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AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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H.766 DVHA Testimony: Prior Authorizations

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Hi, thanks for having me. For the record, I am Sandi Hoffman, the Deputy Commissioner at the Department of Vermont Health Access.

I appreciate the opportunity to talk with you about the DVHA practice. I also think the delay is great because the CMS Interoperability and Prior Authorization Final Rule came out yesterday. I want to give some high points of that and talk about the cultural shift at DVHA regarding prior authorization.

There are two main parts to the final rule.

1. **It requires Medicaid agencies to implement and maintain application programming interfaces (APIs) to improve the electronic exchange of health care data by 1/1/27.**
2. **Also it requires API to permit electronic prior authorization processes for medical services by 1/1/27 (does NOT apply to drugs). This would increase information sharing reducing additional administrative burden for providers pertaining to Prior authorization.**

This to say that they are improvements coming and there are federal requirements for PA turn around time for Medicaid.

As I said before there has been a cultural shift at DVHA regarding prior authorizations. In January of 2021, in response to legislation, a multi -unit work group was established to assess the prior authorization requirements. The group was asked to focus on opportunities to:

1. Remove prior authorization;
2. Align requirements for ACO and non-ACO attributed members; and
3. Align with other insurers where possible.

The public health emergency and the DVHA response to it also provided us with data to consider when evaluating the need for PA. For example, we removed the PA requirement for

imaging, dental, and DME in response to the PHE. We tracked utilization patterns absent the PA requirement and saw there was little shift in utilization. We continued to monitor the utilization trend. That data informed our decision to make permanent the suspension of PA for DME, most dental services, and imaging.

The PA work group meets every other week. The first nine months focused on the review of many different discipline's with PA requirements, some of the services reviewed includes Occupational Therapy, Physical Therapy, Speech Therapy, Chiropractic Care, Hysterectomies, and others. The initial review and determinations were included in the report Sebastian referenced yesterday. I will say that we did align ACO and Non ACO attributed members and aligned with other payors when possible.

The team identified opportunities for monitoring to ensure there were no sudden inexplicable upticks. Part of this strategy was to address concerns identified by our Special Investigations unit and the Clinical Utilization Review Board both consulted during the process. We continue to monitor and report out on the findings.

The team also reviews services regularly to determine the continued need for PA. We do have an imminent harm code list that is updated annually. That list requires PA for all members regardless of ACO status due to the potential of harm to the member.

We also look at limits to services. For example, this year we increased the 25 per year out-patient mental health visit limit to 260. We haven't seen the use at that level but appreciate the potential need and want to support members in the community when clinically indicated.

We also work with our partners to identify opportunities for removal of PA based on specialty, access issues, and high approval rating.

Another practice the DVHA has employed is reviewing the exception and appeals data to ascertain whether additional services should be covered with or without authorization. When we see patterns, we do a clinical review and present the findings to a Multi-disciplinary team that also meets bi-weekly. That team considers the federal requirements, system challenges, integrity risks, coding challenges etc. Recommendations are then submitted to DVHA leadership or the CURB when appropriate.

All of this is just to show that we are committed to reducing provider burden. Again, the cultural shift has our team trusting that the provider knows what is best for the member. We want to support that relationship, AND we have federal requirements that we must adhere to.

As far as PA turnaround time… we adhere to the federal requirements always but also have internal goals. We have Scorecards that show what the turnaround time is, those are recorded quarterly. The time has dropped significantly. In prior years there was a delay in authorization completion because we did everything we could to get to yes. Our clinical team has worked with providers to improve submissions to avoid repeated attempts at approval. That improvement is demonstrated in the scorecards.

Our Pharmacy turnaround time is less than 4 hours 100% of the time and the average time for authorization is 51 minutes. There was testimony yesterday regarding being on hold for hours. I want to assure you that we have service level agreements with our Pharmacy Benefit Manager that requires all calls in the hold queue to be answered within 60 seconds 93% of the time. There also has to be a 5% or less abandonment rate on calls.

PA is important in the Pharmacy world because it allows us to maintain a Preferred Drug List which then allows for the negotiation of supplemental rebates (about 24 million dollars in 2023).

Finally, The DVHA team is exploring an option for electronic submission via the provider portal which we hope will be easier for our providers. It would also likely reduce delays due to required fields within the current antiquated system. Again, the CMS rule that was released yesterday requires interoperability.

Hopefully, that addresses the questions raised yesterday.