State of Vermont
Green Mountain Care Board
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Report to the Legislature

Opportunities for and Obstacles to Aligning and Reducing Prior Authorizations under the All-Payer ACO Model

In accordance with Act 140 of 2020, Sec. 10

Submitted by the Green Mountain Care Board to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance

January 14, 2022

Contents

Executive Summary

Act 140 of 2020, An act relating to miscellaneous health care provisions, required the Green Mountain Care Board (GMCB, or Board), in consultation with the Department of Vermont Health Access (DVHA), certified accountable care organizations (ACOs), payers participating in the All-Payer ACO Model, health care providers, and other interested stakeholders, to evaluate opportunities for and obstacles to aligning and reducing prior authorization requirements under the All-Payer ACO Model as an incentive to increase scale, as well as potential opportunities to waive additional Medicare administrative requirements in the future. The Board was asked to submit the results of its evaluation to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on or before January 15, 2022.

This report provides an overview of the Board's work evaluating the opportunities for and obstacles to aligning and reducing prior authorization requirements under the All-Payer ACO Model Agreement (APM or APM Agreement), background on prior authorization and the APM Agreement, and findings and recommendations from the consulting workgroup. The key takeaways from this report are:

1. The APM Agreement pertains specifically to the State's relationship with Medicare. Traditional Medicare requires prior authorizations only for a small subset of specialized procedures, and hence there is limited ability to use the Agreement as a tool to align prior authorizations.
2. The workgroup agreed it was important to include background information on prior authorization requirements to outline why a clearer focus is essential when considering how to align and reduce prior authorization requirements. The workgroup and other stakeholders expressed that reviewing prior authorization requirements for common, routine chronic medical conditions would be more valuable to providers and patients. Once a review is complete, alignment across payer programs could be explored.
3. With additional stakeholder engagement, future work could be dedicated to understanding alignment, cost, and risk associated with prior authorizations. The workgroup recommends focusing on; 1) aligning prior authorizations where clinically appropriate, 2) narrowing the focus on prior authorization work, 3) developing a more detailed understanding of the prior authorization process, 4) looking into prior authorizations for different provider types, 5) looking at administrative costs, and 6) further discussing the role of value-based payment alternative payment methodologies and provider financial risk.

Although this report does not include pharmacy prior authorizations, some workgroup members and stakeholders noted pharmacy prior authorizations are more common and burdensome than service-related prior authorizations. Pharmacy prior authorizations are especially complex to streamline since rebate contracts require prior authorization for competing products. Additionally, if there is no requirement for pharmacy prior authorizations, a provider may choose to prescribe a higher cost drug with no additional clinical benefit. There is also significant administrative burden to report and monitor prior authorization waiver programs. The workgroup agreed that, though it would be a significant undertaking, further exploration of prior authorization requirements for prescription drugs would be beneficial.

Background

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."[1] While prior authorization protocols vary by health plan, the federal government and state of Vermont have rules and regulations in place to set minimum process standards, consumer protections, and allow patients and providers to appeal a prior authorization denial.

The American Medical Association's (AMA) 2020 prior authorization physician survey[2] clearly outlines the impact prior authorization has on physicians and patients. On average, health practices reported completing 40 prior authorizations per physician per week and spending an average of two business days (16 hours) each week completing prior authorizations. Furthermore, 94% reported that prior authorization delayed access to necessary care for their patients and 30% reported that prior authorization has led to a serious adverse event for a patient in their care.

The AMA's 2020 progress update[3] on improving prior authorization revealed that a majority of physicians report an increase in the number of prior authorizations required for prescription and medical services over the last five years. Additionally, only 11% of physicians report contracting with health plans that offer programs exempting providers from prior authorizations.

Prior Authorization in Vermont

In 2018, the Vermont Medical Society (VMS) conducted a physician and physician assistant survey which included questions related to prior authorization. The VMS survey results showed that, overall, clinicians felt the biggest concern with prior authorization is the amount of time it takes to complete paperwork and felt their experience with prior authorization has gotten worse over time.

In 2018, the GMCB's Primary Care Advisory Group (PCAG) provided recommendations to the Board on prior authorization[4]. While the Board's authorities do not directly pertain to prior authorizations, PCAG moved forward with providing recommendations due to the sweeping impact of prior authorization on physicians and patients in the state. The recommendations are below:

1. Eliminate prior authorization for Vermont primary care providers (PCPs).
2. Prior authorization for medications prescribed by Vermont PCPs could be reconsidered and implemented only after the insurance and EMR industry create a reliable system for updating all formulary changes in real-time for point-of-care access for EMRs used in Vermont.
3. Insurers should provide education to both patients and PCPs regarding appropriate use criteria for imaging, medications, step-therapy, and specialty referrals.
4. Insurers should communicate with "outlier" PCPs whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.

The members of PCAG acknowledged the tradeoffs and challenges associated with these recommendations as insurers, providers, and other stakeholders work to balance cost-containment,

[1] 18 V.S.A. § 9418 https://legislature.vermont.gov/statutes/section/18/221/09418.
[2] AMA 2020 Prior Authorization (PA) Physician Survey. https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf
[3] AMA 2020 Update Measuring Progress in Improving Prior Authorization. https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf
[4] Primary Care Advisory Group Recommendation to Eliminate Prior Authorizations in Vermont. https://gmcboard.vermont.gov/sites/gmcb/files/Peluso%20files%20for%20GMCB%20meeting%2020180919%20%28002%29.pdf

administrative burden, and timely access appropriate to care. The overarching themes of these recommendations are the need to reduce administrative burden and address delays in care by improving the authorization process through real-time information and education on appropriate use.

Act 140 and Prior Authorization

In 2020, the Legislature passed Act 140 to address several health care-related issues, including prior authorization requirements, to reduce administrative burden and improve care. Act 140 also requires health insurers, the Department of Vermont Health Access, and the Department of Financial Regulation to submit additional reports to the Legislature regarding prior authorization.

Report/Legislative Ask	Related Statute	Overview	Due
Prior Authorization Review by Insurers	18 V.S.A. § 9418b (Act 140 of 2020, Sec. 8)	Starting January 15, 2021, health plans shall attest to the Department of Financial Regulation and GMCB annually on or before September 15 that it has completed its review and elimination of prior authorization requirements that are no longer justified or for which requests are routinely approved with such frequency as to demonstrate the prior authorization does not promote health care quality or reduce spending.	9/15 Annually
DVHA Prior Authorization and Provider Exemptions Report[5]	Act 140 of 2020, Sec. 12	DVHA to provide findings and recommendations to House Health Care, Senate Health & Welfare, Senate Finance, and GMCB regarding clinical prior authorization requirements in the VT Medicaid program.	Submitted 9/30/2021
DFR Prior Authorization and EHR Report	Act 140 of 2020, Sec. 9	DFR, in consultation with insurers and provider associations, shall report to legislature and the GMCB opportunities to increase the use of real-time decision support tools embedded in EHRs to complete prior authorization requests for certain services.	1/15/2022
Insurer Prior Authorization and Gold Carding	Act 140 of 2020, Sec. 11	Health insurers with more than 1,000 covered lives for major medical shall implement a pilot program that automatically exempts from or streamlines certain prior authorization requirements for a subset of participating health care providers, some of whom shall be primary care providers. Insurers shall make available electronically, including on a publicly available website, details about its prior authorization exemption or streamlining program.	1/15/2022
Insurer Prior Authorization and Gold Carding Report	Act 140 of 2020, Sec. 11	Each insurer is required to implement a prior authorization pilot program and report to House Health Care, Senate Health & Welfare, Senate Finance, and GMCB.	1/15/2023

[5] DVHA Prior Authorization and Provider Exemptions Report. https://legislature.vermont.gov/assets/Legislative-Reports/DVHA_Act-140-of-2020_Prior-Authorizations-Report_Final-with-Appendices.pdf

Prior Authorization: Key Definitions and Criteria

When submitting a prior authorization request, providers and their patients must provide clinical evidence to demonstrate the medical necessity of a service. While decisions are made on a case-by-case basis, health plans have set definitions for terms like medical necessity, often based on national medical association standards and recommendations by the AMA as well as protocols describing clinical criteria that must be met to grant authorization. For example, CVR 13-174-004 defines "medically necessary" and outlines conditions for coverage of covered services in the Vermont Medicaid program. Similarly, prior authorization in the Medicare program requires that services be medically reasonable and necessary[6] where medically necessary is defined as "health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."[7]

Vermont's Department of Financial Regulation's (DFR) rule H-2011-02 outlines definitions and clinical criteria for key terms for prior authorization, included below.[8]

Medical Necessity:

"Medically-necessary care" means health care services, including diagnostic testing, preventive services and aftercare that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. Medically-necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provided the procedure or treatment, or diagnose or manage the medical-condition, and must be informed by the unique needs of each individual patient and each presenting situation, and;

1. *Help restore or maintain the member's health; or*
2. *Prevent deterioration of or palliate the member's condition; or*
3. *Prevent the reasonably likely onset of a health problem or detect and incipient problem.*

Experimental/Investigational:

"Experimental or investigational services" means health care items or services that are:

1. *Not generally accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are;*
2. *Not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.*

In addition to the DFR definitions above, Blue Cross Blue Shield has an additional definition for services that are "not medically necessary" which includes additional caveats (Appendix A):

[6] Medicare Program Integrity Manual, Chapter 3. Section 3.10 "Prior Authorization. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
[7] Medicare.gov Glossary. https://www.medicare.gov/glossary/m
[8] DFR Rule H-2011-02. https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-regulation-health-h-2011-02-external-review.pdf.

"Not Medically Necessary" is the term applied to health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that:

a) may be in accordance with generally accepted standards of medical practice and/or
b) may be clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; but are:

1) primarily for the convenience of the patient, physician, or other health care provider, and/or
2) more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

All of these terms are important in defining prior authorization policies and protocols. The goal of prior authorization is to determine which services are medically necessary to prevent overuse and misuse of treatments and services. The tradeoff is increased administrative burden for providers and delays in access to care for patients. Each health plan has a prior authorization request and appeals process wherein providers and patients submit clinical documentation in support of the request and the health plan (or third-party administrator) issues a determination based on the evidence submitted. Denials can be appealed internally or elevated to an external appeal, as outlined in 45 CFR § 147.136.

The challenge lies in applying these definitions and clinical criteria to individual circumstances to balance cost-containment with personalized care and safety. What is medically necessary for one individual might not be for another depending on medical factors (e.g., an individual's allergies, comorbid conditions, past clinical outcomes with the preferred option, etc.) or external circumstances (e.g., proximity to care site, profession, etc.). Therefore, attention must be paid to the consideration of patient safety, appropriate levels of care, and understanding of newly available services or changes to existing services and their impact on care.

Vermont's All-Payer Model

Act 140 of 2020, Sec. 10 asks the GMCB *to evaluate opportunities for and obstacles to aligning and reducing prior authorization requirements under the All-Payer ACO Model as an incentive to increase scale, as well as potential opportunities to waive additional Medicare administrative requirements in the future.*

Vermont's All-Payer Model (APM) is changing the way health care is delivered and paid for, with the goal of keeping the state's health care spending in check and improving the health of Vermonters. The APM Agreement is a five-year (2018 – 2022) arrangement between Vermont and the federal government that allows Medicare to join Medicaid and commercial insurers to pay differently for health care. The goal of the APM is to shift payments from a fee-for-service system that rewards the delivery of high-volume,

high-cost services to a payment system based on value, high quality care, and good health outcomes at a lower cost.

This section of the report discusses prior authorization waivers in the context of the Vermont Medicare ACO Initiative (Medicare's Vermont-specific ACO program, modified from the national Next Generation ACO Model as outlined in the APM Agreement), potential future implications for Medicare Advantage business, and DVHA's Vermont Medicaid Next Generation (VMNG) program.

Prior Authorization Waiver and the Vermont Medicare ACO Initiative

Currently, through the APM, flexibilities are specific to the traditional Medicare group and existing federal rules and regulations for prior authorization under this program are limited in scope. For outpatient services in the Medicare program, prior authorization is defined as "the process through which a request for provisional affirmation of coverage is submitted to CMS or its contractors for review before the service is provided to the beneficiary and before the claim is submitted for processing."[9] Through rulemaking, CMS sets a list of services that require prior authorization (42 CFR § 419.83). In contrast to other payer programs, prior authorization requirements are relatively limited in scope within traditional Medicare and, therefore, present limited opportunities for aligning with other payer programs.

Prior Authorization Waivers and Medicare Advantage

Currently, there are no Medicare Advantage plans participating in the Vermont All-Payer ACO Model. It's important to note that, in contrast to traditional Medicare, the use of prior authorization in Medicare Advantage (MA) is more pervasive, though plans were reminded of their flexibilities to waive requirements during the Public Health Emergency.[10] MA Plans are established and regulated by CMS under federal law; the GMCB does not have regulatory authority over these plans. MA Plans are licensed in Vermont by DFR and are required to comply with certain state laws and regulations. A Kaiser Family Foundation analysis of MA plan benefits filed in 2018 found that 4 in 5 MA enrollees are in plans that require prior authorization for some services.[11] In 2018, a report by the HHS Office of Inspector General (OIG) shed light on the rate of prior authorization denials within the MA program. The report examined a total of 448 million requests: 24 million prior authorization requests for services that beneficiaries had not yet received, and 424 million payment requests for services already provided to beneficiaries. Although most of these requests were approved, about 1 million prior authorization requests and 36 million payment requests were denied, for denial rates of 4% and 8%, respectively. The OIG report found a high rate of overturned denials at the MA organization and independent reviewer levels; 1% of denials were appealed by beneficiaries and providers and 75% of appealed denials were overturned. The

[9] 42 CFR § 419.81 https://www.govinfo.gov/app/details/CFR-2020-title42-vol3/CFR-2020-title42-vol3-sec419-81/summary.
[10] COVID-19 Flexibilities Reminder https://images.magnetmail.net/images/clients/AHA_MCHF/attach/2021/August/HPMSMemoCOVID_19FlexibilitiesReminder08202021.pdf.
[11] Prior Authorization in Medicare Advantage Plans: How Often Is It Used? https://www.kff.org/medicare/issue-brief/prior-authorization-in-medicare-advantage-plans-how-often-is-it-used/.

OIG report recommended that CMS enhance its oversight of MA contracts, particularly those with high overturn rates and/or low appeal rates.[12]

There is legislation pending in Congress to address some of these challenges. The "Improving Seniors' Timely Access to Care Act of 2021" (H.R. 3173 / S. 3018) would update prior authorization for MA plans by establishing an electronic, real-time prior authorization program, creating annual reporting on requests approved and average response time, and implementing other standards related to quality and timeliness of prior authorization determinations.

CMMI has statutory authority to approve demonstrations that would include MA plans; however, the Secretary is required to prioritize demonstrations which impact traditional Medicare beneficiaries. See Section 1115A(a)(1); (a)(4)(A) and (d)(1) of the Social Security Act. When approving a demonstration, the Secretary must ensure that the criteria outlined in Section 1115A are met. The authority over MA plans does not appear to have been exercised to date in the design of demonstrations offered by CMMI. While it is potentially feasible that prior authorizations could be addressed in the next All Payer Model Agreement, the state would need to provide CMMI with a complete analysis of the costs and benefits of waiving or limiting prior authorizations in advance. It is also possible that CMMI may not have the resources to begin to address issues in MA plans for just one state. Further study is needed to complete that analysis and to determine the likelihood of success of that request.

In addition, Act 140 of 2020, Sec. 10 legislation indicates that a key rationale for removing prior authorizations is to increase scale in the ACO program. Currently, none of Vermont's Medicare Advantage plans are participating in the ACO programs which is a necessary prerequisite before beneficiaries would be included in the scale calculation. Accordingly, removing prior authorizations in MA plans will not impact scale at this time.

[12] HHS Office of Inspector General. Report (OEI-09-16-00410), 2018. Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials. https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

Prior Authorization Waiver and the Vermont Medicaid Next Generation (VMNG) Program

In 2017, DVHA executed the first Vermont Medicaid Next Generation (VMNG) ACO contract with OneCare Vermont (referred to as "OneCare"). The program stipulates that DVHA will pay OneCare an All-Inclusive Population Based Payment (AIPBP) for DVHA's attributed members to cover the cost of medical care by OneCare's provider network. Because OneCare assumes financial risk for all services included in Total Cost of Care (TCOC), the program has a prior authorization waiver for TCOC services for attributed members, which reduces administrative burden on provider practices and supports providers following best practices and determining appropriate care for their patients.

While implementing the Vermont Medicaid Next Generation ACO program in 2018, DVHA and OneCare sought to make a distinction between prior authorization for the sake of utilization management as opposed to clinical review of requests for reasons related to patient care and safety. Though prior authorization is waived for most ACO-covered services, DVHA retains responsibility for the care and safety of its entire membership and will remain responsible for clinically reviewing prior authorizations for a subset of services (mainly complex durable medical equipment, DME) that have been identified as having the potential to cause harm to members if prescribed or used incorrectly. This responsibility applies to all its members, regardless of ACO-attribution status. DVHA also continues to require prior authorization for a small subset of physician-administered drugs where the prior authorization process is used as a tool to guide providers to select drugs on DVHA's Preferred Drug List (PDL) which result in the lowest net cost for DVHA, or to assure compliance with rebate agreements. DVHA will make further refinements to its claims-processing system to adjust for changes to the prior authorization waiver through the life of the VMNG program.

DVHA Act 140 Report Highlights:

- There is an active waiver of prior authorization through the Vermont Medicaid Next Generation ACO program, and the Department has explored modifying prior authorization requirements at the payer level to more closely align with that waiver where appropriate.
- The Department formed a work group of various subject matter experts in February of 2021 to examine categories of health care services and issue recommendations on modifications of prior authorization requirements for those services.
- Based on that work group's findings, the Department is recommending changes to prior authorization requirements in the following areas: high tech imaging, durable medical equipment/ supplies/prosthetics/orthotics, dental services, physical, occupational, and speech therapies, out-of-network services, chiropractic services, high-dollar services, and imminent harm codes.
- The Department will need to continue to gather stakeholder feedback on these recommendations, seek State and federal approval where necessary for any modifications to its prior authorization rules, determine how to operationalize any modifications in its claims processing system, and conduct outreach, education, and communication to providers and members prior to implementing changes.

The prior authorization waiver as modified and implemented in 2018 continues for ACO-attributed members. In 2022 over 126,290 Medicaid members are prospectively attributed to the ACO and qualify

for the prior authorization waiver. [13] DVHA is actively exploring broadening ACO prior authorization waivers to all Medicaid providers and members based on learnings from the ACO prior authorization waiver, with a goal of reducing administrative burden by creating one uniform set of rules around prior authorization for the entire Medicaid population.

Commercial Insurer Prior Authorization Efforts

In addition to the prior authorization requirements in Act 140 of 2020, Blue Cross Blue Shield of Vermont (BCBSVT) and MVP Health Care (MVP) have implemented additional prior authorization processes and requirements in an effort to reduce administrative burden. These processes and requirements are not currently limited to ACO-attributed individuals or ACO-participating providers.

MVP Health Care created a quick guide on its prior authorization process and requirements for all MVP Health Care health plans. Due to COVID-19, MVP made utilization changes in response to the directive to lessen administrative burden made by the New York State Department of Financial Services. MVP suspended certain prior authorization requirements for all lines of business and continues to review prior authorizations for all other services (see Appendix D for more information).

BCBSVT implemented the Provider Passport Pilot in February of 2020 and is required to publicly report details about its program beginning January 15, 2022, per Act 140, Sec. 11 (see Appendix C for more information). This program divides providers with a required minimum number of studies ordered (20 per year for primary care providers and 50 per year for specialty providers) into three tiers which are segregated by historical rates of adherence to policy criteria. Under the Provider Passport Pilot, providers are authorized exemption from prior authorization for a subset of services for a 2-year period and re-authorization is done through an audit of 10% of previously ordered studies. Furthermore, utilization is monitored quarterly to identify adverse increases. The tiers are broken down by prior authorization approval rates:

- Tier 1: 97%+ approval rate
  - Approval: automatic.
  - Process: simplified. No clinical information or criteria submitted.
- Tier 2: 95-97% approval rate
  - Approval: automatic.
  - Process: clinical criteria submitted to gauge adherence, but service requests are not denied.
- Tier 3: below 95% approval rate
  - Approval: depends on submission.
  - Process: standard prior authorization process.

[13] 2022 DVHA prospective attribution. See slide 90: https://gmcboard.vermont.gov/sites/gmcb/files/documents/OCV_FY22_StaffPresentation_FINAL_20211208_redacted_0.pdf.

Prior Authorization and All-Payer ACO Model Evaluation & Workgroup Findings

Participants in the GMCB-convened workgroup included representatives from the Agency of Human Services (AHS), DVHA, DFR, BCBSVT, MVP, Health Care Advocate (HCA), OneCare Vermont (OCV), HealthFirst, Vermont Association of Hospitals and Health Systems (VAHHS), and Vermont Medical Society (VMS). Over three meetings the workgroup discussed the opportunities for and obstacles to aligning and reducing prior authorizations under the All-Payer ACO Model, revealing the key findings below.

Opportunities to align and reduce prior authorizations under APM

- Quantity limits for prior authorizations can be problematic. For example, for continuous glucose monitors, test strips, etc. for patients with diabetes if not ordered properly could result in gaps in quality care.
- The COVID-19 public health emergency pushed states and health insurers to waive many prior authorization requirements temporarily. Lessons learned from these temporary prior authorization waivers may shed light on opportunities to continue waiving certain requirements.
- Prior authorization requirements are not aligned across payers, which contributes to administrative burden, even though roughly 96% of service-based prior authorizations are approved.[14]
- Physicians and their staff spend an average of two business days (16 hours) each week completing prior authorizations.[15]

Obstacles to aligning and reducing prior authorizations under APM

- Prior authorization requirements are intended to support quality and safety and help to eliminate fraud, along with containing costs.
- The prior authorization process is very complex and must consider the provider taking on financial accountability (risk). Provider accountability for the cost of care under alternative payment models (e.g., ACO arrangements) provide a check on the incentive to refer patients for services that may not be clinically necessary or appropriate. As more providers and payers engage in alternative payment models with provider accountability for cost and quality of care, payers may feel that prior authorization is less necessary as a utilization management tool.
- Medical necessity or review policies are written based on best evidence and prior authorizations exist with the intent to make sure providers are following best practices and clinical guidelines across communities, as well as contain costs. The purpose of this legislative ask is to align providers behind best practices and lower burden. However, if reductions in prior authorization are not made carefully and utilization of higher cost services increases, health insurance rates

[14] 2021 Health Insurers Annual Reports, Act 152: https://dfr.vermont.gov/industry/insurance/health-insurance/reports.
[15] AMA 2020 Prior Authorization (PA) Physician Survey. https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf.

may increase with no clinical benefit. Though not discussed in detail in this report, pharmaceuticals also have an impact on premiums in the commercial market.

Recommendations

Considering the limited scope of prior authorizations under the Medicare umbrella, it would be burdensome for the State to pursue additional exemptions under the current Agreement. However, Vermont should continue to work to reduce and align prior authorization requirements as appropriate for other payers operating in the State. Below is a summary of the recommendations and potential next steps to continue the work around reducing and aligning prior authorization requirements in Vermont. Future work could be dedicated to understanding alignment, cost and risk associated with prior authorization processes through additional stakeholder engagement.

Alignment

- **Align prior authorizations where clinically appropriate.** The workgroup began to crosswalk prior authorizations across payer types, but were hindered by inconsistencies in reporting modality, timeframes, and year-over-year changes.
- **Narrow the focus on prior authorization work.** A dedicated focus to common, routine chronic medical conditions and/or procedures. It is also recognized that attention should be paid to prescription drugs and their impact on overall patient health and safety, as addressed in the HCA's recommendation letter (Appendix E).
- **Develop more detailed understanding of prior authorization process.** The workgroup identified a need for a deeper understanding of the underlying elements and definitions of prior authorization, including patient safety and appropriate care. In addition, new services, changes to existing to services, and changes to best practice guidelines must be regularly incorporated into prior authorization processes.
- **Look into prior authorizations for different provider types.** Primary care providers, specialists/procedural-based clinicians, and facilities may face different issues around prior authorizations and therefore next steps may need to be tailored to different provider types.

Cost

- **Look at administrative costs.** When evaluating programs, consider focusing on administrative costs used to review the prior authorizations at both the payer and provider levels, including administrative procedures necessary to oversee and audit prior authorization waiver programs.

Risk

- **Further discuss the role of value-based alternative payment methodologies and provider financial risk.** It is important to discuss more broadly the transition to value-based payment models where providers are taking financial risk and accountability for cost and quality, and potential impacts of changing payment incentives on the need for prior authorizations at both the payer and provider level.

Conclusion

The workgroup agreed it was important to include background information on prior authorizations to outline why a clearer focus is essential when discussing how to align and reduce prior authorization requirements. The workgroup and other stakeholders expressed that reviewing and cataloging prior authorization requirements for procedures for common, routine chronic medical conditions would be most valuable to providers and patients and would allow for future work on alignment across payer programs. With the specific ask to the GMCB surrounding its involvement in the current APM Agreement, it should be noted that the ability to seek waivers pertains specifically to the State's relationship with Medicare. Traditional Medicare requires prior authorizations only for a small subset of specialized procedures, and hence there is limited ability to use the current Agreement as a tool to align prior authorizations.

The workgroup identified several key areas of further exploration around understanding alignment, cost and risk associated with prior authorization processes that would benefit from additional stakeholder engagement. The GMCB currently has no regulatory authority to require information from payers through the Rate Review process, nor through the voluntary nature of participating in the Vermont All-Payer ACO Model.

Appendices

Definition of "Medically Necessary"

"Medically Necessary" or "Medical Necessity" are terms applied to health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a) in accordance with generally accepted standards of medical practice;

b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c) not primarily for the convenience of the patient, physician, or other health care provider, and

d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

Additionally, the services must meet all of the Medical Technology Assessment Guidelines that appear in Blue Cross Blue Shield of Massachusetts Medical Policy #350.

Definition of "Investigational"

"Investigational" is the term applied to health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a) not in accordance with generally accepted standards of medical practice and/or

b) not clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

Additionally, the services do not meet one or more of the Medical Technology Assessment Guidelines that appear in Blue Cross Blue Shield of Massachusetts Medical Policy #350.

Definition of “Not Medically Necessary”

“Not Medically Necessary” is the term applied to health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that:

a) may be accordance with generally accepted standards of medical practice and/or

b) may be clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; **but are**:

1) primarily for the convenience of the patient, physician, or other health care provider, and/or

2) more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

Additionally, the services must meet all of the Medical Technology Assessment Guidelines that appear in Blue Cross Blue Shield of Massachusetts Medical Policy #350.

Appendix B: Vermont Medical Society
Need for Gold Card Programs/Reduction of Prior Authorizations

- We cannot afford to have one more primary care provider retire early or switch to inpatient practice because of administrative burdens.

- In Vermont, 15% of primary care physician are planning to retire or reduce hours in Vermont within 12 months. (https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-Stats-phys18-ppt-.pdf)

- In the Summer of 2017, the Green Mountain Care Board conducted a Clinician Landscape Survey of over 400 Vermont clinicians to assess overall morale and the factors affecting providers' decisions to practice in hospital or independent settings. The results revealed that *regardless of the employment setting or area of specialization*, "paperwork, billing and administrative/regulatory burden" were among the most frequently cited sources of provider frustration and threat to practice success (https://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/Vermont%20Clinician%20Landscape%20Study%20Report%20October_1_2017_FINAL.pdf)

- A December 2018 survey by the American Medical Association showed that a strong majority **(88%** and **86%)** of physicians report that the **number of PAs** required for prescription medications and medical services **has increased** over the last five years. (https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf)

- The Vermont Medical Society assessed its physician members regarding the state of prior authorizations in 2013. 94% of respondents believed that the prior authorization process had a negative impact on their ability to treat patients, 81% reported that it is very or extremely difficult to determine when a PA will be required and 43% had made an emergency room or specialist referral to avoid having to go through the prior authorization process.

- For every hour of physicians' clinical face time with patients, nearly 2 additional hours are spent on desk work – a recent time study revealed that during the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work (https://pubmed.ncbi.nlm.nih.gov/27595430/)

- Gold Card programs were included as a recommendation in the report of the Rural Health Taskforce both as a workforce initiative and administrative burden initiative (https://gmcboard.vermont.gov/sites/gmcb/files/documents/Rural%20Health%20Services%20Task%20Force-%20Act%2026%20of%202019%20-%20Report%20%26%20Recommendations.pdf)

- The Green Mountain Care Board has been advancing prior authorization initiatives since 2013 when Board Member Dr. Al Ramsey led a prior authorization waiver pilot program to test eliminating prior authorizations for two classes of drugs and MRIs for low back pain

Appendix B: Vermont Medical Society
Need for Gold Card Programs/Reduction of Prior Authorizations

- It is time for meaningful action for every payer to be able to advance a program that includes an exemption for providers who adhere to evidence-based medicine

- Gold Card type programs were the first recommendation in a consensus statement on improving the prior authorization process jointly drafted by the American Medical Association, AHIP, BCBS Association and the American Hospital Association in January 2018 (https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf)

- However, a follow-up survey of providers nationwide after the Consensus Statement was drafted shows that only 8% of physicians report contracting with health plans that offer programs that exempt providers from PA. (https://www.ama-assn.org/system/files/2019-03/prior-auth-survey.pdf)

BCBSVT Provider Passport Pilot

- Timeline leading to development:
  - 2017- BCBSVT discussions with a primary care group re utilization variation in radiology showed practice impact rates ranging from 1-17% at the individual provider level
  - 2017-18 – participated with primary care advisory group of GMCB – discussed burden of prior authorization (PA) for providers but also safety and cost impact – constructive discussions
  - 2018 – Joint PA consensus statement (BCBSA included)
  - September 2018 – GMCB Prior Authorization Panel – discussed impacts of up to 35% (1 in 3 orders) were not consistent with appropriate use criteria in VT but noted a wide variation in provider performance
  - Operational work begins in late 2018 through 2019 with GoLive 2/1/2020

Joint PA Consensus Statement Summary

- "Reduce the number of health care professionals subject to prior authorization requirements based on their performance, adherence to evidence-based medical practices, or participation in a value-based agreement with the health insurance provider." – *BCBSVT Provider Passport Pilot*
- "Regularly review the services and medications that require prior authorization and eliminate requirements for therapies that no longer warrant them." – *BCBSVT performs this at least annually.*
- "Improve channels of communications between health insurance providers, healthcare professionals and patients to minimize care delays and ensure clarity on prior authorization requirements, rationale and changes." – *BCBSVT posts policies on public website, incorporates provider input directly into policies, communicates all changes and works daily with members/patients.*
- "Protect continuity of care for patients who are on an ongoing, active treatment or a stable treatment regimen when there are changes in coverage, health insurance providers or prior authorization requirements." - *BCBSVT regularly grandfathers to address if this occurs*
- "Accelerate industry adoption of national electronic standards for prior authorization and improve transparency of formulary information and coverage restrictions at the point-of-care." *- at BCBSVT 60-80% of submissions are electronic with potential instant approval and real time prescription benefit tool was rolled out in 2019 which provides direct formulary information including patient cost information and PA within EMR workflow.*

Provider Passport Pilot Summary

- Divides providers with a required minimum number of studies ordered, into three tiers which are segregated by historical rates of adherence to policy criteria into the following levels:
  - Tier 1 - for those with high levels of adherence resulting in very low impact/denial rates (<=3%). Clinical review is suspended for a 2 year period.
  - Tier 2 - providers are required to submit clinical information to gauge adherence to criteria but service requests are not denied. Education and radiologic expert consultation would occur on a case by case basis as necessary. If disagreement occurred a conditional approval will be issued. Impact/denial rates between 3 and 5%.
  - Tier 3 – Continuation of current prior approval process.
- Went live 2/01/2020 - prior provider notifications and FAQ documents starting in 12/19
- Utilization monitored quarterly to identify adverse increases
- Re-authorization for next 2 year period begins at 18 months with an audit of 10% of previously ordered studies to qualify for continued status.
- Medical criteria have always been publicly available on our website and are regularly updated

Provider Passport Pilot Providers Identified

- Total Provider Impact #: 136
- Total Impact for Primary Care #: 61 (45%)
- Total Impact for Specialty Care #: 75 (55%)
- Tier 1 Total #: 104
- Tier 1 Primary Care #: 33 (32%)
- Tier 1 Specialty #: 71 (68%)
- Tier 2 Total #: 32
- Tier 2 Education Primary Care#: 28 (88%)
- Tier 2 Education Specialty #: 4 (12%)
- There is a good geographic mix throughout the state with MD/DO, PA, and NP areas represented

Provider Passport Pilot

- What we have learned so far:
  - We can never over-communicate
  - Operational implementation issues are real and require significant teamwork with creative solutions
  - Messaging in larger provider organizations rarely gets down to the front line staff
  - Providers who are enrolled are thankful and appreciative of our efforts
  - Providers are becoming interested in how they can do better who are in tier 3

umpolicyguide

MVP HEALTH CARE

Prior Authorization Process and Requirements

Revised January 2021

Vermont

This UM Policy Guide provides a quick reference of prior authorizations for all MVP Health Care® health plans. The guide should be used in coordination with the **Prior Authorization Request form (PARF)**. All services listed in this document require prior authorization by MVP.

MVP Fully-Insured Plans (HMO, POS, PPO, EPO, and Non-Group Indemnity)

If a procedure or service requires prior authorization, fax a completed PARF to **1-800-280-7346** or call the MVP Utilization Management Unit at **1-800-684-9286**.

The *Prior Authorization Request Form (VT)* can be downloaded by visiting **mvphealthcare.com** and selecting *Providers*, then *Forms*, then *Prior Authorization*.

MVP Self-Funded Plans (ASO-HMO, ASO-POS, ASO-PPO, ASO-EPO, and ASO-Indemnity)

MVP Select Care (ASO) provides self-funded employer groups with customized health benefits packages. All MVP Select Care members have the employer's name and/or logo listed at the top of their MVP Member ID card. If your patient is an MVP Select Care (ASO) member, fax a completed PARF to **1-800-280-7346** or call the MVP Select Care Utilization Management Unit at **1-800-229-5851**.

Prescription Drugs

Self-administered medications covered under the prescription drug rider requiring prior authorization do not appear in this document. They are contained in the Prescription Drug Formularies. To access the Formularies, visit **mvphealthcare.com** and select *Providers*, then *Pharmacy*.

See the *Prior Authorizations Requirements* on page 3 for more information about medications administered in the outpatient setting.

Behavioral Health Services

The final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 become effective July 1, 2014. These rules, known as Federal Mental Health Parity (FMHP) rules, provide guidance on benefits for and medical management of patients receiving care for mental health and/or substance disorder needs.

Under the FMHP final rules, MVP cannot apply medical management standards more stringently to mental health or substance disorder benefits than those applied to similar medical/surgical benefits. This includes, for example, requiring authorization from MVP prior to a provider rendering services. Therefore, MVP will no longer require prior authorization in advance of rendering services related to outpatient mental health and/or substance disorder care. As of September 1, 2018, behavioral health care providers will need to contact MVP for such prior authorization. Please note that prior authorization still is required for the following services: ECT, PHP, substance abuse detoxification and rehabilitation, residential care, and inpatient admissions.

If you have any questions, please contact your MVP Professional Relations Representative at **1-800-380-3530**, option 3 prompt. For authorizations, fax MVP at **1-855-853-4850**.

Radiology and Radiation Therapy

MVP has delegated the utilization management review for all prospective review of Radiation Therapy, MRI/MRA, PET Scan, Nuclear Cardiology, and CT/CTA and 3D rendering imaging to **eviCore healthcare**. eviCore utilizes evidence-based guidelines and recommendations for imaging from national and international medical societies and evidence-based medicine research centers. For more information, refer to Outpatient Imaging Services and Radiation Therapy Management table within this document. For more information about eviCore, visit **mvphealthcare.com/PRM** and select *Inpatient and Outpatient Service Program*. To obtain an authorization, submit requests at **evicore.com** or call **1-800-568-0458** and follow the radiology or radiation therapy prompts.

naviHealth Services Available for MVP Medicare Advantage Members

naviHealth, Inc. provides Utilization Management for Skilled Nursing Facility (SNF), Acute Inpatient Rehabilitation (AIR,) and Home Health services for MVP Medicare Advantage members only. naviHealth staff will be located in each of the MVP regions to visit facilities and manage the transitions. To contact naviHealth, visit **naviHealth.us** or call **1-844-411-2883**.

Chiropractic Services and Acupuncture

MVP is discontinuing its relationship with eviCore (previously Landmark) for Chiropractic and Acupuncture care. MVP Members must utilize the MVP Chiropractic/Acupuncture

network; however, transition of care will be offered for 90 days after January 1, 2021. These services will not require prior authorization and are subject to benefit limitations. Out-of-network rules apply.

Online Resources

To download the *Prior Authorization Request form (PARF)*, visit **mvphealthcare.com** and select *Providers*, then *Forms*, then *Prior Authorization*.

Providers also may review the *Benefits Interpretation Manual (BIM)*, MVP's medical policies, at **mvphealthcare.com**. *Sign In* to your online account and select *Resources*. The BIM allows providers to determine if procedures require an authorization based on CPT code or the member's plan.

Samples of MVP Member ID Cards

Plan information, including samples of MVP Member ID cards, is available as part of the *MVP Provider Resource Manual*. Visit **mvphealthcare.com** and *Sign In* to your online account, then select *Resources*, then *Providers Resource Manual*, then *MVP Plan Type Information* for details.

In-Office Procedure and Inpatient Surgery Lists

Participating providers and their office staff can access the *In-Office Procedure List and Inpatient Surgery List* by visiting **mvphealthcare.com/PRM**.

The In-Office Procedure List details the CPT® codes that MVP requires to be performed in the physician's office. Claims submitted with a place of service other than the physician's office will be denied unless prior authorization is obtained.

The *Inpatient Surgery List* specifies the CPT®/HCPCS codes that MVP will reimburse when performed in the inpatient setting. Claims submitted with an inpatient place of service for codes not on this list will be denied unless prior authorization was obtained.

All procedures are subject to the member's plan type and benefits.

Interventional Pain Management and Musculoskeletal Reviews

MVP has entered into an agreement with **Magellan Healthcare** to implement a Musculoskeletal (MSK) Management program. This program requires prior authorization for MVP members for nonemergent MSK procedures including: outpatient interventional spine pain management services (IPM); and inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Providers can contact Magellan Healthcare to seek prior authorization for procedures. The ordering physician must obtain prior authorization with Magellan Healthcare prior to performing the surgery/procedure. The validity period (authorization time span) for all procedures of this program will be 90 days from the requested date of service. This is a change from MVP's current process.

Ordering physicians will be able to request prior authorization via Magellan Healthcare at **RadMD.com** or by calling **1-866-249-1578**.

Prior Authorization Requirements for All MVP Plan Types

Effective January 2021

Procedures/Services Requiring Prior Authorization	Contact for Prior Authorization
• All Elective Inpatient Admissions • Advanced Infertility • Inpatient Rehabilitation • Skilled Nursing Facilities • Inpatient Rehabilitation for Commercial plan members • Skilled Nursing Facilities for Commercial plan members	Fax a completed PARF* to **1-800-280-7346** or call Provider Services at **1-800-568-0458**. Inpatient Rehabilitation for Medicare and USA Care plan members, and Skilled Nursing Facilities, contact naviHealth: • New requests, call **1-844-411-2883** or fax **1-866-683-6976** • Concurrent requests, fax **1-866-683-7082**
• Transplants	Call **1-866-942-7966**
Medications (IV and most IM dosage forms) given in the office or outpatient setting that require prior authorization: • Commercial Formulary (HMO, POS, PPO, EPO, and some ASO plans) • Medicare Part D Formulary (Preferred Gold, GoldAnywhere, GoldValue, Gold PPO, and USA Care, and WellSelect) • Health Insurance Marketplace Formulary (Individual and Small Group On and Off Marketplace) Formularies are available at **mvphealthcare.com**. Select *Providers* and then *Pharmacy*.	Medicare plans: • Fax a completed PARF* to **1-800-401-0915** All other plans: • Fax a completed PARF* to **1-800-376-6373**

Durable Medical Equipment and Home Care Services

All fully-insured HMO, HMO-POS, EPO, PPO, and Medicare Advantage plans. Self-insured ASO and MVP/Cigna affiliated plans vary by plan type.

Service	Procedures/Services/Treatments Needed	Contact for Prior Authorization
Durable Medical Equipment (DME)	Durable Medical Equipment (DME) can be dispensed/billed from a physician's or podiatrist's office for stabilization and to prevent further injury, without prior authorization. This is to assure safe mobility and transportation home. The DME item must be billed with the office visit.	MVP DME Unit: • Call **1-800-684-9286** or fax to **1-888-452-5947** To access DME Prior Authorization Code List and other DME information, visit **mvphealthcare.com** and select *Providers*, then *Reference Library*.
Home Care Services	• Home Infusion • Speech Therapy • Physical Therapy† • Occupational Therapy† • Nursing† • Terbutaline Therapy	Medicare and USA Care plans: • Call naviHealth at **1-844-411-2883**, fax **1-866-683-6976** for new requests, or fax **1-866-683-7082** for concurrent requests All other plans: • Fax a completed PARF* to **1-800-280-7346** or call **1-800-684-9286**

Musculoskeletal Reviews

All fully-insured HMO, HMO-POS, EPO, PPO, and Medicare Advantage plans. Self-insured ASO and MVP/Cigna affiliated plans vary by plan type.

Plan Type	Services Requiring Prior Authorization	Contact for Prior Authorization
Fully-Insured Plans	Intervention pain management, and Lumbar and Cervical spine surgeries. Surgeries of the hips, knees, and shoulders	Providers can call Magellan Healthcare at **1-866-249-1578** or submit a prior authorization at **RadMD.com**.
Self-Funded Plans	Intervention pain management, and Lumbar and Cervical spine surgeries. Surgeries of the hips, knees, and shoulders *Not all self-insured plans require prior authorization from Magellan Healthcare.*	Call the MVP Select Care Customer Care Utilization Management Department at **1-800-684-9286** to ensure your Select Care member utilizes the services of Magellan Healthcare.

*Prior Authorization Request form (PARF). To download the PARF, visit **mvphealthcare.com** and select *Providers*, then *Forms*, then *Prior Authorization*.
†Home Health Aid agencies to refer to their contract or the MVP Provider Resource Manual. Criteria for these procedures may be found in the MVP Medical Policy (Benefit Interpretation Manual) available at **mvphealthcare.com**.

Prior Authorization Requirements for All MVP Plan Types

Effective January 2021

Outpatient Imaging Service and Radiation Therapy Management

All fully-insured HMO, HMO-POS, EPO, and PPO plans require prior authorization for Imaging Services and Radiation Therapy Management. Self-insured ASO and MVP/Cigna affiliated plans vary by plan type. Medicare Advantage and MVP Medicaid require prior authorization for Radiation Therapy only. As of January 1, 2021, Medicare Advantage, MVP Medicaid, MVP Harmonious Health Care Plan® (HARP), and Child Health Plus do not require prior authorization for MRIs, MRA, CT Scans (including Virtual Colonoscopy), PET Scans, Nuclear Cardiology, and Radiation Therapy when performed by a participating facility. Members will still need prior authorization from MVP for use of out-of-network providers.

Plan Type	Services Requiring Prior Authorization	Contact for Prior Authorization
Fully-Insured Plans	MRIs, MRA, CT Scans (including Virtual Colonoscopy), PET Scans, Nuclear Cardiology, and Radiation Therapy	Imaging reviews for MVP and Radiation Therapy Management requirements: • Call eviCore National at **1-866-665-8341** and follow the imaging prompts or submit requests at **evicore.com**
Self-Funded Plans	MRIs, MRAs, CT Scans, PET Scans, and Nuclear Cardiology *Not all self-insured plans require prior authorization of imaging service.*	Contracts with Imaging Authorization requirements and/or Radiation Therapy Management requirements: • Call eviCore National at **1-866-665-8341** and follow the imaging prompts or submit requests at **evicore.com**
Medicare Advantage Plans	Radiation Therapy	Radiation Therapy Management requirements: • Call eviCore National at **1-866-665-8341** and follow the imaging prompts or submit requests at **evicore.com**
Medicaid, HARP, and Child Health Plus	Radiation Therapy	Radiation Therapy Management requirements: • Call eviCore National at **1-866-665-8341** and follow the imaging prompts or submit requests at **evicore.com**

If a physician sends a patient for a clinically urgent imaging study during nonbusiness hours (i.e., evenings, weekends, or holidays), the physician should call the MVP Customer Care Center for Provider Services at **1-800-864-9286** the next business day.

Additional Services

All fully-insured HMO, HMO-POS, EPO, PPO, and Medicare Advantage plans. Self-insured ASO and MVP/Cigna affiliated plans vary by plan type.

Procedures/Services Requiring Prior Authorization		Contact for Prior Authorization
• Air Medical Transport/Air Ambulance (for nonemergency transport) • Atrial Fibrillation Catheter Ablation • Autologous Chondrocyte Implantation • Bariatric Surgery • Botox Injections (office procedure only) • Breast Implantation • Breast Reduction Surgery • Cochlear Implants and Osseointegrated Devices • Continuous Glucose Monitoring • Cosmetic vs. Reconstructive Surgery • Deep Brain Stimulation • Dental Services (accidental Injury to Sound Teeth, Outpatient Services, Prophylactic) • DME/Prosthetics/Orthotics • Endovascular Treatment for AAA and Carotid Artery Disease • Gas Permeable Scleral Contact Lens • Gaucher's Disease Treatment • Gender Reassignment Surgery	• Genetic Testing/Chromosomal Studies • Hereditary Angioedema • HIFU High Intensity Focused Ultrasound • Hyaluronic Acid Derivatives • Hyperbaric Oxygen Therapy • Hyperhidrosis Treatment • Immunoglobulin Therapy • Implantable Cardiac Defibrillators • IMRT • Infertility (advanced and/or secondary), available with Rider; including drugs (e.g., Follotropins, Menotropins); GIFT/ZIFT are not covered • Intraoperative Neurophysiological Monitoring • Interstim (Sacral Nerve Stimulator) • Laser Treatment of Port Wine Stains • Left Ventricular Assist Device • Lumbar Laminectomy (Discectomy) • Melody Valve • MitraClip • MSLT–Multiple Sleep Latency Testing	MVP Select Care (ASO) plans: • Call the MVP Select Care Member Services Department at **1-800-229-5851** to confirm member benefits • Fax a completed PARF* to **1-800-280-7346** or call the Select Care Utilization Management Department at **1-800-229-5851** All other plans: • Fax a completed PARF* to **1-800-280-7346** or call Utilization Management at **1-800-568-0458** Some employer groups offer more than one MVP plan, be sure to review the patient's MVP Member ID card.

Additional Services Prior Authorization Requirements *continued on page 5*

*Prior Authorization Request form (PARF). To download the PARF, visit **mvphealthcare.com** and select *Providers*, then *Forms*, then *Prior Authorization*.

Prior Authorization Requirements for All MVP Plan Types

Effective January 2021

Additional Services *continued*

All fully-insured HMO, HMO-POS, EPO, PPO, and Medicare Advantage plans. Self-insured ASO and MVP/Cigna affiliated plans vary by plan type.

Procedures/Services Requiring Prior Authorization		Contact for Prior Authorization
• Nasal/Sinus Endoscopy • New Technology • OncotypeDX Prostate Cancer Assay† • OncotypeDX Colon Cancer Assay† • OncotypeDX DCIS Assay† • Oral Surgery/Orthognathic Surgery • Organ Donor • Orphan Drugs • Panniculectomy/Abdominoplasty • Pectus Excavatum • Penile Implants • Percutaneous Diskectomy • Percutaneous Vertebroplasty/Kyphoplasty • Photodynamic Therapy (Malignant conditions) • Prostatic Urethral Lift System (Urolift)	• Rezum-Water Vapor Thermal Therapy • Rhinoplasty • Rhizotomy/Radiofrequency Ablation • Shoulder Resurfacing • Speech Generating Devices • Speech Therapy–Selected Contracts • Spinal Fusion Lumbosacral • Spinal Stimulator • Synagis (Injectable for RSV) • Thoracic Electrical Bioimpedance • TMD/TMJ • Treatment of Obstructive Sleep Apnea (Policies A and B) • UPPP Surgery • Wound Vacs	MVP Select Care (ASO) plans: • Call the MVP Select Care Member Services Department at **1-800-229-5851** to confirm member benefits • Fax a completed PARF* to **1-800-280-7346** or call the Select Care Utilization Management Department at **1-800-229-5851** All other plans: • Fax a completed PARF* to **1-800-280-7346** or call Utilization Management at **1-800-568-0458** Some employer groups offer more than one MVP plan, be sure to review the patient's MVP Member ID card.

*Prior Authorization Request form (PARF). To download the PARF, visit **mvphealthcare.com** and select *Providers*, then *Forms*, then *Prior Authorization*.

†No prior authorization required for OncotypeDX Breast Cancer Assay (81519) and MammaPrint (81521).

Comparison of MVP Plan Types

Effective January 2021

MVP Health Care Fully-Insured Plans

Plan Type	PCP	Referral Required	Prior Authorization Required	Formulary	Reduction of Benefits for Not Notifying MVP of Inpatient Admission	Access to a National Network	Out-of-Network Benefits
MVP HMO/POS	No	No	Yes	Yes	For Out-of-Network Care Only	Yes	Yes
GoldValue HMO-POS							
GoldAnywhere PPO	No	No	Yes	Yes	No	No	Yes
Gold PPO	No	No	Yes	Yes	No	No	Yes
GoldSecure	No	No	Yes	Yes	No	No	Yes
MVP® Mediare WellSelect® PPO	No	No	Yes	Yes	No	No	Yes
Preferred Gold HMO/POS	No	No	Yes	Yes	No	No	Yes
MVP® USA Care® PPO	No	No	Yes	Yes	No	No	Yes
MVP HMO	No	No	Yes	Yes	No	Yes	No
MVP VT	Yes	No	Yes	Yes	No	No	No
MVP VT Plus	Yes	No	Yes	Yes	No	No	No
MVP Secure VT	Yes	No	Yes	Yes	No	No	No

MVP Select Care, Inc. Self-Funded (ASO) Plans

Plan Type	PCP	Referral Required	Prior Authorization Required	Formulary	Reduction of Benefits for Not Notifying MVP of Inpatient Admission†	Access to a National Network	Out-of-Network Benefits
HMO	Yes	No	Yes	Varies by Employer Group	No	No	No
POS	Yes	No	Varies by Employer Group	Varies by Employer Group	For Out-of-Network Care Only	No	Yes
PPO	No	No	Varies by Employer Group	Varies by Employer Group	No	Yes	Yes
Indemnity	No	No	Varies by Employer Group	Varies by Employer Group	No	N/A	Yes
EPO	No	No	Varies by Employer Group	Varies by Employer Group	No	Yes	No

†Reduction of benefits for the member also applies for same day surgery.

Prior Authorization requirements can be confirmed by calling **1-800-684-9286**. Full benefits are not listed above.

MVP has attempted to capture all prior authorization requirements for each plan type in this document. However, benefit plans, as with member eligibility, are subject to change and do, frequently. If you have questions concerning a member's benefit coverage or about services/procedures not part of this document, call the MVP Customer Care Center for Provider Services at **1-800-684-9286**.

MVPFASTFAX

April 9, 2020 – 2020.29

Important News for Providers

Update Regarding Acute Care and Post-Acute Care Services

Utilization Management Changes Due to COVID-19

Effective for 90 Days (March 20 - June 18, 2020)

In response to the directive to lessen the administrative burden during this time, as directed by the NYS Department of Financial Services (DFS) Circular Letter No.8 (2020), MVP Health Care® (MVP) will make the following Utilization Management (UM) changes:

Prior Authorizations

All Lines of Business

MVP has suspended prior authorization requirements for all lines of business for:

- Inpatient surgery and inpatient admissions to any hospital
- Post-acute care services after discharge from any inpatient stay (including prior authorization requirements administered by naviHealth)
- All Radiation Therapy and High-Tech Radiology (MRI's, MRA's, CT's, Nuclear Cardiology and PET Scans) managed by eviCore
- All musculoskeletal codes managed by Magellan/NIA

Commercial Fully Insured, Self-Funded Plans, and Medicaid

MVP will continue to perform prior authorization review for all other services, including:

- Outpatient elective procedures, in-office procedures, durable medical equipment, and physician administered drugs
- Use of out-of-network and out-of-state providers for provider office, ambulatory surgical and outpatient facility care

After June 18, 2020, MVP reserves the right to retrospectively review all admissions that occurred during this 90-day timeframe regardless of notification to MVP.

MVP reserves the right to retrospectively audit any services provided from March 20 - June 18, 2020 that were performed without prior authorization.

Medicare Advantage

MVP will continue to perform prior authorization review for all other in-network services, including:

- Outpatient elective procedures, in-office procedures, durable medical equipment, and physician administered drugs

To view all faxed messages, visit **mvphealthcare.com/FastFax.**

To receive future FastFax messages by email, send a request to **MVPFastFax@mvphealthcare.com**.

Acute Care Facilities

All Lines of Business

As is standard business practice, services performed in an urgent care facility or an emergency room do not require prior authorization.

MVP has suspended the admission and concurrent review requirements for acute care facility admissions. It is encouraged that Facilities continue to notify the health plan within 48 hours of the admission.

MVP is available to accept notifications of admission through your already established processes. The Notification of Unplanned, Urgent, or Emergency Room Admission form is available at **mvphealthcare.com/providers/forms/#admissions**. Supporting documentation is not required during this timeframe.

MVP is available for assisting with discharge planning.

MVP will review and consider a request for determination for a preadmission denial.

MVP has suspended performing retrospective review upon receipt of a claim for an Acute Inpatient admission not previously notified.

After June 18, 2020, MVP reserves the right to retrospectively review all admissions that occurred during this 90-day timeframe regardless of notification to MVP.

MVP reserves the right to retrospectively audit any inpatient claim approvals made from March 20 - June 18, 2020.

Post-Acute Care Services

Skilled Nursing and IP Rehabilitation Facilities

All Lines of Business

MVP has suspended prior authorization for transfers to Skilled Nursing and Rehabilitation Facilities. It is encouraged that Skilled Nursing and Acute Inpatient Rehabilitation Facilities continue to notify MVP (for Medicare Advantage Members continue to notify naviHealth) within 48 hours of admission.

- MVP will waive the 3-day hospital stay rule, if it exists, for all lines of business.
- It is preferred that members continue to be directed to participating facilities. MVP and naviHealth will not reject admissions to non-participating facilities.
    - To find participating rehabilitation facilities and skilled nursing facilities, visit **mvphealthcare.com/searchproviders**. After you enter a zip code and choose the member's plan type, click *Search All*, then type in "rehabilitation" or "skilled

To view all faxed messages, visit **mvphealthcare.com/FastFax.**

To receive future FastFax messages by email, send a request to **MVPFastFax@mvphealthcare.com**.

nursing". You can use the filters to adjust the distance and other preferred attributes.
    - If you need assistance navigating the Provider Search tool, or would like a list provided to you, contact the MVP Customer Care Center for Provider Services at **1-800-684-9286.**
- If you need assistance with discharge planning, please contact your assigned MVP UM representative.
- It is expected that transfers are medically necessary. MVP and naviHealth will perform concurrent review during member stays at skilled nursing and rehabilitation facilities. All Adverse Determination adjudication will follow all applicable NYS DFS rules for 90-day extension of timeframe for appeals.
- **Medicare Advantage Members**
    - If a skilled nursing facility considers care no longer medically necessary, naviHealth should be notified prior to issuing a Notice of Medical Non-Coverage (NOMNC).

After June 18, 2020, MVP reserves the right to retrospectively review all skilled nursing or acute inpatient rehabilitation facility admissions that occurred during this 90-day timeframe regardless of notification to MVP.

Home Care Services

Medicare Advantage

MVP has suspended the prior authorization for home care services for Medicare Advantage members.

- Home Health Agencies may continue to evaluate members home health needs without prior authorization.
- It is encouraged that Home Health Agencies continue to provide minimal demographic information at start of care
    - Name of Agency
    - Name of Patient
    - Date of Birth
    - Member Number
    - Member Address
    - Ordering Physician Name
    - Diagnosis
    - Start of Care or Resumption of Care Date (if following a readmission)
- If the agency determines that they need more than 10 visits, it is encouraged that you submit additional visits and supply naviHealth with the complete OASIS, 485, and last two visit notes for each discipline requested.

To view all faxed messages, visit **mvphealthcare.com/FastFax.**
To receive future FastFax messages by email, send a request to **MVPFastFax@mvphealthcare.com**.

After June 18, 2020, MVP reserves the right to retrospectively review all home health care that occurred during this 90-day timeframe regardless of notification to MVP.

Commercial and Medicaid

As always, prior authorization is not required for home health care services.

Admission Requirements for Behavioral Health

All Lines of Business

MVP has modified the admission requirements for inpatient mental health, mental health residential, inpatient substance use detoxification, inpatient substance use rehabilitation, and substance use residential for 90 Days.

Providers should notify MVP within two business days of the admission to the above levels of care. Concurrent reviews are suspended for all services mentioned above. MVP will continue to assist in coordinating care and discharge planning throughout the member's stay.

MVP clinicians will contact facilities for periodic consultations. These consultations are not for Utilization Review purposes, but rather for coordination of care regarding the member's treatment and discharge plans. MVP is also offering assistance as needed during these consultations to remove any barriers there may be related to post discharge care.

When the member is discharged, the provider should notify MVP of the discharge date along with the discharge plan within 24 hours of discharge. This includes members leaving against medical advice (AMA).

As a reminder, Partial Hospitalization and Continued Day Treatment no longer requires prior authorization as of March 17, 2020.

After June 18, 2020, MVP reserves the right to retrospectively review all admissions that occurred during this 90-day timeframe regardless of notification to MVP.

VERMONT LEGAL AID, INC.

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The Office of the Health Care Advocate (HCA) participated in the ACT 140 workgroup. We bring a consumer perspective to the prior authorization (PA) issue as experienced by the Vermonters who reach out to us for help. We recognize the views of both providers and payers around the importance of reducing administrative expenses, improving quality, and pursuing cost-containment. In our view, PAs often undermine patients' ability to access the right care at the right time. The HCA regularly receives calls involving PA denials for routine medication refills and medical procedures both for children and adults. These denials are often for the treatment of common chronic conditions such as diabetes. Vermonters continually express frustration with the experience of being told by their primary care provider or specialist to pick up a different medication or receive a medical procedure only to have it rejected for reasons that are often arbitrary and technically opaque. To put this into focus, we share a true story from a Vermonter who recently called the HCA about a PA denial issue (*potentially identifying details have been edited to protect client identity*):

> Jason is an older Vermonter and recovering addict. He is proud to have been clean for several years and has been working hard to re-enter society. As part of his rehab, he has been taking a medication that caused him to experience severe vomiting as a side effect. His doctor requested a PA to prescribe him a different medication. The PA request was denied for needing more information, and administrators said that they would require the doctor to observe and document the side effects before approving the PA request. The idea that he would have to take the medication in front of the doctor to "prove" the validity of his side effects hurt his dignity, an issue magnified by the shame and stigma around addiction. After spending several weeks making his case to have the denial decision reconsidered and trying to find transportation back to the doctor's office, Jason gave up fighting. He decided he would rather live with the severe side effects than continue battling administrators.

Particularly given that Vermont is a small state, many people have long-term and trusting relationships with their primary care physician (PCP). We all rely on our care teams to give expert opinions about our health. PA denials regularly take weeks or months to resolve. Many are left unresolved if patients become discouraged by the process and/or logistically do not have the resources to complete the PA requirements. The process routinely requires a substantial dedication of resources from all parties, often leaving patients without the care and services that they need. This burden disproportionately impacts low-income individuals.[1]

The premise of PAs is to reduce costs for the health care system and insurers, and to reduce low-value care.[2,3] We recognize that PA may reduce costs for insurers. In our experience, PA's often come at the expense of consumers who must pay out of pocket for additional consults with their

providers. It is also clear to us that PA systems result in increased administrative efforts and costs on the provider side.[4] This takes a real toll on the health of Vermonters, as delayed or denied care ultimately makes future treatment more difficult and expensive.

We encourage the legislature to build on the shared goal of simplifying and streamlining the PA process. Our office recommends starting by focusing on PA approvals for medications and procedures for common, routine chronic medical conditions. Accessing the right care at the right time is vital to improving population health, and it is our collective interest to work towards it.

The Office of the Health Care Advocate (HCA) is a project of Vermont Legal Aid. The HCA provides free help to all Vermonters with questions or problems with health insurance or access to health care. The HCA works to improve Vermonters' access to quality affordable health care through individual and systemic advocacy. ***You can contact the HCA directly at 1-800-917-7787, email us at hca@vtlegalaid.org, or fill out an online intake form on our website at https://vtlawhelp.org/vtlegal_gethelp***

References

[1] Lewis C, Abrams MK. "Listening to Primary Care Physicians for Low-Income Patients: What Gets in the Way of Good Care?" *The Commonwealth Fund.* 27 November 2018.

[2] Gaines ME, Auleta AD, Berwick DM. "Changing the Game of Prior Authorization: The Patient Perspective." *JAMA.* 2020;323(8):705–706. doi:10.1001/jama.2020.0070.

[3] Turner A, Miller G, Clark S. "Impacts of Prior Authorization on Health Care Costs and Quality: A Review of the Evidence." Altarum Center for Value in Health Care. 2019.

[4] "2020 AMA prior authorization (PA) physician survey." *American Medical Association.* 2021.

Appendix F: OneCare Comments

OneCare Vermont

September 21, 2021

Dear Green Mountain Care Board Act 140 Work Group:

OneCare Vermont has a utilization management workgroup that meets regularly to monitor services provided to OneCare beneficiaries, including those services which previously required prior authorization under the Medicaid program and are waived in the ACO contract. To actively manage this waiver, OneCare's workgroup conducts prior authorization monitoring activities including quarterly meetings with DVHA's clinical unit, reporting on utilization trends for services that previously required prior authorization, and month-to-month monitoring of those services through a customized analytic application OneCare built for this purpose. Prior authorization monitoring from 2017 through March 2021 identified no unexplained over- or underutilization of those services previously requiring prior authorization.

OneCare supports a standardized prior authorization list across all payers that limits the prior authorization requirements to situations in which a secondary review is deemed appropriate. OneCare does not support changes to exemptions that move us away from a streamlined process and results in increased administrative burden for providers. Practices/providers staying below an effective total cost of care would be appropriate for automatic exemption from prior authorizations. In addition, we support exemption from any prior authorizations for providers enrolled in an unreconciled fixed payment model.

Respectfully,

Vicki Loner, RN.C, MHCDS, CEO

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