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?
   Cigna Response:
   Yes, Cigna's Precertification Committee is charged with reviewing the Master Precertification List at least annually to determine the addition or removal of codes, for non-delegated services.

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.
   Cigna Response:
   Code review occurs annually. The two most recent reviews took place on June 2023 and May 2024.

b) Does the health plan ever add/eliminate PA requirements during a plan year (as opposed to between plan years)? Please explain.
   Cigna Response:
   Yes, the Precertification Team meets weekly to conduct routine activities, including reviewing for the release of new services/codes to determine if code(s) relating to services have been retired from use/replaced by another service code(s), or a new therapy becomes available.

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)?

Cigna Response:

For inclusion in the prior auth list the following factors are considered:

1. Experimental/Investigational/Unproven Service (Non-Quantitative)
2. Service Is/May Be Excluded from Benefit Plans (Non-Quantitative)
3. Serious Safety Risk (Non-Quantitative)
4. Significant Variation in Evidence-Based Care (Non-Quantitative)
5. Fraud/Waste/ Abuse (Non-Quantitative)
6. Estimated Average Cost (Quantitative)
7. Return on Investment (ROI) (Quantitative)
8. Exceptions to Quantitative Factors

Thresholds for inclusion by factor type are as follows:

- Non-Quantitative Factors: Any one or combination of the factors identified as non-quantitative may be considered for application of prior authorization.
- Quantitative Factors: Both factors (Estimated Average Cost and Return on Investment (ROI)) must be met for application of prior authorization.

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.

Cigna Response:

In addition to the huge financial costs associated with low value and non-evidence-based care, low value and medically unnecessary care is a known cause of direct harm to patients. In fact, medical errors are the 3rd leading cause of death in the US and are estimated to directly contribute to as many as 250,000 deaths per year. Prior authorization helps to support evidence-based, cost-efficient, high-quality care in the appropriate care setting and at the appropriate level of care.

Waste in healthcare already accounts for a whopping 25-30% of healthcare spending, or about $1 trillion per year, in the US. Low value and medically unnecessary care accounts for at least $100 billion in annual spend. Prior authorization is an important tool to reduce low value and medically unnecessary care and, therefore, overall health care costs. In addition to the contributions of prior authorization to the quality and safety of healthcare and healthcare outcomes, prior authorization is also an important tool to help manage the spiraling and unsustainable costs of healthcare in the US.

The pace of medical discovery has also dramatically increased in recent years. New medical knowledge doubled about every 3-4 years in 2010. In 2020, new medical knowledge doubled approximately every 70 days. Prior authorization, supported by Cigna's evidence-based coverage policies and guidelines, helps to ensure that best medical practices are followed by providers, as it is no longer possible for providers to independently stay fully up to date in all areas of medical knowledge relevant to their specialty. (This knowledge deficit is particularly a challenge for generalists, including primary care providers, due to the very broad nature of their clinical practices.)

Cigna understands that prior authorization can be associated with administrative burdens, for both providers and insurers.

Cigna takes deliberate steps to minimize administrative burdens associated with prior authorization, while still maintaining the important quality, safety, and cost-of-care management functions of prior authorization:

1. Cigna only requires prior authorization for 11% of all CPT/HCPCS codes.

2. Cigna routinely (quarterly) reviews codes on its prior authorization code list and removes codes from this list when they no longer serve the important functions of prior authorization. (For example, codes that are seldom denied, or codes that are associated with low-cost services that are submitted with low volumes, are routinely removed from Cigna's prior authorization code list.)

3. In 2023, alone, Cigna removed over 600 codes from its prior authorization code list, representing a 25% reduction in the number of codes requiring prior authorization. (Since 2020, Cigna has removed more than 1100 codes from prior authorization.)

4. Cigna has also embraced the modernization and streamlining of prior authorization to make the process more efficient and less burdensome for providers. We continue to expand our existing electronic and automated prior auth solutions that allow providers to submit prior auth requests either through a web-based portal or directly from their EMR, because we do recognize the administrative burdens that manual prior auth processes imposes upon busy health care providers, and the importance of minimizing those burdens. (In many cases, electronically submitted prior authorization requests can result in automated approvals within a few minutes of submission by a provider.)

5. Cigna's comprehensive evidence-based coverage policies are reviewed and updated on (at least) an annual basis, including a review of clinical data published in peer-reviewed journals and professional society guidelines. These coverage policies, which also included medical necessity criteria, are published online, and are therefore viewable by anyone.

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?
Cigna Response:
   - See attached document "Procedure Codes Added and Removed from Prior Authorization In 2023"

Procedure Codes Added and Removed

   - Total Procedures added in 2023: 160
     - Rationale:
       - Existing codes are codes that are active and available to be billed

- Codes can be added to the Master Precertification List upon recommendation from various stakeholders, including Medical Directors, Contracting, Special Investigation Unit, Claims Operations, Product, CPU
- Upon recommendation, an analysis is performed by a team consisting of nurses, medical directors, project teams, and data/analytics to determine the feasibility of adding the code
- If after the analysis, the code is recommended for addition to the Master Precertification List, an enterprise impact assessment is completed
- Recommendation is presented to impacted business units for voting
- If approved, a 90-day provider notification is scheduled, and implementation work is initiated

- Total Procedures removed in 2023: 652
  - Rationale:
    - Existing codes on the Master Precertification List are monitored quarterly for performance on Return on Investment (ROI), compliance concerns, benefit changes, savings thresholds, denial overturns, allowed amounts, and total volume of requests.
      - Codes identified for potential removal based on the above factors are presented to the Precert Committee to perform a clinical evaluation
      - Precert Committee makes a decision to remove or maintain the code on the Master Precertification List

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).

   Please see attached:

   VT Prior Authorization Medical

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

Peggy Rupp
State Regulatory Manager
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