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March 5, 2013

**Testimony of Sheldon Toubman in Support of HB 6545, Requiring Written Notice and Followup with Prescribers When Medicaid Enrollees' Drugs Are Electronically Denied, and HB 5919, Establishing Presumptive Eligibility, and in Opposition to "Step Therapy"**

Senator Slossberg, Rep. Abercrombie and members of the Human Services Committee:

My name is Sheldon Toubman and I am a staff attorney with New Haven Legal Assistance Association. I am here to support HB 6454, a bill which would require written notice to both Medicaid enrollees and their providers when prescribed drugs are electronically denied, in whole or in part, at the pharmacy due to lack of prior authorization (PA) or for any other reason programmed into the pharmacy computer system by DSS or its contractor. I also am here in support of HB 5919, which would establish a program of presumptive Medicaid eligibility for the home care program for seniors.

**Support for HB 6454**

First, I should acknowledge that advocates have been urging the legislature for several years to adopt the basic consumer protections set forth in HB 6454. No legislation adopting these commonsense consumer protections has yet been passed.

In January 2008, then Attorney General Richard Blumenthal joined then Child Advocate Jeanne Milstein in writing to DSS to urge that three basic consumer protections be adopted as DSS took over responsibility for prescription drugs from the HUSKY HMOs, in February of that year. In their letter, copy attached, they strongly recommended: (1) automatic one-time 30 day temporary supplies be provided whenever drugs were electronically denied at the pharmacy for lack of PA, (2) follow-up with prescribers be automatically conducted by DSS whenever one of these temporary supplies was provided to advise the prescriber of the need to take further action-request PA or prescribe a different drug that does not require PA- and (3) written notice be mailed out to the enrollee within 24 hours whenever a drug is electronically denied for lack of PA or for any other reason (such as dosage limits imposed on certain drugs). As noted in their letter, all of these steps are essential to reduce harm.

Five years later, only one of the Attorney General's recommendations has been implemented, even for children or for life-sustaining drugs. There initially was a 30-day one-time temporary supply provided, but this was reduced to 14 days by the legislature four years

ago. This action was not accompanied with any mandate to adopt the **other** two consumer protections, such that, today, DSS does not provide written notice to the enrollee when a drug is electronically denied at the pharmacy for any reason, even if no temporary supply is authorized (since the one-time supply has already been provided). There is follow-up with prescribers to advise that only a temporary supply has been provided and that no further supplies will be provided absent PA, but **only for behavioral health medications**. While we of course appreciate that there is this follow-up with prescribers for these drugs, obviously, there are many other categories of prescribed drugs the absence of which can have serious consequences, including hospitalizations at the state's expense.

We do have some quantitative evidence regarding the phenomenon that many people are being denied drugs at the pharmacy and pharmacists are not in a position, in most cases, to take timely action so that the person walks out with a supply of **some** drug, especially if the one-time temporary supply has already previously been dispensed. Thanks to the oversight provided by the Medicaid Council, we have such data -- and it is alarming.

A review conducted by DSS's contractor, Hewlett-Packard, at a Council subcommittee's request, looked only at HUSKY A enrollees, a generally healthier and far less medication-dependent Medicaid population than elderly and disabled Medicaid enrollees. HP found in its review that, just for this healthy population, in a 10-month period from 2008 to 2009, **5,142** claims for drugs were denied by DSS electronically at the pharmacy because the drug the individual sought was not on the state's Preferred Drug List (PDL) and therefore required PA, PA had not been obtained, and the person had already obtained his or her **one-time** 14-day supply before returning to the pharmacy seeking another supply of the same drug. These "second-time-around" denials occur because, with the exception of mental health-related drugs, DSS does not follow up with providers to advise the prescribers that PA is needed for the recipient to get a further supply of the drug (or that a different drug should be prescribed) — this is a kind of follow-up which one of the HUSKY HMOs actually did on its own, before DSS took over the provision of drugs.

I note that, last year, the legislature passed a well-meaning step designed to partially address the total lack of notification when drugs are denied at the pharmacy. It required DSS to produce a generic pamphlet which was to be handed out to individuals who only received a one-time 14-day supply at the pharmacy. But the pamphlet was not required to be specific to the patient, ie, to identify the drug for which they were denied, important information which would help them to follow up with their doctors. More importantly, there is no practical way to make sure that pharmacies actually have these flyers on hand to give out at the counter or that their pharmacists do so.

Thus, for example, I asked a volunteer to go to a random CVS pharmacy in Bridgeport and check on their use of this flyer for this situation. She did so this past Sunday and the pharmacist she spoke to said she was not aware of any such flyers and did not hand **anything** to

the customer when only a one-time temporary supply is provided. This is not surprising because, with modern pharmacy practice, everything is done on the computer, so routinely handing out a flyer, which they would have to know to keep stocked and actually keep stocked, is not likely to happen.

Even if the flyer were handed out, it is not appropriate in the situation where no drug at all is dispensed, because the one-time 14-day supply of that drug has already been given to that patient. A different notice is needed for this situation.

Accordingly, systematized notice issued directly by DSS or its pharmacy processing contractor, as provided for HB 6545, is needed to correct this long-standing access issue and ensure that individualized notice is issued whenever a drug is denied or partially denied at the pharmacy for any reason.

For all these reasons, I urge you to pass favorably on HB 6545.

#### **Opposition to Step Therapy (in Governor's Budget Document)**

Although it is not on the agenda for today, I also wanted to point out that the Governor has proposed an even more harmful policy than prior authorization for drugs not on the preferred drug list—under his “step therapy” proposal, individuals would be entirely blocked from accessing drugs not on the PDL. They only could get one of these drugs if they had actually tried and **failed** on the preferred medication in the same therapeutic class—PA would not be successful absent this. This is truly going to cause harm because it will result in routine total denials at the pharmacy. Individuals will walk out with no drug at all-- not the prescribed drug and not the preferred drug for which there is no prescription.

#### **Support for HB 5919**

Finally, I did want to speak in support of HB 5919, which would ensure a system of presumptive eligibility for home and community based services waiver applicants in need of community services to avoid institutionalization. Unfortunately, the severe delays in processing Medicaid applications at DSS persist, because DSS has failed to hire sufficient staff to keep up with the growing caseload. In light of that failure, individuals who need, have applied for and are **eligible** for the Conn. Home Care Program for Elders, as an alternative to nursing home placement, are going without any action on their applications for months on end, notwithstanding a 45 day federal law deadline.

Although about 220 new eligibility workers were hired last year and that may sound like a lot, this brings DSS only up to about **880** eligibility workers. This needs to be put in context:

- 11 years ago, DSS had **845** eligibility workers and then the numbers dropped as successive administrations took no action to replace departing or transferring workers
- 11 years ago, there were about 326,000 Medicaid enrollees; today there are about 612,000 enrollees, an approximate **88% increase**
- 11 years ago, there were about 13,000 Medicaid applications per month; today, there are about 23,000 applications per month, about a **77% increase**
- So just to keep up with the level of processing in 2002, DSS would need to hire about 650 (77% of 845) new eligibility processing employees on top of the 880 current such employees
- Although DSS is working on a modernization program (ConneCT) which we all hope will be successful, even its most optimistic estimate shows an efficiency savings, when modernization is ultimately completed, of 395 employees, **leaving a deficit of about 255 eligibility employees, just to get us to where we were in 2002 before the large drops in staffing began to occur**
- The 395 figure also is wildly high; even DSS acknowledges the likely efficiency gains to be more modest -- in the mid 200s range.

Accordingly, new hiring at DSS is clearly necessary, notwithstanding the Governor's order to all Commissioners that they are prohibited from asking for new staff. I have urged the Appropriations Committee to include an increased appropriation for DSS eligibility staffing, substantially beyond what the administration has requested.

But, in any event, presumptive eligibility, as provided in HB 5919, is an appropriate way of helping to address a severe backlog in processing one set of Medicaid applications, those of elderly individuals in need of home care services, and avoiding expensive, often-irreversible institutionalizations that happen as DSS is unable to timely act on their applications. This will dramatically streamline a quick assessment of probable eligibility for this waiver program. Since the vast majority of the individuals who will qualify for presumptive eligibility under this bill are in any event going to be found to be eligible for Medicaid, retroactively, the vast majority of the cost of this will be covered by the Medicaid program, reimbursed by the federal government at the usual 50% rate.



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January 22, 2008

Honorable Michael Starkowski  
Commissioner  
State of Connecticut  
Department of Social Services  
25 Sigourney Street  
Hartford, CT 06106

Re: Design of DSS HUSKY Prescription Drug Prior Authorization Process

Dear Commissioner Starkowski:

We are writing to commend you on your decision to take the HUSKY prescription drug benefit, including the coverage determination process, "in house," and to suggest some procedural elements that we believe will make the new DSS prescription drug prior authorization system work more smoothly, more fairly, and in compliance with state and federal law. As you know, coverage administration of prescription medication for HUSKY recipients has previously been performed by contractors -- generally for-profit managed care companies -- whose performance has for years been the focus of continued complaints and litigation. Now DSS has the opportunity to design its own coverage determination process that avoids the defects and problems of the contractor system.

The central problem with contractor-administered preferred drug list (PDL) systems has been the risk, even the likelihood, that recipients needing medication not on the preferred list would be turned away without the medication requested, and without having received a fair opportunity to show their need for the drug prescribed. We believe this problem can be efficiently addressed by including three crucial elements in the new DSS coverage determination process.

First, when a recipient's prescriber has failed to submit a prior authorization request for a non-preferred drug, but the recipient nevertheless presents a prescription for that medication at the pharmacy, he or she should receive a temporary 30-day supply of the medication. This should be an automatic temporary supply which does not require the making of any telephone calls by the busy pharmacist. Information about the availability of the temporary supply should be provided on the pharmacist's computer screen to avoid any confusion or delay.

Second, soon after the temporary supply is issued, DSS should contact the prescribing physician, in writing, and inform the doctor that he or she must submit a prior authorization request if additional medication is to be covered and dispensed, and, if applicable, that there are other drugs on the PDL that may be equally effective but do not require prior authorization. It is crucial that pharmacists not be charged with soliciting prior authorizations. Experience shows that pharmacists, burdened with other duties, often fail to complete this important task.

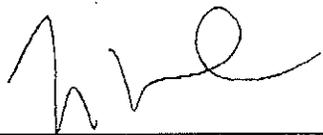
These two steps will insure that the recipient is not denied medically necessary medication before a prior authorization can be submitted and considered, and the attending physician will be clearly and quickly informed about the need to submit a prior authorization request. This will greatly lessen the chance that the recipient will return to the pharmacy after 30 days and, again without prior authorization, request an additional supply of the medication at issue.

Finally, in the event that an individual is denied access to even a temporary supply, either because he or she has returned a second time with a prescription for the same drug without prior authorization having been obtained, or for any other reason, a written notice to the recipient must be mailed out within 24 hours of an electronic denial at the pharmacy, explaining why the drug was denied and the means to request a hearing to review the denial. See 42 U.S.C. §1396a(a)(3) and 42 C.F.R. §§ 431.205(d) and 431.220(a)(1).

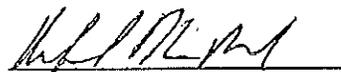
Together, these improvements should finally put an end to the disputes, lawsuits, and headaches that have characterized the MCOs' administration of the pharmacy benefit for HUSKY recipients for many years. We urge you to adopt each of them so that an effective and efficient system of pharmacy benefits will prevail in that program, to the benefit of the agency and its clients alike.

Thank you for your attention to this important matter.

Respectfully,



JEANNE MILSTEIN  
CHILD ADVOCATE



RICHARD BLUMENTHAL  
ATTORNEY GENERAL

## PDL PA Query

1	2	3	4	5	6	7	8	9	10
Initial Claims	Auto PAS	Claims after Auto PA	Paid Claim w/ PA	Denied PAs	Therapy Change	PDL Change	Patient ineligible	Patient deceased	Other
26610	27237	5142	1359	4	2642	146	352	5	1350

### Description of Data Elements

- 1) **Initial Claims-** The number of claims identified between 7/1/08 – 4/28/09 for HUSKY A and HUSKY B recipients that rejected with the following message returned “Non-Preferred Drug Requires PA; For one time authorized fill enter all 9’s in PA Submitted Field.” **Note: this allows the pharmacy to enter all ‘9’s’ and provide the client with a ‘one-time free fill’.**
- 2) **Auto PAs-** The number of Prior Authorizations (PAs) generated automatically by a pharmacy submitting with all 9’s in the Prior Authorization Field for HUSKY A and HUSKY B recipients between 7/1/08 – 4/28/09. **Note: this column shows the number of claims where the pharmacy did in fact enter all 9’s to allow for the ‘one-time free fill’ and the client was able to get their medication.**
- 3) **Claims after Auto PA-** The number of claims identified between 7/1/08 – 4/28/09 for HUSKY A and HUSKY B recipients that rejected with the following message returned “One Time Bypass Fill has been Used. Contact MD to Obtain PA if Non-Preferred Drug is Required or Consult MD on switch to Preferred Alternative.” **Note: this column shows the number of claims where the pharmacist tried to enter all 9’s again for a free-fill, but the free-fill had already been provided to the client. The message they receive back, tells them that and that they should contact the prescriber who needs to obtain a prior authorization or change to an alternative product.**
- 4) **Paid Claim with PA-** The number of claims for HUSKY A and HUSKY B recipients that paid with a PA within 120 days after rejecting with the following message returned “One Time Bypass Fill has been Used.....”
- 5) **Denied PAs-** The number of PAs for HUSKY A and HUSKY B recipients that were denied within 120 days after rejecting with the following message returned “One Time Bypass Fill has been Used.....”
- 6) **Therapy Change-** The number of claims for HUSKY A and HUSKY B recipients that had a change of therapy within the same therapeutic class submitted on the original claim within 120 days after rejecting with the following message returned “One Time Bypass Fill has been Used.....”
- 7) **PDL Change-** The number of claims for HUSKY A and HUSKY B recipients that had a change in PDL status to “Preferred” within 120 days after rejecting with the following message returned “One Time Bypass Fill has been Used.....”
- 8) **Patient Ineligible-** The number of HUSKY A and HUSKY B recipients that became ineligible after the initial Auto PA was generated.