Prior Authorization Attestation Form (2023)

Under 18 V.S.A. § 9418b(h), a health plan shall review prior authorizations (PA) at least annually and eliminate PA requirements for those 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 prior authorization 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 health plan shall attest to the Department of Financial Regulation (DFR) and the Green Mountain Care Board (GMCB) annually on or before September 15 that it has completed the review and appropriate elimination of PA requirements.

To comply with the attestation requirements outlined in 18 V.S.A. § 9418b(h), health plans shall complete the below form and submit it to DFR and GMCB on or before September 15, 2023.

To the extent that a health plan believes that materials requested herein are exempt from public disclosure as a "trade secret" under 1 V.S.A. § 317(c)(9), the plan must request confidentiality prior to submission. Submitted materials will not be exempt from public disclosure unless DFR and GMCB advise in writing that the materials meet the requirements for a trade secret.

Contact information:

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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? **Yes, the list of services subject to prior authorization ("Prior Authorization List" or "PreCert List") and concurrent review is reviewed no less frequently than annually to determine if any services, whether Mental Health(MH)/Substance Use Disorder(SUD) or Medical(M)/Surgical(S), should be removed or added to the list.**

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. **The Plan reviews the PreCert List not less than annually. High-cost/high-frequency services on the PreCert List are subject to ongoing review as new data and research are received. Last reviewed April 2023 and May 2023.**

b. Does the health plan ever add/eliminate PA requirements during a plan year (as opposed to between plan years)? Please explain. **Yes. New codes are added as they are released from the AMA or CMS (January, April, July, and October). Existing codes are added or removed as they are reviewed. The last review conducted which resulted in the removal of codes was May 2023. Cigna removed the codes as of August 2023.**

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)? **To determine**

whether a service may be subject to prior authorization, one or more of the following variables must be met *first,* then a Return on Investment ("ROI") threshold must be established for the service to be subject to prior authorization review:

i. **qualitative variable of whether the service is determined to be experimental, investigational or unproven according to clinical evidence;**
ii. **qualitative variable of whether the service may present a serious customer safety risk;**
iii. **quantitative variable of whether the treatment type is a driver of high-cost growth;**
iv. **quantitative variable of the variability in cost, quality and utilization based upon diagnosis, treatment, provider type and/or geographic region; and**
v. **quantitative variable of treatment type subject to a higher potential for fraud, waste and/or abuse must be met *first,* then a Return on Investment ("ROI") threshold must be established for the service to be subject to prior authorization review.**

For the review period in question, the factors used to determine the application of Prior Authorization to MH/SUD and/or M/S services is the presence of at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0. Services/procedures must meet one of the first five factors (i-v above) before the ROI calculation is applied to determine if the service will be placed on PreCert List. There are instances where certain services may require Prior Authorization that do not meet the ROI of 3.0. These include services cosmetic in nature, services that are determined to be Experimental, Investigational and/or Unproven ("EIU"), services that have not been assigned a CPT/HCPC code, services that may be subject to fraud, waste, and abuse, and certain services that identify customers who may be appropriate for a case management program.

As of August 2023, the ROI threshold for M/S services was raised to 7.5 resulting in the removal of 634 codes, some of which are associated with inappropriate or over utilization. Evernorth is currently evaluating the ROI thresholds for MH/SUD services to determine whether a similar adjustment must be made.

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. **Yes. We frequently receive input from providers and review codes based on the input in addition to our standard reviews.**

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?

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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).

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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)? **Cigna did not have any prior authorization requests (whether urgent or non-urgent) that were granted because processing time exceeded the statutory timeframes.**

Peggy Rupp
State Regulatory Manager
9/14/2023