

To: Chair Lori Houghton & House Health Care Committee Members

From: UVM Health Network; Vermont Association of Hospitals and Health Systems; HealthFirst; Vermont Medical Society

Date: February 23, 2024

Re: Support for H. 766 – Response to Costs of Implementation

Thank you for your Committee's ongoing interest and work on H. 766. We submit this memo in continued support of the bill and to follow-up regarding potential premium impacts of the bill. Please contact Devon Green at devon@vahhs.org and Jessa Barnard at jbarnard@vtmd.org with any additional questions or concerns.

Through the testimony provided by payers, hospitals, independent providers and provider groups there is consensus on several key points:

- There are administrative expenses related to submitting and processing payment for care delivered faced by both payers and providers, adding cost to the health care system
 - Payers spend millions of dollars on vendors and staffing identifying areas for utilization management and claims billing review
 - Providers spend millions of dollars across the state complying with disparate payer payment policies and claim processes
- Payers have varying payment practices pertaining to prior authorizations, claim edits and pre-payment review
 - BCBSVT processes vary significantly from any other payer in Vermont, and NY based on providers' experience
 - Alignment and transparency in concept are a shared goal of payers and providers

While payers and providers agree on the above, there is significant difference in identifying the value of claims edits, prior authorizations and in general how providers are reimbursed. **The differences of opinions relate to the impact of administrative burden on providers and the ultimate value to the health care system.** Payers, specifically BCBSVT, have highlighted the assumed cost of this bill, which again meets the goal of simplification, transparency and reduced health care cost we all agree upon. As BCBSVT provides a price tag associated with this mutually beneficial effort, key points from the providers within the health care system, who are providing care to Vermonters, demonstrate the cost not addressed or acknowledged by BCBSVT. Specifically:

- **Savings through alignment:** Medicare and Medicaid have standardized processes that cover approximately two-thirds of the hospital and provider revenue in Vermont, adding commercial payers to this large volume creates broader scale and efficiencies
 - Through alignment of commercial payers with Medicare and Medicaid, providers will be able to reduce administrative FTEs supporting processing and appeals and better allocate the resources in the organization or within the healthcare system.
 - Payer ability to frequently and unpredictably change policies and procedures requires providers to staff up to respond to the payers' continuous changes, this increases the cost on the provider side to stay open and therefore the cost passed along to payers and ultimately ratepayers. This negates savings projected by payers.

- Alignment allows providers and staff to have a clear understanding of claim processing expectations and as such not continually question their work or need to double check payer policies. This increases workforce satisfaction and reduces burn out—workforce costs are currently the greatest impact to the cost of health care and keeping engaged employees is an essential component to the leveling of health care labor expenses in Vermont.
- Providers agree to measure the impact of this legislation and demonstrate the value, there is a commitment to accountability demonstrating the impact of this legislation.
- Only BCBSVT has provided potential cost related to the H.766 proposal. BCBSVT has not provided the underlying assumptions and detail for providers to respond to. While providers cannot validate BCBSVT’s account of the impact of H.766 there are some key components to consider.
 - **Claim edits**
 - There is no acknowledgement that a payer can apply to have DFR approve any claim edit standards. Are there ones that BCBSVT thinks DFR will not approve and why? How is this different from current statutory language that allows approval of a claim edit by DFR?
 - BCBSVT highlights the impact of \$52M in pharmacy edits—this is distracting as **the legislation proposed does not impact the ability to use pharmacy-based claim edits** and inclusion of this value is inflating the impact of the proposed legislation. Pharmacy edits can continue under (b)(1)(C), “other appropriate nationally recognized edit standards, guidelines, or conventions approved by the Commissioner – which we believe is the current status quo for pharmacy edits.
 - BCBSVT identifies \$6.4M in savings due to claim edits for medical care
 - They do not highlight the dollars they are spending on the vendor to process claim edits or staff to process claims and the incentive of the vendor to deny claims.
 - As to the value of the \$6.4 Million. If you divide 6.4 million by the 220,000 BCBSVT lives, that would be an at best estimate of \$2.42 per person per month in savings due to the payment policy changes. BCBSVT did not project this in filings nor is it clear how this is actually reducing cost to the healthcare of self- insured plans.
 - Hospitals and providers are paying far more than \$2.42 a month to file individual medical records for each claim denied, also reducing access due to BCBSVT policies. That is not included in the evaluation of BCBSVT
 - **Providers dispute a number of the other allegedly prohibited claims edits.** The examples given by BCBSVT are addressed by NCCI.
 - Denying the same codes billed multiple times for the same services by the same provider on the same date for the same patient
 - This is covered by National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs). An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. They cover

DME supplies, outpatient hospital services and practitioner

services: [https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits#:~:text=National%20Correct%20Coding%20Initiative%20\(NCCI\)%20Medically%20Unlikely%20Edits%20\(MUEs,payments%20for%20Part%20B%20claims.](https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits#:~:text=National%20Correct%20Coding%20Initiative%20(NCCI)%20Medically%20Unlikely%20Edits%20(MUEs,payments%20for%20Part%20B%20claims.) (And see NCCI Policy Manual Chapter 1, Section V)

- Also covered by PTP edits: automated prepayment edits that prevent improper payment when you report certain codes together on the same date of service for the same patient and provider. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment, but the Column Two code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported. <https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ntp-edits>
- Denying separate services when a global obstetrical package for uncomplicated maternity is billed, on the same day as the delivery
 - See NCCI Policy Manual Chapter 7 section G
- Denying procedures that are inconsistent with the patient's age based on the code definition (example newborn services on a person over age 65)
 - Understood to be included in MUE edits noted above
- Denying emergency visits when they are billed in any place of service other than the Emergency Department
 - Medicare does use place of service codes and requires that they be included when billing on CMS form 1500: <https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>
- Limit reimbursement of diagnostic tests and radiology services to no more than the amount for the global service
 - The definition of a global service is established by Medicare who creates the NCCI edits, also reimbursement policy is not in our opinion under the definition of/limits of claims edits
- Limit claims to the number of units that exceed the assigned allowable unit
 - See Chapter 1 section V regarding MUE's (both at a claim line level and DOS level)
- **Demonstration of waste in healthcare:** Unaligned claim edits are simply an example of waste in claim processing/payment when ultimately claims are in fact paid
 - The Committee heard testimony of an independent provider stating that after months of denied claims and significant burden BCBSVT did an audit of her billing practices. The result was

100% of her claims were in compliance. While eventually getting a waiver from the process, which may be temporary, the practice incurred administrative expenses appealing denials and chasing dollars owed. This resulted in significant effort on the small practice which was a waste. In this example, access was limited to patients simply due to the payer policy.

- The Committee heard testimony that practices simply were not appealing claims, instead looking to limit access. The \$6.4M asserted by BCBSVT is inflated as billing is likely accurate but providers do not have the staff to compete with the payer policies. Therefore the “savings to BCBSVT” is due to providers not being able to fight the larger entity. This applies to hospitals and independent providers.
- The issue of unaligned claims edits is not a BCBSVT issue alone—BCBSVT simply demonstrated the power payers have to impose rules unilaterally impacting claims processing and how they payer providers. The ultimate result is payers receive value through initial claim denial, confusing and unclear processes, long appeal times and eventually delayed payments.
- **The “savings” payers may note depends on how they are calculating such:** Was it at the initial denial point? Was it after claims processed, noting providers are not taking the time to appeal all claims? **The savings are negated by the experience providers are having, delaying payments and therefore limiting resources in our system.**
 - For example, at UVMMC, with regard to the hospital Modifier 59, disputing the claim edit has resulted in a recovery of over \$1M in dollars. Simply put, effort had to be made to get paid for appropriate care and billing for the care. To do so required single medical record to be provided for each claim by email or “fax.” There is no rhyme or reason for BCBSVT’s process. BCBSVT is not denying all Modifier 59 claims but it is unclear why some are being paid or rejected. Ultimately, after months of FTE time, BCBSVT pays the claim.
 - As of a February claim review the following demonstrates the waste and confusion:
 - UVMMC billed 5,851 claims in 2023 with Modifier 59. Of that amount 2,015 were denied per the claims edit. It is not clear why such a large number were denied but also why those allowed through were paid.
 - To object to the claim edit denials, UVMMC submitted notes on 1,456 individual cases. The over 500 not submitted were either still under review or some were likely selected not to resubmit.
 - UVMMC has initiated a second appeal on some but has written off some due to the burden associated with the appeal process.

- Overall, BCBSVT has paid 83% of claims originally submitted and this is expected to be higher as claims are still being submitted. BCBSVT has not responded to some - specifically there are 141 claims (during this data snapshot) with over 30 days with no response. The time it took to receive \$1,000,000 in claims was a waste on all sides.
 - **The edit is leading to other unaccounted for health care expenses in BCBSVT's measure of "savings":**
 - In at least one instance, as HealthFirst previously outlined, a claims edit was inappropriately driving care to higher cost and in-demand sites, such as ORs and ASCs, when the procedure could be appropriately and safely performed in an office. BCBSVT has since turned off the edit, but only after the physician and practice staff spent a significant amount of time identifying and defending the appropriateness of the office procedure.
- **Prior Authorization:**
 - The focus of the prior authorization conversation in provider testimony has again been on the need for alignment—if providers have clear knowledge of payer policies and aligned payer policies this streamlines administrative requirements and increases patient access to care.
 - BCBSVT provided savings associated with prior authorizations without the underlying data. What was not highlighted in BCBSVT's economic analysis was the cost of access to care by prior authorizations: If medical staff do not have a clear understanding of prior authorization, procedures need to be rescheduled, limiting access. Also, if providers do not have enough staff to process the disparate prior authorization policies amongst payers this impacts the ability to schedule. In all this there is an increase in FTEs that otherwise could be used to support the healthcare system in a more meaningful manner.
 - It is important to note that BCBSVT highlighted potential impact and need for prior authorization by highlighting the cost of an MRI for BCBSVT as compared to Medicaid. This is a red herring. It is acknowledged and agreed that commercial payers pay more than Medicaid. This, however, does not make the need for a clinical medical necessity determination different at BCBSVT compared to Medicaid. What BCBSVT is referring to is the fact they are covering an administrative cost shift and therefore they require more prior authorizations. If this is part of their \$11.5M in "savings" it is not based on clinical determination, which is the basis of a prior authorization review.

Thank you for considering these additional points in support of moving forward with Draft 2.2 of H. 766.