



Prior Authorization

Health Information Technology Advisory Committee

Office of the National Coordinator for Health Information Technology

Kate Berry

Senior Vice President, Clinical Innovation and Strategic Partnerships, AHIP

March 20, 2019
Washington, DC

Who is AHIP?

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage and health-related services that **improve and protect the health and financial security of consumers, families, businesses, communities and the nation.**

Our Mission

America's Health Insurance Plans and its members **create and accelerate positive change and innovation across the health care system for consumers** through market-based solutions and public-private partnerships that advance affordability, value, access, and well-being.

Our Values

We shape and drive market-based solutions and public policy strategies to improve health, affordability and financial security by:



Promoting consumer choice and market competition



Supporting constructive partnerships with all levels of government



Pursuing the promise of clinical innovations while ensuring value



Harnessing data and technology to drive quality, efficiency and consumer satisfaction



Simplifying the health care experience for individuals and families



Partnering with health care providers on the journey from volume to value



Addressing the burden of chronic disease and social factors that impact health

The Value of Medical Management

Wide variations in care with little to no correlation between spending and quality. Many studies show that Americans continue to receive inappropriate and potentially harmful care at a significant cost.

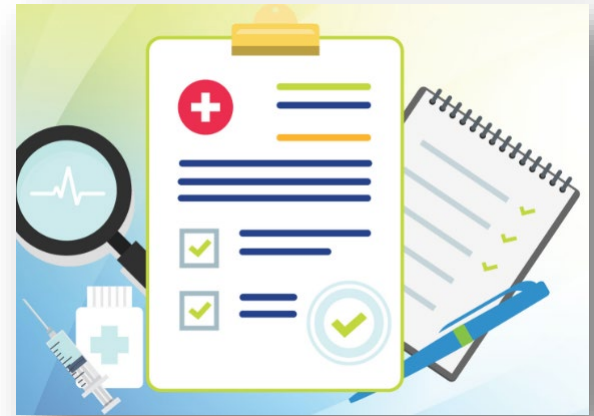
#BY THE NUMBERS#

Stats	Source
65% of physicians reported that at least 15-30% of medical care is unnecessary	PLOS One
Between \$200-\$800 billion is wasted annually on excessive testing and treatment. In 2009 alone, about 30% of spending - \$750B – was wasted on unnecessary services	Institute of Medicine
Many traditional Medicare beneficiaries receive “low value” care – where there is little or no clinical benefit or where risk outweighs potential benefit, at an estimated cost of \$2.4-\$6.5 billion a year	MedPAC
Just 5 low-value services account for more than \$25B in unnecessary spending	Task Force on Low-Value Care
Nearly half of hospitalized children and teens were given at least one drug combination that could have led to adverse outcomes – e.g., opioids, antibiotics, and other infection-fighting drugs	Pediatrics
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
The majority of patients were overprescribed opioids following elective procedures and that there is wide variation in prescribing	Annals of Surgery

Prior Authorization Promotes Safer, Smarter Care

While the percentage of covered services, procedures, and treatments requiring PA is relatively small (typically less than 15%), **insurance providers cite multiple benefits of prior authorization -**

- ✓ Plans report that **up to 25% of PA requests they receive from clinicians are for care that is not supported by medical evidence.**
- ✓ Plans report that **PA is critical to identifying potential overuse, misuse, and safety issues before care is delivered.**
 - ✓ Opioids prescribed for patients also receiving benzodiazepines
 - ✓ MRIs for low back pain without documentation that patient received 6 weeks of conservative therapy, which is recommended by leading medical societies
 - ✓ Medications prescribed “off-label” for indications not approved by FDA
 - ✓ Antipsychotic medications prescribed for children and adolescents
- ✓ A majority of plans also credit PA with **improving physician performance and promoting dialogue between the plan and its clinicians.**
- ✓ PA helps trigger action by the plan to monitor **care coordination.**



Prior Authorization Policies

- Developed using evidence-based criteria, input from clinicians (e.g., P&T committees)
- Reviewed and revised at least annually
- Accessible to participating providers, members
- Exceptions processes
- Many aspects of UM - including use of evidence-based criteria, input from clinicians, exceptions, timeframes, annual review/revision – part of accreditation

Selective Application of Prior Authorization

- Consensus statement on improving the prior authorization process identified several opportunities
- AHIP next steps underway:
 - Selective Application/Delegation of UM for risk-sharing arrangements
 - Automation of prior authorization process
- Collaboration with APG on developing a “delegation continuum” modeled after risk-based payment framework
- Identifies functions and framework for delegation across payment continuum

Challenges with “Gold Carding”

- Performance tends to slip once gold carded
- Performance typically varies across services, so difficult to gold card a provider across all services
- Providers within same clinic/group often perform differently
- Potential conflict with state laws that preclude treating enrollees differently
- Authorization/claims systems not always configurable to support different workflows

A Better Solution: Automating PA

- ePA has potential to streamline process for all stakeholders
- Goals of AHIP's ePA pilot project:
 - Multiple approaches (e.g., clinical domains, clinical settings)
 - Standards-based, scalable solutions
 - Payer agnostic
 - Integrated with practice workflow

Process and Next Steps

- Sent request for proposals (RFP) to vendors
- Finalists presented to AHIP members
- Now scoping projects with 2 vendors
- Will engage independent organization to evaluate impact
- The demonstration is expected to be relatively short term
- Targeting to complete evaluation and release report (late 2019/early 2020)