Coalition of State Rheumatology Organizations
The Coalition of State Rheumatology Organization (CSRO) is comprised of over 30 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality care for the management of rheumatologic and musculoskeletal disease.
CSRO Member States

CSRO Member State/Regional Organizations

[Map showing states with CSRO membership and pending membership]
CSRO Activities

Federal & State Grassroots Engagement & Advocacy

Issue Specific Resources for State Legislation

State Society Formation and Growth

Rheumatology Fellows Initiative
2016 State Legislative Priorities

• Biologics and the introduction & regulation of Biosimilar drugs
• Limiting the practice of step therapy
• Allowing stable patients to continue on the same therapy
• Reducing administrative burden by streamlining prior authorization protocols
• Increasing patient access to medications and supporting limits to out-of-pocket prescription cost
Step Therapy – Key Aspects

• Must “fail first” before coverage is granted for prescribed drug
• Hinders a patient’s ability to access medication leading to adverse outcomes
• No assurance that step therapy protocols are based on the most appropriate clinical practices
• Health care providers are best equipped to determine best treatment for patients
• Goals:
  – Transparent process and exceptions that patients can use to override a step therapy protocol
  – Treatment decisions that are based on a patient’s medical history and recognized clinical practice guidelines
• Products grown from living organisms to specifically target a disease
• Similar vs. Interchangeable
• Notification
• Goals
  • Substitution should only occur for biological products that the FDA has designated as “Interchangeable”
  • Prescribing physicians should be able to prevent a Rx substitution by noting “Dispense as Written” or “Medically Necessary”
  • The prescribing physician should be quickly notified of a substitution before or soon after it is filled
  • The patient or patient’s representative should be notified
  • Pharmacist should keep record of exact product dispensed
Biosimilars

Enacted

Pending
Non Medical Switching

• Switching stable patients for non-medical reasons puts patients at unnecessary risk
• Prescription Benefit Managers (PBMs) provide financial incentives to pharmacists and prescribers to switch stable patients to cheaper, insurer preferred drugs
• Physicians should oversee and determine patient’s therapy
• Switching medications can lead to unintended and adverse health consequences
• Many patients have been through years of painful trial and error with medication
• Goals:
  – Patients are made aware of any switch to their medication
  – Physicians are able to override switching requirements based on medical necessity for individual patients or their therapies
  – Certain disease or drug classes are exempt from switching requirements within a plan or formulary due to known concerns with medical repercussions
Non Medical Switching

Switching

Current Legislation
Uniform Prior Authorization

- Prior authorization refers to an insurance company policy requiring medical providers to obtain the insurer’s approval before it provides coverage for certain medications and treatments.
- Process creates a significant administrative burden on medical providers’ practices which must complete time-consuming forms, phone calls, emails, and faxes seeking approval.
- Patients are adversely impacted when they are denied timely access to necessary services and medications.
- Goals:
  - Require the appropriate state agency to develop an electronic uniform prior authorization form for prescription medications and medical treatments and procedures that all insurers will be required to accept. The form should be developed with input from interested parties.
  - Form should not exceed two pages.
  - Deem “authorization granted” if an insurer fails to utilize or accept the uniform prior authorization form within 48 hours upon receipt of a request from a medical provider.
Uniform Prior Authorization

Uniform Prior Authorization

Enacted
Pending
Cap the Copay – Out of Pocket Limit

• Insurers use tiered cost-sharing in drug coverage to encourage patients to try lower-cost medications
• Common for formularies to high tiers where the cost-share is a percentage of the actual cost vs. a flat copay
• Cost-sharing can require patients to pay up to 50% of a medications cost, sometimes amounting to thousands of dollars per month
• Higher tiers include a significant number and range of medications, including drugs with no generic or cheaper equivalent
• Financial barrier to access leads to inappropriate use of medication, including skipped doses and prescription abandonment
• Goals:
  – Limit Out-of-Pocket costs that patients can be required to pay for each medication
  – Limits should apply irrespective of whether a deductible has been met
Cap the Copay – Out of Pocket Limit

Cap the Copay

- Introduced
- Enacted
CSRO State Activity

• In-state actions
  • Calls to Action
  • Identify and prepare expert witnesses for hearings
  • Letters of support for bills that benefit rheumatology and patient access

• Lead and participate in national, state-focused coalitions

• Collaboration with stakeholders including AF, GHLF, NPF, AAD

• Collaboration with industry partners

• Provide educational support by attending and speaking at state meetings
CSRO Events

Feb. 19-20, 2016
Fellows Conference in San Francisco, CA

July 2016
Federal Advocacy Hill Day Fly-In, Washington, DC

September 2016
State Society Advocacy Conference, Chicago, IL
Connecting with CSRO

• CSRO Policy Update Newsletter

• CSRO Website: www.CSRO.info

• Social Media
  – Facebook.com/CSROAdvocacy
  – @CSROAdvocacy