Statement for Hearing on

"Utilization Management: Barriers to Care and Burdens on Small Medical Practices."

Submitted to the
Committee on Small Business

September 10, 2019

America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) thank the Committee for focusing on the important issue of utilization management. AHIP and BCBSA's member health insurance providers are committed to ensuring patients receive clinically-effective, evidence-based, high-value care. While utilization management tools accomplish several things, these tools have been particularly critical in combatting the opioid epidemic. Further, with 65% of physicians reporting that at least 15-30% of care is unnecessary,[1] and national specialty societies coming together through a program called Choosing Wisely to identify tests and procedures commonly used whose necessity should be questioned by patients and consumers, utilization management is an increasingly important tool to ensure that patients receive safe, affordable, effective care. AHIP and BCBSA's member health insurance providers are committed to improving medical management tools to reduce burden and improve quality and outcomes.

Utilization management, also known as medical management, is used by health plans to protect patient safety; prevent unnecessary, inappropriate, and potentially harmful care; improve and better coordinate care; and increase health care affordability. Examples of medical management approaches include: evidence-based medical necessity review; formulary and provider tiered network designs; prior and concurrent authorization; quantity/dosage limits; and step therapy. Medical management tools are critical to ensure a well-functioning health system. These tools entail significant resources and costs for health plans, are never undertaken lightly, and are

[1] Overtreatment in the United States. Lyu H, et al. PLOS One. Sept. 6, 2017.

overseen by senior physician leadership (e.g., chief medical officers) and staffed with teams of clinicians and experts in evidence-review at our member companies.

Prior Authorization: A Targeted and Effective Form of Medical Management

Prior authorization is one example of effective medical management. Prior authorization takes place when a provider makes a request to the patient's health insurance provider before delivering a treatment or service. If the request is approved, the treatment or service is then covered by the patient's health plan consistent with the terms of that plan. Prior authorization is used to target treatments where there is wide variation in practice and gaps between what the clinical evidence shows and care patients receive. Examples include imaging for low-risk patients before low-risk surgery; imaging for acute low-back pain for the first six weeks after onset, unless there are clinical warning signs; and use of more expensive branded drugs when there are generics available with identical active ingredients. The percentage of covered services and procedures that typically require prior authorization is small—less than 15%.

Prior authorization is most useful in addressing overuse and misuse of treatments and services. For example, prior authorization is often used to:

- Ensure that providers follow nationally recognized care recommendations (e.g., ensure opioid prescribing is consistent with federal guidelines)
- Protect patients from unnecessary and potentially harmful care (e.g., unnecessary exposure to potentially harmful radiation from inappropriate diagnostic imaging, such as computerized tomography (CT) scans for headaches, inappropriate off-label drug use)
- Make sure that a medication is not co-prescribed with another medication that could have dangerous, even potentially fatal, interactions (e.g., opioids and benzodiazepines)
- Ensure that medications are safe, effective, and provide value for specific populations or subpopulations who may be affected differently by a medication (e.g., antipsychotic medications for children and adolescents)
- Ensure that the clinician providing the care has the appropriate training to deliver the care being requested (e.g., limiting prescribing of chemotherapy medications to oncologists)
- Trigger dialogue with clinicians to ensure tailored, patient-focused treatment plans that the patient can follow and that will improve outcomes such as when a patient is being treated for a substance use disorder and has other chronic conditions that need to be carefully managed by multiple specialists
- Ensure that when patients are prescribed a medication such as buprenorphine to treat opioid use disorder, the patient also receives services such as counseling, peer support, or community-based support which are critical to the success of the treatment

When developing prior authorization policies, health plans review information on the use of inappropriate treatments, practice variation for specific services, the extent to which providers deliver care consistent with evidence, safety concerns, and other relevant factors to determine

what services or drugs should be subject to prior authorization. Health plans regularly review the medical services and prescription drugs that are subject to prior authorization and make changes based on new evidence, adherence to recognized standards of care, or, in the case of new and emerging therapies, limited available evidence or safety concerns. These reviews are conducted by Pharmacy and Therapeutics committees with relevant clinical expertise.

Adherence to medical and pharmacy policy is required for network providers except when extenuating circumstances would suggest that an exception may be needed for a particular patient. For the most part, medical policy is managed *without* any pre-authorization requirements. However, consistent with their contracts with providers, health plans have the ability to asses a network provider's performance if retrospective review of their practice patterns shows unwarranted variation may be of concern.

In the case of policies where there is evidence of broad unwarranted variation by providers within a health plan's network, a plan may choose to put in place prior authorization to assure that the patient meets appropriate clinical criteria defined by the established evidenced-based medical or pharmacy policy. The purpose of the prior authorization is to demonstrate that the proposed treatment or procedure is truly indicated for that individual based on clinical evidence.

In addition, health plans have robust processes in place to address circumstances where an individual's attending provider can request an exception to medical management techniques if clinically appropriate. This occurs with step therapy, another type of medical management which encourages prescribers to use prescription drugs that are safe, clinically appropriate, and cost effective before using drugs that could pose safety and complex clinical concerns, have higher costs, or both. Providers can appeal a step therapy requirement if the first prescription drug has been tried (and was ineffective or not well tolerated) or is likely to result in an adverse event for the patient. Health plans take such requests seriously and review requests on an expedited basis for urgent cases.

The Centers for Medicare & Medicaid Services (CMS) has repeatedly recognized prior authorization as a valuable tool to protect patients and the Medicare Trust fund, and has taken a number of actions to thoughtfully expand its use as mentioned below, including expanding Medicare Advantage plans' authority to use prior authorization in conjunction with step therapy for Part B (physician-administered) drugs[2] and expanding the use of prior authorization in Medicare fee-for-service to additional items and services such as durable medical equipment[3] and imaging services.

The Crucial Role of Medical Management in the Opioid Epidemic

[2] Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage, CMS. Aug. 7, 2018.
[3] Medicare Program; Update to the Required Prior Authorization List of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items That Require Prior Authorization as a Condition of Payment, CMS. April 22, 2019.

Medical management has further demonstrated its value as an effective tool in combatting our country's opioid epidemic. Health plans use medical management tools when addressing pain management in patients to encourage providers to try non-opioid approaches to manage pain, limit opioid dosages and duration to reduce unnecessary opioid prescribing and the potential for diversion and treat opioid use disorder (OUD). As a result, data show that opioid prescribing has meaningfully declined in recent years.

Health plans use prior authorization, for example, to protect patients from dangerous combinations of drugs such as when a patient may be prescribed opioids for pain management and another physician prescribes a benzodiazepine which together may result in impaired breathing or other serious drug interactions. Prior authorization can also be used to limit quantity, daily dosages, and the number of refills, consistent with evidence-based guidelines that promote access to appropriate pain care and reduce the risk of addiction. Health plans have used prior authorization as an effective tool to emphasize the Centers for Disease Control and Prevention guidelines which reflect the industry gold standard for opioid prescribing guidance and encourage providers to carefully monitor their opioid prescribing.

Medical management also promotes safe and effective access to medication-assisted treatment (MAT). According to the National Institutes of Health, MAT has the highest probability of being effective in treating OUD when prescribed and monitored safely. Health plans are committed to providing those who have OUD with access to safe and effective treatment options, including MAT, which involves the use of U.S. Food and Drug Administration-approved medications in combination with counseling and behavioral therapies to treat substance use disorders. Medical management can be used to:

- Ensure that the clinician administering MAT has the required training and regulatory approval
- Make sure MAT medications, when co-prescribed with benzodiazepines or other drugs that depress the central nervous system are carefully managed to reduce the risk of serious side effects
- Work with clinicians to ensure tailored, patient-focused treatment programs are in place to promote adherence and improve outcomes
- Encourage the use of "centers of excellence" for OUD that coordinate with specialized staff and peer recovery specialists
- Monitor members newly prescribed MAT medication to make sure the medication is accompanied by services such as cognitive behavioral counseling, peer support, and community-based support groups.

The Use of Medical Management in Public Programs

The value of medical management and prior authorization has not only been recognized in the private sector but by public programs as well. The Medicare fee-for-service program for example, has used prior authorization since 2017 for certain durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that are frequently subject to unnecessary utilization. Medicare has also begun implementation of an evidence-based guideline and prior authorization program for advanced diagnostic imaging. Additionally, Medicare has implemented numerous prior authorization demonstration programs for specific services, including repetitive, scheduled non-emergent ambulance transports, non-emergent hyperbaric oxygen therapy, home health services, and power mobility devices. A recent Government Accountability Office report recommended that Medicare continue these prior authorization efforts, estimating that savings from prior authorization demonstrations through March 2017 could be as high as $1.9 billion.[1] Further, just a few weeks ago, as part of the Fiscal Year 2020 Outpatient Prospective Payment System (OPPS) Proposed Rule, CMS proposed new prior authorization requirements for certain cosmetic-related services as a condition of Medicare payment.

Commitment to Streamlining the Prior Authorization Process

Health insurance providers are committed to reducing unnecessary burden, increasing patient and provider satisfaction and improving quality and outcomes. AHIP and BCBSA and our member health insurance providers worked alongside hospitals, providers and pharmacists to identify a series of recommendations for improving the prior authorization process, including: selective application of prior authorization requirements based on a provider's adherence to evidence, performance, or participation in risk-based contracts; prior authorization program review and volume adjustment to make sure that services requiring prior authorization are current and evidence-based; two-way transparency and communication of prior authorization requirements and clinical information necessary to make determinations; exceptions or special allowances of prior authorization requirements to promote continuity of patient care; and increased automation to improve transparency and efficiency.

AHIP and BCBSA are dedicated to improving the prior authorization process for patients and providers, leveraging the recommendations of the aforementioned multi-stakeholder group. Continued progress will require a willing partnership with the provider community, where the end goal is not to outright ban utilization management tools but to acknowledge the value that these tools provide by protecting patients and promoting affordability, while finding the right balance of these tools so that they do not impede access to timely care.

Ongoing Efforts by Health Plans to Improve the Prior Authorization Process

Building on these recommendations and feedback from health insurance providers, AHIP is conducting a major effort to improve the prior authorization process. These efforts include coordinating a demonstration project with health information technology companies, plans, and providers, to evaluate the impact of automating various components of prior authorization. The project will test prior authorization automation solutions that are as integrated as possible with practice workflow and have the potential for widespread adoption.

BCBSA is a participant on the Office of the National Coordinator's Payer to Provider Task Force, an effort aimed at addressing the interoperability of communications between payers and providers in the clinical data arena, including prior authorizations. BCBSA and member companies have committed funds and resources to federal efforts to make authorization simpler and less burdensome to providers through improved technology solutions.

Both AHIP and BCBSA continue to actively engage with provider organizations to identify ways to improve prior authorization and other medical management tools to ensure patient safety, address the costs of healthcare and reduce administrative burden. In just a few weeks, AHIP will be co-hosting a workshop with America's Physician Groups to explore how medical management and other functions are delegated to physician groups under various risk-sharing arrangements.

Legislation Addressing Medical Management

Efforts are underway in the private sector and within public programs to streamline the use of medical management and prior authorization. Statutory restrictions on medical management will hinder the ability of these tools to address both existing areas of continued misuse as well as future areas yet to be identified. The numerous studies documenting inappropriate care in a variety of settings for different medical procedures, tests and treatments – not to mention the increasing number of emerging therapies entering the market – underscore the continued need for robust tools and strategies that support sound clinical decision-making. AHIP and BCBSA urge the Committee to preserve the flexibility of private payers, medical groups taking on medical management functions and public programs to use these medical management tools to help ensure safe, effective and affordable care for patients.

Conclusion

Needless medical tests harm patients and waste billions of dollars every year; $200-$800 billion is wasted annually on excessive testing and treatment.[4] Medical management ensures patients have access to safe and clinically-effective health care services and addresses this type of waste in our health care system. Health insurance providers are committed to working with stakeholders to ensure medical management tools are used to promote evidence-based care without imposing unnecessary burden.

Thank you for the opportunity to provide these comments. Please contact us if you have questions or would like more information.

[4] Best care at lower cost: the path to continuously learning health care in America. Institute of Medicine. September 6, 2012.