health Network (UVMHN), Beth Anderson and Maurine Gilbert at Vermont Information Technology Leaders (VITL), and colleagues at GMCB for taking the time to provide their insights about the topics discussed in this report. DFR also extends its thanks to Amos Lomaisa for his research assistance.

Feasibility of Requiring Health Insurers to Access Clinical Data from VHIE

To determine the feasibility of requiring health insurers and their PA vendors to access clinical data from the VHIE, DFR met with VITL, BCBSVT, MVP, and Cigna. All parties stated that although using VHIE data is technically feasible, and VITL has policies in place to support insurers having access to the VHIE to support PA requests, there are several practical considerations that precluded use of those data to support PA requests. Because VHIE is intended for providers to make patient information available to each other, it only supports a limited number of data types, including admission, discharge, and transfer (ADT) messages; continuity of care documents (CCDs); laboratory reports; radiology reports; transcribed reports; immunization messages; and home health monitoring data. Moreover, under VHIE's terms of use, VHIE data may be used to approve a request for PA but may not be used to deny a PA request, requiring insurers to ask that providers manually submit clinical information if the PA is not automatically approved.

According to BCBSVT, which participated in a pilot program with VITL in 2022, 83 of 231 inpatient PA requests used in the pilot through October 24, 2022, could be approved using VHIE data. In 55% of cases where VHIE data could not be used, clinical information needed to approve the PA was not available. In other cases where VHIE data could not be used, either the member's clinical information was not in VHIE (3% of cases) or the information in the VHIE would have resulted a denial (3% of cases). Other PA requests could not be approved with VHIE data for a variety of reasons, including out of state providers who did not submit information to VHIE, as well as missing admission records, family histories, and medical histories. In many cases cited by BCBSVT, the member's laboratory results were in VHIE, but not clinical notes supporting an inpatient level of care. For other inpatient services that commonly require PAs, such as sleep studies, MRIs, and genetic testing, there were no notes in VHIE that documented the clinical need for the service. BCBSVT also noted a wide gulf in the usability of data submitted to VHIE by providers, with academic medical centers providing the most usable data in general.

On a positive note, BCBSVT reported to DFR that case management (CM) teams, who work with members to ensure that they have access to the appropriate level of care, found more utility with the data. Because CM teams typically work with claims data, which consists of diagnosis and procedure codes intended for use in medical billing, working with any amount of

clinical information was greatly helpful in informing conversations with the member and their providers.

To get a sense of how BCBSVT's pilot with VITL compared to other medical PA requests, DFR examined information submitted by BCBSVT, MVP, and Cigna under Act 152 of 2015, which requires annual reporting of utilization review metrics, including the percentage of PA requests each insurer denied. As shown in Table 1 below, the denial rate for pre-service medical PA requests has ranged from 35% to as low as 2% since 2018:

Table 1 PA Denial Rate and total Pre-service Medical PA Requests 2018-2021.[4]

Insurer	2021	2020	2019	2018
BCBSVT[5]	7.2% (18,931 requests)	8.0% (15,899 requests)	8.1% (25,313 requests)	2% (20,134 requests)
MVP	20.18% (7,618 requests)	19.57% (5,298 requests)	20% (6,389 requests)	16% (6,294 requests)
Cigna	35% (1,141 requests)	31% (982 requests)	Membership below reporting threshold.	Membership below reporting threshold.

While the small sample size of BCBSVT's VITL pilot makes it difficult to draw conclusions from the data, DFR observed that the percentage of cases in which VHIE data would have led to a PA request being denied was below BCBSVT's overall PA denial rate for pre-service medical PA requests in 2021. DFR also observed that in most instances where VHIE data could not be used to approve a PA request, it was because of deficiencies in data reporting, as opposed to legal or technological limitations with the data set.

Overall, BCBSVT reported that VHIE data was of limited usefulness to support PA requests. It also expressed concern about the long-term cost of service fees charged by VITL to access VHIE data and urged the state to address these fees if insurers were to be required to attempt reviewing PA requests with VHIE data.

There are two forthcoming developments that could make it easier for insurers to use VHIE data to support PA requests. First, VITL is working to expand the number of data types on the VHIE to include social determinants of health, mental health, and substance use disorder services. It is also partnering with the Agency of Human Services to incorporate public health data such as immunizations and vital records into the VHIE.[6] Second, on December 6, 2022, the

[4] All submitted Act 152 reporting is available on DFR's website at: https://dfr.vermont.gov/industry/insurance/health-insurance/reports.

[5] BCBSVT advised with respect to this data that the COVID-19 pandemic led to an overall reduction in PA requests in 2020 and 2021, especially with respect to advanced imaging and chiropractic care, which both require services to be rendered in-person. BCBSVT expects a gradual shift to pre-pandemic utilization patterns and PA requests over 2022 and 2023.

[6] *See* Health Information Exchange (HIE) Strategic Plan 2018-2022 Plan (2021 Update), *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/BoardPres_HealthInformationExchangeStrategicPlan2021Update_AHS_20211117.pdf.

Centers for Medicare and Medicare Services (CMS) proposed rules that, among other things, would require payers to and maintain a provider access application programming interface (API) to automate the process for determining whether a PA is required, identify documentation requirements, and ease the exchange of PA requests and decisions from electronic health record (EHR) systems.[7] The API has the potential of greatly simplifying the process of utilizing clinical data from systems like VHIE.

To further increase the utility of VHIE data for insurers using it to support PA requests, the state should consider:

1. Permitting insurers to use VHIE data to approve and deny PA requests.
2. Providing training, incentives, or leveraging technology to increase the amount and consistency of clinical information submitted to VHIE; and
3. Securing a funding stream for VHIE that is not reliant on user fees for operation.

Prior Authorization Alignment Opportunities.

DFR conducted extensive research to determine whether other states or the federal government had a pre-existing standard for insurers to submit information about their PA requirements. DFR found that several states, including Arkansas, Delaware, Indiana, Kentucky, Texas, Minnesota, and Virginia require insurers to post PA requirements to public websites in an accessible and searchable format, including a list of any supporting documentation the insurer requires to approve a request and applicable screening criteria.[8] However, no states currently require insurers to submit their PA requirements to state regulators in a uniform format. DFR also reached out to CMS to see if the federal government required submission of insurer PA information. CMS confirmed that the federal government does not collect any PA information and that it does not have a standardized format for PA language.

DFR next reached out to the University of Vermont Medical Center (UVMMC), which had expressed an interest in discussing insurer PA requirements. UVMMC provided the DFR with a draft template for insurer PA reporting, including CPT code, site of service, insurance category (i.e., medical, pharmacy, or mental health), and any specific diagnosis-related qualifications. DFR shared UVMMC's draft template with the GMCB and health insurers. The health insurers expressed doubt that a uniform reporting template would serve to align and streamline PA processes, pointing instead to CMS's proposed PA API, discussed above, that would identify PA information and documentation requirements and show them in provider EHR systems.

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[7] *See* Centers for Medicare and Medicaid Services, Proposed Rule, Advancing Interoperability and Improving Prior Authorization Processes for MA Organizations and Medicaid Managed Care Plans, State Medicaid Agencies, State CHIP Agencies, CHIP Managed Care Entities, and Issuers of QHPs in the Federally-Facilitated Exchanges, CMS-0057-P, 87 F.R. 76238 (Dec. 13, 2022), *available at* https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

[8] *See, i.e.,* Minn. Stat. Ann. § 62M.10; Tex. Ins. Code § 1369.304; The American Medical Association maintains a compilation of state prior authorization laws as of April 2021 at: https://www.ama-assn.org/system/files/2021-04/pa-state-chart.pdf. Under 18 V.S.A. § 9418b(d), Vermont requires health insurers to post a current list of services and supplies requiring PA to their websites. However, the law does not require insurer to post PA requirements or make that information publicly accessible or searchable.

Health insurers also expressed concerns about how changes to PA requirements would be communicated to the state, and how often reporting would be required.

DFR noted that Act 183 does not mandate an ongoing reporting requirement like Act 152. However, there are a large volume of procedure codes and prescription drugs that require PA; PA requirements are frequently added, removed, or changed; and there are substantial differences between insurers as to the clinical criteria applicable to each service that requires PA. For example, the drug Ketamine is an anesthetic approved by the FDA for that use in 1970. It is not FDA-approved for the treatment of any psychiatric disorder,[9] although there are studies suggesting it can be used to treat depression.[10] BCBSVT does not require PA for Ketamine when used as an anesthetic but does require it when used to treat depression.[11] Cigna excludes Ketamine from coverage altogether when used to treat depression, considering it to be an experimental or investigational use of the drug.[12]

For these reasons, a one-time snapshot of each insurer's PA requirements would not meaningfully support the analysis of how to achieve the goal of streamlining the PA process, while imposing a substantial administrative burden on insurers to submit the data.

To better satisfy the goals contemplated in Act 183, DFR and GMCB propose to strengthen the attestation requirement for insurers that require prior authorization under 18 V.S.A. § 9418b(h) to better understand and track changes in PA requirements. Under § 9418b(h), a health insurer is required to review "the list of medical procedures and medical tests for which it requires prior authorization at least annually and eliminate the prior authorization requirements for those procedures and tests for which such a requirement is no longer justified or for which requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality or reduce health care spending to a degree sufficient to justify the administrative costs to the plan." DFR and GMCB have allowed insurers to comply with this requirement by submitting a letter signed by a corporate officer attesting to the requirements of the statute to the Commissioner of DFR and Chair of the GMCB. Going forward, DFR and GMCB will require insurers attesting to § 9418b(h) compliance to submit the following:

- A general description of the standards used by insurers to evaluate PA requirements.
- A list of services for which PA requirements were eliminated or added during the preceding plan year and the rationale for changing those requirements.

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[9] *See* Food and Drug Administration, Press Release, FDA alerts health care professionals of Potential Risks Associated with Compounded Ketamine Nasal Spray (Feb. 16, 2022), *available at* https://www.fda.gov/drugs/human-drug-compounding/fda-alerts-health-care-professionals-potential-risks-associated-compounded-ketamine-nasal-spray.

[10] *See* Jennifer Chen, How Ketamine Drug Helps with Depression, Yale Medicine News (Mar. 9, 2022), *available at* https://www.yalemedicine.org/news/ketamine-depression.

[11] Blue Cross Blue Shield of Vermont, Ketamine Corporate Medical Policy (April 1, 2022), *available at* https://www.bluecrossvt.org/sites/default/files/2022-02/Ketamine%20-%202022%20-%20PUBLICATION%2004.01.22.pdf.

[12] Cigna, Drug and Biologic Coverage Policy, Esketamine (Sep. 1, 2022), *available at* https://static.cigna.com/assets/chcp/pdf/coveragePolicies/pharmacy/ip_0220_coveragepositioncriteria_esketamine.pdf

- A list of the ten most requested PA and the PA approval rate for those PA; and
- The percentage of urgent and non-urgent PA requests granted because processing time exceeded the statutory timeframes established under 18 V.S.A. § 9418b(g)(4).[13]

DFR and GMCB also encourage the Legislature to consider amending § 9418b(g)(4) to decrease the timeframe for health insurers to respond to completed PA requests for urgent PAs to 24 hours, as currently required by at least 10 states.[14] The Legislature could also consider prohibiting insurers from requiring reauthorization during the current plan year when a PA has been granted for services deemed preventative by the IRS under 26 U.S.C. § 223(c)(2)(C), which includes prescription drugs for certain chronic conditions.[15] Additionally, the Legislature could consider expanding gold carding pilots instituted under Act 140 of 2020, which required large health insurers to implement programs that automatically exempt or streamline PA requirements for a subset of participating providers. The reports about the Gold Carding Prior Authorization Pilots were submitted to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the GMCB in January 2023. BCBSVT, MVP, and Wellfleet all stated an intent to continue their pilot programs.

The Legislature could also join PA reform efforts undertaken in other states. In Massachusetts, for example, H.4929, enacted as Ch. 254, Acts 2022, limits how insurers can apply step therapy—protocols establishing the sequence in which prescription drugs for a specific medical condition are prescribed. The Massachusetts law prohibits insurers from requiring step therapy when a medication is known to be ineffective for the patient's condition or the patient has already tried a medication in the same pharmacological class. It also prohibits insurers from requiring step therapy if the patient is stable on a medication and switching off it would cause harm and requires insurers to report to the Division of Insurance on the number and type of step therapy exception requests received and approved.[16]

Questions about this report may be directed to Sebastian Arduengo at the Department of Financial Regulation (Sebastian.Arduengo@vermont.gov).

[13] 18 V.S.A. § 9418b(g)(4) requires health insurers to "respond to a completed prior authorization request from a prescribing health care provider within 48 hours for urgent requests and within two business days of receipt for non-urgent requests." If additional information is required, health insurers must request it within 24 hours. And, if a health insurer does not respond to a completed PA request, acknowledge receipt of a request for PA, or request missing information within the statutory timeframe, the PA is deemed to have been granted.

[14] *See* American Medical Association, *supra* note 8.

[15] IRS Notice 2019-45 (2019), *available at* https://www.irs.gov/pub/irs-drop/n-19-45.pdf.

[16] Mass. H.B.1311 (2022), *available at* https://malegislature.gov/Bills/192/H1311.