Chairwoman Black and committee members, thank you for the opportunity to speak with you today.

I am Dr. Wyll Everett. I am a family physician and hospitalist at Grace Cottage Family Health & Hospital, the rural health clinic and critical access hospital in Townshend, VT. I currently serve at the Medical Director of the clinic and Medical Staff president. Also, I am the president elect for the Vermont chapter of the academy of family physicians.

To my understanding, I have been asked to comment on Section 11 of H.585 to provide further context about prior authorizations and the possible impact of the suggested verbiage in the bill. This is something, unfortunately, with which all primary care providers have too much experience.

The definition of prior authorization is fairly straightforward, an insurance company states that before they approve/commit to paying for a service they need some further evidence that the service is warranted. Given the ubiquity of this, it has become standard practice that a healthcare entity will ensure this step is completed before actually offering the service in order to avoid passing the cost to the patient and running a much greater risk of not being reimbursed. While in principle, this relatively straightforward practice does make some amount of sense, the numerous services that prior authorizations are applied to make the administrative burden enormous and the design of the system consistently leads to delays in care. For perspective, a recent KFF poll (KFF Health Tracking Poll: Prior Authorizations Rank as Public's Biggest Burden When Getting Health Care | KFF) showed that 47% of insured adults had a delay in or denial of a medication/service/treatment in the past two years. And 69% of insured adults find that prior authorizations are at least some amount of a burden – greater than any other aspect reported.

This legislation specifically refers to prior authorizations for procedures and imaging studies so I will focus my examples here.

Recently, I had the opportunity to see a woman in her 50s who, a few days before, found herself on the ground, seemingly having passed out. She has no history of heart, metabolic, or neurologic disease that would have obviously caused this. She found the experience odd, but given that she felt completely normal when she got up she did not feel that she needed to be evaluated emergently. When she saw me a couple days later we reviewed her experience, what she was feeling before and after. There were no signs of any active disease process and no recurrence of her symptoms. While the examination was reassuring, it was still quite concerning that a healthy woman suddenly collapsed without explanation. There was significant concern that she was experiencing a heart arrhythmia (abnormal rhythm of the heart) that when active, seemingly without symptoms or a trigger,

caused her to pass out. We obtained an EKG in the office, 10 seconds of heart monitoring. It was unsurprisingly normal, she wasn't having symptoms at the time. What would be most helpful would be a Zio patch – a sticker that goes on someone's chest and sits there for 14 days, constantly monitoring someone's heart rhythm. We usually have a number of them sitting down the hall from my office. Patient was in full agreement given the episode and family history of heart disease. But, this test required a prior authorization per her insurance. So instead of simply walking down the hall and applying the sticker, we then had to send the order to the insurance company with the associated reasoning and wait for a response. Depending on the insurance company this can take days to get back to us. This patient with potential for recurrent symptoms would be left without monitoring for days waiting for the test to be approved. Of note with this case, like many in our community, she has to take off work to come to the office creating significant logistical and financial stress. She ended up having to return 4 days later, again missing part of a work day, to have the Zio patch placed.

It is also quite common for my patients to arrive to the office with abdominal pain. This can vary greatly, but about a month ago I saw Mike. He came in with his wife for 2 days of significantly developing lower abdominal pain to the point that he wasn't really hungry anymore. He didn't have a fever or any other signs of illness. He had no history of abdominal surgeries. His vital signs were perfectly normal. The only abnormal findings were that that he looked quite uncomfortable and when I pressed my hand into his right lower abdomen and let go abruptly, he exclaimed with pain. This is called rebound tenderness. And it made me quite concerned that he had an active infection in his belly. Though abdominal pain can be tricky and many less concerning things could be occurring. The way we clarify that is with a CT scan. What I love about working at a small hospital based practice is that up one flight of stairs from the clinic there is access to, what most of us consider, basic medical tools including a CT scanner. If I was working in a different setting that did not have access to this testing in my facility or in close enough proximity then I would have to send the patient to the emergency room. Instead, I walked down the hall to our patient care coordinator's office and reviewed the situation. They opened up the online portal for the patient's insurance and within minutes of inputting the relevant information the prior authorization needed was obtained. We gave Mike a ride upstairs. I got a call from a radiologist 30 minutes later that Mike had appendicitis which I then relayed to a local surgeon and Mike's care was coordinated safely and appropriately in a timely manner without him having to have a prolonged stay in an ED that would have required ambulance transfer to a facility with a surgeon and the cost associated with such.

To me, this emphasizes the role of prior authorization as a simple administrative burden. There was no thorough review of the medical record or suggestion of other

treatment/evaluation options. A box was checked that the correct code for “abdominal pain” was clicked and then we could proceed. In this case it happened to be fast. In other cases, it’s not.

Mike’s example also illustrates the financial burden on healthcare entities to engage in the prior authorization process. Very few providers that I am aware of actually engage in this process themselves (meaning the processing of the paperwork) unless a final verbal appeal with a “medical specialist” with the insurance company is needed. Administrative staff are hired to do this. For perspective our clinic of less than 10 FTE has one full time prior auth specialist for medications and 2 full time patient care coordinators that process referrals and do the prior authorizations for procedures and imaging studies. Imagine scaling this administrative need and cost to a larger practice or hospital.

I appreciate the verbiage in H.585 limiting prior authorization exemptions to independent practices hopefully with the goal to minimize all administrative burdens to smaller, perhaps less resourced practices. But, in my opinion, it is missing an opportunity to allow all Vermonters to access timely testing and treatment no matter where they happen to access care. Grace Cottage is a hospital-based practice and we are in the middle of nowhere. We are the resource in the area. With the numerous barriers to transportation in our state, many Vermonters don’t have the opportunity or ability to shop around for healthcare based on price or any other factor - even if this was available. Also, many would not want to. The notion of a medical home and continuity of care is important to many in our communities and often they feel very strongly about keeping their care local.

Reducing the prior authorization burden for all practices, including hospital-based practices, only reduces the administrative burden and costs for a clinic or hospital and increases the efficiency of appropriate medical care. There are multiple avenues being explored in our state to minimize the administrative costs of healthcare and to improve access, accessibility, and timeliness of care. Minimizing prior authorizations is a clear opportunity to further these goals.

Thank you for your time today.

In response to the follow-up question at the time of testimony:

I apologize I do not remember which representative asked the question. But just to try to clearly state my attempted response…I believe the concern brought to the committee in separate testimony was a concern that specialists in a hospital-based practice would shunt orders for testing and imaging through primary care in order to avoid the prior authorization process. I do appreciate this as a theoretical concern. To my knowledge, as the system currently stands, if the specialist is the ordering provider then the prior authorization exemption would not be possible as they are not PCPs – no matter which administrative staff help with the process. How this would theoretically work is that a patient would see a specialist, the specialist would create a care plan and then notify the PCP of what testing needed to be ordered. The PCP would then order the tests and which would "avoid" the prior authorization process. This would be distinct deviation from the standard of care. First, the PCP is not the one doing the clinical assessment and creating the care plan and therefore it would not be clinically appropriate for them to be responsible for the results of said testing and how those results affect the treatment plan. Second, to my knowledge, it would not be appropriate on the administrative side for staff to change the name of the ordering provider to, say, the PCP. Third, a major goal of reducing the prior authorization burden is to provide timely care. If a specialist sends me a message about ordering studies/testing, this would go to my digital inbox along with all patient results, patient messages, other updates about prior authorizations, medication requests. For many PCPs, we are usually about a day (or more) "behind" on these messages and results because we spend our business hours providing direct patient care – think about how long your PCP takes to respond to a message or lab result. Inherently, this would lead to the same delay in scheduling that already occurs with prior authorizations and therefore not achieve the goal of providing timely testing and care.

This is why I, perhaps, felt stuck with the question because I cannot see any version of a clear or expedited workflow that would actually be able to be implemented in our medical system.

To round out a summary point, many rural areas of out state rely on hospital-based practices for their care because we are the only feasible option for numerous factors. If the verbiage about excluding hospital-based practices persists, my patients with commercial

insurances will have delays in their care, as outlined above, for the simple fact that they happen to live in this small valley.