Government of the District of Columbia
Office of the Chief Financial Officer

Glen Lee
Chief Financial Officer

MEMORANDUM

TO:	**The Honorable Phil Mendelson** **Chairman, Council of the District of Columbia**
FROM:	**Glen Lee** **Chief Financial Officer**
DATE:	**September 26, 2023**
SUBJECT:	**Fiscal Impact Statement – Prior Authorization Reform Amendment Act of 2023**
REFERENCE:	**Bill 25-124, Draft Committee Print as provided to the Office of Revenue Analysis on September 21, 2023**

Note: An updated version of this fiscal impact statement will be circulated prior to the second reading of the Prior Authorization Reform Amendment Act of 2023 to incorporate costs that have yet to be determined by the Department of Behavioral Health.

Conclusion

Funds are not sufficient in the fiscal year 2024 through fiscal year 2027 budget and financial plan to implement the bill. The Department of Health Care Finance (DHCF) requires $9.66 million ($2.71 million local, $6.95 million federal) in fiscal year 2024 and $25.41 million ($7.10 million local, $18.31 million federal) over the financial plan to implement the bill.

Background

Health insurance utilization review entities are organizations that make prior authorization determinations on behalf of health insurance providers. Prior authorization determinations state whether the cost of a medical treatment or medication will be covered by the insurer. The bill establishes prior authorization guidelines and requirements that utilization review entities must follow. Specifically, the bill requires utilization review entities[1] to:

- Post its prior authorization requirements and restrictions, including its formulary, on a publicly accessible website.

[1] Including those that performs prior authorization for an employer, insurers, preferred provider organization, health maintenance organization, health plans under Medicaid or the DC Health Care Alliance, and any other individual or entity that provides health benefits to a person treated by a health care provider.

- Email or provide a hard copy of, or discuss over the telephone, prior authorization requirements to enrollees and health care providers upon request.
- Make public prior authorization requirements including clinical criteria, a comprehensive listing of drugs that require prior authorization, and the process for submitting information related to a prior authorization.
- Make prior authorization determinations in non-urgent circumstances within three business days of receiving an electronic submission or five business days if received via mail, telephone, or fax.
- Make determinations for urgent care services within 24 hours after receiving a complete request.
- Make determinations on long-term care services within 30 days of receiving a complete request.
- Not require prior authorization for pre-hospital transportation or emergency health care services.
- Notify an insurance enrollee and enrollee's health care provider of its decision within 24 hours of making a determination and provide notice that includes the qualification of the personnel making determinations, explanations for any denial, and information on the appeals process.
- Make available, on its website, to enrollees and providers each insurance enrollee's active requests and requests made over five years including the determinations made for each request starting January 1, 2025.
- Ensure that all adverse determinations[2] and decisions on appeals of adverse determinations are made by a licensed physician that specializes in managing the medical condition or disease involved in a request and is licensed to practice in the District of Columbia, Maryland, or Virginia.
- Notify an insurance enrollee's health care provider when medical necessity is being questioned prior to issuing an adverse determination.
- Allow appeal of an adverse determination within fifteen days of an insurance enrollee's receipt of notice of the adverse determination.
- Require prior authorization only for determination of medical necessity for experimental or investigational care.
- Honor prior authorization granted to an insurance enrollee from a previous utilization review entity for at least 60 days when an enrollee switches health plans.
- Make statistics available regarding prior authorization, adverse determinations, and appeals on their website.

The bill requires that prior authorizations be valid for at least one year from the date of determination, except for treatment of chronic and long-term conditions. Chronic and long-term condition prior authorizations must be valid for the length of treatment except the District's Medicaid program may require annual re-authorization for long-term care. A utilization review entity may not require prior authorization solely based on the cost of a health care service except that plans under Medicaid and the DC Health Care Alliance (Alliance) may require prior authorization based on a preferred drug list. Any failure by utilization review entities to comply with the bill's requirements will result in the health care services in question being deemed authorized.

[2] Adverse determinations are decisions by a utilization review entities that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated.

Financial Plan Impact

Funds are not sufficient in the fiscal year 2024 through fiscal year 2027 budget and financial plan to implement the bill. DHCF requires $9.66 million ($2.71 million local, $6.95 million federal) in fiscal year 2024 and $25.41 million ($7.10 million local, $18.31 million federal) over the financial plan to implement the bill.

Bill 25-124, Prior Authorization Reform Amendment Act of 2023 Total Costs ($ in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
Local	$2,710	$1,437	$1,462	$1,486	$7,095
Federal	$6,950	$3,723	$3,786	$3,851	$18,310
Total	$9,661	$5,160	$5,248	$5,337	$25,405

Table Notes:

(a) Includes costs provided to DHCF by managed care organizations vendors and fee-for-service vendors.
(b) Assumes 1.7 percent growth rate.
(c) Assumes 70 percent federal match for health services for children with special needs (HSCSN) enrollees and a 71.6 percent blended federal match for AmeriHealth Caritas, Amerigroup, and MedStar.
(d) Assumes 75 percent federal match for fee-for-service enrollees due to an enhanced Medicaid match for operation of an approved Medicaid management information system for claims and information processing.[3]

DHCF must modify existing Medicaid contracts to implement the provisions in the bill. DHCF currently contracts with four managed care organizations[4] (MCOs) to provide health care, behavioral health services, and pharmacy services to the District's Medicaid enrollees, Alliance enrollees, and children with special needs. Each MCO contract includes standardized prior authorization guidelines to create uniformity with how MCOs operate. The bill's requirements will result in contract modifications for MCO costs which will be passed on to the District under recalculated capitation rates.

DHCF also contracts with vendors[5] to process claims and to conduct service utilization reviews for its Medicaid fee-for-service enrollees. The costs associated with modifying these contracts are included below.

The Department of Behavioral Health (DBH) completes Medicaid and Alliance prior authorizations for specialty behavioral health services.[6] DBH will need additional resources to implement the bill. The estimated financial impact on DBH is unknown at this time and will be included in an updated fiscal impact statement as soon as costs are determined.

[3] 42 U.S.C. § 1396b.
[4] AmeriHealth Caritas, Amerigroup, MedStar, and Health Services for Children with Special Needs.
[5] Conduent, Comagine, and Magellan Rx Management.
[6] Including assertive community treatment, community-based intervention, rehabilitation day, and supported employment.

Accelerated Prior Authorization Review

Currently, MCO contracts stipulate that standard non-urgent prior authorizations must be completed by a utilization review contractor within 14 calendar days of receiving a request with the option of a 14-calendar-day extension by DHCF. The bill requires a maximum five-day turnaround period for non-urgent authorizations. Likewise, MCO contracts stipulate that urgent care prior authorizations must be completed within 72 hours. The bill requires a turnaround time of 24 hours.

To comply with the accelerated turnaround requirements in the bill, MCOs will need to hire additional staff to complete authorization reviews. The resulting estimated rate increases based on accelerating prior authorization reviews will cost the District $1.72 million ($490,000 local, $1.23 million federal) in fiscal year 2024 and $7.04 million ($2.01 million local, $5.03 million federal) over the financial plan.

Bill 25-124, Prior Authorization Reform Amendment Act of 2023
Accelerated Prior Authorization Review ($ in thousands)

	FY 2024	FY 2025	FY 2026	FY 2027	Total
Local	$490	$498	$507	$515	$2,010
Federal	$1,225	$1,246	$1,267	$1,289	$5,026
Total	$1,715	$1,744	$1,774	$1,804	$7,036

Table Notes:
(a) Based on staffing costs provided to DHCF by three of the current MCO vendors.
(b) Assumes 1.7 percent growth rate.
(c) Assumes 70 percent federal match for HSCSN enrollees and a 71.6 percent blended federal match for AmeriHealth Caritas, Amerigroup, and MedStar.
(d) Assumes 75 percent federal match for fee-for-service enrollees due to an enhanced Medicaid match for operation of an approved Medicaid management information system for claims and information processing.[7]

Five-Year Determination History

The bill requires utilization review entities to make the status of each active determination request and five years of determination history available on its website for enrollees and providers. MCOs currently do not provide access to five years of determination history for each enrollee. In order to comply with the bill, MCOs will need one-time funding to upgrade and maintain website portals that can be accessed by enrollees and providers. The resulting estimated rate increases based on providing enrollees and providers with access to five years of determination history will cost $3.98 million ($1.14 million local, $2.83 million federal) in fiscal year 2024.

Bill 25-124, Prior Authorization Reform Amendment Act of 2023
Five-Year Determination History Cost ($ in thousands)

	FY 2024	FY 2025	FY 2026	FY 2027	Total
Local	$1,144	$0	$0	$0	$1,144
Federal	$2,831	$0	$0	$0	$2,831

[7] 42 U.S.C. § 1396b.

Total	$3,975	$0	$0	$0	$3,975

Table Notes:
(a) Based on IT upgrade costs provided to DHCF by two of the current MCO vendors and the fee-for-service utilization review contractor.
(b) Assumes 1.7 percent growth rate.
(c) Assumes 70 percent federal match for HSCSN enrollees and a 71.6 percent blended federal match for AmeriHealth Caritas, Amerigroup, and MedStar.
(d) Assumes 75 percent federal match for fee-for-service enrollees due to an enhanced Medicaid match for operation of an approved Medicaid management information system for claims and information processing.[8]

Adverse Determination and Appeals Credentialing Requirements

The bill requires that all adverse determinations and decisions on appeals of adverse determinations be made by a licensed physician who specializes in managing the medical condition or disease involved in a request and is licensed to practice in the District of Columbia, Maryland, or Virginia. MCOs and the fee-for-service utilization review contactor must hire subcontractors who meet the credentialing requirements required in the bill. These subcontractors bill MCOs and the fee-for-service utilization review vendor on a per case basis. The resulting estimated rate increases based on enhanced adverse determination and appeals credentialing requirements are $2.68 million ($734,000 local, $1.95 million federal) in fiscal year 2024 and $11.01million ($3.01 million local, $8.01 million federal) over the financial plan.

Bill 25-124, Prior Authorization Reform Amendment Act of 2023 Adverse Determination and Appeals Credentialing Requirements Cost ($ in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
Local	$734	$746	$759	$772	$3,011
Federal	$1,950	$1,983	$2,017	$2,051	$8,001
Total	$2,684	$2,729	$2,776	$2,823	$11,012

Table Notes:
(a) Based on adverse determination and appeals cost increases provided to DHCF by three of the current MCO vendors
(b) Assumes 1.7 percent growth rate.
(c) Assumes 70 percent federal match for HSCSN enrollees and a 71.6 percent blended federal match for AmeriHealth Caritas, Amerigroup, and MedStar.
(d) Assumes 75 percent federal match for fee-for-service enrollees due to an enhanced Medicaid match for operation of an approved Medicaid management information system for claims and information processing.[9]

Public Facing Determination Statistics

The bill requires utilization review entities to publish on their website statistics regarding prior authorization, adverse determinations, and appeals. MCOs and fee-for-service case management

[8] Id.
[9] Id.

vendors must update their websites to provide public facing determination statistics. Each website requires a one-time design upgrade and ongoing maintenance costs. The resulting estimated rate increases based on public facing determination statistics are $1.29 million ($343,000 local, $945,000 federal) in fiscal year 2024 and $3.38 million ($931,000 local, $2.45 million federal) over the financial plan.

Bill 25-124, Prior Authorization Reform Amendment Act of 2023 Public Facing Determination Statistics ($ in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
Local	$343	$193	$196	$199	$931
Federal	$945	$494	$502	$511	$2,452
Total	$1,287	$687	$698	$710	$3,383

Table Notes:

(a) Based on one-time website upgrade and ongoing maintenance costs provided to DHCF by two of the current MCO vendors and the fee-for services pharmacy benefits manager.
(b) Assumes 1.7 percent growth rate.
(c) Assumes 70 percent federal match for health services for children with special needs enrollees and a 71.6 percent blended federal match for AmeriHealth Caritas, Amerigroup, and MedStar.
(d) Assumes 75 percent federal match for fee-for-service enrollees due to an enhanced Medicaid match for operation of an approved Medicaid management information system for claims and information processing.[10]

Extending Prior Authorization Duration to One Year

The bill requires that prior authorizations be valid for at least one year from the date of determination, except for treatment of chronic and long-term conditions. With the exception of institutional care and participant directed services, prior authorizations specify the number of units authorized for a specific treatment. Lengthening prior authorizations to a full year will not have a cost impact because it does not change the number of units authorized.

Private Insurance Market Impact

It is possible the bill's requirements may impact prices of individual, small group, and large group health plans, such as those offered through the District's DC Health Link or those provided by employers. Any increases in premiums due to the bill's requirements may increase the cost of the District's portion of employee's insurance premiums. The impact of the bill's provisions on monthly premium costs in the private insurance market is unknown at this time.

[10] Id.