

Prior Authorization as a Potential Support of Patient-Centered Care

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Abstract We discuss the role of prior authorization (PA) in supporting patient-centered care (PCC) by directing health system resources and thus the ability to better meet the needs of individual patients. We begin with an account of PCC as a standard that should be aimed for in patient care. In order to achieve widespread PCC, appropriate resource management is essential in a healthcare system. This brings us to PA, and we present an idealized view of PA in order to argue how at its best, it can contribute to the provision of PCC. PA is a means of cost saving and as such it has mixed success. The example of the US demonstrates how implementation of PA has increased health inequalities whereas best practice has the potential to reduce them. In contrast, systems of universal coverage, like those in Europe, may use the cost savings of PA to better address individuals' care and PCC. The conclusion we offer therefore is an optimistic one, pointing towards areas of supportive overlap between PCC and PA where usually the incongruities are most evident.

Key Points for Decision Makers

Prior authorization can reinforce, not detract from, patient-centered care (PCC), depending on the characteristics of the healthcare system.

Prior authorization tends to increase the burden on disadvantaged patients in the US system, detracting from PCC.

As such, prior authorization in the US system might need to be restructured to consider PCC.

1 Introduction

Prior authorization (PA), the practice of requiring additional steps or barriers to accessing healthcare treatments, groups patients by type, a practice that appears inimical to the values of patient-centered care (PCC). PCC has assumed increasing importance in medicine, placing individual patients and their values at the center of decision making and thus prioritizing autonomy [1, 2]. By contrast, PA focuses on populations, contradicting doctors' decisions and restricting patient choice.

In this paper, we emphasize an element that to our knowledge has been missing from the discussion: the role of PA in supporting the practice of PCC by directing health system resources to better meet the needs of individual patients. We begin with an account of PCC as a standard in patient care. In order to achieve widespread PCC, appropriate resource management is essential in a healthcare system. This brings us to PA, and we present an idealized

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2 Patient-Centered Care (PCC) and Prior Authorization (PA): Individuals and Groups

PCC insists that medicine be practiced with a focus on individuals, their values, and their involvement in decision making. PCC places distinct emphasis on medical decision making guided by patients' objectives and values. This requires patients to participate in their treatment, and PCC offers an account characterizing good health outcomes as those that are meaningful to the patient [3]. This means that when approaching treatment decisions, physicians should set aside their own concerns and instead focus on those of the patient [1, 4]. PCC is an approach to the values that guide decision making, distinct from personalized medicine and from the view of patients as customers, which entails a shift to performance measures like customer satisfaction. PCC relates to shared decision-making and the bearing that patients' values have; it is not the same as patient satisfaction [5]. The contributions of PCC stem from a normative view of what matters in healthcare decision making and the doctor–patient relationship.

Our discussion of PCC rests on two essential features: it is an expression of autonomy on the part of patients regarding their objectives with their healthcare and their values, and it is a particular nuance to the doctor–patient relationship since it requires doctors to set aside their own objectives, placing the patient at the center of the care team. Trust in this relationship is essential in order for patients to believe their values are appropriately considered, and PCC strengthens the doctor–patient relationship [3]. As a concept and movement in healthcare, PCC seems to name what we each hope to experience as patients: individual attention to and involvement of our concerns and values.

Although accomplishing PCC does not rely on technological innovations or expensive treatments, it does require investment in the health system. In order to successfully implement PCC, physicians must have enough time with patients to discuss their values, incorporate them into a treatment plan, and manage transitions between providers so that the patients' values stay at the forefront of the

clinical journey. In primary care, for example, this would necessitate longer patient visits, decreasing the number of patients seen in a day, and thereby increasing the number of primary care physicians needed in order to cover longer consultations. This has obvious cost implications and also presents a challenge since there is a consistently predicted shortfall in future physician numbers and increasing strain on their time [6, 7]. In order to widely implement PCC, it seems likely that resources will have to be reshuffled or added to existing healthcare systems.

Because of the demands PCC places on systems, PA may play a role in resource management. PA is one of many tools for cost effectiveness that is meant to introduce savings and efficiencies into a health system. We use a fairly broad definition of PA that includes insurer or payer requirements for additional approvals for treatment or step therapy—the requirement to try a less expensive alternative first [8]. PA is a form of cost management in a health system that reduces costs by grouping patients into diagnostic or treatment categories and restricting their choice of treatments. For example, PA is commonly used as an additional safety check to enforce a consideration of the risk–benefits (and costs) of a particular procedure, like CT scans or imaging for low back pain [9]. PA may also cover tiered systems in which payers require that a lower-cost intervention be used before trying a more expensive one, even if the first may be somewhat less effective or have a larger side effect profile (though still clinically appropriate) [10]. There are two main reasons why PA is implemented: it can act as a safety measure and to reduce costs. In this paper, we assume physicians are prescribing and ordering in a safe manner and focus on the latter reason: PA is a tool for resource management and cost control.

PA is one method for healthcare savings and cost-effectiveness implementation, and it has been implemented in a number of systems. In the UK, PA is a common feature of the NHS: some procedures are considered 'low priority' and an Individual Funding Request application must be made to access them [11, 12]. At a national level, the National Institute for Health and Care Excellence (NICE) makes cost-effectiveness determinations for the NHS. In an example of step therapy, the guidance on Alzheimer's and dementia requires that memantine, the more expensive treatment, only be used in more severe cases or if alternative treatments are not tolerated [13]. The Dutch healthcare system, which has adopted patient participation in decision making as an important part of patients' rights, relies on primary care providers to act as gatekeepers since their referral is necessary to see a specialist. It also groups pharmaceuticals into 'therapeutic equivalents', limiting reimbursements to the lower-cost options—if patients choose more expensive options then they pay the difference unless a physician certifies its clinical necessity [14].

These are examples of systems that promote PCC while simultaneously implementing the cost and efficiency measures of PA.

Because PCC is focused on the individual and PA necessarily lumps patients into groups (low back pain, Alzheimer's, etc.), the concepts are essentially at odds. The one seeks out individuality while the other looks for homogeneity. PA and PCC are fundamentally different because of the way they view people either as homogenous groups or as heterogeneous individuals. Despite this difference, if our aim is to increase the use of PCC, then PA is a tool that can contribute to achieving that aim. In the following, we present an ideal version of PA that would better the healthcare system via resource stewardship, allowing for improvements like PCC.

3 An Account of PA as Stewardship

PA directs resources within a healthcare system. An ideal account of PA is that it is a tool of distributive justice and stewardship, and as such it is intended to promote better care for a whole class of patients rather than individuals. This means that though an individual takes on a burden, the end aim is to promote better health across the whole group of patients, including that individual. For example, requiring patients to try less expensive treatments first means cost savings if they prove effective. Extra hurdles for procedures that may not be necessary reduces use and cost rather than promoting a culture of overtesting. These savings of resources—financial, facility availability, or otherwise—ought to feed back into the healthcare system in order to provide more care for its population. Guiding physicians to more cost-effective treatments is not an end in itself, but a way to strengthen a health system so that the economic choices result in increased access [4].

Canadian health systems have been addressing this very issue, as they have struggled to meet the demands of PCC, including increased access to primary care and easing transitions between parts of the healthcare system. Innovations have included triage tools and prioritizations for specialist referrals. These new tools are a form of cost saving and efficiency that are meant to provide the kind of PCC desired in the system [7]. Good resource stewardship strengthens the health system and increases the resources available to meet needs, and it is in this role that PA has its part to play in promoting the PCC approach.

A useful analogy for PA is to look at the role of antimicrobial stewardship programs; through guarding resources they address individual needs as well as those of the larger population. Antimicrobial stewardship programs are increasingly common in hospitals and include expert insight and guidelines both for determining the best

antibiotic for a particular patient as well as protecting the common good by decreasing resistance, overuse, and cost [15]. The proper management of antibiotics is important for the individual patient's outcome, and it is also critical for the health of the population and future patients.

One objection to PA is that it removes from physicians and patients the ability to make autonomous decisions due to constraints by an external party. Regarding physicians, PA intrudes into the doctor–patient relationship and contravenes their clinical judgement. While this is true, PA does not rely on bedside rationing. Therefore, the professional duties of doctors are still to consider what is best for the patients in front of them without having to calculate the needs of others. PA makes these decisions, allowing physicians to cultivate their relationships with patients without simultaneously raising questions about whose interests take priority. With PA, physicians remain patient focused though the external requirements limit the decisions patients and providers may make.

However, where PCC places the patient at the center of decision making, PA limits the options for patients. PA is designed for populations and efficiently addressing their needs, so it does not address the nuances of individuals' decision making or the values that inform a person's choices, which is what PCC prioritizes. It is in this respect that PA and PCC are most fundamentally at odds. The Canadian example illustrates practical efforts to reconcile the decrease in patient choice with PCC: in order to increase access to primary care providers and increase patient involvement, efficiencies have been made elsewhere in the system [7]. Similarly, Sweden's healthcare system has brought PCC and patient rights to the forefront, but it still uses a national system of pharmaceutical benefits that includes step therapy [16, 17]. In these instances, there is a trade-off between limiting patient choice and promoting wider access to healthcare, patient education, and involvement in decision making. In systems of universal coverage, there is a justified integration between PA and PCC, since patients are treated equally in taking on burdens and benefits.

In sum then, we have argued that the ideal account of PA can be a tool to enhance the possibilities of PCC because the stewardship of resources will provide greater opportunity to engage and provide for patients. PA also removes certain decisions from physicians and patients so that resource stewardship can occur but does so outside of the context of the doctor–patient relationship and individuals' values.

4 Pragmatic Problems—the Example of the US

So far, the argument we have given has rested on assumptions about universal health systems and an idealized motivation for PA. We assumed that the health system

aims to reinvest its savings into improving care and that those burdened by PA also stand to benefit from the reinvestment of additional resources. This excludes the (very real) possibility that PA is used to increase profit and that the patients affected are not those who gain from investment into PCC. In the US, omnipresent disparities and inequities of the health system mean that the ideal version we presented above is not practiced, and PA results in further inequities affecting the worst off.

In the US, PA gained traction in Medicaid, the Federal- and state-funded insurance program for the poor, during the 1990s as programs began to adopt PA as a way to control costs. Medicaid now widely uses PA to control pharmaceutical and service costs, as do a number of private insurers [8, 18, 19]. Medicaid patients tend to be poorer, younger, more likely to belong to a racial/ethnic minority, and more likely to have a chronic condition than patients of other insurers [18]. Patients on Medicaid are unlikely to have the resources to circumvent PA or access treatments using their own finances.

PA compounds the health disparities present in the US since its practice restricts patient choice to a question of willingness to pay. This burden differentially affects patients based on their personal means to circumvent PA requirements. The introduction of PA into Medicaid led to decreased access to prescription pharmaceuticals for its enrollees, even when cost sharing was consistent with private insurer rates [18]. Reduced access to mental health treatment has received much focus; mental health patients were less likely to start new treatments and, because of PA rules for atypical antipsychotics, overall antipsychotic prescribing decreased [10, 20–22]. The changes in pharmaceutical use that follow the introduction of PA are also likely to be amplified amongst Medicaid users and those with reduced financial means who cannot seek out alternatives [20]. Step therapy PA limits patient choice to the cheapest option or a decision about willingness to pay. For some patients, this will be a possible trade-off, but for the worst off, there will be no choice at all.

The effect of PA on poorer patients may also be seen in systems with universal health coverage. The Dutch, for example, set reimbursement rates by the lowest cost treatment in a group of comparable effectiveness, and insurers identify preferred pharmaceuticals and only reimburse for the lowest cost option [14]. In systems that mix PA with the option to purchase higher-cost treatments, patients with limited financial means will bear the greatest burden. In the US, this is all the more stark since those patients do not benefit from increased spending on their interests, such as investment in PCC. The implementation of PA raises justice concerns for the health system and its effects on disadvantaged patient populations.

A final concern is that PA, as insurers practice it in the US, simply shifts costs from insurers and payers to physician practice and patients who must invest time into navigating the rules and responding to requests for authorization. PA shifts costs from the payer (the insurer) to the physician and medical staff when they are required to spend time approving treatments and arguing on behalf of their patients [23]. Insofar as PA simply shuffles about costs and moves them from insurer to physician, it fails as a cost-saving measure across the system and off-loads costs to already over-worked physicians and practices. When this is the case, then PA is used merely as a cost-reducing measure for insurers rather than as one that will better the system overall.

The reality of PA means that we cannot endorse its current practice in the US. As PA is used, it reflects some of the goals we outlined above regarding resource management, but it has been implemented in such a way as to reduce patient confidence and introduce new equity and access concerns. At its best, PA could play an important role in resource stewardship, which would provide the opportunity to spread practices like PCC. In systems of universal coverage, like the UK's NHS, PA can be applied uniformly without creating further disparities to access and coverage. Clear communication about reasons and procedures may address concerns and result in agreement on measures like PA and what constitutes reasonable exceptions [24]. Moving forward with PA, health systems should be aiming to promote the health of the patient populations they serve while minimizing detrimental effects and potential inequities.

5 Pulling Together PCC and PA

But what of PCC? PCC is itself an ideal that expresses a way of practicing medicine and relating to patients that seems threatened by billing codes, rushed visits, and competing incentives. It is an ideal about regard for the patient and prioritizing individuals, their values, and their central role in a complex web of care. This is a standard of doctor–patient relationship, integrated care, and clinical encounter that is intrinsically valuable. It requires time, physician skill, doctor–patient trust, and systemic support.

Across the globe, healthcare systems increasingly seek to involve patients, heighten their autonomy, and centralize them and their values during their medical care. Doing so requires investment in integrated, holistic healthcare systems. This is where the ideal account of PA and PCC can merge: supporting a health system with reasonable cost-control measures contributes to the aim of ultimately providing better, considered care to a growing patient population.

We conclude, then, with an optimistic prescription for the use of PA in order to enhance PCC. A well managed and determined system of PA, with physician buy-in, reasonable requirements, and review for exceptions, may be implemented as a cost-saving measure that will shepherd resources in a health system. Resource stewardship is essential for a robust health system, providing the time and ability for physicians to practice PCC. If our aim is healthcare focused on the individual and a high standard of care and involvement, we must also turn attention to the complementary concept of how resource decisions can help achieve that aim.

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Compliance with Ethical Standards

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Conflict of interest ZB publishes frequently on patient-centered care and shared decision making, and sees Medicaid-insured patients affected by prior authorizations as part of his clinical practice. LR declares no conflicts of interest.

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