COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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August 15, 2005

The Honorable Vincent F. Callahan, Jr.
Chairman of the House Appropriations Committee
General Assembly Building
Richmond, Virginia 23219

The Honorable John H. Chichester
Chairman of the Senate Finance Committee
General Assembly Building
Richmond, Virginia 23219

Dear Delegate Callahan and Senator Chichester:

The 2002-2004 Appropriation Act (Item 322J) directs the Department of Medical Assistance Services (DMAS) to collect and report information on all new prior authorization (PA) requirements implemented on or after the start of state fiscal year (FY) 2004 (Appendix A). The PA requirements that are under the purview of this study include Preferred Drug List (PDL) drugs, home health services, outpatient rehabilitation and psychiatric services, and non-emergency diagnostic scans.

In addition to the legislative mandate, I requested that the prior authorization process and savings be examined for home health services, outpatient rehabilitation services, and diagnostic scans. The results of both the data tracking and evaluation are presented in this report.

If you have any questions regarding this report, please contact me at (804) 786-8099.

Sincerely,

P W Finnerty

Patrick W. Finnerty

PWF:ccm

Attachment: Annual Report of New Prior Authorization Requirements

Annual Report of New Prior Authorization Requirements

Virginia Department of Medical Assistance Services

August 2005

TABLE OF CONTENTS

INTRODUCTION

The 2002-2004 Appropriation Act (Item 322J) directed the Department of Medical Assistance Services (DMAS) to collect data and monitor the impact of all new prior authorization (PA) requirements for the fee-for-service program that were implemented on or after the start of state fiscal year (FY) 2004 (Appendix A). Item 322J required that DMAS report on the number of service denials, the number of prior authorization requests submitted, the number of requests approved and denied, the number of appeals from prior authorization denials, the outcome of those appeals, and all associated administrative costs. The PA requirements that are under the purview of this study include Preferred Drug List (PDL) drugs, home health services, outpatient rehabilitation and psychiatric services, and non-emergency diagnostic scans.

In addition to the legislative mandate, the DMAS Director requested that the prior authorization process and savings be examined for home health services, outpatient rehabilitation services, and diagnostic scans. The results of both the data tracking and evaluation are presented in this report. The PDL program was also evaluated for savings, PA process, and outcomes; the results of that analysis will be presented in a separate legislative report, mandated by Item 326BB(8) of the Act.

In FY 2004, DMAS spent $1.5 million (general fund) less than what would have been spent on diagnostic scans, home health, and outpatient rehabilitation and psychiatric services absent any policy or medical use changes. Although there was a clear policy change with the new PA requirements, there were also other policy and medical use changes that affected utilization and cost. Some of the events had the effect of increasing service costs, such as an increased medical use of diagnostic scans and an increase in the number of recipients in Medicaid. Other events had the effect of reducing costs, such as a change to the reimbursement methodology for outpatient rehabilitation that established a new payment ceiling. Taken in combination, the various policy, medical use, and utilization changes, including the changes to the prior authorization requirements, had the overall effect of reducing payments by $1.5 million. The changes to the PA process are still relatively new and will continue to be evaluated by the agency.

The process required for a provider to apply for a prior authorization needs improvement in terms of timeliness and consistency. The agency is in the process of improving the process, and will release a new request for proposal (RFP) in the fall of 2005 to procure a vendor to facilitate the new PA processes for the home health, outpatient rehabilitation and psychiatric services, and diagnostic scans, among other services that require PA. As part of the new contract, improvements, such as relying on national standards and moving towards a paperless system, will be implemented to facilitate a more efficient process.

Prior Authorization for the Services Under Review is Administered by WVMI and DMAS

During the 2003 General Assembly Session, the Appropriation Act was amended to change the prior authorization requirements for certain services in the fee-for-services Medicaid and Family Access to Medical Insurance Security (FAMIS) programs (Appendix B). The two main purposes of the new requirements were to ensure medical appropriateness of services and to produce cost savings. DMAS supported the requirements and implemented the changes as directed on July 1, 2003 (Table 1). Requiring PA for the diagnostic scans was a new activity, as scans had no PA requirement prior to FY 2004. For the remaining services, the limits were changed to require PA earlier in the service plan.

Table 1
Summary of Changes to Prior Authorization Requirements

Service	Prior to July 1, 2003	After July 1, 2003
Diagnostic Scans* Magnetic Resonance Imaging (MRI) Computer Axial Tomography (CAT) Scans Positron Emission Tomography (PET) Scans	No PA Requirement	PA required for all scans
Home Health Physical Therapy Occupational Therapy Speech Therapy Skilled Nursing	32 visits before PA is required	5 visits before PA is required
Outpatient Rehabilitation Physical Therapy Occupational Therapy Speech Therapy	24 visits before PA is required	5 visits before PA is required
Outpatient Psychiatric Services	26 visits before PA is required	5 visits before PA is required

* Diagnostic scan prior authorization began August 1, 2003.

DMAS has a contract with WVMI to facilitate prior authorization for a number of services, including home health and outpatient rehabilitation. When new service limits for diagnostic scans were mandated, that function was added to the WVMI contract. For home health and outpatient rehabilitation, WVMI implemented the reduction in limits. The prior authorization process for outpatient psychiatric services is completed internally at DMAS and the agency implemented the reduction in limits.

DMAS regularly monitors the prior authorization activity for all services through weekly reports by WVMI and DMAS staff. To complete the requirements of this

mandate and that of the agency's Director, the policy and research division collected the reports on PA activity and completed other, more intensive activities, including:

- Data analysis of Medicaid claims data for the affected services,
- Estimation of payments for these services absent policy changes based on three years of claims history and time series analysis,
- Interviews with DMAS staff,
- Interviews with WVMI staff,
- Confidential survey of DMAS and WVMI staff,
- Focus groups with providers in each service category, and
- Review of manuals and other documentation.

This report addresses the outpatient rehabilitation, home health, diagnostic scans, and outpatient psychiatric services. All discussion of the PDL program will be presented in the separate report to the General Assembly, due in November 2005.

In FY 2005, WVMI and DMAS Combined Received Over 84,000 Prior Authorization Requests for the Services Under Review

WVMI administers the PA process for home health, outpatient rehabilitation, and diagnostic scans (MRI, CAT, and PET). Prior to the implementation of these new PA requirements, WVMI had a contract with DMAS to conduct prior authorization activities for inpatient and other Medicaid services. The total administrative cost for administering the PA process, including the additional cost of adding the administration of the new services to the WVMI contract and the DMAS oversight costs, was $465,786 in FY 2005.

WVMI reports PA activity by service category to DMAS weekly. In addition, DMAS collects weekly reports internally from the staff who conducts prior authorization determinations for the outpatient psychiatric services. Table 2 summarizes the activity for FY 2005. As shown, a portion of the PA requests were rejected, which typically means that the patient was not eligible for Medicaid. This is different from a denial, which is based on necessity for services. Of the services detailed in Table 2, there were 137 appeals for re-consideration of denied prior authorization requests. DMAS staff reviewed the appeals, overturning 12 denials and upholding or administratively closing the remaining appeals.

Table 2
PA Information for Home Health, Outpatient Rehabilitation, Scans, and Outpatient Psychiatric Services in FY 2005

	Home Health	Outpatient Rehabilitation	Scans	Outpatient Psychiatric Services
PA Requests	20,384	18,403	15,437	31,086
PA Approvals	17,498	15,687	13,451	21,852
PA Denials	833	460	617*	2,515
PA Rejects	2,086	2,079	0	6,719
PA Appeals	46	7	35	50
Overturned	1	0	9	2
Upheld	27	6	18	39
Case Closed **	17	1	8	9

* Denied or otherwise not approved.
** Closed for administrative reasons, or appeal dropped.

PRIOR AUTHORIZATION PROCESS

The prior authorization processes are guided by regulations, Medicaid manuals and policy guidance, internal policy decisions, and contractual requirements with WVMI. DMAS staff reviewed the processes used by DMAS for psychiatric services and by WVMI for the other services under review to determine whether the processes result in timely, appropriate, and efficient determinations.

To understand providers' satisfaction or frustration with the process, DMAS staff invited provider associations (Appendix C) for each service category to attend focus groups. The focus groups were well attended and yielded substantial information on how to provide a more efficient process. In addition, DMAS staff conducted interviews with key staff at DMAS and WVMI, conducted a confidential survey, and reviewed data, manuals, and operating materials.

The result of the research effort yielded valuable information regarding discrepancies between the process as defined and the process in practice. DMAS has put that knowledge to work and is making appropriate adjustments to improve prior authorization in two ways, through process changes and through policy changes. Changes to the process, such as reducing fax turnaround time and relying on national standards, are intended to address providers' concerns and make the process more efficient. In addition, policy changes and clarifications, such as clarifying retroactive policies, are being implemented to provide a better, more straightforward system.

DMAS is Implementing a Number of Process Changes to Improve Efficiency and Consistency as Part of a Procurement for a Prior Authorization Vendor

DMAS currently contracts with a third party vendor, WVMI, to administer prior authorization for a number of services. WVMI has been administering the prior authorization according to the requirements of their contract. As that contract will soon end, DMAS is in the process of issuing a Request for Proposal (RFP) to competitively bid for a vendor to complete prior authorization activities for the agency. Through focus groups and an internal review of the prior authorization process, DMAS learned that there were considerable opportunities to adjust the process to make it more efficient, more timely, and more in line with the direction of the industry and existing technologies. Therefore, several changes will be made to the upcoming contract to improve the process.

National Criteria for PA Determinations. The PA determinations for the non-emergency diagnostic scans are based on a nationally accepted set of criteria called InterQual. The computer software assists the reviewer in making a determination, and flags cases that need additional information or attention. Professional judgment becomes necessary when the case is unusual or unusually complicated. Because the criteria are nationally established and accepted, both the providers and the reviewers are clear about what is and is not appropriate for payment. This appears to be working well as no providers attended the focus groups dedicated to diagnostic scans and staff has not heard complaints from labs conducting these scans.

For the other services, however, the criteria for making a determination on whether the PA is approved and for how many visits are not straightforward. The agency has developed some guidance through manuals and charts and has provided that information to reviewers; however, the criteria are not nationally developed or published. Professional judgment is necessary and essential to the process; however, to ensure that consistency is maintained as much as possible, the PA process should move towards determinations that are made on criteria that are established and accepted nationally. Therefore, the RFP for a prior authorization vendor requires that the vendor use an established, nationally accepted set of criteria, where available, when making prior authorization determinations.

Internet Interface. The health care industry is moving towards a more paperless, real time system. With the technologies available, an Internet interface could be developed to allow providers to input the information they currently submit over the phone or through fax. Providers indicated that other, private organizations, have this option and it provides greater flexibility for entering necessary information, rather than taking the time to speak it over the phone.

Coupled with the requirement for nationally accepted criteria, this recommendation could further reduce the time it takes to obtain a prior authorization decision, as the initial screening could be automated. Requests that are of concern would be sent to a reviewer for further scrutiny, as is currently done with InterQual for the

diagnostic scans. DMAS supports the movement towards a paperless system, and has included a requirement for a web-based prior authorization interface as part of the RFP.

Fax Turnaround Time. Currently, PA requests that are submitted by fax must have a determination made within ten days. If approved, the approval may begin on the day the fax was submitted. During focus groups, providers indicated that the fax turnaround time was inappropriate and inefficient given the services they render. For example, home health providers argued that skilled nursing visits and services (such as wound care) cannot be delayed for ten days while the provider waits to hear if they are approved. And given the tight budgets within which they operate, it is difficult to take the financial risk of serving a patient and potentially having payment for that service denied.

Given the movement of the health care industry towards a more real-time, paperless, system, the available technology, and the urgency of medical care, it is unreasonable to expect providers to wait ten days for PA approval. If a provider requests the PA by phone, they may have to be on the phone for a period of time, but they may have their approval before they hang up the phone. Therefore, DMAS has included a provision in the RFP to require vendors to submit their proposal for turnaround times for fax, Internet, and phone that are consistent with the industry. This would be in addition to the requirement for a web-based process, as discussed above.

Connectivity of Computer Systems. Currently, the vendor's computer system and the Virginia Medicaid Information Management System (MMIS) do not directly communicate. As a result, when a provider requests a prior authorization, the analyst must use one system to check eligibility and then collect and data enter all demographic information and medical services information into another system for the prior authorization determination. The client specific information, which is already captured in the MMIS system, cannot be downloaded to the vendor's database. Instead, considerable time is spent data entering the information while the provider is on the phone.

To facilitate a more efficient system, reduce the burden on the provider, and reduce the time it takes for each analyst to make a determination decision, the two systems should communicate. Therefore, DMAS has included this requirement in the RFP for a prior authorization vendor.

Outpatient Psychiatric Services. The prior authorization determinations for outpatient psychiatric services are currently administered internally by DMAS staff. The PA process was outsourced to WVMI until January 2003, when it moved in-house. DMAS did not hire any additional staff to complete the reviews; instead, the function was added to existing staff who continue to have responsibilities for hospital desk audits. When the new service limit requirements went into effect in July 2003, the number of requests per week doubled, putting a considerable strain on DMAS staff.

DMAS' goal is to make the process more efficient and consistent. As such, a shorter turnaround on fax requests and an Internet interface is being required of the next vendor. The marginal cost of creating an Internet interface for only the few services that DMAS administers internally appears unnecessary when the agency is already requesting a vendor to create or purchase the technology. Therefore, DMAS is including the administration of the outpatient psychiatric services prior authorization process as part of the contract for a new vendor.

DMAS is Implementing a Number of Policy Changes and Clarifications to Improve Prior Authorization

DMAS staff identified several opportunities to clarify existing policy or make policy changes to improve prior authorization for the relevant services. The focus groups with providers were very informative in terms of understanding how DMAS policies may be confusing or misinterpreted. Based on the discussions, DMAS will make appropriate changes to the provider manuals and be available for training with providers as necessary. In addition, DMAS identified two specific policies that, with minor changes, would make it considerably easier for providers to care for Medicaid recipients.

Retroactive Policies. It is DMAS policy that prior authorizations must be requested *before* the service is provided. The only time a retroactive prior authorization is allowed is when there has been a change in eligibility. Also, prior authorization requests *are* accepted during non-business hours. If approved, the date of approval is the date of submission, whether submitted during business or non-business hours.

During focus groups with providers, it was apparent that a number of providers did not understand the policy. Therefore, the provider manuals will be clarified to state the following:

1. Retroactive prior authorizations (requests made for a past service date) are only allowed when the eligibility of a recipient changes.
2. When a request is made by fax, the approval becomes effective the date the fax was sent, even if the fax was sent during non-business hours.
3. If a request is made by voicemail during non-business hours, the approval becomes effective on the date the voicemail was left.

Skilled Nursing Visits. During the home health focus group, providers indicated frustration with the PA process in that the nurses had to receive prior authorization for each service done during a skilled nursing visit. This is difficult because the nurse does not always know what services are needed until the visit, at which time it is too late to request and receive approval before the services must be provided. For example, a nurse may be attending a patient regularly to do wound care and finds that the patient also needs a urinary catheter change. The nurse needs the ability to complete that other service immediately. If the entire visit was prior authorized, the nurse would have the authorization to provide complete care.

DMAS agrees that the prior authorization should be done by the visit as a whole, allowing the nurse to provide any necessary services. The manual is currently being updated to address this change.

Availability of an Evaluation Visit. For outpatient rehabilitation and home health services, Medicaid will pay for five visits per person per fiscal year before a prior authorization is required. While this appears straightforward, it is actually difficult for providers to navigate. The difficulty is that limit is not "per provider" and providers do not know if a recipient has already received five visits from another provider. DMAS does not know that the first five services have been provided until the agency receives a bill, and as providers have some time post-service delivery to bill for services, there is a clear lack of information. Therefore, providers told DMAS staff during focus groups that "five visits is a myth" and in order to ensure payment, they go ahead and request a prior authorization for all services, even the first five (including an evaluation visit).

Home health providers told DMAS staff that it would be more straightforward and appropriate to allow an evaluation visit per recipient, per provider, per fiscal year, rather than set a limit that has little relevance given the lack of information. This would guarantee that each provider can provide an assessment immediately, and will have all of the information necessary to request the appropriate services through the prior authorization process. Coupled with the changes to make the process more efficient, providers would have more timely information and could provide better service to Medicaid recipients. DMAS is currently considering this change, which would require regulatory change to the federally approved regulations and Medicaid State Plan.

COST SAVINGS

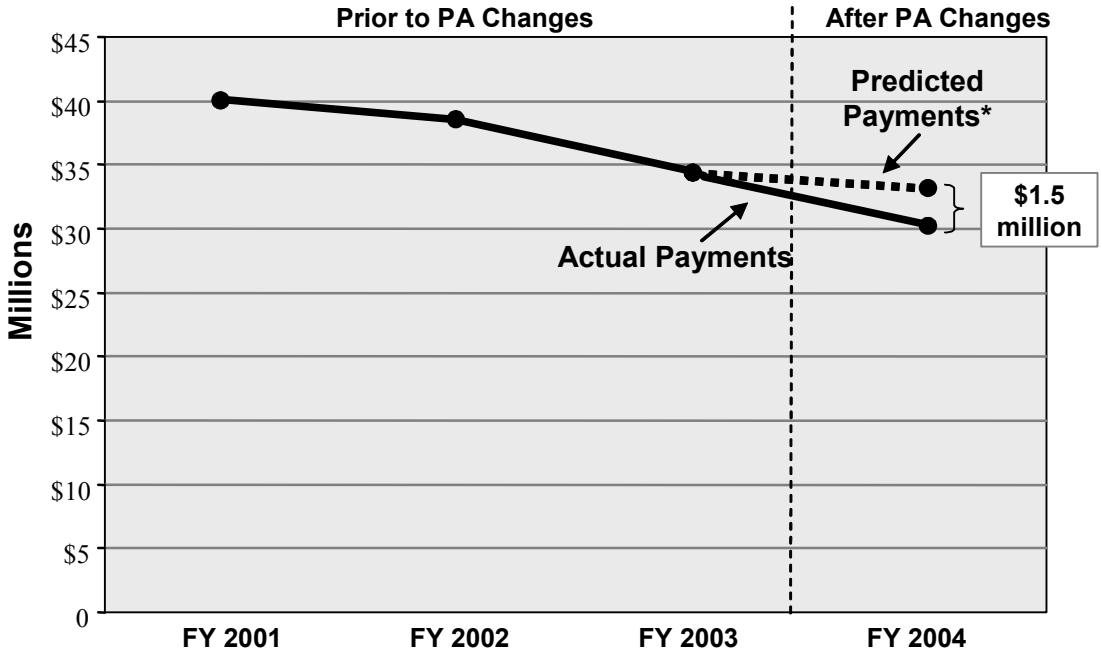
The prior authorization changes were put into place, in part, to achieve cost savings, as it was expected to reduce or eliminate unnecessary services. To measure savings, DMAS budget staff used a time series model and three years of historic claims data to predict what DMAS expected to pay for the services absent any policy changes. The analysis found that the payments in FY 2004 were $1.5 million in general funds less that expected. However, it is important to note that other events, such as the increased use of diagnostic scans and a sharp decrease in outpatient rehabilitation rates, also may have contributed to the observed payment changes.

Payments for Services Under Review Were $3 Million in Total Funds Less Than Would Have Been Expected Absent Any Policy Changes

The predicted savings methodology estimated that prior trends continued, DMAS expected to pay $33.3 million for the four services under review in FY 2004 (Figure 1). DMAS found, however, that the agency actually spent $30.3 million in FY 2004 for the

Figure 1

Estimated Reduction in Payments After PA Changes Were Implemented



* Forecasted payments that would have been made absent any policy changes based on data for the previous three years.

Source: Medicaid claims data.

services, a savings of $3 million total funds ($1.5 million general funds). Savings were observed in all services categories and include the cost of administering the prior authorization program (Table 3). The greatest reductions in cost were observed in diagnostic scans, and the least amount of reductions were observed in outpatient psychiatric services.

Table 3
Difference Between Expected Payments Absent Any Policy Changes and Actual Payments in FY 2004 (in millions)

	Predicted Payments*	Actual Payments**	Difference
Home Health	7.8	6.9	0.9
Outpatient Rehabilitation	4.1	3.1	1.0
Diagnostic Scans	18.4	17.4	1.0
Outpatient Psychiatric Services	3.1	2.9	0.2
Total Funds* **	**33.3**	**30.3**	**3.0**
General Funds* **	**16.7**	**15.1**	**1.5**

* Predicted payments are based on FY 2001 to FY 2003 payment experience and assume no policy changes.
** Actual payments in FY 2004 include administrative costs.
*** May not add due to rounding.
Source: Claims files from the Department of Medical Assistance Services Medicaid Information Management System.

It is important to note that the observed reductions in payments cannot be solely attributed to the change to the prior authorization requirements. A number of other policy, programmatic, and medical use changes occurred simultaneously and it is difficult to tease out the effects of each change without a control group comparison methodology, which was unavailable for this study.

There were two changes that may have had the effect of increasing overall payments. First, the number of Medicaid recipients rose substantially in FY 2004, compared to the trend in the previous three years, potentially resulting in an overall increase in utilization. Also, during the past year, the medical use of PET, CAT, and MRI scans increased substantially.

There were two events, however, that may have had the effect of reducing overall payments. First, while the number of diagnostic scans increased, the type of scan shifted from a more expensive type (PET) to a less expensive type (CAT). Also, outpatient rehabilitation rates decreased substantially through a change to the rate setting methodology that set a ceiling for payment rates. The result would be a considerably decreased payment for the same services.

Conclusion

DMAS staff worked with providers and the current prior authorization vendor to identify ways to make the prior authorization process for outpatient rehabilitation, diagnostic scans, home health, and outpatient psychiatric services more efficient and consistent. Through the procurement process to contract with a new vendor, DMAS will implement the identified improvements and move the process towards a more user-friendly, paperless system.

Based on an analysis of historical payment information, it appears that payments for the services under review were lower in FY 2004 than they were in previous years. However, it is important to note that other policy, procedural, and medical use changes, in addition to the new prior authorization changes, may have affected the payment trends. Without a control group comparison methodology, which was not available for this study, the exact cost savings applicable to the changes to the service limits, cannot be stated with certainty.

APPENDIX A

Study Mandate

Item 322 J of the 2002-2004 Appropriation Act

The Department of Medical Assistance Services shall monitor the impact of all new prior authorization requirements implemented in the fee-for-service program for Family Access to Medical Insurance Security (FAMIS) and Medicaid services that take effect on or after July 1, 2003. The Department shall maintain data including the number of service denials, the number of prior authorization requests submitted, the number of requests approved and denied, the number of appeals from prior authorization denials, the outcome of those appeals, and all associated administrative costs. Such information shall be reported to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees on an annual basis. The first annual report for fiscal year 2004 shall be submitted no later than 45 days after the end of the fiscal year.

APENDIX B

Changes to Prior Authorization Requirements Mandated in the 2002-2004 Appropriation Act

Diagnostic Scans – Item 325 WW

The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to require prior authorization of the following specific high cost non-emergency outpatient procedures: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT) Scans, and Positron Emission Tomography (PET) Scans. The Department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

Home Health and Outpatient Rehabilitation – Item 325 DDD(1)

The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to limit to five visits without prior authorization home health and outpatient rehabilitation services within each fiscal year. Service extensions beyond the initial five visits must be prior authorized. School-based rehabilitation services shall not be subject to any prior authorization requirements. The Department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

Outpatient Psychiatric Services – Item 325 DDD(2)

The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to limit outpatient psychiatric services to five visits without prior authorization in the first year of service only. Service extensions beyond the initial five visits must be prior authorized as well as all service extensions in subsequent years. The Department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

APENDIX C

Provider Associations Invited to Focus Groups

Virginia Pediatric Society

Virginia Health Care Association

Virginia Hospital and Healthcare Association

Medical Society of Virginia

Virginia Academy of Family Physicians

Virginia Association of Community Service Boards

Psychiatric Society of Virginia

Virginia Academy of Clinical Psychologists

National Association of Social Workers – Virginia Chapter

Virginia Counselor's Association

Virginia Association of Clinical Counselors

Virginia Nurses Association

Virginia Coalition of Private Provider Associations

Speech-Language-Hearing Association of Virginia

Virginia Occupational Therapy Association

Virginia Physical Therapy Association

Virginia Association of Personal Care Providers

Virginia Association for Home Care