Vermont Medical Society Comments
Senate Health & Welfare Health Care Reform Bill - Section 15
Reducing Paperwork - Administrative Simplification

VMS strongly supports all efforts to reduce the paperwork burden for Vermont physicians. One of the principles you included in Act 48 is that the Vermont health care system "must include mechanisms for containing all system costs and elimination of unnecessary expenditures, including by reducing administrative costs."[1]

VMS has been involved in efforts to reduce paperwork for many years, and we are grateful for your committee's support for these efforts over the years, including:

- Green Mountain Care Board two prior authorization pilots for drugs and imaging underway now have the potential to be expanded and generalized and to reduce the burden of prior authorization;
- In 2013 Act 79 required DVHA and DFR to ensure that Medicaid and private insurers and their subcontractors include "full transparency of edit standards, payment rules, prior authorization guidelines, and other utilization review provisions, including the source or to Transparency and standardization of claims edits[2] In 2014, as part of the FY 2015 budget[3], Act 79 was amended to allow additional time for the Green Mountain Care Board and the department of Financial Regulation to adopt standards and payment rules for private insurers.
- Also in 2013 time limits for decisions on prior authorization were also established (48 hours for urgent, two business days for non-urgent and notice of receipt of non-urgent requests within 24 hours); if plan does not respond within the time limits, the prior authorization request will be deemed granted. Section 5a, Act 79 of 2013.
- In 2012, health plans were required to accept either HIPAA standard electronic transaction for prior authorization or a uniform form[4] for prior authorization for medical services as of March 2014.[5] Section 11h of Act 171 2012.
- In 2008, Act 203 established standards for insurer contracts, prior authorization, claim processing, uniform provider credentialing standards and time limits for credentialing, time limits for payment of clean claims, and limitations on retrospective denials. [6]
- In 2010 requirements for transparency, evidence-based standards, and a gold card program for Medicaid's prior authorization program for advanced imaging – CT, MRI and PET scans were included in the FY 2011 budget bill, Act 156[7].

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[1] Act 48 Section 3 (10) page 16
http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACT048/ACT048%20As%20Enacted.pdf
[2] Act 79 Section 5b
http://legislature.vermont.gov/assets/Documents/2014/Docs/ACTS/ACT079/ACT079%20As%20Enacted.pdf (at pages 8 and 9)
[3] Act 179, Section E.345.2
[4]http://www.dfr.vermont.gov/insurance/health-insurance/vermonts-uniform-prior-authorization-form-medical-services
[5] 2012 Act 171 Section 11h
[6] Act 203 http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT203.HTM
[7] FY 2011 Budget Section E 309.1, page 98
http://legislature.vermont.gov/assets/Documents/2010/Docs/ACTS/ACT156/ACT156%20As%20Enacted.pdf

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As you know from talking with primary care clinicians, more needs to be done. Paperwork requirements have continued to proliferate, required by state and federal agencies and private insurers. VMS strongly supports the goal of Section 15 of the draft Senate Health and Welfare bill and also supports the language proposed by Dr. Ramsay for the Green Mountain Care Board addressing quality improvement and payment measures, surveys, forms and standards and ensuring that they will be proven and evidence-based.

Section 15 addresses two other types of paperwork – claim administration measures such as prior authorization and edit standards and clinical screening tools and treatment tools such as SBIRT, ACES, VPMS and opioid prescribing policies. VMS strongly supports continuing efforts to increase the transparency of claim administration rules, to increase consistency of claim administration across payers. VMS also supports aligning clinical tools and policies and recommends that these tools be reviewed to ensure consistency, support of their clinical effectiveness, strength of evidence and to avoid duplication.

With respect to claim administration, VMS recommends that two departments that currently regulate payers, the division of insurance at DFR and DVHA work to ensure that existing laws such as those described above are implemented and administrative simplification efforts continue. In an ideal system, clinicians would be able to load claim administration rules and standards into their electronic practice management and billing systems. DFR administers Rule 09-03, formerly known as Rule 10, which establishes standards for health plans.

With respect to the clinical tools, VMS recommends that the Agency of Human Services support this effort, which is likely to involve the Departments of Health, Mental Health, Aging and Independent Living and DVHA.

Thank you very much for your continuing efforts on paperwork reduction. Proposed language follows:

> *(d) The Department of Financial Regulation in coordination with the Department of Vermont Health Access shall convene a working group to review and evaluate the current requirements for claim administration and payment including prior authorization, utilization review, edit standards, payment and credentialing. The working group may propose new requirements as appropriate. The working group shall ensure that current and future claim administration and payment requirements are fully transparent, easy to use, evidence-based, and aligned across payers;*
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> *(e) The Agency of Human Services shall convene a working group to evaluate the current requirements for clinical screening, diagnosis and treatment tools, forms, surveys and standards. The working group shall review current clinical tools to ensure that they are evidence-based, effective, proven and to ensure that tools used are aligned across programs, payers, and initiatives.*