NEHI Network for Excellence in Health Innovation

How Can California Improve the Prior Authorization Process?

California Health Care Foundation &
Network For Excellence In Health Innovation

December 11, 2024 | 11 AM – 12 PM PT

Agenda

11:05 AM – 11:20 AM	Overview of NEHI project findings
11:20 AM – 11:30 AM	Abbreviated overview of recent prior authorization efforts
11:30 AM – 11:55 PM	Q&A
11:55 AM – 12:00 PM	Closing remarks

Lauren Bedel, MPH

Associate Director, Business Development & Data Governance

Massachusetts Health Data Consortium

Kristof Stremikis, MPP, MPH

Director, Market Analysis and Insight

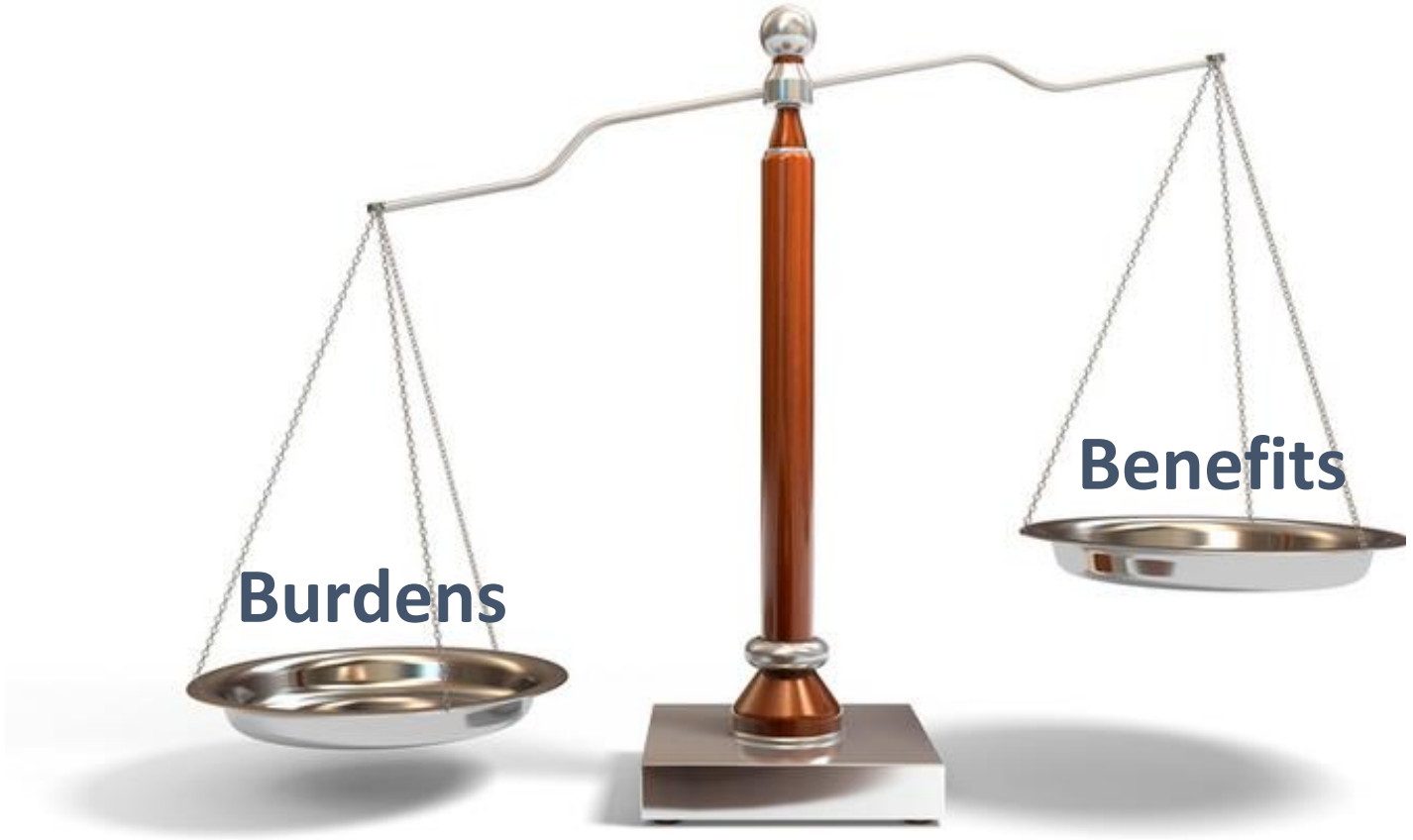
California Health Care Foundation

Wendy Warring, JD

President & CEO

Network for Excellence in Health Innovation

The burdens of prior authorization are increasing, despite its benefits



The Balance…

Benefits:

- Ensures care is medically necessary & safe
- Confirms care is covered & delivered in the right setting

Burdens:

- Delays patient care in certain cases
- Increases payers' & providers' costs and time
- Places financial risk on the provider and patient
- Varies by payer and difficult to evaluate

Primary PA issues flagged by CA stakeholders

- Lack of info on prior authorization (PA) requirements at point of care adds to the cost of PA for providers and payers
- Standard outcomes measures for PA processes are not shared publicly or at actionable levels
- Repeat PAs and concurrent reviews during a prescribed course of treatment can interrupt care and expose consumers to financial liability without altering the treatment course
- PA requirements are not well understood by patients and providers, resulting in the perception that there are ‘too many’
- Providers and patients perceive that medical necessity determinations for certain types of complex care are made by health care professionals without the requisite expertise

Certain reforms emerged as priorities

1

Move quickly to **scale automation** beyond payers subject to the Federal Rule by mandating technical requirements

2

Refine **public reporting requirements** to promote trust, accountability, and enable evaluation of reforms

3

Extend the **duration and scope of prior authorization approvals** for ongoing care with a defined and professionally recognized course of treatment

4

Develop **transparent principles for the annual review** of prior authorization requirements

CMS and Congress are tackling some of these issues

- In January 2024, the Centers for Medicare & Medicaid Services (CMS) finalized a rule that requires public payers—excluding Medicare Fee-for-Service—to:
  - Automate the end-to-end prior authorization process between payers and providers by implementing a Health Level 7 FHIR (Fast Healthcare Interoperability Resource) Prior Authorization API (application programming interface)
  - Beginning primarily in 2026, meet certain decision time frames for requests for prior authorization (complementing Medicare Advantage (MA) requirements finalized in CY 2024)
  - Include the reason for a decision denying an authorization request
  - Publicly report certain prior authorization metrics annually

- Congress has proposed bipartisan legislation to enshrine such rules into law governing Medicare Advantage plans. Key provisions of the Seniors' Timely Access to Care Act of 2024:
  - Require MA plans to establish an electronic prior authorization program consistent with the Federal Rule (both standardized processes for transactions and clinical attachments as well as decision time frames)
  - Improve transparency around prior authorization for patients and providers through submissions of information to the Secretary of the US Department of Health and Human Services, which must be published and include rates of requests, denials, appeals, denials overturned, resolution times, and the technology used to make determinations (such as AI)

States are actively pursuing reforms along these lines, among others (though no. 4 is novel)

1

Move quickly to **scale automation** beyond payers subject to the Federal Rule by mandating technical requirements

- WA; VA (pending)

2

Refine **public reporting requirements** to promote trust, accountability, and enable evaluation of reforms

- AR, DC, IN, MN, NJ, ND, OH, TN, TX

3

Extend the **duration and scope of prior authorization approvals** for ongoing care with a defined and professionally recognized course of treatment

- MN, DE, GA, IL, KY, VT

4

Develop **transparent principles for the annual review** of prior authorization requirements

California has targeted prior authorization reforms in several areas

Process Improvements	• Standardized response time frames • Standardized ePA form for prescription drugs • Requires use of recognized medical necessity criteria for behavioral health services across payers • Prohibits prior authorization for certain services • *Automation (failed)*
Process Integrity	• Requires annual medical necessity updates and review • Mandates sharing reasons for denials
Provider & System Performance	• *Gold-carding (failed)*

And payers are removing some prior authorization requirements while testing health IT vendor solutions

	**Blue Shield of California** and **Salesforce** have partnered to **automate the prior authorization process** using HL7 FHIR standards	Testing begins early 2025 All providers can take advantage of near real-time prior authorization in January 2026
	**Humana** initially partnered with **Cohere Health** in 2021 to pilot an **automated prior authorization process for musculoskeletal (MSK) care** across 12 states	Processed 95% of authorizations with median approval time of zero (0) min Expanded usage to all states for commercial and Medicare enrollees in 2022 Announced in 2024 the partnership will expand to include diagnostic imaging and sleep services
	**Massachusetts Health Data Consortium** (home to the **New England Healthcare Exchange Network**) is developing a cost-effective, collaborative, open standards-based data exchange network to **automate prior authorization and quality measurements** among Massachusetts providers and payers	Participant implementation begins January 2, 2025

The Rationale for Our Recommendations

NEHI Network for Excellence in Health Innovation

What does automation look like?

01

Provider decides on an order/ treatment/etc.

02

Prior authorization & coverage requirements automatically shared between Payer & Provider systems

03

Payer gathers information for the prior authorization request from the Provider's EMR

04

Provider has the opportunity to review the data that was automatically pulled from the EMR

05

Payer/Intermediary processes request & Payer sends decision

06

(Possible) Payer requests additional info/documents from Provider

1 A statewide mandate to automate the prior authorization process is feasible! It would coordinate and accelerate the automation impact across all business lines

- Provides an opportunity to make adjustments and improvements to a statewide technical implementation framework
- Ensures standardization throughout the implementation and authorization processes
- Fosters collaboration among payers and providers with different resources/capabilities to automate

2 Mandating public data on the prior authorization process provides critical insight into its efficacy and efficiency

- Requiring public data on prior authorization could answer questions like, **‘How well does the process work?’ ‘Where are additional reforms needed?’** and **‘Which reforms are likely to succeed?’**
- California would have an opportunity to identify additional reporting requirements that provide insight into stakeholder interests, such as:
  - Prevalence and impact of denials, especially for:
    - Well-established care pathways
    - Behavioral health and substance use disorder care
    - Generic and low-cost prescriptions
  - Step therapy requirements for chronic conditions
  - UM reviewers’ credentials
  - Costs associated with prior authorization

◊ **Coupling this reform effort with automation would also reduce reporting burden**

3

Extending the duration of an approval would ameliorate one of the most irritating issues for providers and patients

- California could consider extending:
  - **The period for which an authorization is effective for conditions with well-defined courses of treatment**
    - **Washington DC** requires that prior authorizations are valid for as long as medically reasonable and necessary to avoid disruptions in care
    - **Minnesota** recently passed legislation that will extend authorizations for chronic care treatment (i.e., no expiration as long as the therapy remains consistent)
  - **The period for which an authorization is effective during insurance transitions**
    - **Medi-Cal** permits members with an active authorization who are transitioning from a FFS to a managed care plan to continue treatment for 90 days under the new plan
  - **The scope of a prior authorization approval for a group of codes**

- California could monitor impact through sporadic audits

4 Sharing principles for the annual review of prior authorization requirements will reduce variation in prior authorization requirements among payers and enhance trust

- CA payers claim to review their prior authorization requirements at least annually, though there is significant variation in payers' prior authorization requirements
- Publishing high-level criteria/principles for review could:
  - Reduce variation in prior authorization requirements across payers
  - Increase trust and transparency in the review process among provider and consumer stakeholders
  - Provide regulators and other stakeholders insight into the utility of the review process