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Testimony Senate Finance Committee
H.766 Prior Authorizations and Direct Billing

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- 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.
  - 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 Prior Authorization Experience and Administrative Burden

- 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 (Medicare Advantage), 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 manage, interact, and monitor.
  - 1 Contracting FTE (with an MBA degree), Provider Billing Teams, Hospital Billing and Underpayments Team
  - Payment policies are often not focused on patient care or quality but rather on what is billed and coded.

What this Bill Does:

- Step Therapy
  - **Allows for Step Therapy:**
    - Payers can use step therapy protocols
    - Exceptions to protocols can be based on clinical decisions but not on different pricing discounts each payer may be able to procure
    - Allows for tiering of costs for different therapies
  - **Removes Barriers to Care**
    - Removes barriers to continuation of medication when someone has a known long-term condition
    - Allows for a clinical exception to Step Therapy with proven documentation and clinical reasoning
- Claim Edits
  - **Allows for Claim Edits**
    - NCCI (National Correct Coding Initiative) edits are not created by Medicare but rather a national organization and are used for CMS and Medicaid covering all payers.

        - Hospital and Professional Claim Edits from NCCI and are allowed along with request for additional edits.
        - Pharmacy edits are permitted thus not subject to the conversation.
    - **Institutes Standard Processes**
        - Payers have to follow aligned release of edits and processes. This allows providers, staff, and patients to know what is expected and that the rules will not change outside of designated periods.
        - Supports timely payment, which is not occurring to date, yet allowing for audit to ensure proper coding and payment
        - Prevents automatic pre-adjudication requests for medical records which will significantly remove manual efforts by both payers and providers/provider staff
- Prior Authorization
    - **Allows for Prior Authorization**
        - Medicaid, a statewide insurer covering about a third of provider panels, provides a substantial number of PAs based on clinically accepted protocols
        - Allows for PA's for services not covered by Medicaid
        - Allows for differential benefit structures
    - **Streamlines and Improves Processing**
        - Quicker turn around for PAs—for an Urgent PA that could be done in a radiology setting this process would allow and avoid an ER visit
        - Transparency in publishing PA lists—currently not the practice leading to provider confusion
- Accountability
    - Payers and Providers must report the impact to this work with transparency resource and financial impact considerations ensuring the balance of cost of care and removing administrative burdens is addressed and does not negatively impact Vermonters.

Why we are Here—A Case Study: BCBSVT Cotiviti Policy Demonstrating Lack of Transparency and Process Alignment

- Not standardized within one payer- BCBSVT applied to commercial and out of state BlueCard claims but not Medicare Advantage or some self-insured programs creating inconsistencies within one payer.
- The value add of edits is unclear (not denying due to "bad" coding) 74% of all claims denied are getting overturned.
    - Team is only working claims with values higher than $50 thus not capturing all that should be overturned.
- 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.
    - 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) BCBSVT has 60 days to review and respond; we have examples of claims (over 60) that have reached that 60-day mark with no BCBSVT response.

Overall Impact of Payer Administrative Processes

BCBSVT is not alone in using payment process changes, policies, and prior authorizations to reduce revenue to providers. All payers use some form of these administrative burdens, some more than others, and the primary issue is lack of alignment between payers and the unilateral power the payer holds to make changes to processes whenever they wish.

- Patient Impact:

    - Delayed claims processes results in delayed patient billing and patient understanding of liability or impact to deductibles and benefits.
    - Staffing resources allocated to claims processing and appeals limit the staff available to patient care and clinic operations –thus delaying access.
- Clinic/Staff Impact:
    - Frustration and lack of understanding tied to payer requirements resulting in provider/clinic staff burn out
- Operational Impact:
    - Increasing staff required to manage prior authorization processes, call payers, and submit appeals. Staffing includes many clinical staff.
    - Staffing costs continue to increase in revenue oversight and processes to cover additional manual work.
    - Inability to operationalize streamlined workflows and processes due to the changing rules and varied payer requirements.
    - Significant loss in revenue through write-offs and claim denials not considered during the budgeting process.

Cost to the System

Administrative billing processes add cost to the health care system both on the payer side and provider side. Transparency, payer alignment, and removal of non-value processes is how we can start reducing the cost and burden that offers no value to patients, families, and communities. Payers, particularly BCBSVT, noted the "cost" of the proposed bill. Below addresses a few of the BCBSVT points. However, the most important note is that providers are committed to reporting the impact of this bill and maximizing operational efficiencies that can result from its passage.

Section 1 - Step Therapy *- Requiring patients to try and fail different medications before obtaining the medication recommended by their prescriber.*

H. 766 does not eliminate step therapy

- H. 766 allows clinicians and patients to request exceptions from step therapy in certain circumstances, but it does not eliminate step therapy.
- Near identical language is already in effect in Massachusetts and New York and the payers have not testified to any evidence showing that these laws increased premiums in our neighboring states.
- When asked in the House Health Care Committee, MVP could not state that the law in New York impacted their costs.
- Step therapy itself can increase health care costs: When step therapy leads to a patient failing to take their medication or having to take an ineffective medication for a prolonged period, this can lead to irreversible disease progression, lengthy hospital stays and other side effects. Payers have not included any of these avoided costs in their estimates.

Sections 2 & 5: Claims Edits *– Aligning billing standards with national standards*

H. 766 will not significantly reduce claims edits from current practice

- Under H. 766 a payer can apply to have DFR approve any claim edit standards. Payers have not stated any specific claim edit standards that they think DFR will deny and why.
- Providers have offered to list additional claim edit standards in the language of H. 766 – payers have been unable to provide a list of the claim edit standards they would like included.
- BCBSVT highlighted in House testimony the impact of $52M in pharmacy edits—this is distracting as the legislation proposed does not impact the ability to use pharmacy-based claim edits.
- Providers also dispute other allegedly prohibited claims edits as these are already incorporated into Medicare's claim edits and would be allowed under H. 766.
- BCBSVT has not filed reductions in premiums due to claim edits
- If this claim edit process saves money for BCBSVT, why do they only use them on a portion of their business?

Section 3 – Prior authorization – A*ligning prior authorization standards with Medicaid*

Estimated costs of aligning prior authorization ignore crucial details such as which services must be aligned, and costs added to the health care system because of prior authorization

- H. 766 already exempts huge swaths of services from alignment – pharmacy and out of network services.
- DVHA evidence has shown that eliminating prior authorization for services like advanced imaging did not increase health care costs.
- Of over 38k PAs submitted for outpatient clinics (diagnostics etc.) in 2022 the UVMMC approval rate was 99% (noting limited data)
- The per unit cost of the service is irrelevant in this analysis compared to the payer's trend in numbers of images and procedures ordered – providers do not differentially order services based on a patient's insurance provider.
- Prior authorization leads to increased health care costs when care is delayed, such as ER visits and hospitalization; it leads to higher administrative costs for the entire health care system such as the need for contractors, staff to process paperwork, high staff turnover and burnout, and pulling clinicians away from patient care and forcing them to spend hours on the phone or computer.