



Health Services Advisory Council

October 8, 2025

Agenda

1. Welcome and Housekeeping

- Confirming March Minutes
- New member introductions
- New chair volunteer
- Meeting format
 - Topic Introduction
 - Discussion and Recommendations
 - Policy Development

2. Prior Authorizations – Program integrity

- Laurie Engeldinger

3. Conclusion and Adjournment

- Next meeting date
- Next meeting tentative agenda
- Adjournment



Streamlining Prior Authorizations: Understanding the New CMS Rules

Laurie Engeldinger, RN – Inpatient Policy Coordinator

Prior-Authorization Problems

- **Administrative Burden**
- **Patient Care Delays**
- **Clinician burn-out caused by manual processes**

Note: Definition Variables

- **Authorization**- approvals for retrospective claims if we would have approved pre-service/procedure. (up to one year).
- **Prior or pre-authorization**- needing an approval date in the system prior to the procedure or service.

- Introduce the new rule as a solution to increase efficiency
- Reduce burden for providers
- Improve access to care for patients

Based on final rule issued January 2024

Who is Affected

- Impacted Payors:
 - Medicare advantage payors
 - Medicaid
 - CHIP managed care plans
 - Fee-for-service programs
 - Qualified health plan issuers on the federal exchange

Not included:

- Traditional Medicare fee-for-service

Key Changes to Turn-Around Times

Effective January 1, 2026

- Payors must make decisions on standard requests within 7 calendar days and on expedited requests 72 hours.
 - This is down from 14 days

Increased Transparency and Specificity

- Clearer Communication
 - Payors must provide specific member- level reasons for denials and clearly state the duration of approved prior authorizations
 - We use a third-party reviewer that has expertise in utilizing the standard criteria for decision making on prior authorizations. (InterQual).
- Public reporting
 - Starting by March 31, 2026, payors publicly report prior authorization metrics including approval rates and average response times.

Moving to Electronic Prior Authorizations

- Beginning January 1, 2027, payors must have a system in place to allow providers to check requirements, submit requests, and receive responses directly through their EHR or practice management systems.
- Reviewing responses will be valuable for resubmissions and appeals.
- Starting in 2027, each provider will have to attest to sending at least one prior authorization through the electronic system. This impacts their performance scores.

MHCP requires authorization as a condition of MHCP payment if a health service, including a drug, meets one of the following:

- The health service could be considered, under some circumstances, to be of questionable medical necessity.
- Use of the health service requires monitoring to control the expenditure of MHCP funds.
- A less costly, appropriate alternative health service is available.
- The health service is investigative or experimental.

- The health service is newly developed or modified.
- The health service is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial.
- The health service is comparable to a service provided in a skilled nursing facility or hospital but is provided in a member's home.
- The health service could be considered cosmetic.

Members always have the right to appeal a decision.

Provider actions:

Reconsideration of a decision: Your provider can submit further information to the medical review agent for further review and potential approval.

Level Two reconsideration: In writing within 30 days of the denial.

- Two options:
 - Peer-to-peer with a provider from the medical review agent's office.
 - Peer review panel: the provider requests a review by a panel of medical professionals.

MHCP Members have the right to appeal their case to a human services judge

- Request a fair hearing
- Can be requested in writing or by phone
- Judge will either uphold or reverse the agencies decision
- 30 days to file after notice or action.

Examples of Codes Under Review With Changes

- For prosthetics, before the 2025 law, we only covered one device with authorization always. For amputees, we now cover the initial devices for everyday use and bathing without authorization, with some exceptions. We require authorization for all subsequent devices.
- For mobility devices, we no longer require authorization for most manual wheelchairs. We used to require authorization for all purchases and rentals after three months. We now require authorization for all rentals and purchases for devices that are not listed in the bulleted list above. I highlighted standard, hemi, and lightweight wheelchairs as examples.

Recent Changes to Prior Authorization in MHCP

[Chapter 127 - MN Laws](#) (see articles 55 and 57, various sections)

The 2024 Legislature also made some changes to prior authorization in MHCP, effective January 1, 2026, including:

- Applying certain provisions of chapter 62M that currently apply to health plans to MA and MinnesotaCare (both fee-for-service and managed care/county-based purchasing plans), as well as new provisions for both.
- Prohibits prior authorization for
 - any class of drugs approved by the FDA for the treatment or prevention of HIV and AIDS
 - outpatient mental health or outpatient SUD treatment, except for medications;
 - antineoplastic cancer treatment consistent with NCCN guidelines, except for medications;
 - services with an A or B rating from the USPSTF, immunizations recommended by ACIP, or certain preventive services/screenings for women;
 - pediatric hospice services;
 - treatment delivered through a neonatal abstinence program operated by a pediatric pain or palliative care subspecialist.

Questions to HSAC

- In your practices, are there specific prior authorization workflows that you find frustrating/unwarranted?
- What information would be helpful to you and other providers as these changes are implemented?
- Are there specific procedures you believe should no longer need prior authorization?
- In your personal experiences have you had to go through steps to get a procedure prior authorized? What were the frustrations?

Thank you!

- Other questions or comments?

Conclusion and Adjournment

- Next meeting date
 - Wednesday December 10th 5:30 – 7:30pm
- Adjournment



Adjournment

Thank you