VERMONT

DEPARTMENT OF FINANCIAL REGULATION

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

Section 9 Act No. 140 of 2020,
Prior Authorization; Electronic Health Records; Report

REPORT

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Report to the General Assembly and the Green Mountain Care Board

Submitted by

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Under Act 140 of 2020, the Department of Financial Regulation (the Department), in consultation with health insurers and health care provider associations, is required to report to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Green Mountain Care Board on "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, including options that minimize cost for both health care providers and health insurers."[1]

Along with member cost-sharing and provider auditing, prior authorization is one of the primary mechanisms used by health care payers to manage utilization and reduce waste. According to America's Health Insurance Plans (AHIP), a national association representing the interests of health insurers, prior authorization is "most effective in addressing overuse and misuse of treatments and services."[2] Provider advocacy groups such as the American Medical Association (AMA), however, claim that that prior authorization itself tends to be overused and hinders access to necessary patient care.[3]

Under 18 V.S.A. § 9418(15), prior authorization is defined as "the process used by a health plan to determine the medical necessity, medical appropriateness, or both, of otherwise covered drugs, medical procedures, medical tests, and health care services." Subject to state and federal laws and regulations, health plans typically have bespoke processes for administering prior authorization requests.

For fully insured health plans in Vermont, the prior authorization process is governed by 18 V.S.A. § 9418b and Department Rule H-2009-03. Section 9418b requires health plans to, among other things, promptly pay claims for covered services for which prior authorization was granted; respond to prior authorization requests within 48 hours of receipt for urgent requests and two business days for non-urgent requests; and to annually review medical procedures and tests for which prior authorization is required and eliminate the prior authorization requirement for services for which prior authorization is no longer justified or for which requests are "routinely approved."[4] Plans must accept "the national standard transaction information, such as HIPAA 278 standards, for sending or receiving authorizations electronically."[5] Health plans must also attest to the Department and to the Green Mountain Care Board that prior authorization requirements are reviewed and eliminated if appropriate.[6]

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[1] Act 140 of 2020, § 9.
[2] America's Health Insurance Plans, Frequently Asked Questions: Medical Management and Prior Authorization, *available at* https://www.ahip.org/wp-content/uploads/Prior-Authorization-FAQs.pdf.
[3] American Medical Association, 2020 Update, Measuring Progress in Improving Prior Authorization, *available at* https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf.
[4] 18 V.S.A. § 9418b(a), (g)(4), & (h)(1).
[5] *Id.* § 9418b(g)(1)(A)(i).
[6] *Id.* § 9418b(h)(2).

Rule H-2009-03 regulates utilization management generally, requiring that utilization management mechanisms not deter timely access to care or compromise a patient's safety and require that determinations to deny, limit, reduce, terminate, or modify otherwise covered services be made by a physician under the direction of the plan's medical director.[7] Rule H-2009-03 also requires health plans to have data systems sufficient to support their utilization management programs and to maintain written procedures for making utilization review decisions and notifying members.[8] Nothing, however, in Vermont law or regulations mandates that health plans operate their prior authorization systems uniformly or be interoperable with all electronic health record systems used by health care providers.

Because each health plan has some discretion within these statutory standards to determine its own prior authorization procedures, including deciding when prior authorization is necessary and the criteria used to adjudicate prior authorization requests, there is significant variation between plans—increasing the complexity and time required for providers to submit requests.[9] This variation extends to prior authorizations submitted electronically. Although providers can complete electronic prior authorization requests more quickly, as requests have traditionally been completed by telephone, fax, or postal mail, each health plan generally has its own unique portal for submitting electronic prior authorizations that may or may not integrate with a given provider's electronic health record system.[10] To get a better sense of the particular electronic prior authorization systems used by Vermont health plans and identify opportunities to integrate real-time decision support tools, known in the industry as "touchless" prior authorization, the Department convened a group of stakeholders for three meetings between October and December 2021 to discuss: 1) prior authorization for imaging services; 2) prior authorization for pharmacy services; and 3) the prior authorization process used by Vermont Medicaid. Participants included:

- Department of Vermont Health Access (DVHA);
- Green Mountain Care Board;
- Blue Cross Blue Shield of Vermont (BCBSVT);
- MVP Health Care (MVP);

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[7] DFR Rule H-2009-03 § 3.1(D), (G)(2).

[8] *Id.* §§ 3.1(I), 3.2 (A).

[9] The administrative burden of prior authorizations on health care providers has been thoroughly addressed in other reports on prior authorization mandated by the Legislature under Act 140. For general information on the impact of prior authorization on health care providers, see the American Medical Association 2020 Prior Authorization Physician Survey, *available at* https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf.

[10] *See* Network for Excellence in Health Innovation, *Innovations in Automation of Prior Authorization: Tackling the Issues from a Multi-Stakeholder Perspective* (June 7, 2021), *available at* https://www.nehi-us.org/news/599-innovations-in-automation-of-prior-authorization-tackling-the-issues-from-a-multi-stakeholder-perspective/view; RTI International Center for Health Care Advancement, *Evaluation of the Fast Prior Authorization Technology Highway Demonstration* at 4 (Feb. 25, 2021), *available at* https://www.ahip.org/wp-content/uploads/Fast-PATH-Evaluation.pdf.

- Cigna;
- eviCore;[11]
- Optum;
- CVS Health;
- Bi-State Primary Care;
- Vermont Medical Society;
- Vermont Association of Hospitals and Health Systems;
- Vermont Information Technology Leaders (VITL);[12]
- Vermont Retail Drug Association; and
- Office of the Health Care Advocate.

In each meeting, stakeholders heard presentations from BCBSVT, MVP, Cigna, and DVHA about each plan's particular implementation of electronic prior authorization and how it integrated into provider electronic health record systems. Provider stakeholders had an opportunity to ask questions and submit topics for discussion. The Department also engaged VITL to discuss the feasibility of using patient health data it aggregates to support touchless electronic prior authorization requests for providers whose electronic health record systems do not integrate with health plan prior authorization portals.

A summary of the electronic prior authorization process for BCBSVT, MVP Health Care, Cigna, and Vermont Medicaid is provided below:

1) Blue Cross Blue Shield of Vermont.

a) *Imaging Services.* Like many Blue Cross Blue Shield plans nationwide, BCBSVT contracts with AIM Specialty Health (AIM) to provide prior authorization and post service medical necessity review for imaging services.[13] AIM offers a free online provider portal through which providers can electronically submit prior authorization requests. When a prior authorization request is submitted via the provider portal, it is automatically reviewed for clinical appropriateness using BCSBVT's criteria. If a request is not automatically approved, providers can request manual review including consulting with a clinician employed by AIM. According to BCBSVT, in 2020, 87% of in-network providers used the AIM provider portal to submit prior authorization requests, and over 80% of those requests are automatically approved. In 2022, BCBSVT's in-network providers will be able to use an application programming interface (API) that integrates

[11] As described further below, eviCore is a healthcare management firm contracted by MVP and Cigna to manage their electronic prior authorization systems.
[12] VITL operates the Vermont Health Information Exchange, which aggregates patient health data from different health care providers. *See* https://vitl.net/.
[13] For more information about AIM's technology and clinical review process for imaging services, see https://aimspecialtyhealth.com/solutions/health-plans/clinical-solutions/radiology/.

with major electronic health record systems, including EPIC, to allow for touchless prior authorization submission and approval.[14]

b) *Pharmacy Services.* On July 1, 2021, BCSBVT changed its pharmacy benefit manager (PBM) from Express Scripts, Inc. to Optum. Both PBMs use an online portal called CoverMyMeds for electronic prior authorization requests. In 2018, CoverMyMeds was used by over "62,000 pharmacies, 700,000 providers and most health plans and PBMs" for electronic pharmacy prior authorizations.[15] Optum also publishes an API called PreCheck MyScript (PCMS), that integrates with major electronic health record systems. With PCMS, as soon as a provider adds prescription details into a patient's electronic health record, the patient's benefits are automatically checked, and the provider has access to information on drug pricing, potential alternatives, and coverage information. If prior authorization is required, the patient's information is pre-populated into a patient-specific request form and routed to Optum for processing.[16] In 2020, BCBSVT reported that 75% of pharmacy prior authorization requests came in electronically with 12% performed over the phone and the remaining 13% by fax. BCBSVT is actively engaging with providers, including pharmacists, to identify obstacles to integrating PCMS into provider workflows.

2) **MVP Health Care & Cigna.** Because MVP and Cigna use the same vendor, eviCore, for electronic prior authorization with respect to imaging services, they will be discussed together. Neither MVP nor Cigna provided the stakeholder group with utilization metrics for electronic prior authorization.

a) *Imaging Services.* eviCore offers a free online portal for providers to submit electronic prior authorizations. eviCore uses clinical questionnaires and "predictive intelligence" software to evaluate prior authorization requests in real time, with a goal of approving 50% or more of requests automatically. If a request is not automatically approved, it is manually reviewed for medical necessity. According to eviCore's website, it has "more than 800 medical directors and 300 nurses" available to consult with providers about prior authorization requests and works with providers to provide support and educational resources.[17] MVP and Cigna's in-network providers will soon have access to intelliPath, which is eviCore's API for provider electronic health record integration.[18]

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[14] For more information about AIM's API for electronic health record integration, AIM Inform, see https://www.aiminform.com/.

[15] Press Release, Angela Masciarelli, *2018 ePA National Adoption Scorecard Offers Updated Industry Trends, Research, Data* (Feb. 20, 2018), *available at* https://www.covermymeds.com/main/insights/articles/2018-epa-national-adoption-scorecard-offers-updated-industry-trends-research-data/.

[16] For more information about PCMS, see https://www.optum.com/business/resources/library/precheck-myscript.html.

[17] For more information about eviCore's technology and clinical review process for imaging services, see https://www.evicore.com/solutions/health-plan/utilization-management/radiology.

[18] For more information about intelliPath, see https://www.evicore.com/evicore/data/prior-authorization-automation/evicore-intellipath.

intelliPath automatically submits prior authorization requests through electronic health record software when a service that requires prior authorization is ordered, automatically incorporating elements from the patient's chart to support the request. The software then lets the provider know whether the request was approved or whether additional clinical information is needed.

b) *Pharmacy Services, MVP*. MVP's PBM, CVS Caremark, processes electronic prior authorization requests in partnership with CoverMyMeds and Surescripts. In the electronic prior authorization process, the provider uses either CoverMyMeds or Surescripts to request a prior authorization question set, which is submitted through the online portal or the provider's electronic health record. CVS Caremark then automatically evaluates the clinical data and communicates its decision to the provider.[19] MVP also utilizes a proprietary CVS Caremark tool called Novologix that functions similarly to PCMS, offering providers "real-time access to an automated [prior authorization] process[.]"[20] For MVP, Novologix provides the added benefit of managing pharmacy spending under both the pharmacy and medical benefits of their plans.

c) *Pharmacy Services, Cigna*. On December 20, 2018, Cigna merged with the PBM Express Scripts to create one of the country's largest health care conglomerates.[21] In addition to supporting the CoverMyMeds and Surescripts portals for electronic prior authorization requests, Express Scripts maintains its own portal called ExpressPAth.[22] Express Scripts also offers an API called ScriptVision that integrates into major provider electronic health record systems, and includes real-time decision support tools, including enabling providers to see a patient's estimated out-of-pocket costs, coverage alerts, and other therapeutic options prior to prescribing.[23] As of November, 2021, Real Time Benefit Check (RTBC), also known as "Real Time Prescription Benefit," is turned on for all of Cigna integrated pharmacy customers, and provides patient specific pharmacy benefit information at the point of prescribing to providers within their electronic prescription

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[19] For more information about CVS Caremark's clinical review process for pharmacy services, *see* https://www.caremark.com/wps/portal/!ut/p/z1/jY9LC4JAFIV_iwu3zk3FtJ1I-chCCR_NJjSmUVBHximhX5_YKijp7s7h-w5chFGOcFc8alqImnVFM-UzNi5utDc87QQhmKoG8dayguMuWoFroGwGbDdNYnDWBviODr6apu7B02cA_-PDj7PhP38BwMvzAcK0YeX7VbsrNZMizMmNcMKVO5_qSoh-2MggwziOCmWMNkS5slaGb0rFBoHyTxL1bZLkz5BktiS9AOlcC6E!/dz/d5/L2dJQSEvUUt3QS80TmxFL1o2X0I4Nzc4S1IxVURQTDAwSTYzRUxIMUQzR1M1/.

[20] For more information about Novologix, *see* https://payorsolutions.cvshealth.com/insights/innovative-cross-benefit-management.

[21] Press Release, *Cigna Completes Combination with Express Scripts* (Dec. 1, 2018), *available at* https://newsroom.cigna.com/Cigna-Completes-Combination-with-Express-Scripts-Establishing-a-Blueprint-to-Transform-the-Health-Care-System.

[22] For more information about Express Scripts's online electronic prior authorization portals, *see* https://www.express-scripts.com/corporate/healthcare-providers/physician-resources.

[23] For more information about ScriptVision, *see* https://www.express-scripts.com/corporate/scriptvision.

workflow. To access real-time benefit check, providers must have the most current version of their vendor's electronic health record system, and the system must be contracted with Surescripts, RxRevu, or CenterX.

3) **Vermont Medicaid.** By design, member cost-sharing for Medicaid members is significantly constrained, with members paying an annual maximum of 5% of their adjusted gross income (AGI) out of pocket. Thus, Medicaid is reliant on prior authorization for utilization management to a far greater extent than commercial health plans. In the context of pharmacy services, all "non-preferred" drugs require prior authorization. Although most Medicaid prior authorization requests are completed by fax, Medicaid also offers an online provider portal, and has forms available through CoverMyMeds and Surescripts. In early 2022, Change Healthcare, Vermont Medicaid's PBM, is expected to merge with UnitedHealth Group, Optum's parent company.[24] When the merger is complete, Vermont Medicaid anticipates having access to PCMS to further streamline its prior authorization process.

To identify potential opportunities for integrating real-time decision support tools into the electronic prior authorization process, especially with respect to providers whose electronic health record systems are not supported by the various APIs developed by insurers and their vendors, the Department first engaged with Vermont Information Technology Leaders (VITL).

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 VITL to the Vermont Health Information Exchange (VHIE) in accordance with Vermont's State Health IT Plan.[25] Because many providers already submit clinical information to VITL for the purpose of sharing with other providers, the Department explored the possibility of leveraging clinical data from the VHIE to support prior authorization requests. After meeting with representatives from eviCore, VITL reported that while it would indeed be possible to provide clinical data needed to make a prior authorization determination when an immediate answer could not be given, the VHIE could not be used to support touchless prior authorization because it does not contain future appointment data from providers. Adding that data element would require significant effort on the part of both VITL and providers submitting data. Therefore, it is unlikely that the VHIE could be utilized as a real-time decision support tool in the near-term.

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[24] Susan Morse, *UnitedHealth Group and Change Healthcare Amend Merger Timeline*, Healthcare Finance News (Nov. 8, 2021), *available at* https://www.healthcarefinancenews.com/news/unitedhealth-group-and-change-healthcare-amend-merger-timeline.

[25] 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; Information about the entities that exchange data through VITL may be found at: https://vitl.net/about-the-vhie/vhie-participants/.

The Department also considered the possibility leveraging its regulatory authority under 8 V.S.A. § 11(a)(2) and 18 V.S.A. § 9401(a) to require that health plans under its jurisdiction adopt an interoperability standard for electronic prior authorizations. The most advanced interoperability standard is currently the DaVinci project, which "enable[s] direct submission of prior authorization requests from [electronic health record] systems using [the Fast Healthcare Interoperability Resources] standard already widely supported by most [electronic health records.]"[26] When fully implemented, DaVinci promises to ensure that prior authorization requests are sent automatically when necessary and contain all relevant clinical information to make a determination based on the initial submission.

Although implementing DaVinci would require significant effort on the part of electronic health record and health information technology vendors, some of that work is already underway. On December 18, 2020, the Centers for Medicare & Medicaid Services (CMS) published the Reducing Provider and Patient Burden by Improving Prior Authorization Processes and Promoting Patients' Electronic Access to Health Information proposed rule (the "Interoperability Proposed Rule") in the Federal Register.[27] Among other things, the Interoperability Proposed Rule would have required certain payers, including Medicaid and Qualified Health Plan (QHP) issuers on federally-facilitated exchanges to:

- Build and maintain FHIR-enabled document requirement lookup service APIs that can integrate with provider electronic health record systems and allow providers to easily locate each payer's prior authorization requirements within their workflow;
- Build and maintain FHIR-enabled prior authorization APIs that can send requests and receive determinations electronically within provider electronic health record systems;
- Include a specific reason for denying a prior authorization request, regardless of the method of sending the determination to facilitate better communication between payers and providers; and
- Report data about prior authorization processes, including: the percent of requests that are approved, denied, and approved after appeal; and average time between submission and determination.

On March 17, 2021, CMS withdrew the Interoperability Proposed Rule in the face of opposition from health plans, who argued that it required payers to build out APIs but did not require

[26] For information on implementing the DaVinci project in the context of prior authorization may be found see: https://build.fhir.org/ig/HL7/davinci-pas/; For more information about the Fast Healthcare Interoperability Resources (FHIR) standard, see: http://www.hl7.org/fhir/overview.html

[27] *See* Reducing Provider and Patient Burden by Improving Prior Authorization Processes and Promoting Patients' Electronic Access to Health Information, 85 F.R. 82586 (Dec. 18, 2020), *available at* https://www.federalregister.gov/documents/2020/12/18/2020-27593/medicaid-program-patient-protection-and-affordable-care-act-reducing-provider-and-patient-burden-by.

providers to adopt them.[28] Congress, however, remains interested in streamlining prior authorization. On October 28, 2021, U.S. Senators Chris Van Hollen (D-Md.), Sherrod Brown (D-Ohio), and John Thune (R-S.D.) requested an update from CMS on efforts to streamline prior authorization across federal programs, including Medicare Advantage.[29] The Senators also urged CMS to use its regulatory authority to establish an electronic real-time prior authorization process across federal programs and have introduced federal legislation that would put elements of the Interoperability Proposed Rule into law.[30]

With a federal rule or statute mandating APIs to support touchless prior authorization on the horizon, the Department believes that requiring health plans within its jurisdiction to adhere to a federal interoperability API when it is eventually enacted—even if it does not apply to insurers that do not offer Medicare Advantage plans or QHPs on federally-facilitated exchanges—presents the best opportunity to increase the use of real-time decision support tools in completing prior authorization requests. Following a federal standard would allow Vermont health plans to leverage resources and support created for plans to comply with federal law, while avoiding any technological issues that might be caused by requiring adoption of an interoperability standard unique to Vermont.

Until a federal standard is in place, the Department will explore requiring insurers and their prior authorization vendors to request clinical data from the VHIE whenever possible to support prior authorization requests in situations where a request cannot be automatically approved. While not as seamless as a touchless prior authorization process, such a requirement could potentially relieve providers of the burden of faxing or otherwise transmitting data that is already in the VHIE.

The Department would like to extend its gratitude to stakeholders who provided input to this report, particularly Nancy Houge, Director of Pharmacy Services for DVHA; Beth Anderson, VITL President & CEO; and Chris Hammond, eviCore Director of Strategic Accounts.

Please contact Sebastian Arduengo, Assistant General Counsel (Sebastian.Arduengo@vermont.gov) or Emily Brown, Director of Insurance Regulation (Emily.Brown@vermont.gov) with any questions or comments about this report or the recommendations made therein.

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[28] Sara Hansard, *Rule Easing Patient Care Authorization Pulled From HHS Website*, Bloomberg Law (Feb. 11, 2021), *available at* https://news.bloomberglaw.com/health-law-and-business/rule-easing-patient-care-authorization-pulled-from-hhs-website.

[29] *See* Press Release, *Van Hollen, Brown, Thune Push Biden-Harris Administration to Adopt Bipartisan Plan to Improve Prior Authorization in Medicare Advantage Plans* (Oct. 28, 2021), *available at* https://www.vanhollen.senate.gov/news/press-releases/van-hollen-brown-thune-push-biden-harris-administration-to-adopt-bipartisan-plan-to-improve-prior-authorization-in-medicare-advantage-plans.

[30] *See* H.R.3173 - Improving Seniors' Timely Access to Care Act of 2021, 117th Cong. (2021-2022), *available at* https://www.congress.gov/bill/117th-congress/house-bill/3173.