

April 11, 2024

Thank you for inviting me to testify today. I am speaking as a member of the Green Mountain Care Board's Primary Care Advisory Group (which I'll refer to as PCAG). We are a diverse group of 16 primary care providers from across the state, from private practices, FQHCs and hospital-owned practices. We are MDs and nurse practitioners, family physicians, pediatricians, and geriatricians. PCAG has made decreasing the burden of prior authorizations a priority since its inception in 2016. In my testimony today, I will be giving you specific examples from members of PCAG about the cost and harms caused by PAs. We urge you to support H.766, a bill that stands to improve multiple critical issues in primary care including patient access, patient outcomes, high cost, fragile primary care infrastructure, workforce shortage and professional burnout.

Insurance companies will tell you that they save money with PAs. But *they do so on the backs of already overburdened primary care practices. Where I work, at Wells River Clinic, part of Little Rivers Healthcare, we have one full-time staff member working solely on PAs for 4 providers. Estimates from other PCAG members are similar; 1 employee working on PAs for every 4- 6 providers. This is financially draining and decreases patient access to primary care. Think for a moment how we might be able to expand *meaningful* primary care services if our nurses could spend their time in actual patient care, such as regular calls to check on our frequent ED users, or education for newly diagnosed diabetics.

Prior authorizations cause real harm to patients. Some examples from PCAG members:

“I am currently caring for a 21-year-old with an unintended pregnancy which occurred when she missed several days of her birth control while waiting for a PA to come through.”

“I recently cared for a cancer patient who, due to bowel damage from radiation therapy, was unable to absorb oral pain medications, so she used a topical narcotic patch. During her terminal illness, there were two week-long delays in getting the PA for the patch. We were told that further clinical information was required, even though the rationale was clearly outlined in the office notes. We were told our faxes hadn't come through, even though they were documented as successfully sent in our system. We were told that the “appeals window” had expired and we had to reapply. Twice, her husband chose to pay hundreds of dollars out of pocket so that she could have end-of-life pain relief and avoid narcotic withdrawal.”

“A patient's insurance stopped covering her asthma inhaler, which had been working well. She had an adverse reaction to the new inhaler, progressive worsening of her asthma, and required hospitalization. Subsequently, multiple PAs for alternative inhalers were denied. The appeals rep wouldn't accept a verbal appeal and sent yet another form to fill out. We are still waiting for a response two weeks later”.

“I have an 11-year old patient with such severe behavioral problems that he cannot safely be in school without his medication. He’s had a remarkable sustained response to medication, which allows him to attend school and learn. His mother changed insurance, and they won’t cover the medication until he has *tried and failed two other medications*”. Think of the repercussions for this child, his education, his school, and his mother during this trial.

Prior Authorizations increase cost and decrease access to primary care. Insurers will tell you that PAs are done within 48 hours and call wait times are less than 8 minutes. If you are inclined to believe them, the members of PCAG invite you to spend a day in our clinics. Here are some of our experiences:

“We’re often told we’ll get a call back and don’t. This happened when the insurance company phone recording warned of one hour wait times. It has happened when we’ve scheduled peer-to-peer consults (the last step in the appeal process) with our providers”.

“Often the Insurance company provider on peer-to-peer calls hasn’t even read the clinical note outlining our rationale for the needed testing. We have filled out forms, faxed documentation and clinical notes, and the insurance company’s decision-maker hasn’t even looked at it.”

“Our staff has been on hold for an hour *simply to ask if a prior authorization is needed.*”

“When looking into a delay on a PA, we were told we’d faxed the appeal to the wrong number, even though it was the one on the denial form.”

Many PCAG members say they have sent patients to the ED and to specialists to get testing done. An example is a child with head trauma needing a head CT. Delay in PA caused the pediatrician to send the child to the ED.

Delays caused by PAs are common with antibiotic, cardiac and asthma meds, which are time-sensitive medications in preventing ED visits, hospitalizations, and patient harm.

Two PCAG members have had patients require hospitalization because of delays in getting home oxygen approved.

It’s important to point out that the PA process feels irrational and burdensome. It contributes to professional burn-out.

“PAs feel like a game of trying to use the correct language that the insurance company prefers”.

“Many denials are not about clinical judgement, but about technicalities in the ordering process that lead to initial denials and delay medical care”.

“The greatest frustration is that there is NO access to the actual criteria used to cover tests or medications! My staff will sometimes answer questions in all different ways on the on-line system to try to discover what might result in coverage!”

PCAG members report having specialists tell patients to ask their PCP to order certain tests that require PA, thus off-loading the PA burden onto primary care. A recent example is a cardiologist recommending sleep apnea testing but telling the patient to ask the PCP to order it. The PA burden then becomes unpaid work for the PCP.

“We had denial of 4 birth control prescriptions in a row for a 17-year-old patient. There was no list of covered birth control pills on the insurer’s website. We just had to keep putting in different prescriptions until one was covered”.

Even when system works as the insurers claim, with 8 minute call times and 48 hour turn-around, it is a nonstop administrative burden for our staffs. We understand that 90% of PAs ultimately are approved, which only adds to the absurdity of the workload.

The term moral injury is increasingly used in studies of provider burnout. It refers to the psychological toll of taking part in actions that go against the clinician’s morals and values. We know what our patients need and are unable to provide it. Practicing medicine in this setting contributes to provider burnout.

We know that you as legislators, you are well aware of the recurring issues in today’s challenging health care scene: patient access, patient outcomes, high cost, fragile primary care infrastructure, workforce shortage, and burnout. H.766 plays a role in addressing all of these. We urge you to provide your full support.

Many thanks for your attention today, and for your dedication to improving health care in Vermont.

Questions.

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Representing PCAG
04/11/24