AMERICAN COLLEGE OF RHEUMATOLOGY

POSITION STATEMENT

SUBJECT: Prior Authorization

PRESENTED BY: Committee on Rheumatologic Care

FOR DISTRIBUTION TO: Members of the American College of Rheumatology
Medical Societies
Members of Congress
Health Care Organizations/Third Party Carriers
Insurance Companies and Commissioners
Pharmacy Benefit Managers
Managed Care Entities
Other interested parties

POSITIONS

1. Prior authorization (PA) requirements for approval of prescription medications and medical services create a significant burden on rheumatologists and rheumatology professionals, delay patient care, and may lead to treatment abandonment.
2. Prior authorization procedures must be modernized and simplified to ensure access to care for patients, by focusing on the following areas of improvement:
    a. Reduce the number of rheumatologists and rheumatology professionals subject to PA requirements
        i. The number of rheumatologists and rheumatology professionals subject to prior authorization requirements should be reduced based on performance, adherence to evidence-based practices, and/or participation in a value-based agreement with the health insurance provider.
    b. Reduce the number of services and medications that require a PA
        i. The services and medications that require prior authorization should be reviewed regularly, and prior authorization requirements should be eliminated for those therapies that no longer warrant them.
    c. Improve transparency
        i. Improve channels of communication between health insurance providers, health care professionals, and patients to minimize delays in care and ensure clarity on PA requirements, rationale, and changes.
        ii. Ensure requests are reviewed by qualified personnel with specialty-specific credentials and that rationales for denials are provided.
    d. Protect continuity of care
        i. Ensure no interruption of care for patients who are on an ongoing, active treatment or a stable treatment regimen when there are changes in coverage, health insurance providers or prior authorization requirements.
        ii. Require timely determinations by the health insurance provider.

e. Adopt national electronic standards for PA's
    i. Accelerate industry adoption of national electronic standards for PA's and improve transparency around formulary decisions and coverage restrictions at the point of care.

BACKGROUND

Prior authorization (PA) is the process whereby insurers require health care providers to obtain approval before providing specific pharmaceuticals and medical services, with the goal of reducing health care expenses by controlling plan members' access to expensive treatments. PA requirements often involve time-consuming processes that divert valuable and scarce provider resources away from direct patient care. There is no uniformity in the requirements for PA's between different insurers, and the processes frequently involve manually filling out multi-page forms for each patient for whom the provider has, via shared decision making with the patient, determined that a particular pharmaceutical or service is the best treatment option.

PA procedures interfere with patient care. The 2018 American Medical Association (AMA) Prior Authorization Physician Survey of 1000 practicing physicians quantified the significant burden that PA policies have on physician practices and on patients. The survey results made clear the **delays in patient care** that occur when PA is required: 65% of physicians reported waiting on average at least 1 business day for a response from the health plan, and 26% reported an average wait of at least 3 days before receiving a response to a PA request. 91% of the survey participants reported that PA requirements cause delayed access to necessary care for their patients. More than a quarter of the physicians surveyed reported that PA procedures had led to a serious adverse event for at least one patient in their care (a serious adverse event was defined as death, hospitalization, disability/permanent bodily damage, or other life-threatening event).

In addition to causing treatment delays, the PA process frequently leads to the patient abandoning the recommended course of treatment. In the AMA survey, 75% of physicians surveyed reported that PA's sometimes or often lead to patients abandoning recommended therapy. In addition, 91% of physicians surveyed perceive that the PA process has an **overall negative impact on patient clinical outcomes**.

PA burdens on medical practices have been increasing, as reported by the majority of physicians in the AMA survey. 88% of the physicians surveyed reported that in the last five years, the burden associated with PA procedures has increased, with 50% of the physicians surveyed indicating a significant increase. The increasing burden of PA procedures has particularly impacted rheumatology practices, as rheumatic disease is often treated with medications requiring a PA. The most common diagnosis for established patients seen in rheumatology practices is rheumatoid arthritis (RA), a condition for which patients may require biologics to achieve optimal disease control. One registry of rheumatology patients in the US, the RAPP database, found that on average about 40% of the established patients seen each week in a rheumatology practice have a diagnosis of RA. Analyses from another large national registry of rheumatology patients, the RISE registry, have shown that in a calendar year, an average of 38% of patients with a diagnosis of RA are prescribed a biologic or a kinase inhibitor (a newer category of medication for rheumatic disease with pricing similar to biologics, and therefore requiring PA by payors). Based on these data, 15% of established patients in a typical rheumatology practice have RA and are

treated with a medication requiring PA. For each of these patients, a rheumatologist or rheumatology professional must go through the PA process a minimum of once a year (insurance plans require annual PA renewals for continuation of therapy). For the subset of patients who require a change of therapy due to side effects or incomplete response to medication, multiple PA procedures must be performed each year. Moreover, these numbers do not capture the full burden of PA procedures on rheumatology practices and rheumatology patients, as there are many other common and uncommon conditions appropriately treated by rheumatologists and rheumatology professionals with biologics and kinase inhibitors, including psoriatic arthritis, ankylosing spondylitis, vasculitis, etc. With each PA procedure, the rheumatologist or rheumatology professional loses time which could otherwise be spent in direct patient care, and patients face delayed access to necessary care for their rheumatic disease.

To summarize the above, PA procedures impose a barrier to care that may lead to patients receiving less effective therapy, no treatment at all, or even potentially harmful therapies. These procedures interfere with execution of treatment plans based on a rheumatologist or rheumatology professional's clinical judgment and patient access to prescribed treatment, yet are increasingly used by health insurers as a cost-control measure. To reduce the potential for harm, the PA process must be modernized and simplified to ensure access to care for patients.

Stakeholders have identified a number of areas to target for improving PA procedures. In January 2018, a consensus statement issued by a number of groups including the American Medical Association and ACR, laid out principles to guide utilization management programs in reducing the burdens placed on patients and providers by these programs. Based on these principles, five areas of improvement were identified (see POSITIONS above), and ACR is confident that significant improvements in PA processes will be made with careful, deliberate application of these principles on the targeted areas of improvement.

As with any efforts to improve the systems utilized in healthcare, proposed changes must be considered carefully prior to broad implementation. For example, ACR supports efforts to develop electronic PA (ePA) options for prescribing, as these should streamline the process for PA and reduce delays related to PA procedures. However, even ePA could have unintended consequences. While we anticipate that ePA will simplify the process of PA overall, it must be implemented with consideration of workflow within the clinic, as well as with a goal of minimizing additional data entry and reducing the risk of inaccuracy. For example, if the ePA process creates unintended disruptions to workflow, then patients may experience delays in access to care. Such delays could occur if the ePA system were to require that rheumatologists or rheumatology professionals enter data for ePA at the point of care (rather than data entry being performed by clinical staff), resulting disrupted workflow, and thereby lengthening patient wait times. Alternatively, if automation is used to extract clinical information from the electronic health record, more efficient and rapid exchange of data should be possible. The improved PA efficiency related to automation could have the unintended consequence of incentivizing payers to increase the number of medications and procedures requiring PA, as their processing time for data would be significantly decreased by the automation. If the improved efficiency of the PA process leads to a significant increase in the number of PA procedures required, then the burden on patients and providers will not in the end be reduced.

In order to fully address the problems associated with PA procedures while minimizing the risk of unintended consequences, ACR believes that improvements to PA should ultimately include all of the targeted areas of improvement.

EXECUTIVE SUMMARY

PA procedures cause delays in patient care and have an overall negative impact on patient care. The PA process must be modernized and streamlined to improve efficiency and reduce the burden on practicing physicians. Improving PA procedures will allow rheumatologists and rheumatology professionals to spend more time with patients, and allow patients to receive the treatment they need without unnecessary delays created by haphazard PA procedures.

RESOURCES

1. 2018 AMA Prior Authorization (PA) Physician Survey. https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf
2. Consensus Statement on Improving the Prior Authorization Process. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf
3. Sikes D, Crump G, Thomas K, et al. Population management of rheumatoid arthritis (RA) in rheumatology practices: A quality improvement project. Arthritis Rheumatol: Abstract Supplement. 2014;66(11): S596.
4. Variability in Biologic Prescription Patterns for Rheumatoid Arthritis Patients in the American College of Rheumatology Informatics System for Effectiveness (RISE) Registry. Douglas White et al. http://scientific.sparx-ip.net/archiveeular/?c=a&view=4&searchfor=&item=2019OP0312.
5. White D, Evans M, Schmajuk G, Myslinski R, Kazi S, Yazdany J. Analysis of Provider-to-Provider Variability in the Use of Biologics: Data from the Rheumatology Informatics System for Effectiveness Registry [abstract]. Arthritis and Rheumatolology. 2017;69 (suppl 10).
6. Practice Variation in Prescriptions of Non-TNFi Biologics and Tofacitinib: Data from the Rheumatology Informatics System for Effectiveness (RISE) Registry. Gabriela Schmajuk et al. https://acrabstracts.org/abstract/practice-variation-in-prescriptions-of-non-tnfi-biologics-and-tofacitinib-data-from-the-rheumatology-informatics-system-for-effectiveness-rise-registry/.