Frequently Asked Questions
Prior Authorization

Why can't doctors just make the decisions about patient care – don't they know the appropriate treatment for patients?
Prior authorization is not intended to replace a physician's decision-making about a patient's care. Rather, prior authorization is used to ensure that services and procedures ordered by a provider will be covered by the health plan consistent with their terms and conditions. Prior authorization assists providers in providing evidence based alternatives or directing patients to lower cost sites of care. Since most providers are paid under fee for service and are rewarded financially for every test and procedure ordered, employers buy health insurance policies with managed care components including prior authorization as a way to ensure that providers will deliver the authorization to further this goal.

Prior authorization is part of a broader medical management strategy that includes offering providers evidence-based resources, comparisons to their peers, and incentives to provide value based care. Studies have shown that it takes, on average, seventeen years for the results of clinical trials to become standard practice. Since health plans are statutorily required to remain up to date on the most recent peer reviewed evidence based studies, condition specific and service specific public clinical guidelines, and federal studies or guidelines in establishing their prior authorization programs, these tools are valuable in guiding providers to the most effective treatment.

What about providers whose prior authorization requests are approved 95% of the time? Or services for which prior authorizations are approved 95% of time? What's the need for prior authorization in these instances?
There's no magic percentage of provider or service approval rates that changes the need for prior authorization to ensure that patients are receiving the right care, in the right setting. Where prior authorization has been lifted at a set percentage of approvals – like 90 or 95% - health plans have observed provider performance slipping once the provider has gold card status. The Milliman study quantifies this as the "sentinel effect." In addition, performance typically varies across services, so it is difficult to grant gold card status to a provider across all services. Granting gold card status at the practice or clinical group level is also particularly challenging, as providers within the same clinic often perform differently. Finally, without an incentive to manage the costs of care, providers are unlikely and often unable to identify the most cost-effective course of treatment for a patient.

Health plans have found some success in delegating prior authorization to high-performing providers that take significant downside risk, with robust audit mechanisms to ensure patient safety, provider best practice, and cost-effectiveness.

Providers claim that health plan prior authorization requirements are opaque. How can they find information about what services, treatments, and medications are subject to prior authorization?

In Massachusetts, health plans are required to post their prior authorization requirements on the health plan website under Chapter 176O. While health plans are not required to disclose licensed, proprietary criteria publicly on their websites, they must disclose the criteria relevant to particular services or treatments upon request. In addition to public facing materials, providers are also issued comprehensive materials outlining prior authorization requirements upon contracting with the plan, which are updated regularly as requirements change, and have access to all materials via their provider portal.

Recently several national payers announced significant reductions in prior authorization. If they are able to reduce prior authorization, why was it necessary in the first place?
Health plans regularly review the services, treatments, and medications subject to prior authorization with input and guidance from experts, including local physicians and in-network physicians practicing in the same field. Individual plan decisions to reduce the number of services subject to prior authorization are based on updated clinical practice guidelines, practice patterns of network providers, and the member population served, as well as negotiated prices for high cost medications and treatments.

Why is prior authorization required for generic drugs? Aren't generic drugs cheaper and proven to be safe?
Whether a drug is generic or branded does not impact clinical or safety indications associated with prescribing the drug. Where a health plan would conduct prior authorization for clinical reasons for the branded drug, the same prior authorization would apply to the generic. Some examples include polypharmacy, preventing drug to drug interactions, acting in accordance with FDA guidelines, or when a drug is prescribed for off-label use.

In addition, generic drugs are not always the most cost-effective choice. There are many instances where a health plan would prefer a brand name drug over its generic equivalent because the net cost of the brand name drug adjusted for rebates is lower than the net cost of the generic equivalent, resulting in savings for the premium payer. This often occurs when a branded drug newly loses patent exclusivity and generics come onto the market – the drug company will rebate its branded version significantly to make it the lowest net cost option, to avoid competition or the uptake of generics.

Does prior authorization impact equitable access to care?
Through utilization management tools like prior authorization, health plans help to ensure equitable access to care for patients at a cost they can afford. Managed care tools, specifically prescription drug prior authorization helps to promote appropriate, safe, and cost-effective use of medications. In fact, these tools allow health plans to reduce the health care costs consumers bear through generic and therapeutic substitution of commonly prescribed drugs. Prior authorization requirements, written in accordance with the latest clinical guidelines and evidence-based medicine, are utilized by health plans to ensure all patients have access to safe, quality care with improved health outcomes. While falsely associated with delays in care, prior authorization allows health plans to ensure all patients receive the right care at the right time, in the right setting, as providers care can often differ by site of care.

One of the primary complaints from providers is the length of time it takes for a health plan to respond to a prior authorization request. What are health plans doing to fix this?
In Massachusetts, fully insured commercial health plans are required to respond to a completed prior authorization request within 2 business days. In MassHealth, the turnaround time for a prior authorization request is 14-20 business days. In Medicare, the turnaround time is 14 business days for an initial request and 20 business days for a resubmitted request. There is a pending rule at the federal

level that would change the turnaround time to 72 hours for expedited requests and 7 business days for a standard non-urgent request.

Given capacity challenges voiced by post-acute care facilities and hospitals, wouldn't lifting prior authorization for discharges to post-acute care permanently be beneficial?
The experience of health plans in the 3 month period during which PA was waived for admissions from acute care hospitals to post-acute care facilities raises serious concerns about the impact of waiver PA on members' care and health care spending. One plan found that waiving PA increased overall admission to post-acute care facilities by 14%, increased use of non-participating providers by 50%, and resulted in an inordinate number of members who were admitted to inappropriate levels of care because of the PA waiver. Another plan found that 22% of members were inappropriately discharged to a SNF because of the PA waiver. Both plans indicated increased spending as a result – up to $2M. For members with complex medical and behavioral health needs, inappropriate placement can prolong inpatient care and exacerbate existing conditions.

What have health plans done to address provider concerns about prior authorization and administrative burden?
MAHP and our member plans recognize that while prior authorization is critical, the process can be burdensome to patients, providers, and to health plans when outdated, manual, or paper-based systems are utilized. That is why Massachusetts health plans have standardized prior authorization requirements for all behavioral health care, prescription drug, imaging and radiology prior authorizations in the fully insured market. Health plans also regularly review and update the scope of services subject to prior authorization, on an annual or more frequent basis. And as technology has advanced, health plans are at the forefront, exploring opportunities to advance automation of prior authorization, in collaboration with the Network for Excellence in Health Innovation (NEHI) and with the state's Health Policy Commission. These efforts will address many of the burdens associated with today's manual processes and provide greater transparency into the efficacy and value of prior authorization programs.