Act 183 (2022) Report: Prior Authorizations; Administrative Cost Reduction

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Outline

- What is Prior Authorization (PA)?
- History of Work on PA in Vermont
- Act 183 Report:
  - Real-Time PA / Clinical Data from the Vermont Health Information Exchange (VHIE)
  - Alignment Opportunities
  - Opportunities for Legislative Action

What is Prior Authorization?

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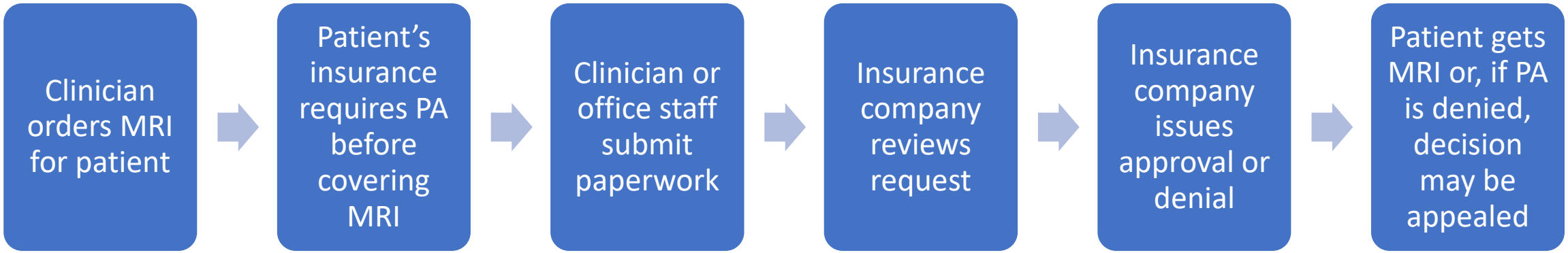
“Prior authorization” means the process used by a health plan to determine the medical necessity, medical appropriateness, or both, of otherwise covered drugs, medical procedures, medical tests, and health care services. The term “prior authorization” includes preadmission review, pretreatment review, and utilization review.

18 V.S.A. § 9418(15)

What is Prior Authorization?

The below diagram shows a simplified version of the PA process that we will reference throughout this presentation:



- PAs can apply to a wide range of services and prescription drugs.
- PA requirements vary across health insurance plans based on what the insurance plan covers and insurer specific clinical guidelines.

What is Prior Authorization? Insurer Perspective

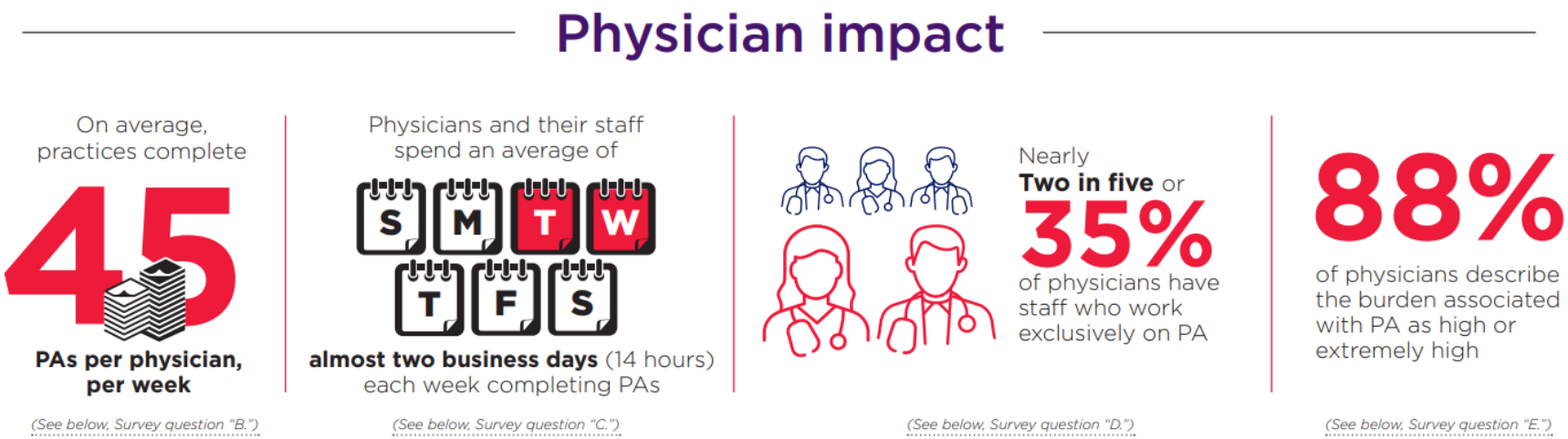
Health insurance companies use PAs as a cost containment tool and align PA requirements with clinical standards set by each insurance company.

- From DVHA's Act 140 Report: "Though prior authorization is a prominent lever used by payers to effectively **manage costs**, it is also used by payers like the Department of Vermont Health Access as a mechanism to **ensure the safety of its members and to prevent imminent** harm from occurring, as well as to **uphold clearly established standards of care**. For example, prior authorization and clinical review are required for complex durable medical equipment (DME) to ensure that equipment such as wheelchair and hospital beds are fitted properly to the member to avoid injury or other negative outcomes. Prior authorization is also used to **ensure adherence to criteria for procedures** that are appropriate for very specifically defined clinical conditions, such as low-dose computer tomography (CT) scans for certain types of lung cancer. Other **secondary outcomes from the prior authorization process** include the discovery of fraud, waste, or abuse, findings of quality of care issues, and addressing access issues (such as arranging transportation for out of state care)."

https://legislature.vermont.gov/assets/Legislative-Reports/DVHA_Act-140-of-2020_Prior-Authorizations-Report_Final-with-Appendices.pdf

What is Prior Authorization? Provider Perspective

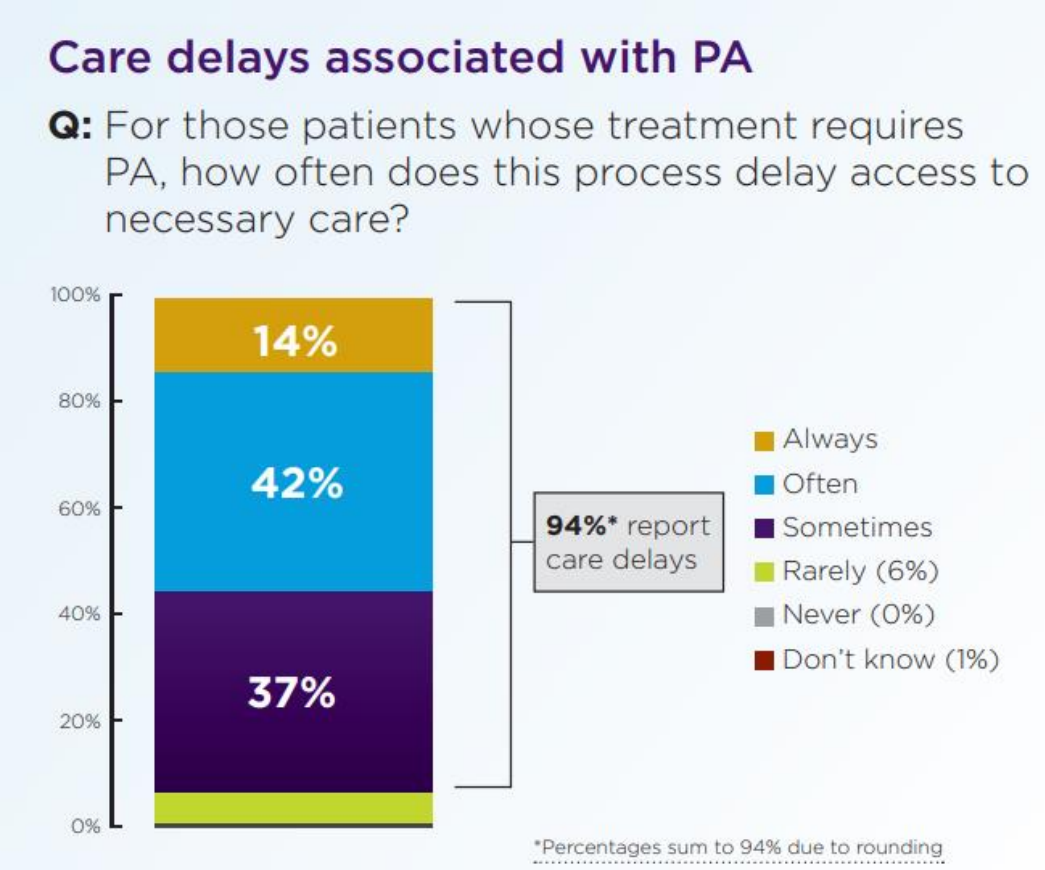
- Clinicians report administrative burden associated with the PA process.
- The American Medical Association has conducted a national survey of physicians about the impact of prior authorization:



[2022 AMA prior authorization (PA) physician survey]

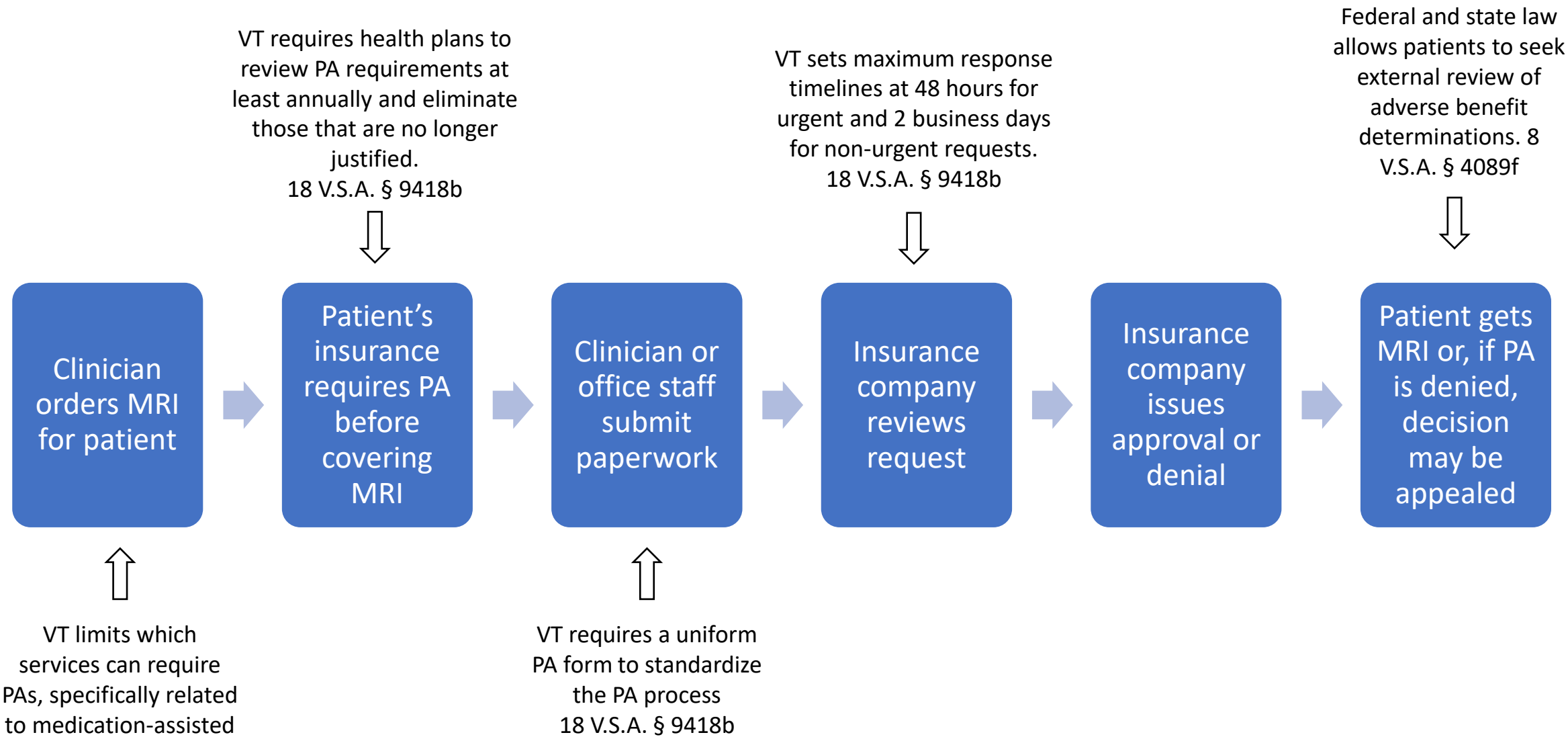
What is Prior Authorization? Patient Perspective

- The American Medical Association survey also highlights the impact on patients



[2022 AMA prior authorization (PA) physician survey]

Existing Laws and Rules for Prior Authorization



*Note applicability of VT laws is limited to state regulated plans

History of Work on Prior Authorization in Vermont

Past Work on Prior Authorization

Year	Action
2013	**Standard Prior Authorization Forms (Act 171 of 2013)** The Department of Financial Regulation (DFR) was tasked to work in consultation with the Department of Health Access (DVHA), the Vermont Medical Society (VMS), and health insurers to develop a "clear, uniform, and readily accessible" prior authorization form for use by all relevant Vermont providers. The uniform prior authorization form will be used for all types of medical treatment that requires prior authorization, including mental health and substance abuse. The uniform prior authorization form for medical service requests was finalized by September 1, 2013, as required.
2013-2016	**Prior Authorization Pilots** In 2013, 18 V.S.A. § 9377a was added, directing the GMCB to work with health care professionals and health care insurers to implement a prior authorization pilot program. Through a workgroup convened by GMCB, the pilot program ultimately focused on eliminating PAs for two classes of drugs (PPIs and statins) and one procedure (non-contrast MRI of the spine for low back pain). This work laid the groundwork for future Gold Carding pilots.
2017	**Medicaid ACO Prior Auth Waiver** In 2017, DVHA implemented a PA waiver through its Vermont Medicaid Next Generation ACO Program, negotiated with OneCare, for services included in TCOC. Modifications in 2018 to have waiver follow Medicaid member (not provider in VMNG) to reduce admin burden and confusion among providers (e.g. referrals). Information from DHVA Act 140 report
2018	**Primary Care Advisory Group provided recommendations to GMCB on PA** [see next slide]
2020	Legislature passes Act 140, requires gold carding pilots for insurers (with over 1,000 covered lives for major medical health insurance in VT) to exempt from or streamline certain PAs for a subset of providers (Sec. 11(a)).
2021	GMCB convened a workgroup (AHS, DVHA, DFR, BCBSVT, MVP, HCA, OCV, HealthFirst, VAHHS, and VMS) to discuss opportunities for and obstacles to aligning and reducing PAs under APM (results in GMCB Act 140 Report)
2021 Annually	Prior Auth Attestation: Annually, starting in 2021, health plans shall attest to DFR and GMCB annually that it has completed review and elimination of PAs that are no longer justified or for which requests are routinely approved.
2021-22	Reports under Act 140 about PAs: DVHA PA and Provider Exemptions Report; Opportunities for and Obstacles to Aligning and Reducing Prior Authorizations under the All-Payer ACO Model (GMCB); Opportunities to Increase the Use of Real-Time Decision Support Tools Embedded in Electronic Health Records to Complete Prior Authorization Requests for Imaging and Pharmacy Services (DFR)
2023	Insurer PA and Gold Carding Reporting from each insurer required to implement a pilot program, due to GMCB, HHC, SH&W, and Senate Finance.

GMCB Primary Care Advisory Group PA Recommendations from 2018

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.

Gold Carding Reports Summary

	Results	Cont. ?	Provider Feedback	Admin Costs of Program (for insurer)
BCBSVT Began 2020	• Three tiers based on previous denial rates (2-5%) and volume. • Advanced imaging, includes primary care and specialists. • Initial analysis shows increase in utilization among providers in pilot program, however, overall utilization trends also increased.	Yes	Limited data. Low awareness of pilot, but providers who did respond said program reduced admin burden.	ROI provided about PA programs, did not include costs/savings of running program.
MVP Began 2022	Methods vary by pharmacy, imaging, and medical: • Qualifying services determined by look back period from 12-18 months and more than 12-15 requests. • Qualifying providers (awarded at TAX ID level) for 5+ requests over 6-month look back, and approval thresholds of 80-95% • 7 provider groups were eligible, 6 for imaging, 2 for pharm.	Yes	Reduced admin burden, recommend align across payers. Limited data.	No addt. fees from PA vendors. Estimated $5,000 savings in pharmacy PA review costs.
Cigna	No providers qualified for the program.	No	None	$13,240.00 in admin costs for PAs in 2022 VT plans.
Wellfleet	No providers met 30 requests threshold to qualify for program.	Yes	None	Staff time to create program, no savings from program.

Current Reporting on Prior Authorization

- Annually, DFR collects reporting from Vermont-licensed health insurers with over 2,000 covered lives on a range of topics related to claims processing, including utilization review determinations (Act 152 of 2015).
- The reporting provides aggregate information about the number of PAs by category, the denial rates, and appeals (1st and 2nd level and independent external review).
- This information is helpful to understand the overall landscape of PAs for health insurers.
- DFR makes all reporting available to the public at: https://dfr.vermont.gov/industry/insurance/health-insurance/reports

Current Reporting on Prior Authorization

Example Act 152 filing from BCBSVT (2021). Full reporting includes similar tables for concurrent and post-service prior authorizations

Table 3.1: Pre-service Prior Authorization

	PA request		PAs at 1st level appeal				PAs at 2nd level appeal				PAs at independent external review level appeal			
(1) PA category	(2) Count of PA types	(3) Percent of total PA denied	(4) Count of PAs appealed to 1st level	(5) Percent of total of PAs appealed to 1st level	(6) Count of PAs appealed to 1st level that were overturned	(7) Percent of PAs appealed to 1st level that were overturned	(8) Count of PAs appealed to 2nd level	(9) Percent of total of PAs appealed to 2nd level	(10) Count of PAs appealed to 2nd level that were overturned	(11) Percent of PAs appealed to 2nd level that were overturned	(12) Count of PAs appealed to independent external review	(13) Percent of total of PAs appealed to independent external review	(14) Count of PAs appealed to independent external review that were overturned	(15) Percent of PAs appealed to independent external review that were overturned
Medical	18,931	7.2%	20	0.1%	11	55.0%	1	0.0%	1	100.0%	0	0.0%	0	0.0%
MHSA	1,254	3.8%	4	0.3%	0	0.0%	1	0.1%	0	0.0%	0	0.0%	0	0.0%
Pharmacy	11,996	27.5%	157	1.3%	108	68.8%	7	0.1%	5	71.4%	1	0.0%	1	100.0%
Grand Total	32,181	14.6%	181	0.6%	119	65.7%	9	0.0%	6	66.7%	1	0.0%	1	100.0%

PA requests and denial rate

PA appeals, 1st level

% overturned (PA granted)

PA appeals, 2nd level

% overturned (PA granted)

PA appeals, external

% overturned (PA granted)

Act 183 Report
Alignment Opportunities

Act 183 Report
Real-Time PA / Clinical Data from VHIE

- In 2022, BCBSVT participated in a pilot program with VITL, using clinical data in the VHIE to support PA requests
- Approximately 36% of requests could be approved using VHIE data
- For requests that could not be approved using VHIE data:
  - the member's clinical information was not in VHIE
  - the information in the VHIE would have resulted a denial (3% of cases)
  - out of state providers did not submit information to VHIE
  - missing admission records, family histories, and medical histories
  - missing clinical notes supporting an inpatient level of care or clinical need for services such as sleep studies, MRIs, and genetic testing

Takeaway:

in most instances where VHIE data could not be used to approve a PA request, it was because of deficiencies in data reporting, as opposed to legal or technological limitations with the data set.

Comparison to Act 152 Reporting

Table 1 PA Denial Rate and total Pre-service Medical PA Requests 2018-2021.[1]

Insurer	2021	2020	2019	2018
BCBSVT[2]	7.2% (18,931 requests)	8.0% (15,899 requests)	8.1% (25,313 requests)	2% (20,134 requests)
MVP	20.18% (7,618 requests)	19.57% (5,298 requests)	20% (6,389 requests)	16% (6,294 requests)
Cigna	35% (1,141 requests)	31% (982 requests)	Membership below reporting threshold.	Membership below reporting threshold.

[1] All submitted Act 152 reporting is available on DFR's website at: https://dfr.vermont.gov/industry/insurance/health-insurance/reports.

[2] BCBSVT advised with respect to this data that the COVID-19 pandemic led to an overall reduction in PA requests in 2020 and 2021, especially with respect to advanced imaging and chiropractic care, which both require services to be rendered in-person. BCBSVT expects a gradual shift to pre-pandemic utilization patterns and PA requests over 2022 and 2023.

Forthcoming Developments

- According to the Health Information Exchange (HIE) Strategic Plan, approved by the GMCB, VITL is working to expand the number of data types on the VHIE to include social determinants of health, mental health, and substance use disorder services.
    - VITL is also partnering with the Agency of Human Services to incorporate public health data such as immunizations and vital records into the VHIE.
- The Centers for Medicare and Medicare Services (CMS) proposed rules that, among other things, would require payers to and maintain a provider access application programming interface (API) to automate the process for determining whether a PA is required, identify documentation requirements, and ease the exchange of PA requests and decisions from electronic health record (EHR) systems.

Opportunities to Increase the Utility Of VHIE Data to Support PA Requests

- Permitting insurers to use VHIE data to approve and deny PA requests.
- Providing training, incentives, or leveraging technology to increase the amount and consistency of clinical information submitted to VHIE; and
- Securing a funding stream for VHIE that is not reliant on user fees for operation.

Act 183 Report
Opportunities for Data Collection

Act 183 Report
Opportunities for Data Collection

- DFR conducted extensive research to determine whether other states or the federal government had a pre-existing standard for insurers to submit information about their PA requirements:
  - Several states, including Arkansas, Delaware, Indiana, Kentucky, Texas, Minnesota, and Virginia require insurers to post PA requirements to public websites in an accessible and searchable format, including a list of any supporting documentation the insurer requires to approve a request and applicable screening criteria.
  - Under 8 V.S.A. § 9418b(d), health plans have to “post a current list of services and supplies requiring prior authorization to [their] website.”
  - No states currently require insurers to submit their PA requirements to state regulators in a uniform format.
  - The federal government does not collect any PA information and that it does not have a standardized format for PA language.

Act 183 Report
Opportunities for Data Collection

Act 183 does not mandate an ongoing reporting requirement.

Collecting a one-time snapshot of each insurer's PAs for purposes of aligning and streamlining PAs would present several challenges:

- Voluminous reporting due to large volume of procedure codes, with variation for diagnosis-related qualifications;
- PA requirements are frequently added, removed, or changed;
- Substantial differences between insurers as to the clinical criteria applicable to each service that requires PA.

For these reasons, a one-time snapshot of each insurer's PA requirements would not meaningfully support the analysis of how to achieve the goal of streamlining the PA process, while imposing a substantial administrative burden on insurers to submit the data.

Act 183 Report
Opportunities for Data Collection

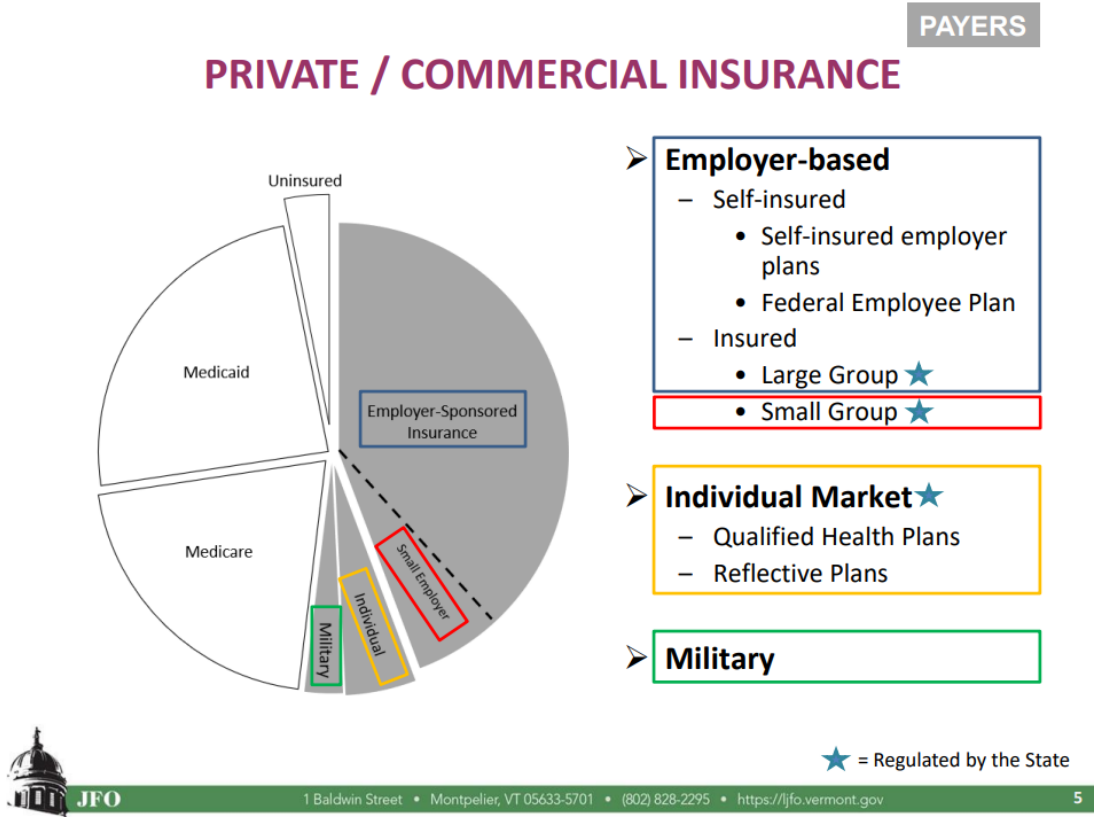
Going forward, DFR and GMCB will require insurers attesting to § 9418b(h) compliance to submit the following:

- A general description of the standards used by insurers to evaluate PA requirements.
- A list of services for which PA requirements were eliminated or added during the preceding plan year and the rationale for changing those requirements.
- A list of the ten most requested PA and the PA approval rate for those PA; and
- The percentage of urgent and non-urgent PA requests granted because processing time exceeded the statutory timeframes established under 18 V.S.A. § 9418b(g)(4)

Act 183 Report
Opportunities for Legislative Action

Scope of Legislative Action

- As with other policy topics considered by the committee, any legislative action will be limited to state regulated plans.
- As it relates to PAs, this means that changes to streamline processes and reduce administrative burden will not apply to all patients seen by Vermont providers.
  - For example, changes will not apply to self-insured employer plans

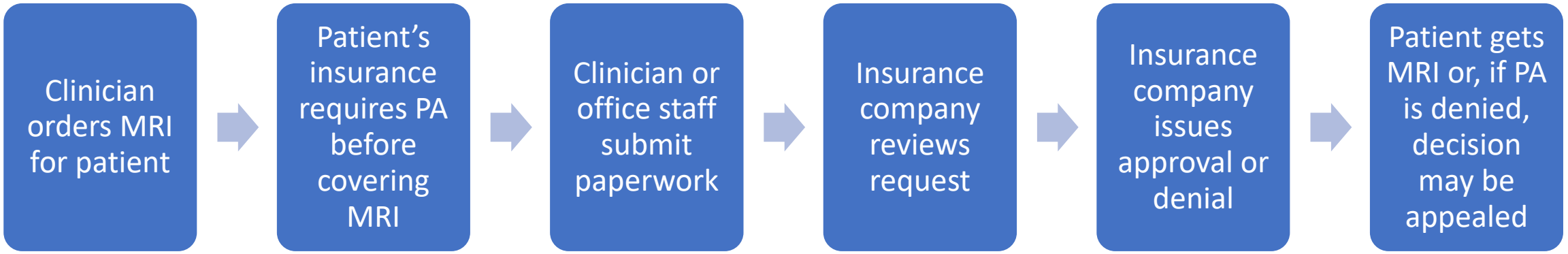


[Screenshot from Nolan Langweil's presentation to HHC on 1/17/2023]

Opportunities for Legislative Action on Prior Authorization

Expand **Gold Carding** programs to exempt providers from PAs for certain services

Consider amending § 9418b(g)(4) to **decrease** the **timeframe** for health insurers to respond to completed PA requests for urgent PAs to 24 hours, as currently required by at least 10 states



Limit how insurers apply **step therapy** protocols for prescription drugs, which has been done in other states including MA.

Improve quality and quantity of **clinical data in the VHIE**

Consider prohibiting insurers from requiring **reauthorization** during the current plan year for preventative services.

*Note applicability of VT laws is limited to state regulated plans

Act 183 Report
Opportunities for Legislative Action

- Consider amending § 9418b(g)(4) to decrease the timeframe for health insurers to respond to completed PA requests for urgent PAs to 24 hours, as currently required by at least 10 states.*
- Consider prohibiting insurers from requiring reauthorization during the current plan year when a PA has been granted for services deemed preventative by the IRS under 26 U.S.C. § 223(c)(2)(C), which includes prescription drugs for certain chronic conditions.
- Expand Gold Carding programs instituted under Act 140 of 2020.

* https://www.ama-assn.org/system/files/2021-04/pa-state-chart.pdf

Act 183 Report
Opportunities for Legislative Action

- Limit how insurers apply step therapy – protocols establishing the sequence in which prescription drugs for a specific medical condition are prescribed.
  - The Massachusetts law prohibits insurers from requiring step therapy when:
    - A medication is known to be ineffective for the patient's condition or the patient has already tried a medication in the same pharmacological class.
    - If the patient is stable on a medication and switching off it would cause harm.
  - Massachusetts also requires insurers to report to the Division of Insurance on the number and type of step therapy exception requests received and approved