POSITION STATEMENT

Utilization Management Restrictions in Long-Term Post-Acute Care Facilities (LTPAC)

Position Statement

Prescription drug plans authorized or operated by Medicare, Medicaid and commercial insurers have developed a variety of utilization management restrictions (UMR) tools to enhance quality and reduce costs associated with medication use. The unique nature of long-term post-acute care facilities (LTPAC) and clinical characteristics of residents of LTPAC facilities present challenges to the safe and successful implementation of various UMR. This position statement advocates for (1) the involvement of both a pharmacist with experience in geriatric drug therapy and a geriatrician in all decisions regarding development and implementation of UMR and (2) avoidance of non-medical switching of drug therapy to satisfy UMR requirements in medically stable residents of LTPACs, including switching to an agent that is not FDA-approved for treatment of the resident’s condition.

Background

Prescription drug plans authorized or operated by Medicare, Medicaid and commercial insurers have developed a variety of tools to enhance quality and reduce costs associated with medication use. These UMR tools commonly include prior authorization (PA), step therapy, quantity limits, and drug utilization review. PA is a mechanism to restrict access to designated medications by requiring the prescriber to obtain special permission to use that medication. Step therapy requires the prescriber try other formulary medications, usually generic equivalents, and/or document that the patient either could not tolerate or did not obtain an adequate therapeutic effect from formulary medication(s) before the plan will authorize coverage of the non-formulary or restricted medication. Quantity limits, the least restrictive of these tools, generally limits the quantity dispensed to a 30-day supply. Drug utilization review is a method to guide utilization of particular medications or classes of medications. When used improperly, UMR can impede access to needed and appropriate medications and reduce access and quality of health care services provided to beneficiaries.

Research and Arguments

UMR can have two fundamental purposes:

1) To reduce inappropriate use of medications, particularly those that are expensive. For example, prescription plans may require verification of diagnosis or require a designated specialist to prescribe in order to ensure that
medications are being used for an appropriate indication, dose or duration.  

2) To direct prescribers to use less expensive medications within a therapeutic category. For example, many prescription plans have implemented PA programs that restrict access to medications made by manufacturers that do not provide the plan with satisfactory price concessions.

Non-medical switching refers to changing of drug therapy for reasons other than poor clinical response, side effects, or nonadherence, and is often the result of UMR-based medication cost containment strategies. Current Medicare Part D policy requires sponsors to include all drugs in six categories (classes) on their formularies except in limited circumstances. The CMS consideration to exclude coverage for the six protected classes (antineoplastics, anticonvulsants, antipsychotics, antidepressants, immunosuppressants, antiretrovirals) is a prime example of non-medical switching.

When UMR is used as a tool for cost containment, it is important to evaluate whether reduced costs are being achieved with the program. A 2020 study reported that PA volume is increasing year over year. Providers’ PA processing cost was $528 million in 2019. Providers conducted 73 million manual PAs in 2018. The survey-based report added the category of “partially electronic” PA transactions in 2019 and found 27 million manual and 52 million partially electronic PA transactions that year. Partial electronic transactions aim to capture more detail about PAs conducted through tools such as patient portals. The cost and time per manual PA transaction increased from $6.60 in 2018 to $10.92 in 2019 and from 16 minutes in 2018 to 21 minutes in 2019, respectively. The amount of time consumed by providers per transaction in 2019 was starkly different for three types of PA transactions: 21 minutes for manual, 8 minutes through a web portal, and 4 minutes for electronic transmission. The study recognized that providers can anticipate PAs will probably increase in the future because of new technologies and medications on the horizon.

The high cost of performing UMR may outweigh the savings obtained from denying coverage of expensive medication and/or requiring less expensive, generic alternatives to be attempted before a more expensive alternative is approved and may not represent true savings in overall health care costs. If limiting access to medications results in increased utilization of other health care services, such as physician office visits, emergency room visits, and hospitalizations, the drug cost savings may be negated by these other health care costs. A review of 38 studies evaluated the impact of non-medical switching across multiple conditions that included hypertension, hyperlipidemia, diabetes, acid suppression, and psychiatric disorders. Based on outcome type, non-medical switching was associated with a negative impact on clinical (26.9% of cases), economic (41.7% of cases), healthcare utilization (30.3% of cases) and medication-taking behavior (75.0% of cases) outcomes. A retrospective analysis that looked at the impact of antipsychotic switching concluded that emergency room visits and inpatient admissions occurred earlier for switchers than for non-switchers and suggested that switching is associated with an increased risk of relapse in patients with schizophrenia, bipolar depression and major depressive disorder.
UMR are time-intensive for patients as well as the interdisciplinary care team including the prescriber, pharmacist, nurse and caregivers. Burdensome and duplicative patient data often are required to be captured and submitted in varying formats imposed by different prescription plans. For example, federal requirements associated with some Medicare or Medicaid prescription drug plans will exempt specific individuals or care settings from certain requirements, however, the requirements also include language that allows for a state to implement them as they see fit, effectively allowing for reversal of those exemptions. This disparity can further complicate medication availability if each different contracted Managed Care sponsor in a state has different data collection requirements. This administrative burden may prevent the patient from receiving timely access to appropriate and necessary medication and is a time expense for the prescription plan, the provider and the pharmacist that detracts from the focus on optimal patient-centered care.

UMR also can have a disproportionate impact on special populations. Medications subject to prior authorization are often the most effective or safest of available medications to treat older adults. Some less-expensive generic medications require more frequent dosing or have troublesome side effects that can result in decreased adherence to therapy and poor outcomes of care, especially in older adults and frail younger individuals who reside in long-term care (LTC) facilities. In addition, these less expensive generic medications are often considered potentially inappropriate in older adults. With UMR limiting access to newer medications, individuals residing in LTC facilities are at risk for increased medication-related problems, emergency room visits, hospitalizations and other adverse outcomes.

**Special Considerations in LTPAC**

LTPAC settings present unique challenges to the UMR process. Many UMR programs are developed around the ambulatory care setting and do not include provisions to accommodate the needs of LTPAC settings. As a result, a pharmacist with experience in geriatric drug therapy and a geriatrician should be involved in development and implementation of UMR programs. The following are concerns of note in LTPAC settings:

1) **Medically Complex Patients**: Individuals residing in LTPAC facilities are medically complex with multiple chronic physical and psychological conditions. Data from the 2004 National Nursing Home Survey indicate that nearly 40% of residents take 9 or more medications and 82.5% have four or more comorbidities.6

2) **Federal Regulations**: Some LTPAC facilities are required by federal regulation to provide prescribed medications to residents in a “timely manner.”7 Because of this requirement, the program must provide for needed medications to be given to the resident while the PA process is pending.

3) **Fragmented Health Records**: Medical records for LTPAC residents are located at the facility, not in the physician’s office. This causes difficulty when patients’ information is needed from their medical chart to answer PA requests. The
information gathering process is often left up to the LTC nurses and pharmacists. There is an increased need for process adaptations and communication between these healthcare professionals and the PA reviewers. In addition, the time frame for the initial supply of medications, while the PA process is pending, should be a minimum of two weeks to allow for delays in gathering and communicating needed information.

4) **Age-related Physiologic Changes and Drug Therapy Response:** UMR programs designed to direct prescribers toward use of a particular agent within a therapeutic category for cost-saving purposes are particularly problematic frail older adults. Medications may be generally similar but differ with regard to side effect profile, drug interaction potential, pharmacokinetics, effectiveness and other parameters. Thus, drug selection can have significant clinical implications based on a resident’s kidney and liver function, multiple chronic diseases and multiple medications. Changes to drug therapy must be made incrementally, avoiding multiple changes at one time to allow for careful monitoring and dose adjustments.

**Summation**

Consultant pharmacists are required to review each LTPAC resident’s medication regimen upon admission and at least monthly thereafter, evaluating medications for appropriate diagnosis, dose and duration of therapy, therapeutic benefit, avoidance of therapeutic duplication and the presence of adverse effects. Upon review, consultant pharmacists recommend interventions to minimize adverse effects, dosage adjustments and/or drug discontinuation when therapeutic benefit outweighs the risk for a particular medication. Consultant pharmacists also manage medication costs, advising LTPAC facilities and facility prescribers of less expensive, therapeutically appropriate options that may be suitable for a particular resident. By actively and routinely evaluating each LTPAC resident’s medication regimen, as well as working in conjunction with the facility geriatricians, consultant pharmacists promote use of necessary and appropriate medications. For these reasons, special consideration should be given to LTPAC facilities as these pharmacist-based services mandated by federal regulations decrease the role of clinically based UMR requirements in the LTPAC setting.

**References**