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Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Follow Up to Patients over Paperwork Listening Session Regarding Evidence-Based Medical Management

Dear Administrator Verma:

Thank you for inviting America's Health Insurance Plans (AHIP) to participate in a recent listening session on Patients over Paperwork to discuss how we can streamline administrative processes to improve the patient experience. AHIP and our member companies agree that Americans deserve safe, effective, efficient care that delivers better health outcomes, as well as better value. When health insurance providers employ data-driven, evidence-based medical management tools like prior authorization, it should be done in such a way that delivers on this commitment.

We understand that the Centers for Medicare and Medicaid Services (CMS) may announce recommended approaches for improving prior authorization processes in the coming weeks, and we stand ready to take meaningful action to make prior authorization better for patients and consumers. We are committed to and working diligently to demonstrate the value of prior authorization while streamlining the process, continuing to protect patients, and improving affordability. We believe these efforts could help inform your discussions and wanted to share our perspective.

Patient Care Should be Based on Proven Evidence

Americans deserve affordable coverage choices that allow them to get the high-quality care they need at a price they can afford. That means ensuring that health care providers focus on value and outcomes – not the volume of services. Unnecessary, low-value care, wide variations of unproven treatments, and treatments that may be clinically appropriate only for patients with specific conditions undermine quality and value for everyone.

That is why evidence-based medical management is so essential to a well-functioning health care system. Just like doctors use scientific evidence to determine the safest, most-effective treatments, health insurance providers rely on data and evidence to understand what tools, treatments, and technologies best improve patient health and provide the best value.

Value-driven solutions like prior authorization work. The percentage of covered services, procedures and treatments requiring prior authorization is small – less than 15 percent. Insurance providers use prior authorization in certain circumstances including for those prescription drugs and services that require special care, such as when:

- The risk of addiction looms large, such as opioids for chronic pain. Prior authorization can ensure that opioid prescribing complies with federal recommendations and other requirements (e.g., state laws) to promote safety and prevent abuse.
- Unnecessary treatment can be harmful. For example, protecting patients from unnecessary exposure to potentially harmful radiation from inappropriate diagnostic imaging, such as computerized tomography (CT) scans for back pain.
- The risks of a procedure may outweigh any benefits, such as in the case of power laparoscopic morcellators, which were found to cause and spread cancer in women who underwent gynecological surgery. The FDA also recently pulled vaginal mesh from the market because it caused health problems in women including infections, incontinence and chronic pelvic pain.

The following are real examples from Chief Medical Officer leaders within health insurance providers that demonstrate the effectiveness and importance of prior authorization:

- A provider prescribed opioids for pain management for a patient who was also taking benzodiazepines, which can result in severe drug interactions, adverse events, or even a potential overdose.
- A clinician prescribed a bilateral fusion of the spine in the lower back without supporting evidence, which can lead to more surgery, more complications and more costs for the patient.
- A doctor prescribed alprazolam (Xanax) when the patient was also receiving ketoconazole (an antifungal), which is contraindicated for patient safety reasons because the combination can result in potentially severe reactions such as slowed breathing.
- Unnecessary tests with ionizing radiation were prescribed for a patient that had already had higher exposure to radiation from previous tests – this could have put the patient at risk, exposing them to dangerous levels of radiation.

In Medicare Advantage, too, we see the value of medical management, including prior authorization. Extensive studies comparing Medicare Advantage to traditional Medicare have shown remarkable care improvements. A recent peer-reviewed study found that, on average, Medicare Advantage provides "substantially higher quality of care" by outperforming traditional Medicare on 16 out of 16 clinical quality measures, and achieving equivalent or higher scores on five out of six patient experience measures[1]. In other studies, Medicare Advantage plans have been shown to reduce hospital readmissions and institutional post-acute care admissions while also increasing rates of annual preventive care visits and screenings[2345].

[1]Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. Health Services Research 52(6), Part I: 2038-2060. December 2017.
[2] Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. Health Affairs 36(1): 91-100. January 2017.
[3] Sukyung, Chung, Lesser, Lenard I., Lauderdale, Diane S., et. al. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. Health Affairs 34(1): 11-20. January 2015
[4] Ayanian, John Z., Landon, Bruce E., Zaslavsky, Alan M., et al. Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional Medicare. Health Affairs 32(7):1228-1235. July 2013.
[5] Lemieux, Jeff Sennett, Cary Wang, Ray, et al. Hospital readmission rates in Medicare Advantage plans. American Journal of Managed Care 18(2): 96-104. February 2012.

AHIP and our members have worked consistently to convey information and provide education on the benefits of medical management and prior authorization to providers, patients, policymakers, and other stakeholders. Its value has been recognized not just in the private sector by plan sponsors (e.g., employers) but by public programs as well. Both Medicaid and Medicare rely on medical management to improve outcomes and value:

- The Institute of Medicine estimates that 10 to 30 percent of health care spending is wasted on excessive testing and treatment[6].
- Medicare fee-for-service beneficiaries receive a significant amount of "low-value" care, with conservative estimates of cost ranging from $2.4 billion to $6.5 billion per year[7].
- Needless medical tests waste billions of dollars every year – between $200 billion to $800 billion is wasted annually on excessive testing and treatment[8].

Improving the Prior Authorization Process

We recognize and understand that prior authorization can and should be improved. We can balance efficiency and evidence with safety and medical necessity. We can reduce our health care system's continued reliance on paper transactions and enhance the role of automation and interoperability. We're committed to reducing unnecessary burden, increasing patient and provider satisfaction, and improving quality and outcomes. Here are some ways in which health insurance providers are working with other stakeholders to improve the prior authorization process:

- **Areas of Opportunity for Biggest Improvements:** In collaboration with groups representing health insurance providers, hospitals, providers, and pharmacists, a series of recommendations were identified that represent areas of significant opportunity to improve the prior authorization process. The five recommended areas included: (1) selective application of prior authorization requirements based on a provider's adherence to evidence, performance, or participation in risk-based contracts; (2) prior authorization program review and volume adjustment to make sure that services requiring prior authorization are current and evidence-based; (3) two-way transparency and communication of prior authorization requirements and clinical information necessary to make determinations; (4) exceptions or special allowances of prior authorization requirements to promote continuity of patient care; and (5) automation to improve transparency and efficiency.

- **AHIP Demonstration Project on Prior Authorization Automation:** Building on the recommendation to improve transparency and efficiency, AHIP is in the process of coordinating with two expert health information technology companies, multiple plans and providers to evaluate the impact of automating various components of the prior authorization process. The goal is to learn what works and to make recommendations for more widespread adoption. Our demonstration project will consider the impact on patients, providers, and plans of using different technology approaches to automate prior authorization that are standards-based, scalable, payer agnostic, and as integrated as possible with practice workflow. We have already learned a great deal about how to improve prior authorization solutions currently available in the market.

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[6] Variation in Health Care Spending: Target Decision Making, Not Geography; Institute of Medicine; July 24, 2013.
[7] Report to the Congress: Medicare and the Health Care Delivery System; MedPAC; June 2018.
[8] Best Care at Lower Cost: The Path to Continuously Learning Health Care In America; Institute of Medicine; September 6, 2012.

- **AHIP Prior Authorization Landscape Survey:** AHIP's Board of Directors has identified improvements to prior authorization as an important opportunity to reduce provider abrasion and improve patient experience. AHIP is completing a survey of the health plan community to understand the landscape of the use of prior authorization, including how it is used and why, the types/categories of services where there may be greater use, opportunities for improvement, etc. We are fielding the survey in the coming weeks and anticipate that results will be available before the end of the year.

- **Utilization Management Delegation Models and Best Practices:** AHIP has been collaborating with America's Physician Groups on delegation models. When providers and plans share financial risk and responsibility for managing populations, plans may delegate to providers some "insurance functions" including utilization management. We have held a series of meetings to understand the best practices, lessons learned, and a possible roadmap for plan/provider collaboration.

When patients do better, we all do better – for healthier individuals, a healthier community, a healthier nation. We welcome opportunities to work together to improve patient health, patient safety and affordability for everyone, and we welcome additional conversations with you and your team.

Sincerely,

Matthew Eyles
President and CEO