MVP Health Care Responses
Vermont Prior Authorization Attestation Form (2023)

Questions:
The below questions apply to health plans as defined in 18 V.S.A. 9418(a)(8) (including third party administrators, to the extent permitted under federal law):

1. Has the health plan reviewed the list of medical procedures and medical tests for which it requires prior authorization (PA) at least once during the proceeding plan year and eliminated the PA requirements for procedures and tests for which such a requirement is no longer justified or for which requests are routinely approved with such frequency as to demonstrate that the PA requirement does not promote health care quality or reduce health care spending to a degree sufficient to justify the administrative costs to the plan?

    a. What is the health plan's timeline for reviewing and eliminating prior authorization requirements? In answering this question, please provide the dates for the two most recent review cycles.

        MVP Response: MVP continuously brings our clinical policies and data through our independent, physician run committee process. Below is a list of meeting dates, by MVP committee, where relevant PA policies and criteria were reviewed.

2023		
Medical Management Committee	**Pharmacy & Therapeutics Committee**	**Clinical Operations Committee**
2/16/2023	1/19/2023	Q1: 1/3/2023
3/16/2023	2/16/2023	Q2: 4/10/2023
7/20/2023	3/16/2023	Q3: 7/10/2023
8/17/2023	4/20/2023	
	5/18/2023	
	6/15/2023	
	7/20/2023	
2022		
Medical Management Committee	**Pharmacy & Therapeutics Committee**	**Clinical Operations Committee**
1/20/2022	1/20/2022	Q1: 2/7/2022
2/17/2022	2/17/2022	Q2: 4/25/2022
3/17/2022	3/17/2022	Q3: 8/1/2022
4/21/2022	4/21/2022	Q4: 10/31/2022
5/19/2022	5/19/2022	
6/16/2022	6/16/2022	
7/21/2022	7/21/2022	
8/18/2022	8/18/2022	
9/15/2022	9/15/2022	
10/20/2022	10/20/2022	
11/17/2022	11/17/2022	
12/15/2022	12/15/2022	

Additionally, MVP performed annual reviews of its PA criteria on the following dates:
- 9/2/2021
- 9/6/2022

b. Does the health plan ever add/eliminate PA requirements during a plan year (as opposed to between plan years)? Please explain.

MVP Response: MVP may add or eliminate PA requirements during a plan year. As previously stated, MVP does not just review the PA data once a year, so if a trend is identified, removal of PA requirements may occur at any time during the year.

c. What are the standards used by the health plan to evaluate PA requirements as outlined in 18 V.S.A. § 9418b(h) (including the thresholds the health plan considers in looking for routinely approved PAs, how the health plan determines whether PAs are promoting health care quality or reducing health care spending to a degree sufficient to justify the administrative costs to the plan)?

MVP Response: MVP considers multiple factors:

- Volume (those test & procedures with sufficient volume to reliably assess PA value)
- PA approval percentage (at least a 90% approval rate)
- Updates to standard of care and current literature supporting PA or removal
- Appeal and overturn rates
- Regulatory Requirements, drug safety, and quality of care are also weighed for removal of utilization management
- Delineation of impact of PA on health care spend to a degree sufficient to justify administrative costs to the plan (quantitative - plan ROI including review cost / excluding alternative care costs)

To the extent that the plan balances factors such as medical literature, quality, and cost (or others included in answer to Q1C), please explain the weight applied to each factor.

MVP Response: In general, equal weighting is applied to each factor, but weighting can vary depending on the specific type of treatment, procedure, or drug therapy. For example, in instances where there are clear clinical or quality standards that need to be followed, those are prioritized regardless of cost.

d. Does the health plan take into account the administrative burden of PAs on health care providers and patients and whether the administrative barriers to submit PAs may inhibit access to medically necessary care? Please explain.

MVP Response: MVP does evaluate the PA volume by provider and reviews utilization trends for certain services to ensure medically necessary care is being provided. MVP also does receive feedback from our participating providers and has modified and/or removed PA on specific services based upon their feedback.

Explain how provider administrative burden is weighted against other factors when deciding whether to apply a PA to a given service. What assumptions does the plan make with respect to the administrative burden associated with a PA requirement in terms of provider/patient time spent submitting the request, cost to providers (administrative staff, time spent on paperwork instead of with patients), member impact (potential second visit, adverse medical consequences as result of deferred/delayed care).

MVP Response: Improving member experience and meeting their healthcare needs are central to MVP's core values. The organization strives to reduce unnecessary administrative burden on providers, and any resultant friction it may cause for members' experience. When

implementing a PA program, MVP seeks the minimum necessary information to meet the clinical standards of care or quality recommendations.

Importantly, any PA requirements also add costs and burden for MVP. These programs require additional policy development, systems configuration, IT investments, and additional staffing to support the numerous phone calls, provider and member communications, and internal/external appeals. State and federal medical loss ratio (MLR) requirements effectively cap what MVP can spend on non-medical, administrative costs—including those described here.

To attract and retain members, MVP must keep its administrative costs as low as possible to offer the most competitively priced products. Similarly, member experience also drives consumer decisions on whether to stay with MVP, or to switch health plans. So, it's not in MVP's interest to incur unnecessary administrative costs or establish burdens and barriers that diminish member or provider experience. When MVP implements a PA requirement, there are very clear and obvious quality, efficacy, and cost related reasons for doing so.

MVP is also constantly exploring new innovations and investments that can reduce this administrative burden for all parties. Online provider portals, electronic health record systems, and automation provide endless opportunities to ease the manual paperwork, phone calls, and any other associated administrative costs.

Lastly, alternative provider payment models provide opportunities that benefit providers, members, and health plans alike. MVP is actively working with its provider network partners to establish new capabilities and advance models that empower and incentivize providers in different ways. Ultimately, these models can delegate more clinical autonomy to provider partners by establishing a shared commitment around costs, quality, and efficacy of member treatment.

2. What medical procedures and tests had PA requirements eliminated or added during the preceding plan year and what was the rationale for changing those requirements?

MVP Response: Removed Musculoskeletal service PAs including surgical procedures of spine, hip, knee, shoulder, and interventional pain management as of 7/1/2023. Additionally, the chart below outlines all PA changes made since February 2022.

CPT Code	Service (Procedure)	Change	Prior Auth	Reason	Effec. Date	LOB
53854	Rezume BPH Tx	Remove	N/A	Moved to covered	2/1/22	All
0089U	Pigmented Lesion Assay	Add	N/A	Investigational	2/1/22	Commercial, ASO, Medicaid
0090U	myPath Melanoma	Add	N/A	Investigational	2/1/22	Commercial, ASO, Medicaid
E0691	Phototherapy	Remove	Prior Auth	Moved to covered	2/1/22	All
E0692	Phototherapy	Remove	Prior Auth	Moved to covered	2/1/22	All
E0693	Phototherapy	Remove	Prior Auth	Moved to covered	2/1/22	All
E0694	Phototherapy	Remove	Prior Auth	Moved to covered	2/1/22	All
Q4249	Skin substitutes	Add	N/A	Investigational	2/1/22	All
Q4250	Skin substitutes	Add	N/A	Investigational	2/1/22	All
Q4251	Skin substitutes	Add	N/A	Investigational	2/1/22	All
Q4252	Skin substitutes	Add	N/A	Investigational	2/1/22	All
Q4253	Skin substitutes	Add	N/A	Investigational	2/1/22	All

Q4254	Skin substitutes	Add	N/A	Investigational	2/1/22	All
Q4255	Skin substitutes	Add	N/A	Investigational	2/1/22	All
43497	POEM	Add	Prior Auth	High cost	4/1/22	All
43180	Linx	Add	N/A	Investigational	4/1/22	All
43257	EsophyX	Add	N/A	Investigational	4/1/22	All
H0019	Residential Tx	Add	Prior Auth	Inpatient cost	4/1/22	All
J7402	Sinuva	Add	Prior Auth	High cost	4/1/22	All
S1091	Propel	Add	Prior Auth	High cost	4/1/22	All
A4238	CGM supplies	Add	Prior Auth	High cost	4/1/22	All
E2102	CGM supplies	Add	Prior Auth	High cost	4/1/22	All
	Zoladex	Add	Prior Auth	NYS DOH requirement	5/14/22	Medicaid
81420	cfDNA	Remove	N/A	Regulatory	7/1/22	Medicaid
81507	cfDNA	Remove	N/A	Regulatory	7/1/22	Medicaid
77089	Trabecular Bone Score	Remove	N/A	High volume	7/1/22	All
	Ondansetron	Remove	PA	Approval rate	7/1/22	Medicare
S0515	Scleral lens	Remove	Prior Auth	Low denial volume	8/1/22	All
93356	myocardial strain imaging	Remove	N/A	Moved to covered	8/1/22	All
64628	Intracept System	Add	N/A	Investigational	8/1/22	All
64629	Intracept System	Add	N/A	Investigational	8/1/22	All
0037U	pharmacogenomic testing	Add	N/A	Investigational	8/1/22	All
20560	dry needling	Remove	N/A	Moved to covered	8/1/22	All
20561	dry needling	Remove	N/A	Moved to covered	8/1/22	All
0253T	iStent	Remove	N/A	Moved to covered	8/1/22	All
64910	nerve grafting	Add	N/A	Investigational	8/1/22	All
64911	nerve grafting	Add	N/A	Investigational	8/1/22	All
	Ondansetron	Remove	QL	Approval rate	8/1/22	Non-MED D
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask	Remove	Prior Auth	Low denial volume	9/1/22	All
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask	Remove	Prior Auth	Low denial volume	9/1/22	All
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube	Remove	Prior Auth	Low denial volume	9/1/22	All
E0562	Humidifier, heated, used with positive airway pressure device	Remove	Prior Auth	Low denial volume	9/1/22	All
E0601	Continuous positive airway pressure (CPAP) device	Remove	Prior Auth	Low denial volume	9/1/22	All
0446T	implanted CGM	Remove	N/A	Moved to covered	10/1/22	Commercial, ASO, Medicaid
0447T	implanted CGM	Remove	N/A	Moved to covered	10/1/22	Commercial, ASO, Medicaid

0448T	implanted CGM	Remove	N/A	Moved to covered	10/1/22	Commercial, ASO, Medicaid
31647	Valve Devices	Add	Prior Auth	High cost	10/1/22	All
31648	Valve Devices	Add	Prior Auth	High cost	10/1/22	All
31649	Valve Devices	Add	Prior Auth	High cost	10/1/22	All
31651	Valve Devices	Add	Prior Auth	High cost	10/1/22	All
64640	cryoneurolysis ablation	Add	N/A	High cost, low volume	10/1/22	Commercial, ASO, Medicaid
	Alvesco	Add		Exchange benchmark	1/1/23	Exchange
	Metaxalone 800mg	Add		Exchange benchmark	1/1/23	Exchange
	Chlorzoxazone	Add		Exchange benchmark	1/1/23	Exchange
	ASA/Caffeine/orphenadrine	Add		Exchange benchmark	1/1/23	Exchange

3. What are the ten most requested PAs for **both** medical PAs and prescription drug PAs (20 total) during the preceding plan year? For each of the 20 PAs, please provide the number of PAs requested and approval rate for each PA (PAs in this list may overlap with eliminated PAs identified in question 2).

MVP Response:
The ten (10) most requested PAs for medical services are as follows:

Procedure Code and Description	Approved	% Approved	Denied	% Denied	Total Auths
95810: Overnight sleep study	234	87.97%	32	12.03%	266
E0562: Humidifier heated used w PAP	209	95.87%	9	4.13%	218
E0601: Cont airway pressure device	195	96.53%	7	3.47%	202
95811: Overnight sleep study	190	96.45%	7	3.55%	197
62323: Inject medication around spine	177	90.77%	18	9.23%	195
K0553: Ther cgm supply allowance	102	73.91%	36	26.09%	138
81420: Genetic analysis	5	3.94%	122	96.06%	127
93356: Image of heart tissue	0	0.00%	97	100.00%	97
64493: Spine injection	82	87.23%	12	12.77%	94
64483: Spinal injection for disc pain	84	93.33%	6	6.67%	90

The ten (10) most requested PAs for pharmacy services are as follows:

Product Name	Approved	% Approved	Denied	% Denied	Total Auths
TADALAFIL	11	20.37%	43	79.63%	54
DUPIXENT	35	89.74%	4	10.26%	39
FLUTICASONE PROPIONATE	0	0.00%	39	100.00%	39
SILDENAFIL CITRATE	3	8.33%	33	91.67%	36
AJOVY ***	34	100.00%			34
HUMIRA PEN	32	96.97%	1	3.03%	33
ONDANSETRON ODT	23	69.70%	10	30.30%	33
EMGALITY ***	32	100.00%			32
STELARA	25	89.29%	3	10.71%	28
XIFAXAN	14	50.00%	14	50.00%	28

*** *These were added to gold card pilot program for part of reporting period.*

4. What percentage of urgent and non-urgent PA requests are granted because processing time exceeded the statutory timeframes established under 18 V.S.A. § 9418b(g)(4)?

   MVP Response: 2.6%

   Is that number combining urgent and non-urgent categories? If possible, please submit this information broken out by urgent and non-urgent percentages.

   MVP Response:
   Urgent: 6.8%
   Non-urgent: 3.7%