2024 Annual Health Equity Analysis

In April 2023, CMS finalized a new regulation at § 422.137, which requires all MA organizations that use UM policies and procedures to establish a Utilization Management Committee to review and approve all UM policies and procedures at least annually and ensure consistency with Traditional Medicare's national and local coverage decisions and relevant Medicare statutes and regulations. In 2024, CMS issued additional requirements that beginning January 1, 2025, the UM committee must include at least one member with expertise in health equity. In addition, the UM committee must conduct an annual health equity analysis of the use of prior authorizations. The objective is to ensure that utilization management (UM) policies and procedures, including those for prior authorization, are reviewed from a health equity perspective and do not disproportionately impact specific groups of enrollees.

The analysis examines the impact of prior authorization at the plan level 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 (2) having a disability. Disability status is determined using the variable original reason for entitlement code (OREC) for Medicare, based on information from the Social Security Administration and Railroad Retirement Board record systems. CMS selected these SRFs because they align with the SRFs that will be used to measure the Health Equity Index reward for the 2027 Star Ratings (see § 422.166(f)(3)). CMS requires this analysis at the MA plan level because the relevant information regarding enrollees with the specified SRFs is available at this level and this level of analysis is important to discerning the actual impact of the use of utilization management on enrollees that may be particularly vulnerable to health disparities.

To gain a deeper understanding of the impact of prior authorization practices on enrollees with the specified SRFs, the analysis compares metrics related to the use of prior authorization for enrollees with the specified SRFs to those without these SRFs. This comparison allows the MA plan and CMS to identify whether the use of prior authorization causes any measurable disparities among enrollees with the specified SRFs. The analysis uses the following metrics:

- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.

- The percentage of standard prior authorization requests that were denied, aggregated for all items and services.

- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.

- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.

- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.

- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.

- The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, aggregated for all items and services.

- The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, aggregated for all items and services.

Additionally, CMS added that by July 1, 2025, and annually thereafter, the health equity analysis be posted on the plan's publicly available website in a prominent manner and clearly identified in the footer of the website. The health equity analysis must be easily accessible to the general public free of charge, without requiring the establishment of a user account or password, without the need to submit personal identifying information (PII), and in a machine-readable format.

The following analysis was completed for the 2024 calendar year for the plan:

Measure	Enrollees without Social Risk Factors	Enrollees with one or more Social Risk Factors
The percentage of standard prior authorization requests that were approved, aggregated for all items and services.	98.78%	98.68%
The percentage of standard prior authorization requests that were denied, aggregated for all items and services.	1.19%	1.32%
The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.	0.16%	0.03%
The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.	0.02%	0.03%
The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.	98.16%	97.61%
The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.	1.84%	2.39%
The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, aggregated for all items and services. (days)	Average: 0.4453 Median: 0	Average: 0.4936 Median: 0
The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, aggregated for all items and services. (days)	Average: 0.2250 Median: 0	Average: 0.2732 Median: 0