VERMONT
GREEN MOUNTAIN CARE BOARD

Act 140, Sec. 10 Report: Prior Authorizations & the All-Payer Model

Green Mountain Care Board

Primary Care Advisory Group

October 20, 2021

DRAFT for discussion purposes only

Report Timeline

VERMONT
GREEN MOUNTAIN CARE BOARD

- Summer into Fall: Stakeholder engagement
- September 30, 2021: DVHA Act 140, Sec. 13 report submitted (shared with PCAG)
- October through December: Drafting report
- December and early January: Review process
- January 15, 2022: Report due to legislature

Outline of Report

VERMONT
GREEN MOUNTAIN CARE BOARD

1. Introduction
2. Background
3. Stakeholder Engagement
4. Recommendations & Next Steps
5. Appendices

VERMONT
GREEN MOUNTAIN CARE BOARD

Introduction

Statutory Requirement

VERMONT
GREEN MOUNTAIN CARE BOARD

- Act 140, Section 10 of 2020: Prior Authorization; All-Payer ACO Model; Report
  - The Green Mountain Care Board, in consultation with the Department of Vermont Health Access, certified accountable care organizations, payers participating in the All-Payer ACO Model, health care providers, and other interested stakeholders, shall 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.
  - On or before January 15, 2022, the Board shall submit the results of its evaluation to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Related Act 140 Asks

VERMONT
GREEN MOUNTAIN CARE BOARD

Report	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 DFR 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	Act 140 of 2020, Sec. 12	DVHA to provide findings and recommendations to HHC, SH&W, SF 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 HHC, SH&W, SF, and GMCB.	1/15/2023

All-Payer Model

VERMONT
GREEN MOUNTAIN CARE BOARD

- Specifically, Act 140 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.*
- The Medicare FFS program (excluding MA) has a very limited set of prior authorization requirements, mostly around very specialized services or DME requests.

Vermont Medicaid Next Generation Program

VERMONT
GREEN MOUNTAIN CARE BOARD

- **2017:** DHVA executed 1-year Medicaid Next Generation ACO pilot contract with OneCare Vermont (OCV)
  - Stipulates DVHA will pay OCV and All-Inclusive Population Based Payment (AIPBP) for attributed members to cover cost of care by its provider network
  - OCV assumes financial risk for all services in the Total Cost of Care (TCOC) & chose not to require PA for those services for members, reducing administrative burden and supporting providers to follow best practices

- **2018:** DVHA and OCV sought to make a distinction between PA for the sake of utilization management and clinical review requests for reasons related to patient care and safety.
  - DVHA retains responsibility for the care and safety of its entire membership and remains responsible for clinically reviewing PAs for a subset of services. This responsibility applies to all its members, regardless of ACO-attribution.

Vermont Medicaid Next Generation Program

VERMONT
GREEN MOUNTAIN CARE BOARD

- **2020:** Over 110,000 members attributed to ACO and qualify for PA waiver. DVHA is exploring modifying PA requirements at payer-level based on learnings from ACO PA waiver. Goal is to reduce admin burden by creating one uniform set of rules around PA for Medicaid population

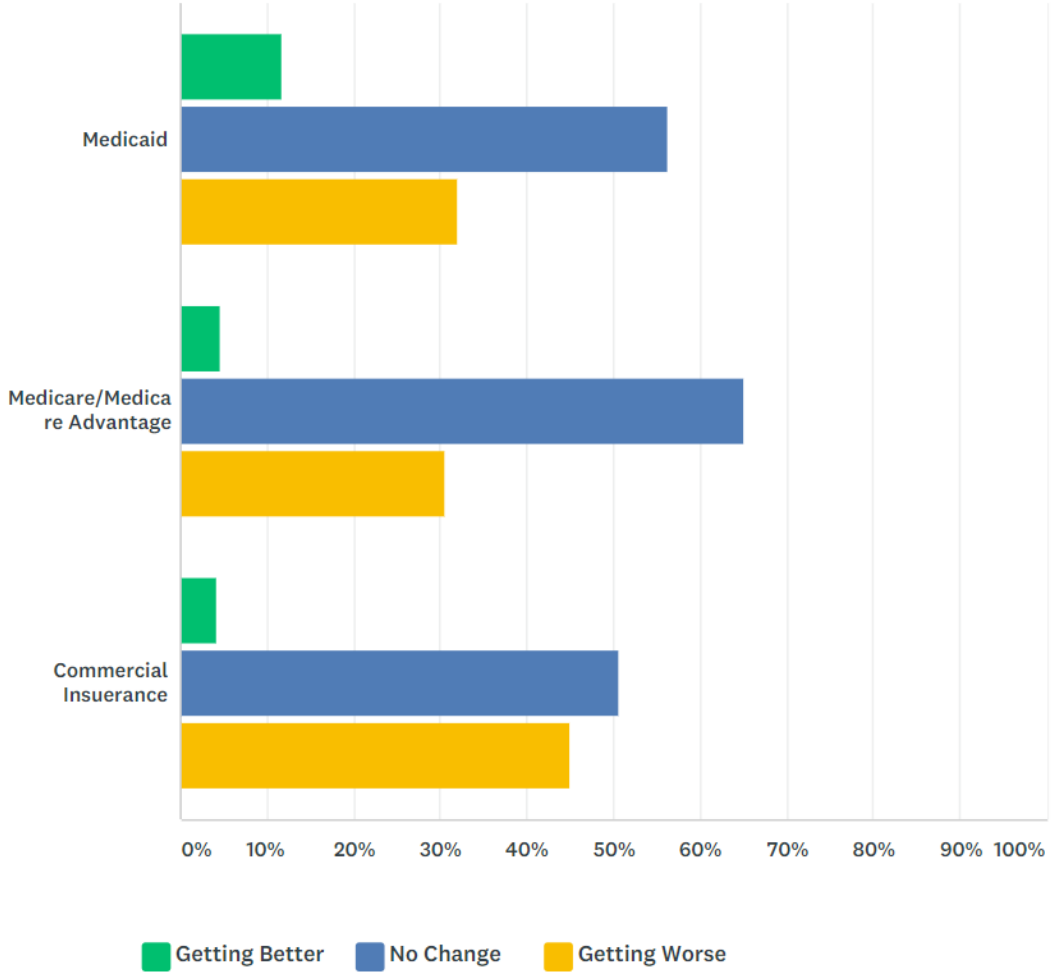
VERMONT
GREEN MOUNTAIN CARE BOARD

Background

VMS 2018 Physician & Physician Assistant Survey

VERMONT
GREEN MOUNTAIN CARE BOARD

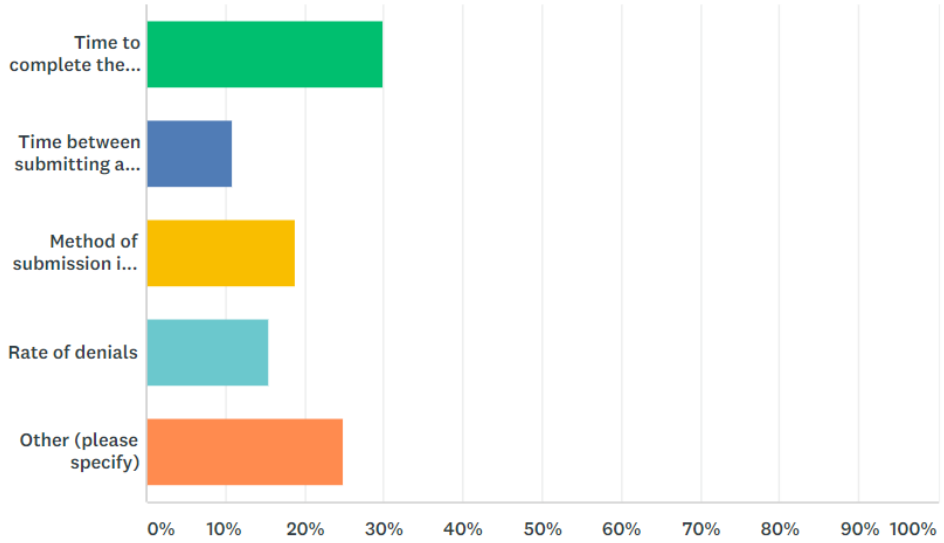
1. What has been your experience with prior authorizations?



VMS 2018 Physician & Physician Assistant Survey

VERMONT
GREEN MOUNTAIN CARE BOARD

2. What are your biggest concerns with prior authorizations?



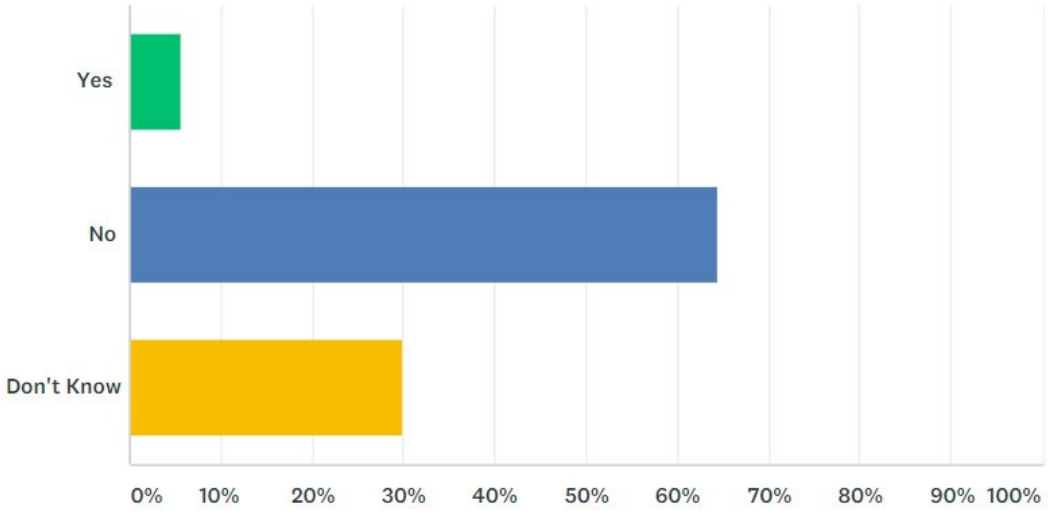
ANSWER CHOICES	RESPONSES	
Time to complete the paperwork	30.00%	72
Time between submitting a PA and a response	10.83%	26
Method of submission is burdensome	18.75%	45
Rate of denials	15.42%	37
Other (please specify)	25.00%	60
TOTAL		240

4 of 8

VMS 2018 Physician & Physician Assistant Survey

VERMONT
GREEN MOUNTAIN CARE BOARD

3. Are you participating in pilots to reduce prior authorizations?



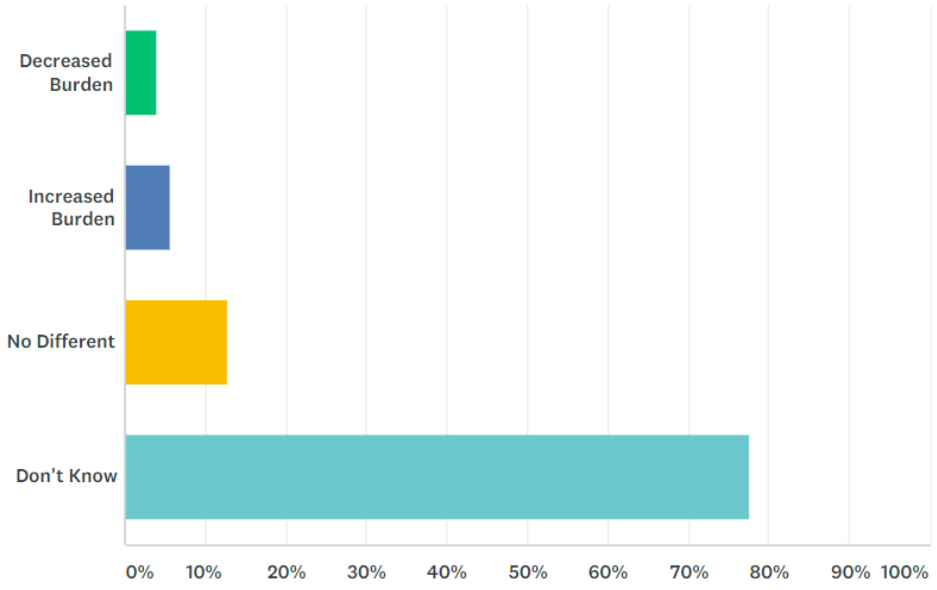
ANSWER CHOICES	RESPONSES	
Yes	5.74%	14
No	64.34%	157
Don't Know	29.92%	73
TOTAL		244

VMS 2018 Physician & Physician Assistant Survey

VERMONT
GREEN MOUNTAIN CARE BOARD

3a. If yes, what impact have these had on your level of admin burden?

Answered: 125 Skipped: 125



ANSWER CHOICES	RESPONSES	
Decreased Burden	4.00%	5
Increased Burden	5.60%	7
No Different	12.80%	16
Don't Know	77.60%	97
TOTAL		125

PCAG Prior Authorization Recommendations (Jan. 2018)

VERMONT
GREEN MOUNTAIN CARE BOARD

- PCAG recommendations to the GMCB regarding PAs:
  1. Eliminate PAs for Vermont PCPs.
     a. Insurers concerned about cost-containment could redeploy PA staff to educate certain PCPs and/ or patient groups about appropriate use.
  2. PAs for medications prescribed by Vermont PCPs could be reconsidered and implemented only after the insurance and EMR industry creates 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.

AMA Prior Authorization Surveys (2020)

VERMONT
GREEN MOUNTAIN CARE BOARD

- AMA 2020 Prior Authorization Survey:
  - On average, practices complete 40 prior authorization per physician per week
  - Physicians and their staff spend an average of 2 business days (16 hours) each week completing prior authorizations
  - 30% of physicians report that prior authorization has led to a serious adverse event for a patient in their care
  - 40% of physicians have staff who work exclusively on prior authorizations
- AMA 2020 Progress Update on Improving Prior Authorization:
  - Majority of physicians report the number of prior authorizations required for prescription and medical services has increased over the last 5 years.
  - Only 11% of physicians report contracting with health plans that offer programs that exempt providers from prior authorizations.

Prior Authorization Definitions

VERMONT
GREEN MOUNTAIN CARE BOARD

Prior authorization requirements must keep in mind several factors and definitions, including; medical necessity, investigational services, and not-medically-necessary.

Medical Necessity - "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.

Prior Authorization Definitions

VERMONT
GREEN MOUNTAIN CARE BOARD

Investigational – 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.

Not Medically Necessary – 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.

Commercial Insurers

VERMONT
GREEN MOUNTAIN CARE BOARD

- MVP Health Care Prior Authorization Process and Requirements Quick Guide
  - 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 NYS Department of Financial Services.
  - MVP suspended certain prior authorization requirements for all lines of business and continued to review prior authorizations for all other services.

Commercial Insurers

VERMONT
GREEN MOUNTAIN CARE BOARD

BCBSVT Provider Passport Pilot (live February 2020)

- 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:
  1. 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.
  2. 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%.
  3. Tier 3: Continuation of current prior approval process.
- 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 publicly available on website and regularly updated

DVHA Research

VERMONT
GREEN MOUNTAIN CARE BOARD

- We are working to collect the following from DVHA:
  - Research on prior authorization denial rate by service type
  - Data regarding what happens when you reduce prior authorizations

VERMONT
GREEN MOUNTAIN CARE BOARD

Stakeholder Engagement

Stakeholder Participation

VERMONT
GREEN MOUNTAIN CARE BOARD

- Workgroup participants included representatives from AHS, DVHA, DFR, BCBSVT, MVP, HCA, OneCare Vermont, HealthFirst, VAHHS, and VMS

- The workgroup met three times over the summer:
  - Meeting 1: July 20, 2021
  - Meeting 2: August 10, 2021
  - Meeting 3: August 31, 2021

Discussion Questions

VERMONT
GREEN MOUNTAIN CARE BOARD

Opportunities and obstacles to aligning and reducing prior authorization under the APM

a) How aligned are prior authorization requirements now?
   i. How do prior auth requirements vary by payer for APM participants (ACO network providers)?
   ii. Discuss feedback on current prior authorization waivers (e.g., VMNG)

b) How do prior auth requirements vary by payer for APM non-participants (non-ACO providers)?

Discussion Questions

VERMONT
GREEN MOUNTAIN CARE BOARD

Opportunities and obstacles to aligning and reducing prior authorization under the APM

a) Do you believe there are opportunities to increase APM participation by aligning or reducing prior authorization requirements for APM/ACO participating providers? Is this a significant incentive to participate?
   i. How do you believe prior authorization requirements should change for APM/ACO participating providers?

b) Thoughts and recommendations regarding gold carding

Workgroup Feedback

VERMONT
GREEN MOUNTAIN CARE BOARD

- Main point: The Act 140 legislative ask doesn't really fit into APM unless it's a risk program. The burden is really on payers. Also, Medicare does not require prior authorizations.

- What's missing: Education around prior authorizations

Recommendations & Next Steps

VERMONT
GREEN MOUNTAIN CARE BOARD

1. **Narrow focus.** Focus on PA approvals for medications and procedures for common, routine chronic medical conditions (HCA recommendation)
2. **Need more detailed understanding of prior authorization process.** Many factors are not being considered, including patient safety and appropriate care. Newer services are always coming out and changes to existing services are continuously being made.
3. **Further discuss APM role.** Discuss more broadly the change the APM brings about with providers taking on risk, and whether there's an incentive to overbill and investigate whether that will that lessen with APM.
4. **Consider who is taking on risk.** If risk goes to provider, then it's up to them to decide how they want to approve/disapprove these services.
5. **Look at administrative costs.** When we're looking at these programs, we should be looking at administrative costs used to review the prior authorizations on both payer and provider sides.
6. **Look into prior authorizations for different provider types.** Primary care providers and hospitals have different issues around PAs.
7. **Potential Expansion of Gold Carding Programs.** Gold Carding programs were included as a recommendation in the report of the Rural Health Services Task Force as both a workforce and administrative burden initiative. It was also 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.

Questions for PCAG

VERMONT
GREEN MOUNTAIN CARE BOARD

1. What is the report missing from a provider perspective?
2. Do you agree with the 2020 AMA survey results?
3. A component of the APM is the associated risk program(s) that allow for flexibilities, including PA waivers (as seen in the Medicaid program), what has been your experience with waivers in this area?
   a) There were PA exclusions during the Public Health Emergency – how did this impact your daily practice?

VERMONT
GREEN MOUNTAIN CARE BOARD

Questions/Follow-Up

Christina McLaughlin, christina.mclaughlin@vermont.gov

Michele Degree, michele.degree@vermont.gov

Resources

VERMONT
GREEN MOUNTAIN CARE BOARD

- Act 140, Section 10
- Documents used by legislative committees while drafting:
  - House Health Care
  - Senate Appropriations
  - Senate Health and Welfare
- Gold Carding Issue Brief
- The Evolution of the Prior Authorization Waiver in the VT Medicaid Next Generation Program
- 2018 PCAG Prior Authorization Recommendation