1/17/24

Testimony for House Committee for Healthcare- Payer Administrative Burden H.766 Prior Authorizations

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- Current Role (2.5 Years):
  - Oversee all negotiations for Commercial, Medicare Advantage and Managed Care Payers
  - Oversee day-to-day payer escalations: policy disputes, patient access concerns, prior authorization and utilization management concerns, etc.
  - Negotiate contracting of value based programs
- Background
  - Juris Doctorate, Western New England University School of Law (2007)
    - Focus on Contracting and Health Care Law
  - Prior Experience: VP of Strategy, Adirondacks ACO (1.5 years); Corporate Director Health Care Reform and Director of Contracting roles, BCBSVT (10 years), Defense Counsel, Ryan Smith and Carbine, Rutland VT (3 years).

Current Payer Prior Authorization Experience and Administrative Burden

- Number of Payers in VT: More than 20
- Network Volume of Payer Policy Changes: Estimated 2100 policy changes per year (40/week average) **(See Testimony to House Committee for Health Care 1.10.24 for summary of policy review process)**
- Current Environment
  - Nearly impossible to quantify the volume of changes as it varies by payer, by service, by Line of Business, by member benefit plan, and is constantly evolving.
    - Low estimate is a minimum of 5-20 code changes per payer per month, likely more on average (actual number of notices depends on payer format)
    - With 8 larger payers at 160 changes per month, we experience at least 1920 PA changes per year
  - Changes to policies are made throughout the month and with notices provided in various formats such as newsletter or individual notices per change.
  - Payers with authorization “grids” tend to make changes monthly– changes include additions and deletions, but those are often not highlighted on the new grid requiring manual review and confirmation through notices or alternative sources
  - Primary PA Focus Areas
    - Pharmacy Formularies – change at least annually if not more frequently (MVP changes almost monthly)
      - Step Therapy (pt must try Drug A and have documentation of not being able to use it before the insurance will authorize Drug B)

        - Preferred Drug changes – can cause a burden as sometimes patients have to change the medication they are taking, or appeal noting the new medication is not appropriate
        - New Drugs to Market – I understand we don't really have control over when the FDA approves something; but it still contributes to the burden
    - Durable Medical Equipment
    - Place of Service—limiting where members can go for services (ex. Infusion centers vs. outpatient clinics
    - Labs
    - Hospital Services (Infusion, Surgery, Cardiology, etc.)
  - PA's are often/can often be handled by 3rd party vendors (EviCore, Optum, etc.) – Each of which can have different forms/portals/etc.
  - Medicare Advantage PAs are a primary focus of CMS improving electronic access, improving timeliness, improving reporting and removing PA requirements.
- Prior Approval Experience
  - Payer response to prior approvals vary, at times more than 14 days, at times delaying care and causing rescheduling
  - Data is limited due to recent system-wide Epic Conversion and changing payer policies along with payer specific processes / reporting.
  - Of over 38k PAs submitted for outpatient clinics (diagnostics etc.) in 2022 the UVMMC approval rate was 99% (noting limited data)
  - PA staff must look up each payers rules through payer portals due to frequency of changes
  - "Gold Carding", or limited PA waivers, are not successful due to limited nature and very specific application.
- Potential Future Improvements
  - Consistent response time frames support patient access and allow for streamlined processes
  - Consistent payer reporting of PA lists allowing for process automation
  - Limit PAs to high-cost services and potentially align with CMS