Principles for Prior Authorization Policies in Value-Based Care Arrangements

The challenges and inefficiencies with prior authorization policies are well documented. They often impose significant burdens on patients, providers, payers, and purchasers that can manifest themselves in delayed or denied care. A broader description of these concerns is outlined at the end of this document. The Health Care Transformation Task Force is dedicated to advancing the adoption of value-based care models as a lever to accelerate the transition to a sustainable, cost efficient, consumer focused health care delivery system. We view value-based care arrangements as an opportunity to greatly streamline and reduce the need for prior authorization while limiting low or no value items or services and supporting patient safety through guideline-adherent care.

This resource provides a framework for improving prior authorization that: (1) promotes the delivery of guideline-adherent care, (2) serves as a guardrail for patient safety, (3) minimizes delays in care and patient burden, and (4) reduces administrative costs and friction between payers and providers. The prior authorization framework is comprised of principles, drivers, and actions that seek to advance more consistent, effective, and efficient policies across all populations for payers, purchasers, and providers transitioning to, or continuing to operate under, value-based care arrangements. The principles center on the premise that prior authorization policies should be (1) collaborative, (2) safe, (3) transparent, (4) efficient and patient-centered, and (5) expedient and are supported by the related drivers and actions detailed below.

Principles, Drivers, and Actions

Principle 1. Collaborative: Prior authorization policies should be developed in collaboration with providers and adjusted to account for shifting provider incentives under value-based care arrangements.

- **Drivers**
    i. **Stakeholder Involvement**: Payers and purchasers should develop clearly defined processes for engagement with providers and patient groups on the design and implementation of prior authorization policies.

ii. **Delegation**: Prior authorization policies should account for the varying incentives created by payment models as providers adopt greater levels of financial responsibility for the cost and quality of care under value-based payment contracts. As providers take on more risk, payers should delegate greater prior authorization functions to providers. This will allow providers greater flexibility in managing the cost and quality of care, with payers retaining appropriate auditing authority over these determinations.

- ***Actions***
  i. *Convene a multi-stakeholder committee with representation from providers, patient/member groups, and other payers (in the case of multi-payer alignment efforts).*

  ii. *Establish shared goals and priorities for prior authorization requirements and processes.*

  iii. *Engage multi-stakeholder committees throughout the design and implementation of prior authorization policies and create dedicated communication channels for stakeholders to offer feedback.*

  iv. *Dedicate time for payers, purchasers, and providers to evaluate contracts, financial risk, and rates of prior authorization approvals to determine appropriate delegation of prior authorization functions to providers and sharing of costs of prior authorization programs.*

Principle 2. Safe: Prior authorization standards should prioritize patient safety, the minimization of medically unnecessary services, and the promotion of high-quality care.

- **Drivers**
  i. **Guideline-Adherent:** Payers and purchasers should ensure that prior authorization criteria align with the standards for guideline-adherent care recognized by relevant medical/specialist groups.

  ii. **Medically Necessary:** Payers and purchasers should ensure individuals have access to medically necessary items and services when designing benefit packages and prior authorization requirements.

- ***Actions***
  i. *Establish a consistent and transparent process for selecting clinical guidelines for use in prior authorization. Guidelines should be developed by sophisticated provider-led*

Resources and entities such as Change Healthcare's InterQual Solution, MCG Health, and Choosing Wisely offer evidence-based, nationally recognized clinical guidelines that can be used to determine medically necessary and appropriate clinical guidelines.

entities or industry experts with disclosed or minimal conflict of interest, demonstrate a thorough analysis of the evidence, and be updated at least annually as required by the National Committee for Quality Assurance (NCQA).

ii. *Establish a consistent and transparent process for developing prior authorization policies when guidelines are not available, such as with new items or services. This process should include an evaluation of published evidence and consensus positions from relevant specialty societies that follow rigorous methodologies like RAND or GRADE that can serve as temporary standards until formal clinical guidelines are developed. Establishing consistent authorization policies offers an opportunity for payers and purchasers to align on these guidelines through the creation of an industry standard, which would reduce administrative costs and burden on providers.*

iii. *Conduct equity evaluations of guidelines and consensus positions to identify, to the extent possible, limitations of recommendations due to adverse bias in measurement tools, algorithms, and clinical trials that underrepresent certain groups of people and may lead to inaccurate recommendations.*

iv. *Regularly evaluate prior authorization decisions to ensure that the cases reviewed, and decisions made are consistent with the clinical guidelines or consensus positions selected. Decisions should also meet standards for interrater reliability defined by the NCQA as the extent to which two or more independent surveyors produce similar results when assessing whether the same requirement is met.*

v. *Review and clarify off label usage policies, especially in rare conditions when research is still being developed. This frequently creates confusion for providers and can compromise patient care.*

Equity evaluations of guidelines and consensus positions are vital for ensuring the inclusion of race-based data does not infuse bias into clinical decision making. One clinical tool used to predict kidney function, was found to incorrectly predict greater kidney function when a modifier for Black race was used. This has led to delays in assessment and treatment for Black patients compared to white patients of comparable kidney function.

The Regional Coalition to Eliminate Race-Based Medicine, a group of Philadelphia-area health organizations convened by Independence Blue Cross, is leading efforts to remove race-based "adjustments" from 15 commonly used clinical decision support tools that may adversely impact patients' outcomes.

vi. *Use evidence to advance the use of items and services that promote health and health outcomes and limit access to medically unnecessary and low value items and services that jeopardize patient safety. Payers and providers can utilize CMS' coverage determinations as a starting point for medical necessity determinations for Medicare.*

Principle 3. Transparent: The prior authorization process should be transparent for patients, purchasers, and providers.

- **Drivers**
  i. **Process:** All stakeholders involved should be informed about the prior authorization process, including when a prior authorization is required, why it is necessary, documentation submission requirements, expected timelines for a decision, potential outcomes of the process, and opportunities to appeal.

  ii. **Requirements:** Payers, purchasers, and providers should ensure that providers and patients are aware of what items and services **do** and **do not** require prior authorization to minimize unnecessary requests or delays in care.

  iii. **Denials:** When a prior authorization request is denied, payers should clearly communicate the reason for the denial and the process for appealing the decision to the provider and patient. This includes details on options to submit additional information, remove code(s), and update the case without going through a peer-to-peer process.

- ***Actions***
  i. Make available documentation detailing which items require prior authorization to providers up front and update regularly to prevent time intensive follow-up between payers and providers.

  ii. Provide the denial notification in language that is easy to understand and do not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained. The notification should also reference the specific criterion used to make the denial decision, which should be specific to the patient's condition or to the requested services. If a payer denies a request due to lack of clinical information, the payer should specifically note this.

  iii. Include a description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal, an explanation of the appeal process including members' rights to representation and appeal time frames, a description of the expedited appeal process for urgent denials, and a notification that the expedited review can occur concurrently with the internal appeals process for urgent care in the denial

notice. Payers should also allow a reasonable amount of time after notification of the denial for the patient to file an appeal.

Principle 4. Efficient and Patient-Centered: The prior authorization process should be efficient, minimizing the burden on patients, providers, and payers, and should prioritize continuity of care for patients.

- **Drivers**
  i. **Interoperability:** Providers and payers should proactively adopt industry standards for interoperability across systems to facilitate data exchange as well as automation of the clinicians' evidence-based care decision-making steps and actions – both payer-to-payer and between payers and providers. By automating the collection and analysis of a clinician's evidence-based decision-making, most of the clinical prior authorization demands on clinicians should be eliminated.

  ii. **Elimination:** Providers should take steps to eliminate unnecessary prior authorization requests (requests for items and services that do not require it) which slow the payer review process for the required prior authorization requests.

  iii. **Minimization:** Payers and purchasers should routinely review and refine their prior authorization policies to align with the latest clinical guidance and eliminate prior authorization for items and services that are routinely approved or determined to be of low-risk and high-value or are inconsistent with other payer or provider standards.

  iv. **Provider Flexibilities:** Payers should evaluate opportunities to lower the demand for prior authorization reviews by reducing requirements for organizations and providers in value-based payment arrangements as well as those with a track record of appropriate utilization and prior authorization approvals.

  v. **Patient Flexibility:** When a prior authorization request is denied, payers and providers should assist patients with finding suitable alternative treatment options.

  vi. **Continuity of Care:** Prior authorizations should remain valid for the duration of the prescribed order or course of treatment, where clinically appropriate, without requiring additional determinations. When a patient changes plans or insurance companies, payers and purchasers should have transition period policies for managing pre-existing prior authorization approvals to avoid disruptions to patient care.

  vii. **Redeterminations:** Redeterminations of prior authorization approvals should prioritize patient safety by ensuring the item or service remains the most appropriate treatment. When there are updates to prior authorization policies or requirements for reevaluating a previously

approved item or service, payers should communicate upcoming redetermination dates, processes and timelines to providers and patients with sufficient lead time to ensure reauthorization can be completed without delaying care.

- ***Actions***
  - *i. Establish a process by which payers develop a transition of care file providing information on the patient's care and existing prior authorizations to the new health plan. The file should be easily accessible by the new payer's utilization management system.*
  - *ii. Consider retiring or restructuring prior authorization requirements and coding protocols for items and services that are commonly approved.*

Principle 5. Expedient: The prior authorization process should minimize delays in care for patients.

- **Drivers**
  - i. **Timeliness:** Prior authorization requests should be reviewed and processed by payers in a timely manner. Appeals of denials should be resolved expeditiously.
  - ii. **Electronic Prior Authorization:** Payers and providers should seek to maximize the proportion of prior authorizations processed electronically and should fully use the contents recorded in the EMR to achieve efficiencies and avoid delays in care. Payers should work with providers with limited resources to identify opportunities for them to develop the capacity for fully electronic prior authorization.

State laws and requirements for payer timelines for non-urgent prior authorization requests vary. As of this writing, review times vary from 2 business to 15 calendar days for standard requests. For urgent/expedited requests, requirements vary from 24 hours to 72 hours.

- ***Actions***
  - *i. Establish prior authorization timeframes that align with the NCQA standards for non-electronic prior authorization: 24 hours for commercial and Marketplace urgent concurrent decisions, 72 hours for Medicare and Medicaid urgent concurrent decisions, 72 hours for urgent preservice decisions, 15 calendar days for nonurgent preservice decisions, and 30 calendar days for post-service decisions.*
  - *ii. Ensure technological infrastructure to support electronic prior authorization including hardware, software, and network capabilities to handle electronic communications with payers.*

iii. *Adhere to industry standards for data exchange and interoperability to ensure that electronic prior authorization systems can communicate effectively with payer systems.*

Task Force Member Concerns on the Impact of Prior Authorization Delays on Patients

In its current form, prior authorization often poses significant challenges to patients in accessing care, causing frustration at best, and leading to adverse health outcomes at worst. Patients and caregivers face significant administrative burdens when advocating for prior authorization approval for items and services prescribed by their health care providers. A commonly raised issue is the lack of coordination across payers and providers resulting in patients taking on a large advocacy role to initiate the prior authorization process, ensure payers and providers are following up, and to request a timely decision. Lack of coordination and interoperability also leads patients to unnecessarily repeat previously unsuccessful treatments to satisfy step therapy requirements. Another concern is the impact of these policies on underserved patient populations facing reduced access to care and a lack of time and resources to navigate the appeal process.

Value-based care models are designed to create provider accountability for the cost and quality of patient care and can significantly reduce incentives for overutilization and low value care. This lessens the need for prior authorization as a check against these concerns, allowing policies to focus on promoting patient safety and guideline-adherent care. Regardless of the payment structure, prior authorization policies should be designed in ways that significantly reduce delays in care and denied care that lead to adverse health outcomes. When patients are unable to achieve timely access to care, they can become at risk of experiencing worse health outcomes and requiring higher levels of care, which adds burden to the health care system. The prior authorization process should focus on ensuring patients receive high-quality, safe, and appropriate care in a timely manner which is dependent on greater standardization and efficiencies of the prior authorization process.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.