VERMONT MEDICAL SOCIETY

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To: AHS Medicaid Policy Unit via email to AHS.MedicaidPolicy@vermont.gov

From: Jessa Barnard, Esq., General Counsel & Vice President for Policy
Paul Harrington, Executive Vice President

CC: Tom Simpatico, MD, Chief Medical Officer, Department of Vermont Health Access
Vermont Medical Society Council
Green Mountain Care Board Members

Re: **Vermont Medical Society Comments, Proposed GCR 15-058, Cardiac Imaging Prior Authorization**

Thank you for the opportunity to present comments from Vermont Medical Society members regarding the proposed Global Commitment Register Policy 15-058, Cardiac Imaging Prior Authorization. As you know, this proposed policy would require clinicians to submit prior authorizations for cardiac imaging services effective October 1, 2016. The prior authorization process would be administered by eviCore healthcare.

The Vermont Medical Society is the state's largest physician membership organization, representing over 2000 physicians, medical residents and medical students across specialties and geographic location. VMS has distributed a summary of the proposed policy to all of our members and collected their responses.

Below is a summary of the feedback we have received and VMS' concerns and recommendations regarding DVHA's proposed policy.

1. **The policy is premature and runs counter to legislative action requiring the state and payers to find ways to reduce the administrative burden of prior authorization on physicians**

Prior authorization imposes a significant administrative cost on physician practices. As Allan Ramsay, MD, of the Green Mountain Care Board presented to the Vermont Senate Committee on Health and Welfare in 2014, there is lack of research showing the effectiveness of prior authorization on improved quality and reduced cost and also research showing the significant cost of administrative compliance.[1] For example, one study has revealed a cost of $68,274 per physician per year for medical practices to interact with health plans.[2] Physicians are feeling overwhelmed with the time and attention required to comply with administrative requirements imposed by insurance carriers rather than attending to clinical patient needs. In a survey VMS conducted in 2013 of primary care physicians in Vermont, 52% of

[1] legislature.vermont.gov/assets/Documents/2014/WorkGroups/Senate Health and Welfare/Bills/S.44/Witness Testimony/S.44~Allan Ramsay~Prior Authorization¦ S.44; Act 79 and Primary Care~2-27-2014.pdf

[2] Casalino LP, Nicholson S, Gans DN, Hammons T, Morra D, Karrison T, Levinson W. What does it cost physician practices to interact with health insurance plans? Health Affairs (Millwood) 2009;28(4):w533–w543, http://content.healthaffairs.org/content/28/4/w533.full

respondents reported spending up to 10 hours per week of physician and staff time dedicated to obtaining prior authorizations while 47% reported that their practice spent 11 or more hours per week dedicated to the prior authorization process. 94% of respondents believed that the prior authorization process had a negative impact on their ability to treat patients, 81% reported that it is very or extremely difficult to determine when a PA will be required and 43% had made an emergency room or specialist referral to avoid having to go through the prior authorization process.[3]

In response to concerns regarding the prior authorization process, in 2013 the legislature included in Act 79 of 2013 a provision to create prior authorization pilot projects. Section 40a of Act 79 / 18 V.S.A. § 9377a directs the Green Mountain Care Board to develop and implement a pilot program for the purpose of measuring the impact of eliminating prior authorization requirements for imaging, medical procedures or home care. As DVHA is aware, the GMCB undertook a pilot project, working with private insurers and Vermont Medicaid, to study the impact of removing the prior authorization process for advanced imaging procedures for patients with back pain for MRI spine (CPT #72148). **The Pilot came to a conclusion in May 2016 and the GMCB is still assessing the impact of the program, with a report expected this summer or early fall** though preliminary data shows that nearly all tests ordered in the sites without a prior authorization requirement met the clinical criteria established for appropriate imaging**.**

In 2016, the legislature took further action to address reducing the burden of prior authorizations. Section 9 of Act 113 of 2016 directs the Green Mountain Care Board to examine the effectiveness of existing requirements for health care professionals, such as quality measures and prior authorization, and to evaluate alternatives that improve quality and reduce costs and administrative burdens. Section 10 of the Act directs the Board to create a Primary Care Professional Advisory Group to provide input and recommendations related to the administrative burden facing primary care professionals, including creating opportunities to reduce prior authorization requirements for radiology, medication, and specialty services. **The GMCB has recently solicited applicants for the Advisory Group, is currently reviewing candidates and the group will begin meeting in September.**

In light of the ongoing activities to review the effectiveness of prior authorizations, VMS recommends:

a. **Implementing a new prior authorization requirement at this time is premature.** DVHA should await final results of the high tech imaging pilot and review by the GMCB of the cost effectiveness of prior authorizations under Act 113 before implementing an additional prior authorization requirement.

b. **DVHA continue to participate in a prior authorization pilot program and expand the number of codes or service areas exempt from prior authorization for high tech imaging** rather than add additional codes to the prior authorization requirements.

2. The proposed prior authorization requirement does not meet the statutory requirements put in place for the high-tech imaging prior authorization process.

The FY 2011 Budget Bill (Act 156 of 2010) authorized the creation by DVHA of the prior authorization process for high-tech imaging, including CT scans, MRI and PET scans. **Act 156 also established nine requirements for the prior authorization process, including:**

[3] VMS Survey: Prior Authorization – Impact on Patient Care in Vermont (March 2013), data available on request

- **Approval guidelines that are transparent, readily available and based on peer-reviewed, published clinical standards;**
- Decisions be made in a timely manner;
- DVHA form an **advisory committee** to comment on the evidence-based guidelines used and the process for prior authorization "**with the goal of minimizing the administrative burden** on health care professionals;"
- A prohibition on financial incentives for any vendor reviewing requests to deny requests;
- DVHA or the vendor conduct **training about the prior authorization process "at least 60 days prior to the implementation of the process**" including face-to-face regional meetings, webinar and other trainings;
- DVHA or the vendor must "**distribute information** about the prior authorization approval guidelines and the process to all participating providers **at least 60 days prior**" to implementation and must "**provide an on-line tool to allow health care professionals to determine if prior authorization is required;"**
- DVHA must track and report statistics including imaging usage rates, requests processed and average transaction time;
- DVHA must perform a **satisfaction survey** of health care professionals annually and meet with health care professionals and the Vermont Medical Society to discuss survey results; and
- DVHA or the vendor must establish a **process to "exempt health care professionals** from the prior authorization process when the health care professionals routinely order imagining consistent with the department's evidence-based guidelines. . . " (the creation of the so-called "Gold Card" process).

In addition, Act 79 of 2013 (section 5b(c)(1)) requires that: "The Department of Vermont Health Access shall ensure that contracts for benefit management and claims management systems in effect on January 1, 2017 **include full transparency of . . . prior authorization guidelines** and other utilization review provisions, **including the source or basis in evidence for the standards and guidelines**.

VMS Recommends:

a. **Any prior authorization process for cardiac imagine meet the statutory requirements put in place by Act 156** – including, but not limited to: disclosing the evidence-based clinical standards used to review/approve prior authorizations; training and information about the PA process beginning at least 60 days prior to the initiation of the PA process; and creating on an online tool for checking if a prior authorization is required.
b. **DVHA create a Gold-Card exemption process for those practices that routinely meet the prior authorization standards or other appropriateness criteria** according to which clinicians who can demonstrate a high level of compliance with evidence-based guidelines for ordering cardiac images, such as those established by the American College of Cardiology, are not subject to the prior authorization process. This is particularly critical for practices that order a high number of cardiac images.
c. **DVHA more broadly market the existence of the Gold Card, including the criteria, how to apply** and the number of physicians participating. A recent search of the DVHA provider materials and website, including the Medicaid Covered Services Rules, Provider Manual, Clinical Coverage Guidelines webpage, and Policy regarding the Diagnostic Imagining Management Program (Revised 3/10/2011) yielded no reference to or

information regarding the existence of the Gold Card program or how to apply for a Gold Card.

3. **The proposed policy is not coordinated with the prior authorization process of other payers**

Part of the administrative burden placed on physician practices is caused by conflicting policies between payers. Blue Cross and Blue Shield of Vermont has confirmed that they have a prior authorization process in place for the same CPT codes proposed under this policy yet the vendor is different, requiring physician practices to comply with a different set of processes and procedures to obtain prior authorizations.

VMS Recommends:

a. **Postponing the implementation of the policy to allow time to coordinate requirements between payers**, including vendor policies and procedures and any Gold Card or exemption process. Blue Cross Blue Shield of Vermont has indicated to VMS a willingness to work to coordinate requirements.

Thank you for considering the comments of Vermont Medical Society members and we look forward to working with the Department of Vermont Health Access in the process of crafting policy for prior authorizations that works for clinicians, patients and the State. Please let us know if you have any questions or if we can be of further assistance.