

## **Key Prior Authorization Reforms in PA (Act 146)**

1. Expansion of reforms to include all insurers plus the state's Medicaid and CHIP managed care plans.
2. Expanded definition of urgent health care service to include "treatment of an acute condition with symptoms of sufficient severity that the absence of significant medical intervention is likely to result in serious, long-term health complications or a material deterioration in the enrollee's condition and prognosis."
3. Expanded definition of emergency services and clarification that no prior auth is required, with inclusion of testing and other diagnostic services medically necessary to diagnose, evaluate or treat an emergency medical condition.
4. Time Frames for decisions – from time of initial request (not "completed request"):
  - a. Urgent health care services: as soon as possible, but no more than 72 hours. If request is made 24 hours prior to reduction or termination of treatment, within 24 hours.
  - b. Non-urgent medical services: not more than 15 days total.
  - c. Prescription drugs – Urgent requests not more than 24 hours; Standard requests, not more than two business days and not more than 72 hours.
5. A requirement that any denial of prior auth can only be after review by or consultation with a licensed medical professional in the same or similar specialty.
6. In the case of denials, peer-to-peer reviews must be offered in same or similar specialty. Physicians can delegate the peer-to-peer to a proxy.
7. If at any time after requesting prior authorization, the health care provider determines the enrollee's medical condition requires emergency services, such services may be provided without prior authorization.
8. In the event a request for prior authorization is considered missing clinical information necessary to complete a review, the insurer must notify the provider as soon as reviewed, with enough specificity to enable identification of the necessary information required to complete review. The provider can request up to 45 days additional time beyond these limits if necessary.
9. Significantly expanded definition of what constitutes "medical or scientific evidence" and clinical standards to support approvals.
10. Medically Assisted Treatment: Mandates that insurers make at least one FDA approved Buprenorphine/naloxone prescription drug combination product, Injectable and oral Naltrexone, and Methadone available for OUD treatment without prior

authorization. The insurer may designate preferred medications when multiple medications are available at the lowest cost tier for patients.

11. Expansion of “closely related services” not requiring PA to include “prudent health care provider reasonably expected to perform in conjunction with or in lieu of an originally authorized service in response to minor differences in patient characteristics or needs for diagnostic information not readily identifiable before performing the authorized service.” If diagnostic testing demonstrates need for additional services, these would be covered under revised definition, not just issues identified during procedures or surgeries.
12. Transparency requirements:
  - a. A requirement that insurers, etc. adopt, maintain, supply on request and publish a definition of medical necessity easily understandable by the layperson. Must also provide description of benefit limitations and exclusions of coverage and post its medical policy online via website and patient portal.
  - b. A requirement that a list of all services and drugs requiring prior authorization be provided and available online.
  - c. A requirement that all insurers publicly post a list of health services that require prior authorization.
  - d. A requirement that insurers report number, type and disposition of all complaints and grievances and adverse benefit determinations, filed to the Insurance Department for enforcement and compliance.
  - e. A requirement that insurers post their medical policies on their websites and on patient portals.
  - f. A requirement that insurers review each adopted medical policy on an annual basis and notify providers of changes at least 30 days prior to application.
13. Step Therapy: Requires insurers to issue a prior authorization determination for a prescription drug medication or a decision on step therapy for an urgent request in not more than twenty-four (24) hours and for a standard request - not more than two (2) business days and not to exceed seventy-two (72) hours.
14. Continuity of care provisions for 60 days for enrollees after being notified that their physician’s contract is being terminated, and through postpartum care related to delivery if patient is in second or third trimester of pregnancy. (does not apply if terminated for cause, fraud, etc.)
15. Similarly, a new enrollee may continue ongoing course of treatment with a nonparticipating provider for up to 60 days from enrollment – which may be extended if clinically appropriate. Same applies to patients in second or third trimester of pregnancy.

