State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

[Phone] 802-879-5900

Agency of Human Services

To: House Committee on Health Care

From: Sandi Hoffman, Deputy Commissioner, Department of Vermont Health Access

Date: January 24, 2024
Re: H.766 Testimony – Prior Authorization

As a result of legislation, the DVHA team embarked on a project with the objective to "take a methodical approach to reviewing the codes that require a prior authorization (PA) in order to be able to make data driven recommendations on where a PA is necessary and where we can remove the PA requirement in compliance with Bill H.960 and in alignment with our work with the ACO." That was the original objective for the workplan that was developed on the onset of the project. There were two deliverables identified:

1. To create a dynamic list of codes requiring prior authorization and a documented process for reviewing the list.

2. Provide findings & recommendations to a group of interested parties identified in the legislation regarding clinical prior authorization requirements in the Vermont Medicaid program on or before 09/31/21.

The team was originally comprised of members from the DVHA senior leadership, clinical, payment reform, and data teams. Other units were consulted as needed. Eventually, it became obvious that we needed input from the Special Investigations Unit so they joined the team. We set up a meeting frequency of 1 time every two weeks. We outlined a work plan that had the original 8 areas for review. These included:

1. High tech imaging
2. Pediatric PT/OT/ST (this evolved to include adults)
3. Out of Network Services (elective and non elective)
4. Imminent Harm Codes (including hysterectomies)
5. Chiropractic Care
6. Durable Medical Equipment/supplies
7. High Dollar services
8. Orthodontics

As I shared last week the team was asked to focus on opportunities to remove prior authorization, align requirements for ACO and non-ACO attributed members, and align

with other insurers where possible. In order to do this, we identified claims data that was needed, points where literature review was required, and where we wanted to bring in Subject matter experts (either internal or external) to provide information to the team. We also researched what other insurers were doing and outreached them when we didn't understand the rationale. There was an identified lead for each area that presented the information. The group members reviewed and/or researched information outside of the meeting times and came prepared to discuss and make decisions. It was very mission driven. The original project wrapped up in September of 2021 and culminated in a memo that was submitted in September.

The outcome of the original review was waiving of PA requirements for High tech imaging, aligning the number of PT/OT/ST services with other insurers which was 30 visits without PA. That reinstated PA requirements for ACO attributed members for therapies when it wasn't required before but raised the minimum number of visits without PA for members that were not attributed to the ACO. Putting the PA on was largely based on a much higher number of visits for ACO attributed members not needing PA and not in alignment with the clinical guidelines we reviewed, also without evidence of better outcomes. The Out of Network services review yielded a list of hospitals that would no longer be required to seek PA prior to treatment mainly to support access for members. These are hospitals that are close and frequently used by our members. The hysterectomy PA requirement was lifted and a standard operating procedure for imminent harm code review was established. Chiropractic Care visits were aligned with other insurers. DME PA requirements were lifted provided they didn't fall on the imminent harm code list and there was a recent review of limits in the system that is likely going to result in a reduction in claims suspension due to limits. A new high dollar review process was established with an increase in the dollar amount requiring review/PA. And Orthodontic PA was also waived.

The team continues to meet. Recently, we identified codes that still require PA for non-attributed members, and we are planning to review this quarter.

Again, as I said last week, this team is also responsible for monitoring ongoing utilization and reporting anomalies that don't have explanations to senior leadership, the SIU, and the CURB.