Prior Authorization Attestation Form (2023)

Under 18 V.S.A. § 9418b(h), a health plan shall review prior authorizations (PA) at least annually and eliminate PA requirements for those procedures and tests for which such a requirement is no longer justified or for which requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality or reduce health care spending to a degree sufficient to justify the administrative costs to the plan. A health plan shall attest to the Department of Financial Regulation (DFR) and the Green Mountain Care Board (GMCB) annually on or before September 15 that it has completed the review and appropriate elimination of PA requirements.

To comply with the attestation requirements outlined in 18 V.S.A. § 9418b(h), health plans shall complete the below form and submit it to DFR and GMCB on or before September 15, 2023.

To the extent that a health plan believes that materials requested herein are exempt from public disclosure as a "trade secret" under 1 V.S.A. § 317(c)(9), the plan must request confidentiality prior to submission. Submitted materials will not be exempt from public disclosure unless DFR and GMCB advise in writing that the materials meet the requirements for a trade secret.

Contact information:

- Sebastian Arduengo—Department of Financial Regulation (Sebastian.Arduengo@vermont.gov);
- Julia Boles—Green Mountain Care Board (Julia.Boles@vermont.gov).

Questions:

The below questions apply to health plans as defined in 18 V.S.A. 9418(a)(8) (including third party administrators, to the extent permitted under federal law):

1. Has the health plan reviewed the list of medical procedures and medical tests for which it requires prior authorization (PA) at least once during the proceeding plan year and eliminated the PA requirements for procedures and tests for which such a requirement is no longer justified or for which requests are routinely approved with such frequency as to demonstrate that the PA requirement does not promote health care quality or reduce health care spending to a degree sufficient to justify the administrative costs to the plan?
    a. What is the health plan's timeline for reviewing and eliminating prior authorization requirements? In answering this question, please provide the dates for the two most recent review cycles.
    b. Does the health plan ever add/eliminate PA requirements during a plan year (as opposed to between plan years)? Please explain.
    c. What are the standards used by the health plan to evaluate PA requirements as outlined in 18 V.S.A. § 9418b(h) (including the thresholds the health plan considers in looking for routinely approved PAs, how the health plan determines whether PAs are promoting health care quality or reducing health care spending to a degree sufficient to justify the administrative costs to the plan)?
    d. Does the health plan take into account the administrative burden of PAs on health care providers and patients and whether the administrative barriers to submit PAs may inhibit access to medically necessary care? Please explain.
2. What medical procedures and tests had PA requirements eliminated or added during the preceding plan year and what was the rationale for changing those requirements?
3. What are the ten most requested PAs for **both** medical PAs and prescription drug PAs (20 total) during the preceding plan year? For each of the 20 PAs, please provide the number of PAs requested and approval rate for each PA (PAs in this list may overlap with eliminated PAs identified in question 2).
4. What percentage of urgent and non-urgent PA requests are granted because processing time exceeded the statutory timeframes established under 18 V.S.A. § 9418b(g)(4)?