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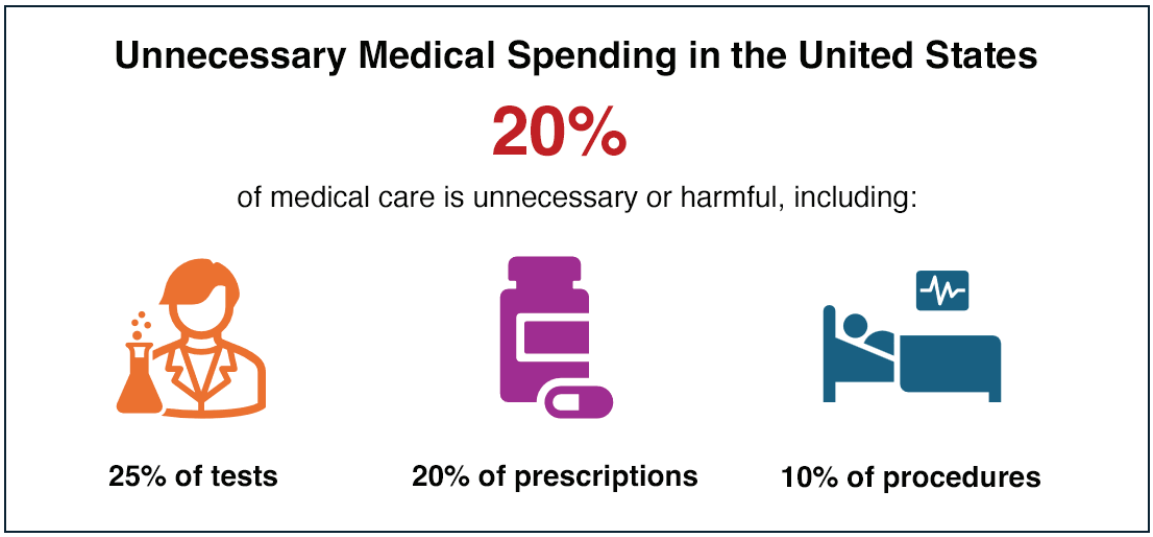
Prior Authorization: Right Care, Right Place, Right Time

In 2023, the Commonwealth Fund's Scorecard on State Health System Performance ranked Massachusetts the seventh worst-performing state on "avoidable use and costs."[1] While the primary driver of health care costs in Massachusetts is unit price, unnecessary utilization of health care services, including those deemed to be avoidable, also drives excess medical spending. The overprovision of health care services and treatments is often the result of variation in care delivery, driven largely by financial self-interest, the influence of the pharmaceutical and medical device industries, and fear of malpractice litigation.[2] Physicians themselves report that more than 20% of medical care is not needed, including about a quarter of tests, more than a fifth of prescriptions, and more than a tenth of procedures.[3]



The provision of these services is often referred to as "low-value care," or care that, according to the best available evidence, provides little to no benefit to patients, is likely to cause more harm than benefit, and is too costly given its benefits.[4] The American Board of Internal Medicine's Choosing Wisely initiative, launched in 2012, produced a list of more than 550 services that fall under this definition. In some instances, an initial low-value screening or test can cause a chain reaction, or a "cascade of care," which results in ill-advised tests or treatments that may cause avoidable adverse effects and/or morbidity. Indeed, a 2019 survey of physicians in the U.S. found that 398 out of 400, or 99.5%, of the physicians surveyed have seen cascades of care following incidental findings that did not lead to clinically meaningful outcomes, yet caused harm to patients.[5]

But unnecessary care isn't just costly, it can be harmful to patients. Exposure to unnecessary radiation, missed diagnoses and false positives, and ineffective procedures and treatments can have a profound impact on patients.[6] A study from Johns Hopkins suggests that medical errors, including "unwarranted variation in physician practice patterns that lack accountability," are now the third leading cause of death in the United States.[7]

As health care costs continue to rise and new medications, services, and treatments are increasingly marketed to consumers, patients are more vulnerable than ever to inappropriate or ineffective care, services, and treatment. This policy brief explains the critical role that health plan prior authorization processes play in ensuring members receive the right care in the right setting at the right time.

What Is Prior Authorization?

Prior authorization is a process whereby a provider, on behalf of their patient, requests confirmation from the patient's health plan that provision of a service, treatment, or medication is covered by the health plan. This ensures patients have access to safe, clinically appropriate, evidence-based care by preapproving services, catching unsafe or low-value care that is inconsistent with clinical evidence before it occurs, and directing patients to lower-cost alternatives where appropriate. Prior authorization is one example of a range of evidence-based medical management tools adopted by government programs like Medicare and Medicaid as well as health plans to ensure that patients receive optimal care based on well-established evidence of efficacy and safety.

Prior Authorization

Is...	Is not...
✓ Based on nationally and locally recognized standards of care	× Based on arbitrary standards that frequently change
✓ Comprised of policies that are regularly reviewed by providers and health plans to ensure adherence to up-to-date, evidence-based guidelines	× Made up of outdated or rarely reviewed policies
✓ Conducted by experts with commensurate licensure	× Conducted by non-experts or unlicensed customer service agents
✓ Required for a limited number of services	× Required for all covered benefits
✓ Designed to maximize patient safety and quality care	× Designed to deny care

How Do Health Plans Decide What Services Require Prior Authorization?

Health plans and government programs like Medicare and Medicaid utilize prior authorization for a limited set of health care services, most often for treatments, tests, or prescription drugs that are high risk and/or high cost in order to ensure patient safety and avoid unnecessary treatment. Health plans look at data on variation, adherence to evidence-based medicine, safety concerns, and other relevant factors to decide what services should be subject to prior authorization. State law requires health plans to develop the medical necessity guidelines used for prior authorization decisions with input from practicing physicians and participating providers in the health plan's service area.[8]

Any changes to prior authorization policies are informed by the latest peer-reviewed literature, guidelines, or studies from federal agencies like the Centers for Medicare & Medicaid Services (CMS) or the Centers for Disease Control and Prevention, condition-specific and service-specific public clinical guidelines, and the health plan's internal data on utilization. When changes are recommended based on new evidence, adherence to recognized standards of care, or in the case of new and emerging therapies, limited available evidence or safety concerns, they are done so through Medical Policy Committees and Pharmacy and Therapeutics Committees with relevant clinical expertise.

What percentage of covered benefits are subject to prior authorization?

5% of behavioral health

25% of prescription drugs

Benefits requiring prior authorization range from a low of 5% of behavioral health services to a high of 25% of prescription drugs.

What are the Top 3 Reasons for Prior Authorization Denials?

Missing medical necessity information or incomplete request

Experimental, investigational, or unproven treatment

Not a covered benefit

On at least an annual basis, health plans conduct a comprehensive review of their prior authorization policies, including review of the full list of medical services and prescription drugs subject to prior authorization, in order to identify therapies that no longer warrant prior authorization due to things like low variation in utilization or updates to standards of care. The annual review process also helps identify services, including new and emerging therapies, where the evidence basis for effectiveness is incomplete or there are safety concerns.

Low-Value Care in Massachusetts
The Health Policy Commission Weighs In

The Health Policy Commission (HPC) first examined the cost impact of low-value care in its 2018 *Health Care Cost Trends Report*, selecting 19 measures of low-value care identifiable in the Massachusetts All-Payer Claims Database.

The HPC found that more than 20% of patients received at least one instance of low-value care, with patients bearing nearly 15% of the unnecessary spending—**close to $12 million**—in the form of higher out-of-pocket costs. In total, there were nearly 800,000 low-value services identified over the study time period, accounting for nearly **$80 million in health care spending**.[9]

The following year, the HPC refined its study of low-value care to focus on seven measures across three domains (screening, preoperative, and procedure) and to identify variation in provision of low-value care services by provider organization. The HPC identified $13 million in unnecessary health care spending across more than 100,000 patients in a single year and found substantial variations across organizations in provision of these low-value services.[10]

How Does the State and Federal Government Regulate Prior Authorization Today?

Health plans in Massachusetts are heavily regulated, and their prior authorization policies are subject to strict scrutiny. Health plans are required to include prior authorization requirements in their plan benefit packages and formularies, which are submitted to, reviewed by, and approved by the Division of Insurance and, if applicable, CMS. Health plan medical necessity criteria, used to determine approval of a prior authorization request, must be applied consistently and made easily accessible and kept up to date on the health plan's website.[11] As part of their yearly Market Conduct Annual Statement, health plans are also required to report by coverage type the number of prior authorizations requested, approved, and denied for medical benefits, mental health benefits, behavioral health benefits, substance use disorder services, and pharmacy benefits[12]. Beginning in March 2026, health plans providing coverage in MassHealth, in Medicare, and on federal health exchanges will be required to publicly report on a comprehensive set of prior authorization metrics annually by posting them on their website.[13]

In addition, health plans in Massachusetts are held to strict turnaround times for responding to prior authorization requests in the commercial market. Massachusetts requires health plans to issue a determination within two business days of receipt of a prior authorization request. If a health plan fails to respond within two business days, the request is deemed approved.[14] In the Medicare space, CMS requires plans to respond within 14 days for standard requests and within 72 hours for expedited requests. For Part D requests, health plans must respond within 72 hours for standard requests and within 24 hours for expedited requests. Beginning January 1, 2026, these time frames will shorten under CMS's Interoperability and Prior Authorization Final Rule, which will require health plans to respond to standard prior authorization requests within seven calendar days.[15]

There are also strict state guidelines for both internal and external appeals of health plan prior authorization determinations. Health plans must resolve member appeals in writing within 30 calendar days of receiving the request for standard appeals and within 72 hours for expedited appeals.[16] If the health plan fails to do so, it must pay for the treatment or service originally denied. If the appeal deals with ongoing services or treatments, those services or treatments must be covered by the health plan until the end of the internal appeal. If the internal appeal is denied, members are able to request an external review through the Office of Patient Protection.[17]

Prior Authorization Promotes Safer, Smarter Care

Prior authorization is a fundamental tenet of managed care, most effective in addressing overuse and misuse of treatments or services. Health plans' prior authorization processes ensure that the member receives treatment that is safe and effective for ***that particular patient*** based on the best available clinical evidence, like opioid-prescribing criteria consistent with federal guidelines or substance use disorder treatment in line with the American Society of Addiction Medicine's clinical criteria. Prior authorization is also used to ensure that medications are not co-prescribed with other drugs that could have dangerous or even fatal interactions and to ensure that medications prescribed are safe, effective, and provide value for specific populations or subpopulations that may be affected differently by a medication, like children or the elderly.

In many instances, prior authorization practices are employed hand in hand with care management, such as ensuring that members newly prescribed a medication or treatment intervention are also offered accompanying services like community-based supports for elders with new home care needs or peer supports for individuals in recovery with newly prescribed medication-assisted treatment. Since significant gaps continue to exist between evidence-based practice and the care actually being delivered to patients, prior authorization helps ensure safer, smarter care for health plan members.

How Does Prior Authorization Impact Affordability and Patient Safety?

In late 2023, actuarial consulting firm Milliman released a report studying the financial impact of restricting or eliminating prior authorization in Massachusetts. The study—which analyzed 2022 claims experiences trended to 2023 cost levels, including member cost-sharing for a Massachusetts sample of commercial enrollees that purchased or were provided a typical major medical policy in 2022, as well as 2020 Massachusetts Medicaid data from the Transformed Medicaid Statistical Information System monthly claims files, a CMS data set—found that removing health plans' ability to conduct prior authorization will result in commercial premium increases ranging from 9.1% to 23.3% annually, **or between $2.2 billion and $5.6 billion in additional premium costs.** In the Medicaid program, the impact would result in increases to capitation payments ranging from 3.9% to 15.5% annually, or between $0.4 billion and $1.6 billion in additional capitation payments.[18] At the federal level, a 2022 study from the Congressional Budget Office examining the potential impact of eliminating or restricting prior authorization in the Medicare Advantage program estimated an additional $16 billion in costs over a 10-year period as a result of increased utilization.[19]

Experiential data from the period from December 6, 2022, through March 6, 2023, during which health plans waived prior authorization for admissions from acute care hospitals to post-acute care facilities, provides similar insight into the role prior authorization plays in ensuring patient safety and appropriate placement. During this 90-day period, the Massachusetts Association of Health Plans member plans tracked member experiences and found that waiving prior authorization created care coordination challenges, raised concerns about members being placed in inappropriate or ill-equipped post-acute care facilities, and increased out-of-network charges for members. Rather than facilitating placement in appropriate post-acute care sites—including at home with services—eliminating prior authorization for this period resulted in increased admissions to post-acute care facilities by 14%, exacerbating existing capacity challenges; increased use of nonparticipating providers by 50%; and resulted in a significant number of members being admitted to inappropriate sites of care. For members with complex medical and behavioral health needs, inappropriate placement can prolong inpatient care and exacerbate existing conditions.

What Is the Future of Prior Authorization?

As the health care landscape continues to change, so too will prior authorization processes. Emerging technologies like automated prior authorization and electronic prior authorization offer tremendous opportunities to streamline the prior authorization process. With integration into a medical practice's workflow, prior authorization decisions can be made in real time. Since the major underlying cause of frustration with prior authorization is not with the fundamental tenets of prior authorization itself but with the manual process, integration and automation will not only streamline the administrative process but also improve the patient experience.

Health plans in Massachusetts and nationally are working to implement electronic prior authorization pursuant to CMS requirements. Prior to the release of the CMS final rule, health plans in Massachusetts voluntarily worked alongside the Network for Excellence in Health Innovation (NEHI) on their research and project to advance prior authorization automation among health plans and providers in Massachusetts.[20]

Released in April 2023, the final NEHI report, *Advancing Prior Authorization Automation Across Massachusetts*, details health plans' critical involvement in the Automation Advisory Group to develop a road map for the adoption of full prior authorization automation in anticipation of the CMS final rule. In continuing the advancement of integration and automation, health plans are now working alongside the New England Healthcare Exchange Network (NEHEN) and the Massachusetts Health Data Consortium (MHDC) to explore a cost-effective and collaborative pathway to the future of prior authorization automation.

ePA, FHIR, API: Decoding Prior Authorization Automation

Prior authorization automation, or electronic prior authorization (ePA), is the is the adoption of an end-to-end prior authorization request completed electronically using a defined set of data exchange standards and technologies. With automation, the entire health care community, health plans and providers alike, will utilize the same data standards.

Data standards, or a fast health care interoperability resource (FHIR), is a framework of structured data definitions used as resources for application programming interfaces (API). These data standards and automation solutions are integrated directly into provider's electronic health record (EHR), allowing the prior authorization process to begin immediately when a service is requested.

The automation solution, or API, extracts the necessary medical information based on the health plans medical necessity criteria, auto-populates the request form, and sends the prior authorization request to the health plan. In most circumstances, a health plan's system can provide an immediate response to the prior authorization request without human intervention.

In early 2024, CMS issued requirements for Medicare Advantage, Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan issuers on the Federally Facilitated Exchanges to automate prior authorization processes. The rule mandates the implementation of a Health Level 7 FHIR Prior Authorization API to automate prior authorization processes. Beginning January 1, 2027, impacted health plans will be required to support an electronic prior authorization process.[21]

Conclusion

Unlike many other sectors of the economy where consumers have the knowledge or can easily access the information necessary to verify the appropriateness or quality of the goods and services they purchase, it is often difficult for consumers to determine whether their health care providers are delivering clinically appropriate and cost-effective care. Health plans, acting on patients' behalf, use evidence-based clinical guidelines and government-directed standards to ensure patients are receiving appropriate care in the right setting. Employers purchasing health care coverage rely on health plans to conduct utilization management and to increase engagement among their employees in efforts to avoid unnecessary medical care that carries a risk of harm to patients and avoidable costs. And together, employers, consumers, and the government rely on health plans to use utilization management tools to constrain excessive health care spending and meet the state's health care cost growth benchmark. Prior authorization is a meaningful tool for all in the health care ecosystem.

Reducing administrative complexity through prior authorization automation benefits the health care system by reducing time, cost, and administrative burdens for patients, providers, and health plans. The Council for Affordable Quality Healthcare's (CAQH) 2023 Index Report found that in addition to the $193 billion health plans and providers have saved annually due to previous automation efforts, the U.S. health care industry can further save $18.3 billion by transitioning to fully electronic prior authorization transactions.[22] Rather than enacting policies to restrict or eliminate the use of prior authorization, Massachusetts has an opportunity to advance technological solutions that will streamline the prior authorization process and preserve its critical value while achieving significant cost savings.

Footnotes

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