2024

Health Equity Analysis on Prior Authorizations

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Introduction

Prior authorization is a process that The Health Plan uses that requires clinicians to obtain approval for specified medical services prior to the service being completed. The goal of a prior authorization is to ensure that clinicians are utilizing evidence-based medical standards, limit unnecessary services being completed, and reduce health care costs. Research has shown that prior authorization may negatively impact the most vulnerable populations.

Health equity is defined as the attainment of the highest level of health for all people, with a focus on eliminating disparities, and creating fair opportunities for everyone to achieve their full potential for health and well-being. With this definition in mind, the Centers for Medicare and Medicaid's (CMS) 2025 Final Rule put into place a requirement to conduct an analysis of the use of prior authorization at the plan-level. The inaugural analysis is to be completed on calendar year 2024. The objective of the analysis is to examine the impact of prior authorization on enrollees with one or more of the following social risk factors (SRFs): (1) receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid (LIS/DE); or (ii) having a disability.

Data Sources

The following sources of data were utilized to conduct this analysis:

- **The Health Plan's public prior authorization list.** This list is reviewed, updated, and published at least quarterly. Substantive changes to services added or removed are reviewed and approved by the Medical Director Oversight Committee (MDOC) and the Physician Advisory Committee (PAC).
- **Claims data.** A universe of the prior authorizations from 2024 was obtained with all the relevant data needed to complete this analysis.
- **The Health Plan's UM policies and procedures.** A variety of policies were reviewed to determine what services utilized prior authorization, and what kind of impact a prior authorization on those services would have.
- **Enrollment data**. Enrollment data was utilized to determine a population breakdown.

Population Analysis

This analysis is being conducted on the Medicare Advantage population that The Health Plan had in 2024. At the end of 2024, The Health Plan had a total of 9,284 Medicare Advantage members dispersed among the HMO, PPO, and dually eligible special needs (DSNP) populations. For the purposes of this analysis, only the HMO and DSNP populations will be reviewed, as their benefits and prior authorization requirements align more appropriately.

Table 1: A breakdown of each group within The Health Plan's Medicare Advantage population.

Group	Total Members
Secure Care (HMO)	5,419
Secure Care DSNP (HMO)	2,799

Table 2: The gender breakdown of The Health Plan's Medicare Advantage members by group, and by total population measured.

	Secure Care (HMO)	Secure Care DSNP (HMO)	Total
Female	55.83%	55.37%	55.67%
Male	44.17%	44.63%	44.33%

Table 3; The race and ethnicity breakdown of The Health Plan's Medicare Advantage members by group, and by total population measured.

	Secure Care (HMO)	Secure Care DSNP (HMO)	Total
American Indian or Alaska Native	0.10%	0.00%	0.06%
Asian or Pacific Islander	0.05%	0.05%	0.05%
Black or African American	2.62%	1.23%	2.14%
Filipino	0.02%	0.00%	0.02%
Form Left Blank	16.00%	3.02%	11.53
Hispanic	0.02%	0.05%	0.03%
I choose not to answer	22.26%	60.63%	35.47%
Native American	0.02%	0.05%	0.03%
Other Asian	0.02%	0.00%	0.02%
White	58.88%	34.98%	50.65%

Table 4: A breakdown of languages spoken within The Health Plan's Medicare Advantage members by group and by total population measured.

	Secure Care (HMO)	Secure Care DSNP (HMO)	Total
Dakota	0.02%	0.00%	0.02%
Egyptian	0.05%	0.00%	0.03%
English	98.34%	99.77%	98.84%
Eskaleut Eskimo	0.00%	0.05%	0.02%
Spanish	0.05%	0.00%	0.03%
Zuni	0.19%	0.14%	0.17%
Form left blank	1.34%	0.09%	0.90%

Prior Authorization Analysis

Statistical significance analysis was completed utilizing the A/B Statistical Testing where the p value represents the probability that we would get the observed difference between the two populations by random chance.

Table 1: The percentage of standard prior authorization requests that were approved and denied, aggregated for all items and services. The results for approved standard prior authorizations are not statistically significant with a p value of 0.7889. The results for denied standard prior authorizations are not statistically significant with a p value of 0.8219.

	Approved	Denied
Secure Care (HMO)	81.59%	1.39%
Secure Care DSNP (HMO)	80.86%	1.26%
P Value	0.7889	0.8219

Table 2: The percentage of standard prior authorization requests that were approved and denied after appeal, aggregated for all items and services. The results for approved prior authorizations after appeal were not statistically significant with a p value of 0.5486. The results for denied prior authorizations after appeal were not statistically significant with a p value of 0.3897.

	Approved	Denied
Secure Care (HMO)	74.65%	12.68%
Secure Care DSNP (HMO)	73.53%	14.71%
P Value	0.5486	0.3897

Table 3: The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved and denied, aggregated for all items and services. The results for the approved prior authorizations for which the timeframe for review was extended was not statistically significant with a p value of 0.2965. The results for the denied prior authorizations for which the timeframe for review was extended was not statistically significant with a p value of 0.7035.

	Approved	Denied
Secure Care (HMO)	66.67%	33.33%
Secure Care DSNP (HMO)	83.33%	16.67%
P Value	0.2965	0.7035

Table 4: The percentage of expedited prior authorization requests that were approved and denied, aggregated for all items and services. The results for approved expedited prior authorizations was not statistically significant with a p value of 0.9665.

	Approved	Denied
Secure Care (HMO)	90.91%	0.00%
Secure Care DSNP (HMO)	61.54%	0.00%
P Value	0.9665	N/A

Table 5: The average and median time, in days, that elapsed between the submission of a request and a determination by The Health Plan for standard prior authorizations, aggregated for all items and services.

	Average	Median
Secure Care (HMO)	5.49	3.0
Secure Care DSNP (HMO)	5.66	4.0

Table 6: The average and median time that elapsed between the submission of a request and a decision by The Health Plan for expedited prior authorizations, aggregated for all items and services.

	Average	Median
Secure Care (HMO)	6.73	2.0
Secure Care DSNP (HMO)	2.46	4.0

After careful review of available data, there were no statistically significant findings related to the prior authorizations completed on either population. Additionally, there were no statistically significant differences between the race, ethnicity, or genders of the members that had prior authorizations in 2024. There are no recommendations, currently, for updates to policies and procedures based on these findings.

References

Smith, Anna Jo Bodurtha et al. "Insurance and racial disparities in prior authorization in gynecologic oncology." *Gynecologic oncology reports* vol. 46 101159. 11 Mar. 2023, doi:10.1016/j.gore.2023.101159