Dear Chair Houghton:

Our provider organizations (HealthFirst, UVMHN, VAHHS, VMS) look forward to participating in the stakeholder process to continue making progress on H. 766.

We are sending this email in follow-up to BCBSVT's responses to the claims edits questions posed by the Committee. We found that many responses did not address the essence of the questions and the limited information provided does not offer compelling evidence that Vermont providers are incorrectly coding to the degree mentioned in Dr. Weigel's example.

Furthermore, the responses do not reflect the real world provider – and we believe payer - administrative burden associated with BCBSVT's claim edit processes. For example, BCBSVT glazed over the process of what happens after the claim is withheld by Cotiviti. They mention notification within 24 hours but then they jump to step 2 where the note is reviewed, and a response is given. They leave out the huge lag between when the note is submitted, and the answer provided. We also dispute the reported 17:05 wait time, as our providers report encountering much longer wait times on a regular basis.

BCBSVT also makes it sounds like many other local and national payers are applying these edits the same way. BCBSVT's pre-payment denial on modifiers 25 and 59 is unique. Other payers apply the edits, but they do not automatically deny payment prior to submission of medical record documentation, nor do they have the associated crushingly burdensome processes.

We also believe the overturn data is artificially low. We are certain that there are providers who don't even bother to appeal because the process is just too onerous. How many of those would be overturned if they had appealed? Dr. Lin's practice is the perfect example. Many of their claims were being denied. They tried to work within BCBSVT's process, but it was just so onerous, so they gave up. When they finally invited BCBSVT into their practice for a detailed look, 100% of their claims were approved. BCBSVT's is saving money in part by denying valid claims and weakening the provider network in the process. Their figures don't reflect that.

Please reach out to any of us with questions or to discuss these concerns further.

<u>Specific comments to BCBSVT responses are also included below:</u>

Question 3: BCBSVT provides that edits are made in alignment with Medicare. The roll out of the Cotiviti edits was not in alignment with Medicare's process. Additionally, the communication and sweeping number of edits does not align with Medicare's process.

Question 4: BCBSVT identifies the number of plans using Cotiviti and pre-adjudication process. Of the plans noted it is not clear that the plans implement the edits in the same manner and do hard stops for pre-adjudication. Additionally, it is not clear if the payers identified apply all the same edits or chose only a few. For example, we know Cigna stopped applying Modifier 25 edits, therefore there is not consistency amongst payers as is indicated. Additionally, it was not reflected that some of BCBSVT's own plans are not implementing the edit process, such as self-insured plans and their own Medicare Advantage plan.

Question 5: BCBSVT indicates the basis for their implementation of the Cotiviti edits was based on a new recommendation from CMS. They did not indicate what that recommendation was and if it applied to the multitude of codes implemented. No other payers tool this approach or followed a CMS recommendation in this manner. Also,

BCBSVT indicates 10 out of 37 Blues plans use prepay edits, less than a third, it is not indicated if those plans apply the prepay edits across the board or to targeted providers after education. Additionally, BCBSVT does not provide how those plans process the holds and if the time frame to respond is the same as providers are experiencing in VT.

Question 6: BCBSVT indicates 2021 was used to identify potential savings of $12M due to edits. The resulting savings they provide is $34M. It is not explained why there is such a large difference. Even accounting for the fact 2021 was still impacted by reduced utilization by COVID the magnitude of $34M compared to $12M is not explained. This could indicate providers are being impacted much greater than anticipated.

Question 7: BCBSVT indicated the CMO is responsible for decisions regarding claim edits. It does not indicate if self insured plans have the option to opt out of claims edits and make the decision if or if not to implement.

Question 8: BCBSVT notes their vendor, Cotiviti, does a pause and pay approach. As testimony indicated we feel this is a deny approach. Additionally, BCBSVT does not indicate how the vendor relationship is financially arranged, is Cotiviti paid by denial or a percent of dollars "saved"?

Question 9: BCBSVT summary of the notice process and education does not reflect the provider experience. The original notice of edit changes lacked sufficient detail to understand how edits would impact providers from an operational or financial standpoint. The education that was originally provided was only the very large edit manual. Additionally, the coding education provided by BCBSVT only occurred after many provider complaints, provider meetings with BCSBVT and a large group meeting with DFR. There was no education or identification of coding concerns prior to the new Cotiviti edits.

Question 10: BCBSVT identified "improvements" applied to ease provider burdens including: detailed spread sheets, outreach to providers and coding education. They do not identify that the spreadsheets providers receive are not tied to the billing system therefore the spreadsheet must be manually compared to the denials. Additionally, providers had to outreach for more detail after months of noting lack of clarity as to why claims are being denied. UVMHN has requested a performance report from BCBSVT identifying the billing compliance rate. BCBSVT provided for smaller utilized services but will not provide a report on Modifier 25 or 59 until there is a full year of experience.

Question 11: BCBSVT indicates that within 24 hours of receipt of medical records supporting reversal of a claim edit providers receive an email confirmation of receipt. This does not occur. The remainder of the response moves to the appeal process and does not address the review process of the medical records for the claim edit dispute. UVMHN is still awaiting responses to emails / medical record submission that are over 60 days old.

Question 12: BCBSVT was asked to provide the notice providers received relative to a claim edit denial. They did reply with a typical "denial" letter but this ignores again the first part of the process. When a claim edit is applied the claim is not paid, but it is not "denied" per the payment process. The only notice providers receive is a code on a remittance advice noting not paid. The code is not specific, which is why the additional spreadsheet is required. The "denial" notice provided in BCBSVT's response is only after the claim edit is held up as accurate, which can occur after 60 days as described above.

Question 13: BCBSVT mentions claim *lines* that have been impacted – that implies a single claim could have more than one denial – is this expressed in their spreadsheets that they are sending providers?

Question 18: The savings are summarized but does not get to the overall PMPM impact of the edits when distributed among the population.

Question 19: BCBSVT appears to be justifying the claim edit based on a finding from over 20 years ago with a sample of 450 total claims. If this is indeed based on 450 claims across the whole country that would not be a large enough sample to extrapolate data reliably on. Similarly, a sample size of 1 provider in a state is not something that can be extrapolated to others.