Report of Council on Legislation
Ensuring Transparency in Prior Authorization
Approved by the CMS BOD: 1-18-19

The question before board of directors: To discuss and act on bill specifications resulting from the Council on Legislation's December 12, 2018 meeting that will ensure transparency of prior authorizations.

Background:
CMS member surveys consistently demonstrate a high level of physician dissatisfaction with administrative barriers to care, especially prior authorization programs. Physicians want assistance in decreasing burdensome prior authorization requirements, while also increasing transparency and standardization of prior authorization requirements across payers. The following specifications were drafted following careful review of current Colorado law regarding prior authorization, as well as other state and national efforts to make prior authorization less burdensome.

Specifications for approval :
The goal of this legislation is to promote safe, timely, and affordable access to evidence-based care for patients; enhance efficiency; increase transparency; and reduce the variations among payers and utilization management organizations by streamlining the overall prior authorization process.

- **Selective application of prior authorization**. Differentiate the application of prior authorization based on the participating physician's performance on quality measures and adherence to evidence-based medicine, or other contractual agreements (i.e., risk-sharing arrangements). This will help in targeting prior authorization requirements where they are most needed and reduce the administrative burden on high performing physicians
    - The criteria for such selective application of prior authorization should be transparent and easily accessible for participating physicians.
    - Participating physicians' performance should be compared to the selective application criteria and their status revised accordingly on an annual basis.

- **Prior authorization program reporting, review and adjustment**. Regularly review the list of medical services and prescription drugs that are subject to prior authorization requirements to identify therapies that no longer warrant prior authorization, as well as identifying services (e.g., new services) where prior authorization may be warranted.
    - Payers and utilization review organizations should make statistics available regarding approvals, denials and appeals resulting in an overturn of the original determination.
    - Such analytics, and up-to-date clinical criteria should be used to revise the prior authorization requirements at least annually.
- **Prior authorization criteria should be clinically based** and where applicable align with any other quality initiatives. The use of up-to-date clinically based utilization management criteria should result in similar, if not identical, requirements across payers and utilization review organizations.
    - Alignment of clinically based criteria across all organizations will reduce the administrative burden on physicians and improve adherence.
- **Prior authorization shall not be required for emergency services** (C.R.S. 10-16-704 (5.5)(a)(I)).

- **Improve transparency and communication regarding prior authorization**. Effective communication between payers, physicians and patients is necessary to clearly articulate prior authorization requirements, criteria, and rationale; ensure timely resolution of prior authorization requests; and minimize care delays.
    - Prior authorization requirements should be easily accessible for physicians and their patients. Such requirements should be described in detail and easily understandable.
        - The rationale and clinical basis for the review criteria should be included, as well as any supporting information that will be required to complete the prior authorization review determination.
        - If a prior authorization is denied, the basis for the denial should be fully explained, as well as the physician/patient's appeal rights.
    - Physicians and patients should be able to rely on a prior authorization determination approval as a commitment to coverage and payment.
        - Eligibility, benefit coverage, and medical policy determinations should be performed as part of the prior authorization process.
        - Services that have been approved cannot be retrospectively denied (C.R.S. 10-16-704 (4), (4.5)).
    - Medical services and prescription drugs that routinely require medical necessity review to determine coverage should be included in the prior authorization process and not routinely handled through post-payment review determinations.
- **Continuity of patient care** is vitally important for patients undergoing an active course of treatment.
    - Patients who are stable on a particular medication or therapy should be given a 60-day grace period upon enrollment in the plan during which any medical treatment or drug regimen should not be interrupted.
    - Patients who have changed health plans should not be required to repeat step-therapy protocols or treatment regimens that failed under other benefit plans before qualifying for coverage of a current effective therapy.
    - A drug or medical service that is removed from the plan's formulary or is subjected to new coverage restrictions after the enrollment period has ended should be covered without restrictions for the duration of the patient's benefit year.
    - Prior authorization should be valid for the duration of the prescribed/ordered course of treatment.
- **Timeliness**
    - If prior authorization is required for non-urgent care, a determination should be made, and the provider notified within 48 hours of obtaining all necessary information.
    - For urgent care, the determination should be made within 24 hours of obtaining all necessary information.
- **Appeal** - when patient or the physician receives an adverse determination for care, the payer or utilization review entity has a responsibility to ensure that the appeals process is fair and timely.
    - Should the physician determine the need for an expedited appeal, a decision on such an appeal should be communicated by the payer or utilization review entity to the physician and patient within 24 hours.
    - For all other appeals physicians and patients should be notified of decisions on within 10 calendar days.
    - All appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the as the prescribing/ordering physician and (b) was not involved in the initial adverse determination.