Prior Authorizations

KEY POINTS

- Concerns about prior authorizations have grown given research demonstrating inconsistent coverage and review policies across insurers, interruptions to care, high provider burden and higher healthcare costs.
- Tennessee policymakers and insurers have recently taken appropriate measures to ease the concerns and minimize unnecessary barriers. TennCare changed their policy on buprenorphine allowances in May 2023, essentially removing the prior authorization barrier for buprenorphine/naloxone preferred products.
- This is a significant step for Tennesseans given that the research shows that once the prior authorization process was removed for medications for opioid use disorder (MOUD), patients with opioid use disorder (OUD) were 47 percent less likely to relapse, hospital and emergency use decreased, and healthcare costs decreased.

WHAT IS A PRIOR AUTHORIZATION?

The United States (U.S.) Centers for Medicare and Medicaid defines a prior authorization as "an approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan." The prior authorization process is requested by insurance providers once a healthcare provider has initiated a medical service or prescribed medication. The healthcare provider is then responsible for filling out and submitting paperwork that includes additional justification and patient information. Insurers require this paperwork before they will determine coverage of the prescribed medication or service. In other words, even though a healthcare provider prescribed a test, treatment or service, the insurance company requires additional paperwork before they will consider paying for that test, treatment or service. It is not always known to the provider when an insurer will request a prior authorization. Additionally, insurers do not always cover the medication or service after the prior authorization as they can also deny the request, ask for more information, or suggest an alternative medication or service.

Prior authorization exists as a process that allows the insurer to unilaterally determine if the service or medication is medically necessary, saving the insurer money by offloading the cost to the patient or another payer. In most cases, the insurers develop their own standards for review based on information like costs, effectiveness, and medical guidelines. These standards are seldom available to the public.

DECISION TIME FRAMES

According to Cigna, prior authorizations can take between five to 10 business days for the insurer to review the request and make a decision. However, the time a decision takes can vary depending on the service requested, the method of submission for the prior authorization, or the patient's insurer. Tennessee's neighboring state, North Carolina, reports a 24-hour decision time for prescription drugs and 15 business days for other types of prior authorization requests for Medicaid beneficiaries. Insurers do not widely report their prior authorization times frames and many do not include specific time frames for medications. For example, BlueCross BlueShield of Tennessee, which holds 72 percent of the market share for insurance in Tennessee, provides a general statement that it can take them up to 14 calendar days (2 weeks) to make a decision on prior authorizations.

PRIOR AUTHORIZATION CONCERNS

Continuity of Care

The American Medical Association (AMA) found that 94 percent of physicians reported care delays due to prior authorizations and 80 percent reported that it could sometimes lead to treatment abandonment. When it comes to the risk of opioid use disorder relapse, two weeks is a dangerously long window of time.

Research of U.S. Medicaid beneficiaries found that the uninterrupted treatment of medications for opioid use disorder (MOUD) was associated with a substantial reduction in overdose risk. When discussing prior authorizations for MOUD, they are required at the initial fill and depending on the insurer can be required six months to a year later. However, still requiring some kind of prior authorization can cause interruptions. The continuation of care is critical in preventing overdoses and death, and prior authorizations may negatively impact the time and quality of that care.

Provider Burden

Provider burden is a significant concern in the conversations of prior authorizations. The AMA reports that 88 percent of physicians found the burden of prior authorizations as high or extremely high with nearly two out of five physicians having staff who solely work on prior authorizations. Prior authorizations in the field of addiction medicine are of particular concern since they contribute to the barriers that healthcare providers face when prescribing MOUD. For example, physicians expressed insurance obstacles, like prior authorization requirements, as the most common barrier when prescribing buprenorphine and extended-release naltrexone. In another study, nurse practitioners and physician assistants also named insurance prior authorization as a leading barrier in prescribing buprenorphine.

Transparency and Standardization

Additionally, there is limited reporting regarding the determination and denial process, which has led organizations like the AMA to call for greater transparency and standardization of the prior authorization process. Research from 2022 found a large variation in coverage and prior

authorization policies for MOUD across state Medicaid plans and programs. This variation can affect a patient's access depending on where they live and what plan they have. The U.S. Department of Health and Human Services also found that 13 percent of prior authorization denials were for service requests that met the Medicare coverage rules, stating that the denials likely prevented or delayed medically necessary care for beneficiaries.

Furthermore, many in the medical field question the practice of people without medical training making decisions about which services or treatments are "medically necessary," especially if those decisions overrule those of individuals with medical training. There is limited research across all of the insurance plans on who makes the prior authorization decisions. However, some insurers provide this information publicly.

BlueCross BlueShield of Tennessee shares that prior authorizations are initially reviewed by clinical review managers or licensed practical nurses. If the reviewer is unable to approve the service based on the clinical criteria, then the prior authorization is submitted to the medical director for additional review. According to Cigna, their decision responses are based on input from pharmacists and medical doctors who review the request. However, there is no mention of whether these professionals are within the same specialty as the provider initiating the service.

As demonstrated, certain insurers may use the appropriate professionals. However, the reviewer's qualifications vary by insurer since there is no reported regulated standard within Tennessee and many other states. Regardless of the reviewer's qualifications, the patient's care is disrupted or at least complicated because health decisions are not being made solely between the attending healthcare provider and the patient.

TRENDS OF PRIOR AUTHORIZATION REGULATION

While every state has some prior authorization regulations, there are notable federal regulations efforts to discuss. Through the Affordable Care Act, emergency room services do not require prior authorizations; otherwise coverage of these services is just subject to the patient's plan. In September of 2022, the U.S. House of Representatives passed legislation that would require insurers to implement an electronic process for real-time prior authorization decisions. However, this bill did not pass the Senate to become law. In response to the growing concerns, the Centers for Medicare and Medicaid Services proposed new rules for prior authorizations in December 2022, which included improvements for time frames, denial reasons, and reporting metrics. This included a requirement for insurers to implement an electronic prior authorization process to help decrease decision time frames. The available research shows that the implementation of electronic prior authorizations was associated with shorter decision times, but there was no change in medication adherence and no association with lessened provider burden. Federal legislation addressing these proposed rules has still not been enacted as of June 2023.

TennCare MOUD Prior Authorization Policy

As of 2019, 18 states have passed some form of policy on MOUD prior authorization prohibitions whether it was for all insurance, Medicaid only, or non-Medicaid insurance. Tennessee is not one of those states. However, some insurers took action to minimize or eliminate prior authorizations for MOUD, and Tennessee's Medicaid program has enacted a new policy without any legislative imperative. TennCare, which services 1.7 million Tennesseans, changed its policy on buprenorphine coverage in May 2023:

> All TennCare providers can now prescribe up to a five-day supply of preferred buprenorphine/naloxone **tablets** with a max daily dose (MDD) of 16 mg or less and **no prior authorization will be required**. Providers can do this every six months to TennCare members for therapy induction and no prior authorization will be required.

This means that **any** provider accepting TennCare can initiate buprenorphine treatment on TennCare recipients without needing prior authorization. This would include many emergency departments and primary care providers, representing a significant strengthening of access to and continuity of care.

The greatest change to their policy affects TennCare's Buprenorphine Enhanced Medication Assisted Recovery and Treatment (BESMART) providers:

> For TennCare's BESMART providers, **prior authorization is no longer required** for buprenorphine/naloxone **tablets and films** as long as it is a preferred product and the prescription is equal to or less than the MDD of 16mg.

The BESMART program began in 2019 as a specialized provider network focused on bringing together medication-assisted treatment (MAT) providers (MAT) to build more comprehensive care for members with opioid use disorder. As of 2021, there are 278 active BESMART providers located in 39 out of the 95 Tennessee counties and three other states (Alabama, Kentucky, and Virginia). With the new changes to TennCare's prior authorization policy, providers could have a greater chance of successful treatment for their patients.

Deregulation Outcomes

In other state Medicaid programs that removed prior authorization for buprenorphine, there was a significant increase in the number of buprenorphine prescriptions filled. Hence, people had increased access to the medication needed for treatment. Evidence shows patients with opioid use disorder initiating MAT were 47 percent less likely to relapse when prior authorization was removed. The removal of prior authorization for buprenorphine-naloxone was found to be associated with decreased hospital and emergency department use, as well as decreased overall healthcare costs.

Although Tennessee has not adopted insurance-wide prior authorization prohibitions at the legislative level, most insurers have taken the initiative to change the policies on their own. For the patient, this results in decreased costs, increased access and continuity of care, and reduced physician burden (and thus burnout). TennCare, having formally prohibited prior authorizations for MOUD, has taken a decisive step in the direction of strengthening access to and continuity of care.

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