Prior Authorization

Karlee Tebbutt
Regional Director, State Affairs
North Dakota Health Care Committee
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About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Agenda

- **Background on Prior Authorization**

- **AHIP/Health Plan Initiatives to Improve Prior Authorization**
  - Prior Authorization Consensus Statement
  - AHIP/Health Plan Initiatives to Improve Prior Authorization
  - 2022 AHIP Industry Survey

- **Federal Policy Update**
  - CMS Advancing Interoperability and Improved Prior Authorization Processes Final Rule

Prior Authorization

What is Prior Authorization?

- A process for health care providers to get approval from a patient's health plan before care is delivered to qualify for coverage

Who Uses PA?

- Commercial plans
- State employee plans
- Medicaid plans (FFS and MCO)
- Medicare (FFS and MA)
- TRICARE

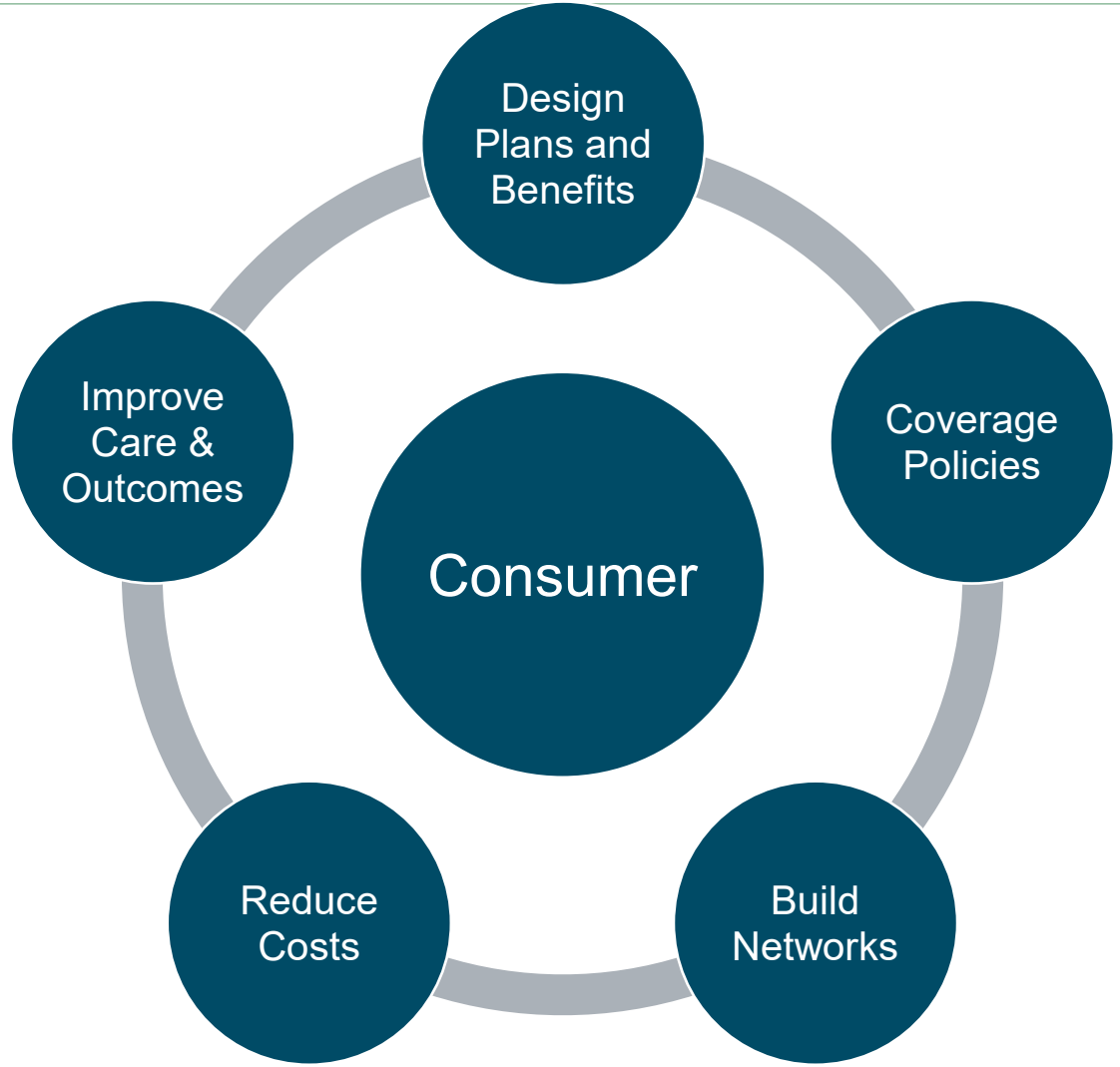
Why do Health Plans Use PA?

Promote evidence-based care to

- Improve quality
- Protect patient safety
- Address areas prone to misuse

Health Insurance Providers = 360º View

MEDICAL



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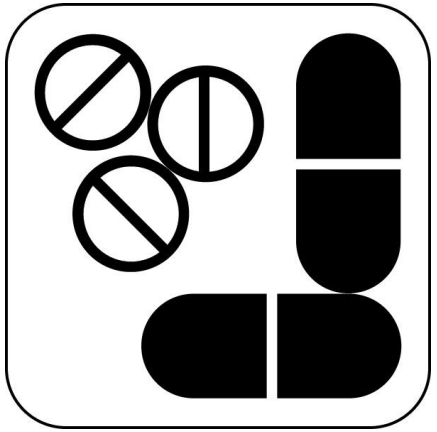


Prior Authorization – Necessary for Patient Safety

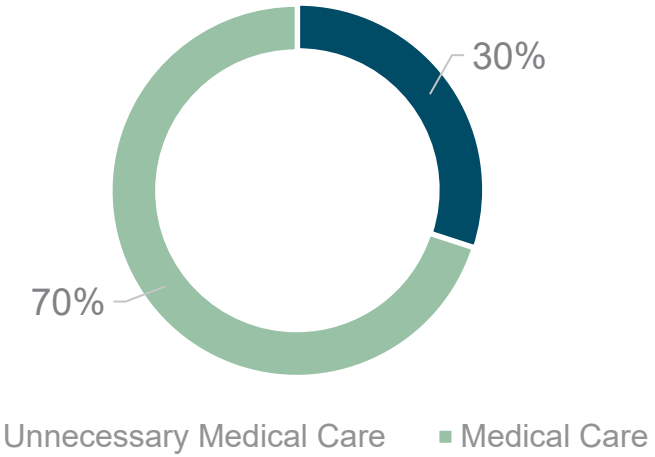
Wide variations in care occurs with little to no correlation between spending and quality.

- ***Inappropriate Care:***
  - Majority of patients were **overprescribed opioids** following elective procedures and there is wide variation in prescribing. (Annals of Surgery)
  - 1 in 4 children in children's hospitals are prescribes antibiotics incorrectly, contributing to dangerous drug resistance bacteria. (Washington Univ School of Medicine)
  - **Up to half of all antibiotic use is inappropriate**, exposing patients to additional risks. (JAMA)
  - 30-60% of diagnostic imaging for three common conditions in one state was inappropriate. (Int. Journal for Quality in Health Care)
- ***Medical Knowledge Moves Too Fast***:
  - Amount of medical knowledge **doubled every 73 days** in 2020, making it impossible for physicians to stay on top of new findings, innovative care options or changes to medical guidelines. (American Clinical and Climatological Assn)
  - Primary care providers would have to practice medicine for nearly 27 hours per day to keep up with the latest guidelines. (Journal of Internal Medicine)
  - There is a high-degree of care variability that exists from institution to institution, and physician to physician. (NBER)

Prior Authorization – Necessary for Costs

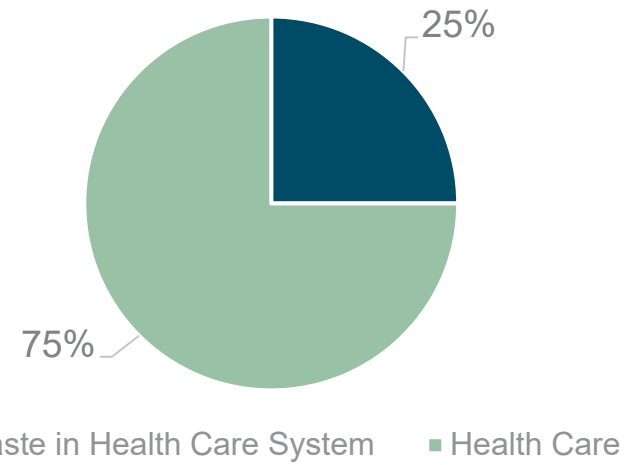
PLOS One Report

Majority of providers report 15-30% of medical care is unnecessary



JAMA Report

Cost of waste in the US health care system ranged from $760-$935 billion



AHIP/Health Plan Initiatives to Improve Prior Authorization

Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

   We agree to:

   - ***Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine***
   - ***Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers***

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2018 Consensus Statement

Stakeholders signing the consensus statement committed to work together to improve the prior authorization process.

Goals of the commitment:

- Promote safe, timely, and affordable access to evidence-based care
- Enhance efficiency
- Reduce administrative burdens

Recognized the prior authorization process can be burdensome for all involved but there is wide variation in medical practice and adherence to evidence-based treatment.

5 areas of opportunities for improvement to achieve meaningful reform:

- Selective application
- Program review and volume adjustment
- Transparency and communication
- Continuity of patient care
- Automation to improve transparency and efficiency

Fast PATH

In January 2020 AHIP worked with two technology partners and several member insurance providers to launch the Fast Prior Authorization Technology Highway (Fast PATH) initiative to better understand the impact of electronic prior authorization on improving the prior authorization process.

- Fast PATH Webpage
- Fast PATH Results
- Final Report
- Peer-Reviewed JAPhA Article Highlights Results Fast PATH Initiative to Improve Prior Authorization

- **Faster time to decision:** Median time between submitting a PA request and receiving a decision from the health plan was more than 3 times faster, falling from 18.7 hours to 5.7 hours – a reduction of 69%.
- **Faster time to patient care:** 71% of providers who used the technology for most or all of their patients (referred to as experienced users) reported that patients received care faster after providers implemented ePA.
- **Lower provider burden from phone calls and faxes:** 54% of experienced users reported fewer phone calls and 58% reported fewer faxes after implementation of ePA. 62% of experienced users reported less time spent on phone calls and 63% reported less time spent on faxes after implementation of ePA.
- **Improved information for providers:** 60% of experienced users said ePA made it easier to understand if PA was required.
- **Greatest benefit for experienced users:** The more frequently a provider used the technology solution, the bigger the benefit the provider experienced in reducing the burden and improving the ease of understanding PA information.

Clinical Appropriateness Measures Collaborative Project

In 2020-2021, AHIP launched a project with Dr. Martin Makary (Johns Hopkins Univ. School of Medicine) on a data-driven, collaborative approach to promote evidence-based care.

In this research, the team analyzed data using physician-led appropriateness measures based on consensus among specialists.

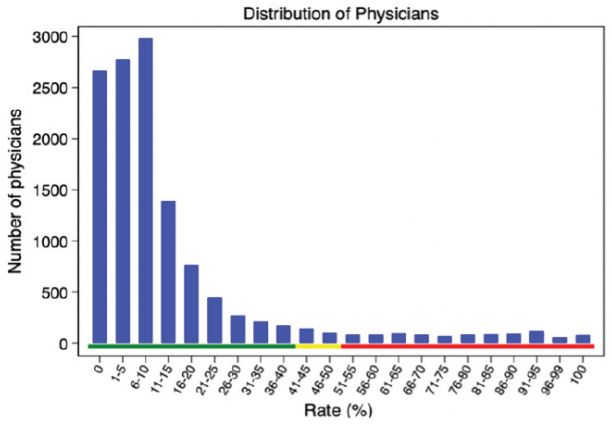
Physicians were then benchmarked to their peers, and data was shared at an individual physician level.

- Clinical Appropriateness Measures Collaborative Project Results

- In collaboration with 7 AHIP members, Dr. Makary's team analyzed 5 measures of interest in the specialties of gastroenterology, orthopedic surgery, and nephrology.
- About 10% of physicians provided care inconsistent with evidence-based standards of care, as defined by their respective specialty societies.
  - While this number may seem small, each of these physicians treats many patients, **making the number of affected patients significant**.
  - Improving physician performance will result in better care and outcomes for patients.
  - Studies have shown that physicians presented with data showing their performance relative to their peers can influence under-performing providers to change their behavior.
- Policymakers should consider these findings when restricting or limiting the use of medical management tools designed to promote evidence-based care, such as prior authorization.

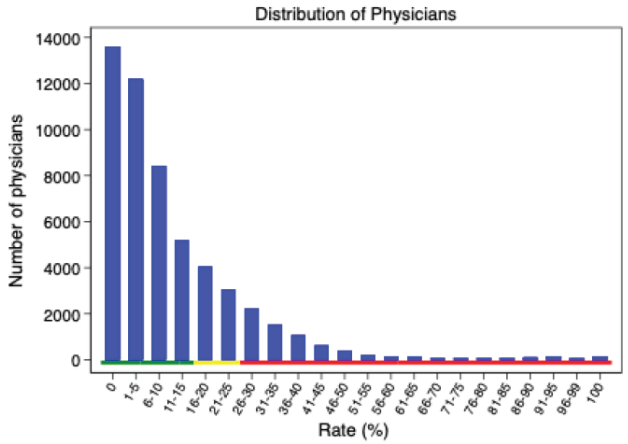
Rate of Different Day Bidirectional Endoscopy

Of 12,851 physicians included in the study, **7.4%** (946 physicians) performed outside of consensus-based standards of care.[4]



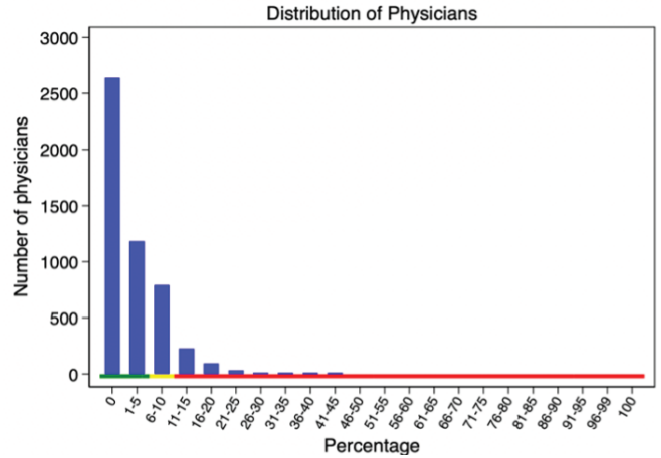
Rate of Add-on Upper Endoscopy During a Screening Colonoscopy

Of 53,388 physicians included in the study, **13%** (6,936 physicians) performed outside of consensus-based standards of care.[5]



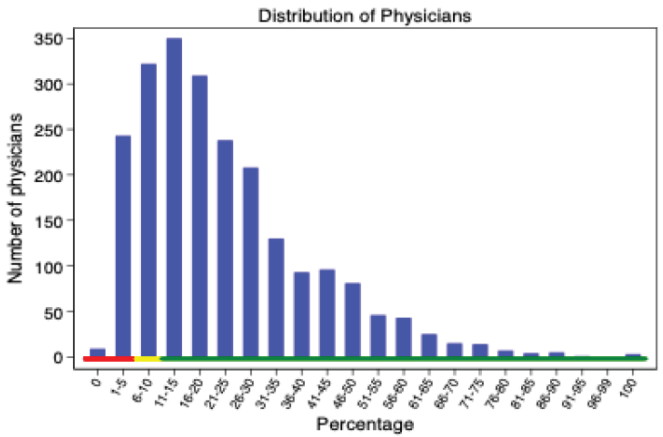
Rate of Knee Arthroscopy Prior to Knee Replacement Surgery

Of 4,975 physicians included in the study, **7.3%** (364 physicians) performed outside of consensus-based standards of care.[7]



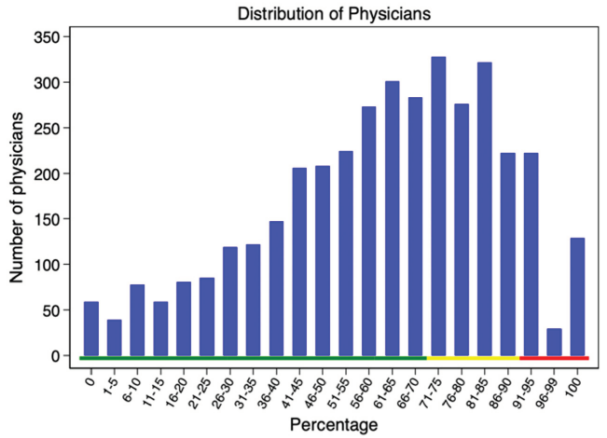
Rate of Home Hemodialysis

Of 2,242 physicians included in the study, **11.2%** (252 physicians) performed outside of consensus-based standards of care.[8]



Rate of Knee Arthroscopic Procedures that are Meniscectomy Only

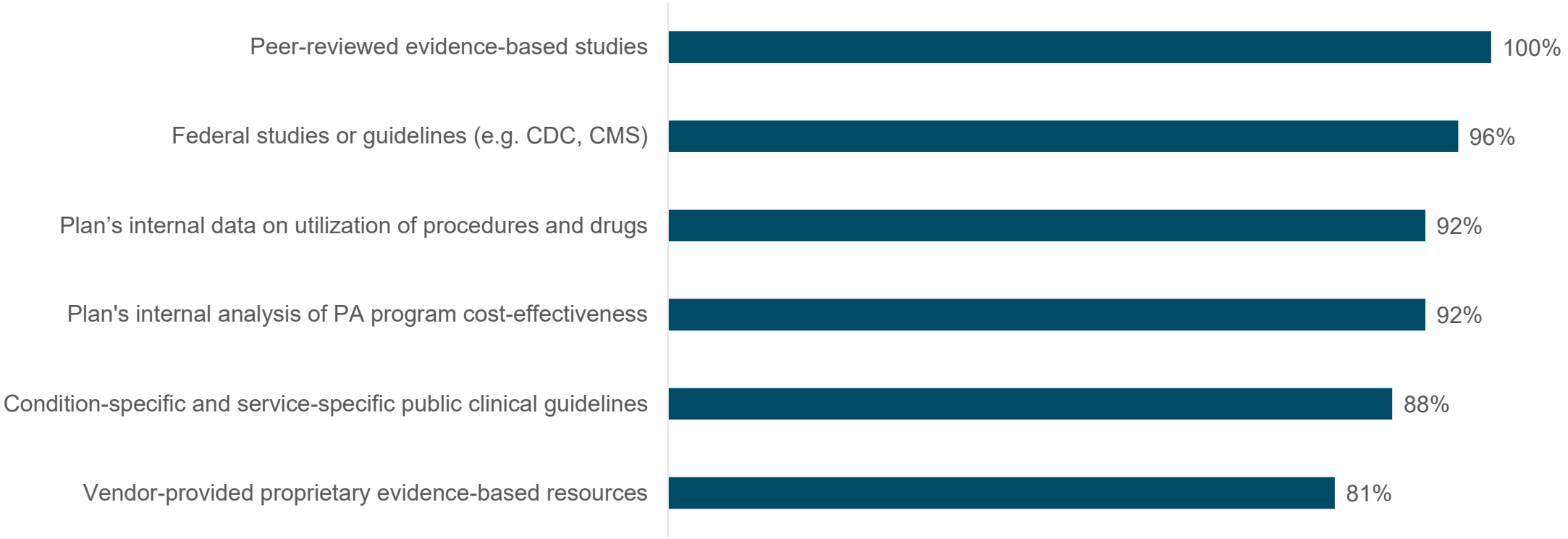
Of 3,812 physicians included in the study, **10%** (380 physicians) performed outside of consensus-based standards of care.[6]



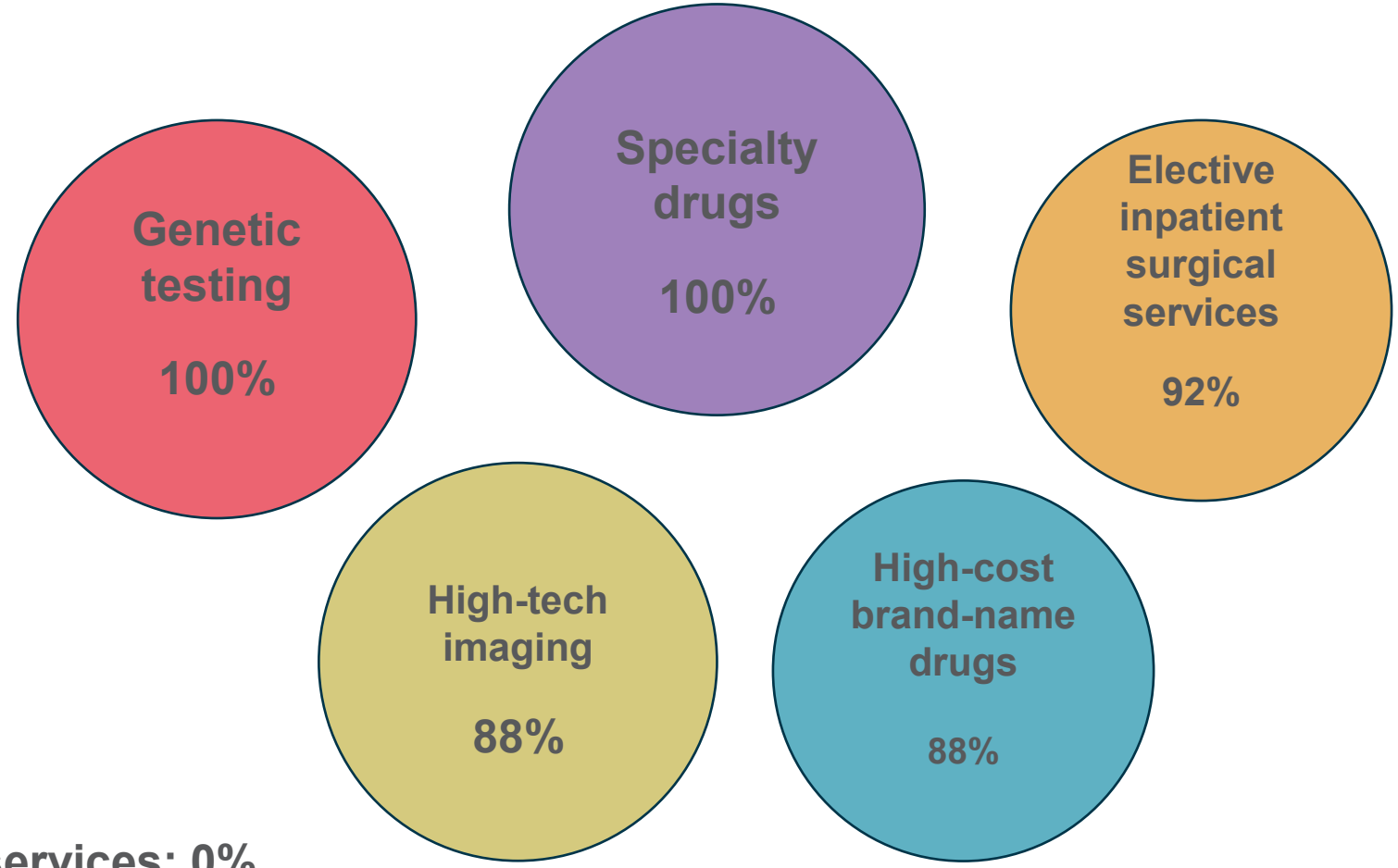
2022 AHIP Industry Survey

AHIP Survey:
Prior Authorization Programs Are Evidence-Based

When asked what resources are used in designing their prior authorization programs, plans reported using a range of evidence-based resources



AHIP Survey:
Most Common Treatments Subject to Prior Authorization



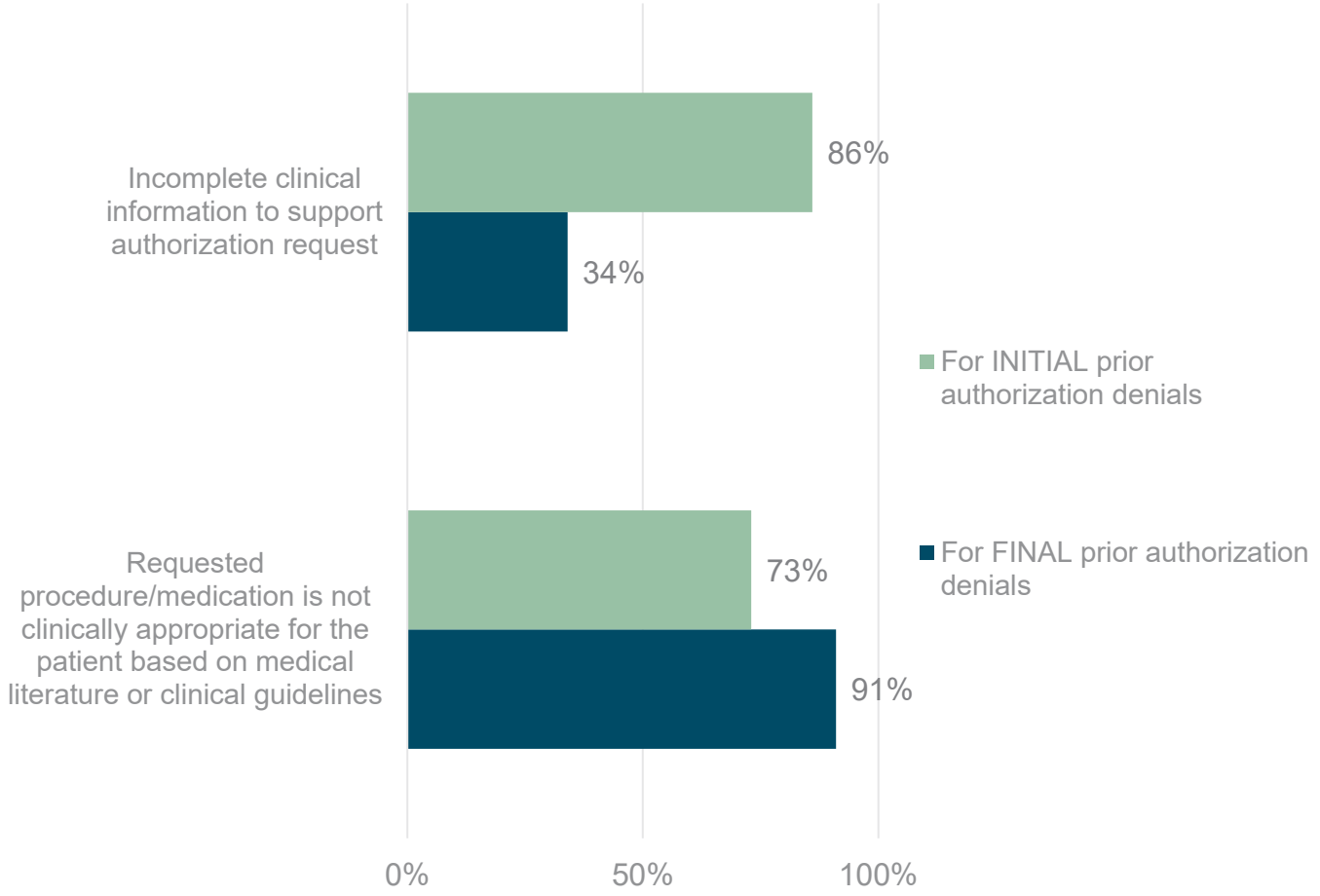
Primary care services: 0%
Emergency services: 0%

AHIP Survey:
Prior Authorization Requests

Incomplete information from providers is the most common reason for an initial denial.

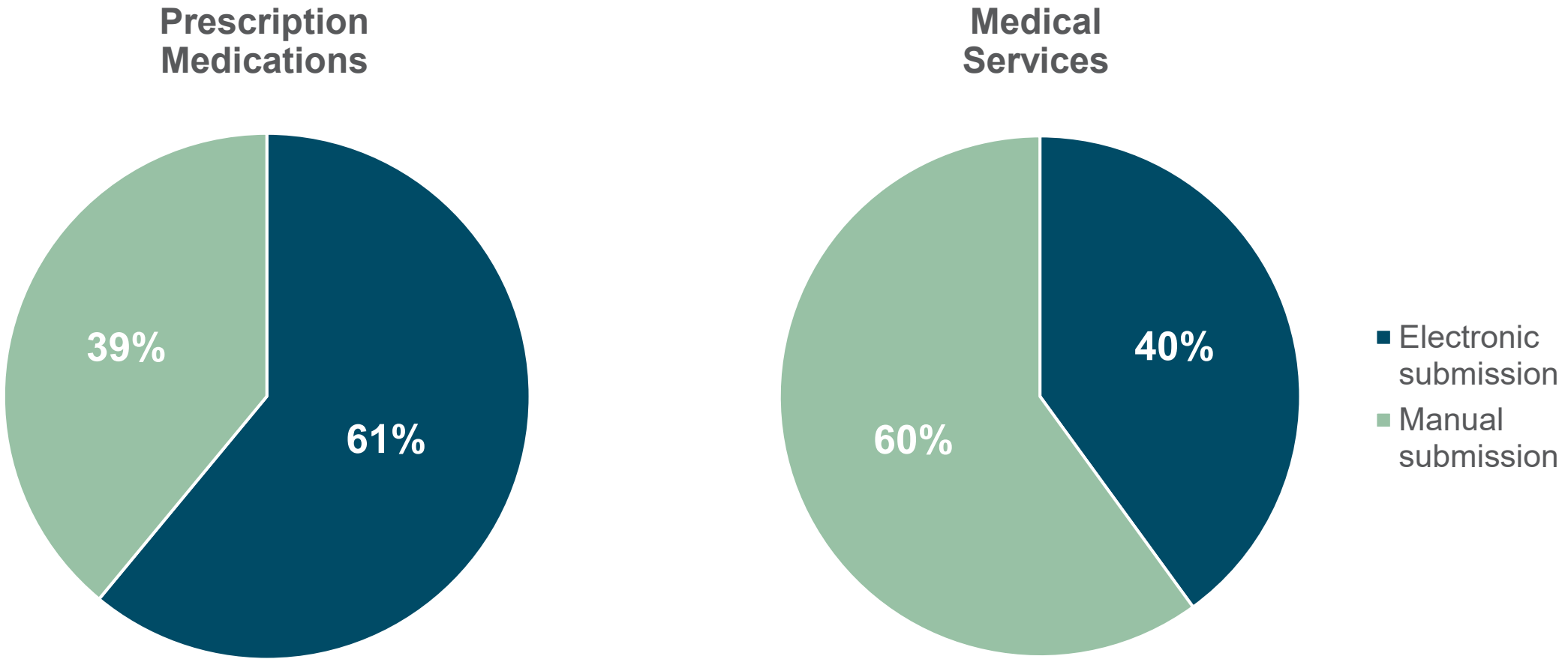
Requested medical service or medication not being evidence-based is the most common reason for a final denial.

Most Common Reasons for Denials



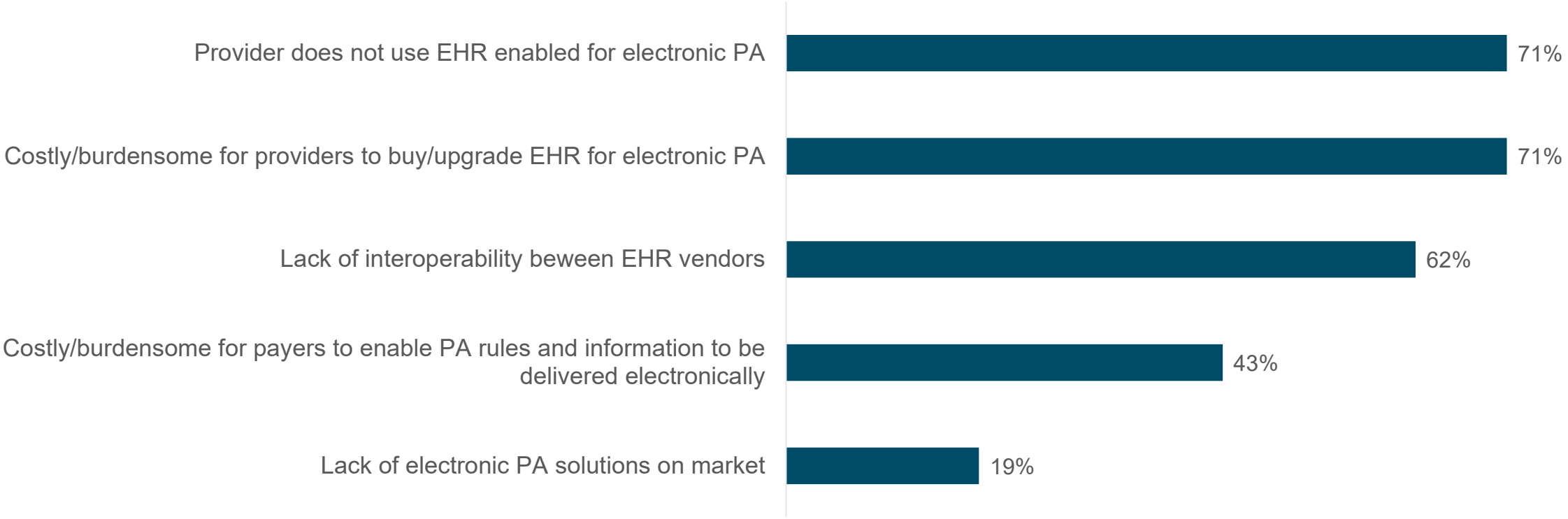
AHIP Survey:

Large Percentage of Prior Authorization Requests Submitted Manually



AHIP Survey:
Barriers to Prior Authorization Automation

Providers not using EHRs enabled for electronic prior authorization is the main barrier to greater use of ePA



Federal Policy Update

CMS Advancing Interoperability and Prior Authorization Processes Final Rule

CMS Advancing Interoperability & Prior Authorization Processes Rule

- Released 1.17.24
- CMS Final Rule
- CMS Fact Sheet

Impacted Parties:

- Issuers of QHPs on the FFE
- Medicaid MCOs & State Medicaid Agencies
- CHIP Agencies & CHIP MCOs
- Medicare Advantage Plans

Prior Authorization Standards

- **Response Timeframes:** Impacted payers must send a prior authorization decision within 72 hours for expedited/urgent requests and 7 calendar days for standard/non-urgent requests.*
- **Reason for Denial:** Impacted payers must specify a reason when they deny a prior authorization request.
- **Electronic Process for Requests and Decisions:** Impacted payers must build standardized electronic prior authorization systems to communicate when prior authorization is needed, necessary documentation, and communicate both. requests and decisions.
- **Provider Uptake:** Providers must adopt electronic prior authorization to meet quality requirements
- **Public Reporting:** Impacted payers must annually report certain prior authorization metrics on their website.

*Response time standards do not apply to commercial payers or QHPs, in part because CMS believes existing minimum internal claims and appeals standards for individual market insurers adequately protects patient interests.

CMS Advancing Interoperability and Improving Prior Authorization Processes Final Rule: **APIs**

- **Prior Authorization Requirements, Documentation, and Decision (PARDD) API:** Automates the process for providers to determine if prior authorization is necessary, the information required, and electronically exchange the request and the response
- **Patient Access API:** Allows patients to access claims and other information (including prior authorization information) through third-party apps of their choice
- **Provider Access API:** Shares clinical, encounter, and claims data and prior authorization requests and decisions with in-network providers
- **Payer-to-Payer API:** Allows insurers to share clinical and claims data (including prior authorization information) when consumers change insurers

Thank You!

Karlee Tebbutt
Regional Director, State Affairs
ktebbutt@ahip.org
720.556.8908