

Human Services Committee Testimony
***H.B. No. 6545 (RAISED) AN ACT CONCERNING DRUG PRIOR AUTHORIZATION
FOR MEDICAID RECIPIENTS.**

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Senator Slossberg, Representative Abercrombie, and Respected members of the Human Services' 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 providing care to about 250 patients with HIV/AIDS. 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. For the record, I offered testimony last year before the Appropriations' Committee regarding the same problem, and at the testimony I provided examples of patient problems that resulted directly from the Prior Authorization system, including one with Maria that led to a hospital admission. I regret that despite the limited change made by the General Assembly to require pharmacies to hand a flyer to patients when a prior authorization is required, I have seen no substantial change in problems resulting from the prior authorization system as it currently exists, and present you with another real case that has adversely affected one of my patients who relies on Medicaid to provide her health care needs.

Several months ago, Andrea, patient of mine with AIDS and cervical cancer was started on chemotherapy. She had lost a substantial amount of weight from her HIV, and the significant nausea from her chemotherapy made it increasingly difficult for her to eat. I prescribed a medication that would both stimulate her appetite and help control her nausea. She filled the prescription, but was apparently only given a 14 day supply, unbeknownst to me. She contacted me by phone to state that the medication was helping her nausea and her appetite were both improved since starting on the medication. However, she stated that she could not get a refill without my filling out a prior authorization. I promptly filled out the Prior Authorization form, faxed it to DSS, and assumed that everything would be fine. Unfortunately, the system at DSS never notifies the prescriber that a Prior Authorization request is needed, has been granted or denied, so I erroneously assumed that everything was OK, and that DSS had granted approval to what was a reasonable request. I should note that DSS has always granted my prior authorization requests for non formulary items, because I have only made such requests for medications that were clearly needed, according to my judgment. The patient contacted me about 10 days later to state that the pharmacy again told her that they were still waiting for a Prior Auth form to be sent by me to DS, and until then, she would continue to go without her medication. I was surprised to hear this, and thought that perhaps the faxed form had not reached DSS. I reviewed the patient chart and found a confirmation that the fax had gone through, but re-sent the form a second time. One week later the patient contacted me yet again to say she was still unable to get her medication, and again, the only way I learned this was by the persistence of my patient. I finally called Jason Gott, the pharmacist at DSS, who immediately fixed the problem and called me to state that the patient would now be able to get her medication. It seemed that the

pharmacy originally filled a generic version of the medication, and since the brand name was what DSS would authorize (who's to figure), and since I did not mention on my prior authorization that I cared whether the patient received a brand name or a generic, the pharmacy continued to put through a request for the generic, and it continued to be denied. While Mr. Gott at DSS promptly fixed the problem once he got involved, it was not until the patient went a considerable time without medication.

In the case I bring to your attention today, my patient should be commended for her persistence. Unfortunately, many of my patients are far more passive, are quick to assume that a denial of medication is something they have no power to address, or have other barriers such as language issues, housing issues, employment demands, etc. to allow them to chase their provider or pharmacy to get the medication they need. They often do not understand what a formulary is, or what a prior authorization means if in fact, a pharmacist tells them one is needed.

I have no problem with Medicaid using a formulary of preferred drugs that saves the State money. The formulary is based on providing necessary medications at the lowest price. However, 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 was 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 medically necessary 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 is that the pharmacy provides a onetime 14 day supply of 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 further medication.

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 to change 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. Some pharmacies explain to patients that they need to speak with their provider, and other pharmacies simply do not give the patient the required medication after the 14 day supply has been used.

Most health providers are too busy addressing health issues with patients, and are often unaware of what insurance a patient may have or not have on any given day. And with preferred drugs on the formulary sometimes changing month to month, it is hard to know what drugs are covered.

Fortunately, the solution to this communication problem is not a complicated one. If DSS or its Administrative Services Organization sent a fax, letter, or email to the prescriber and patient making them aware that their patient has only been given a two week supply of medication, and the prescriber either needs to switch to a formulary med, 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. However without the provider in the loop to know what is needed and how it might be addressed, problems with patients not receiving their prescribed medications will continue to exist.

I fully support the State's need to conserve resources, and utilize a preferred drug list, but without enacting this means to communicate in writing with the health care providers who write the prescriptions and the patients themselves that there is a problem, it is the patients who will continue to suffer.

Thank you for considering this testimony.

FACTS about **Making Drug Prior Authorization Work for Medicaid Recipients and Providers**

Prior authorization (PA) is required for certain drugs prescribed to Medicaid recipients. If formal prior authorization from the prescribing doctor hasn't been properly obtained, DSS has authorized pharmacies to dispense a temporary 14 day supply.

But, no written notice is provided to the prescriber regarding the need for PA and the temporary nature of the supply of drug that was given. DSS simply relies on the pharmacist to relay information to the client and provider regarding the need for PA. During the 2012 legislative session, language was passed requiring the pharmacist to hand out a flyer to the client with this information. So far, there is no definitive evidence that the flyer is effective in conveying this information to the client.

Federal Medicaid law however, requires that an enrollee be notified in writing within 24 hours whenever a drug is denied for any reason. Medicaid requires due process protections when a service or treatment is denied. This notification must contain the reason for the denial, information on the right to an appeal and how to lodge an appeal.

This system can work better:

- Clients and prescribers should automatically receive a written notice that a 14 day temporary supply has been provided and that prior authorization or a change in drug is required prior to the next fill. There should also be follow-up with the prescriber if PA is subsequently not approved.

According to data produced by the DSS contractor administering the Medicaid prescription benefits, in a 10-month period from 2008 to 2009 (the latest data available at this writing):

- **5,142** claims for drugs were denied by DSS electronically at the pharmacy because the drug the individual sought did not have proper prior authorization and the 14 day temporary supply had already been obtained.
- A full 120 days later, **1350** of these claims still had not resulted in PA for the particular drug being obtained or a switch to a different drug not subject to PA.

These "second-time-around" denials occur with frequency because, with the exception of mental health-related drugs, DSS does not follow up with providers to remind them that PA is needed for the recipient to get a further supply of the drug (or that a different drug should be prescribed).

Approximately 600,000 Medicaid recipients would be affected by this change.

Doctors are often unaware of what drugs require PA as these lists change frequently. The prior authorization process needs to be more user-friendly for patients, doctors and pharmacists.