

# Prior Authorization Facilitates Safe, Evidence-Based Care

Fact Sheet JANUARY 2021

## Key Facts

- Prior authorization ensures beneficiaries receive the most clinically appropriate and cost-effective care.
- 99 percent of Medicare Advantage enrollees are in plans that utilize prior authorization.
- Prior authorization protects patients from unexpected medical bills and reduces exposure to duplicative and unnecessary services.
- Prior authorization allows patients to access an equally effective, lower-cost generic prescription medication.
- Health plans work to simplify the process for providers and reduce uncertainty for beneficiaries.

## BMA Policy Recommendations

The Centers for Medicare and Medicaid Services (CMS) should continue to allow Medicare Advantage plans to use utilization management tools, such as prior authorization, that provide value to patients. Medicare Advantage plans should continue their efforts to streamline and simplify the process for patients and providers.

Medicare Advantage plans use various medical management and care coordination tools to ensure beneficiaries receive the most clinically appropriate and cost-effective care. A commonly used tool is prior authorization, in which the beneficiary's health care provider works with the insurer to make certain a treatment or service is the best option for the needs of the individual patient. It works to guarantee the most appropriate option available is used and that it will be covered by the health plan. Prior authorization promotes better, smarter health care delivery and protects seniors from unnecessary services and unexpected or out-of-network medical bills.

## Prior Authorization Benefits Patients

Prior authorization is often applied to certain procedures, medical equipment and prescription medications to ensure they are based on the best, most current evidence-based medicine. Prior authorization typically requires that a patient receive approval for referral to a medical service, and 99 percent of Medicare Advantage enrollees are in plans that utilize prior authorization. Plans work to simplify the process for providers and reduce uncertainty for beneficiaries, so that it is as timely and predictable as possible. The benefits of prior authorization include:

- Protecting patients from unexpected medical bills arising from receiving an item or service that is not covered by the health plan;
- Producing cost savings for the patient (i.e., lower co-pays) by ensuring that a clinically-equivalent, lower-cost alternative is offered first;
- Reducing the risk posed to patients by unnecessary services and procedures that may needlessly expose them to harm, such as advanced imaging procedures;
- Minimizing the utilization of services that are unnecessary, duplicative, or broadly agreed to be of low clinical value;
- Ensuring that care is delivered in the most appropriate setting, at the right time, and by the most appropriate in-network provider;
- Promoting communication between providers and health plans to ensure the coordination of care and alignment with patient-centered care plans.

## Prior Authorization and Prescription Drugs

Certain prescription medications may require approval from a health plan and be subject to prior authorization before the patient can access them. Medications that typically require prior authorization include high-cost brand name drugs for which an equally effective and lower-cost generic is available and to ensure adherence to evidence-based criteria for commonly abused drugs, such as addictive opioids. Prior authorization promotes the safe and effective use of prescription drugs by:

- Recognizing and preventing a prescribed drug from having an adverse interaction with another medication the patient may be taking;
- Ensuring that a drug is prescribed appropriately and is used to treat the condition or illness for which it was intended;
- Allowing the patient to access a cheaper, generic alternative if available; and
- Identifying when the prescribed dosage exceeds evidence-based criteria.