**Testimony before the Appropriations Committee Concerning Notice and Follow-up Requirements for Medicaid Drug Denials Involving Prior Authorization**

Gary F. Spinner, P.A., MPH
February 17, 2012

Senator Harp, Representative Walker, and Respected members of the Appropriations Committee:

My name is Gary F. Spinner, and I am a Physician Assistant at Southwest Community Health Center in Bridgeport, where I am an HIV Specialist with a large population of people with HIV that I care for. Nearly all of my patients either receive Medicaid, or are uninsured. I speak to you today to alert you to a problem with the Medicaid prescription drug formulary, and to offer a solution that will improve health care, and prevent potentially catastrophic and very costly outcomes.

Maria is a 62 year old Spanish-speaking factory worker with diabetes whose health care is covered by Medicaid. She reported that the insulin I had prescribed for her caused her to develop intense itching, so I switched her to another type of insulin which worked as well without the adverse side effects she had previously experienced. When she returned to see me several weeks later, I learned that in the interval between appointments, she had run out of her insulin and could not get more because the pharmacy had told her Medicaid would not pay for it. She had gone without insulin for a week before requiring an emergency room visit due to high blood sugar. After some investigation on my part, I learned from her pharmacy that the insulin was not on the Medicaid formulary, and that I needed to apply for a prior authorization for Maria to get what I had prescribed. Learning this, I filled out the paperwork, faxed it, and Maria eventually received her insulin, but not without first suffering the effects of **several weeks of severe high blood glucose**. Had I known initially that prior authorization was needed I would have taken the time from my busy practice to apply for this.

Another recent patient, Carmen, is a 57 year old Spanish-speaking woman with HIV and elevated cholesterol. Because the formulary cholesterol medication that she was taking was not potent enough, she required a different and more potent medication. She took her new prescription to the pharmacy and was given only a 14 day supply by the pharmacy, and when she returned two weeks later for a refill, she was told it was not covered. **It was not until six weeks later when Carmen came for her next appointment that I learned that she had been off her medication,** and that it required a prior authorization from Medicaid.

Medicaid in Connecticut uses a formulary of preferred drugs that saves the State money. The formulary is based on providing necessary medications at the lowest price. It is not uncommon for health care providers to write prescriptions for which reasonable alternatives on the Medicaid formulary would be adequate, but the prescriber is unaware of which of the many alternative medications are on the formulary. In fact, every insurance plan besides Medicaid has its own changing formularies, and there are dozens of Medicare Part D plans that our patients are

covered by as well each with their own differing list of preferred drugs. In addition, like Maria and Carmen, patients sometimes have a medical need for an alternative medication that is not on the formulary.

The procedure for Connecticut Medicaid when a patient brings a prescription to the pharmacy for a non-formulary medication for which prior authorization is required but has not yet been obtained is that the pharmacy provides a one-time 14 day supply of the medication, after which a written Prior Authorization request must be made by the prescriber, and the request needs to be granted in order for the patient to be given any further supply of that medication. But the prescriber has to **know** that this has occurred in order to take timely action before the one-time supply runs out.

I have generally not had problems getting approval from DSS once the form is submitted and if justification can be demonstrated that a non-formulary item is necessary. Nor is the problem in many circumstances changing the prescribed medication to one that is on formulary when a suitable formulary alternative exists. The problem is that there is most often no communication to the person writing the prescription that they either have to switch the patient to a suitable formulary medication, or fill out a Prior Authorization request for approval of the non-formulary one. After using the 14 day supply of non-formulary medication, the patient often is told by the pharmacy that the medication is no longer covered, and there is little understanding by many of our patients how they might get an alternative medication—and that is even the case with my English-speaking patients.

Every week I have patients who have not been able to obtain needed medications because of what I have described with both Carmen and Maria. I polled my colleagues about the problem prior to writing my testimony, and every one of them identified having similar experiences with their patients on a regular basis. The problem is caused by a lack of adequate communication, and I do not believe this problem can be blamed on the pharmacist who doesn't contact the provider, nor on the provider who may be unaware of what is on the Medicaid formulary. In our busy patient practice, with our focus on addressing health issues with our patients, we are sometimes even unaware of what insurance a patient may have or not have on any given day. Nor should we blame the patient who may not even understand what a formulary is, or the language spoken to her by the pharmacist.

Fortunately, the solution to this communication problem is not a complicated one. If DSS or its Administrative Services Organization quickly sent a fax, letter, or email to both the prescriber and patient making them aware that their patient has only been given a 14-day supply of medication, and the prescriber either needs to switch to a formulary medication, or submit a Prior Authorization form, the problem could be rectified. The 14 day supply of medication given would allow adequate time to allow this to happen, and the patient's health would not be jeopardized. I have received such written notices from some commercial insurance companies, and it immediately alerted me to the problem.

I fully support the State's need to conserve resources, and utilize a preferred drug list, but without enacting this means to communicate with the health care providers who write the prescriptions that there is a problem with what they have written, it is the patients who will

continue to suffer. Ultimately, it is the taxpayers who foot the bill for expensive hospital-based care resulting from the lack of timely access to needed medications. I therefore urge you to adopt this common sense requirement.

Thank you for considering this testimony.