Legislative testimony 4/10/2024

Senate Health and Welfare Committee

House Bill H.766

I would like to thank the Senate Health and Welfare Committee for this opportunity to address you today in regards to bill H.766. My name is Rick Dooley, and I am a full time family practice PA at Thomas Chittenden Health Center in Williston. In addition, I am the Clinical Network Director for HealthFirst, an independent practice association representing both primary care and specialty independent practices throughout the state.

I'd like to tell you about my practice in Williston. We are a family practice serving approximately 13,000 patients. We have a full service clinic including 12 FTE PCP's, a nutritionist, a social worker, two part time psychiatry nurse practitioners, three part time care coordinators, and a full slate of clinical and non-clinical staff. In fact, we have almost 3 staff for every 1 PCP. Some of our other Healthfirst practices have as much as 4 staff members for every PCP. The need for such an expansive staff is two-fold – 1, it requires a significant amount of clinical staff to provide the growing number of services, both medical and social, that are expected from primary care, and 2, the administrative requirements around billing, payment processing, insurance requirements, prior authorizations, audits and reporting are onerous and time consuming.

The burden of prior authorizations for medication is crushing. At the start of every year we begin the annual slog of expired prior authorizations for medications that patients have been on for the previous 12 months. Hours and hours of staff and provider time is spent daily over the first two months completing online forms, combing charts to provide dates of previous trials and failures, and writing out justification for why a specific medication should continue to be covered. It is not unusual for a nurse or medical assistant to spend 45 minutes to an hour on hold on the phone trying to get a single prior authorization. My nurse spends an average of 2-3 hours every day working on prior authorizations in between rooming patients and taking calls. In addition, the start of the year frequently brings formulary changes. This means that the medication that a patient has been on for several years may now be considered non-formulary, requiring a higher copay or a trial of a different medication. Patients often react differently to different medications even within the same class, so any change in medication requires close follow up. Sometimes the formulary changes result in an entire class of medication being excluded, resulting in a need to trial a medication that I may feel is not appropriate for the patient. The end result is a tremendous amount of primary care resources expended so that a medication that is less expensive to the insurer can be prescribed, at least for the next 12 months until the formulary changes again.

In addition, I strongly support is the adjustment of the step-therapy protocols allowing for more provider discretion. The decision to use a specific medication is not made lightly. We as providers are balancing not only the mechanism of action, but also the likely side effects, interactions with other medications, ability of the patient to maintain the dosing schedule, et cetera. I've just started by 30th year in family medicine. There are differences between drugs even within the same class. I'll use the antidepressants as an example. Most people have heard of the SSRI class of medication – Prozac, Paxil, Zoloft, etc. These medications came to the market really just as I was starting medical practice, so I've been using them really since they came onto the scene. Prozac (fluoxetine) has a very long half life,

meaning it takes up to 5 weeks for it to buildup to its maximum therapeutic impact, and likewise may take 5 weeks to completely clear from your system after you stop taking it. However, that also means that if you miss a day or two, you are unlikely to have any adverse effect on your mood. I would prefer to use that in a patient where compliance may be an issue. Lexapro (escitalopram) has a much shorter half life and a smaller dose range, so I can typically get folks on a therapeutic dose within a couple of weeks, but folks are much more sensitive to mood changes if they miss a dose. I may use that one if I have someone who I need to have a more rapid effect but I know they'll be compliant. Paxil (paroxetine) is known to be more sedating than the other drugs in the class, so I would use that in a patient where anxiety is a predominant complaint, whereas I would avoid it in a patient where fatigue was a big component of their depression. Zoloft (sertraline) has a wide dose range, from 25mg to 200mg, so I would use that in someone who is more medication sensitive, as it allows for a slower titration upward. These are all SSRI's, all within the exact same class, and according to insurance formularies, all interchangeable. But that completely discounts the art of medicine that comes with experience. I have 1500 patients in my panel right now, and I couldn't begin to count the number of patients I've treated for mood disorders over the past 30 years. I can tell you that when thinking about prescribing a medication for depression, I need to consider all these factors – compliance, rapidity of therapeutic effect, associated side effects – before picking a medication. The same can be said for blood pressure medications, diabetes medications, cholesterol medications – with each class of medication, I can point to specific attributes of one over the other than make it a better choice for a specific patient. The consequences of choosing an inappropriate medication for a patient can be severe, and may include missed days or even dismissal from work, expensive emergency room visits, increased suicidal ideation, heart attacks or strokes brought on by hypertensive emergencies from noncompliance – the list is long.

With regard to prior authorizations for imaging or treatments, there are various points of frustration, and I'm glad to see H766 addressing some of these. One issue is timeframes around approvals. Oftentimes an imaging or treatment facility will not schedule an appointment until the prior authorization is approved. My scheduling staff will work diligently to complete the paperwork, and then get approval for a specific site within a specific time frame. When they go to schedule the patient, they are given an appointment that falls outside of the specified time frame, so they need to redo the prior authorization a second time. Alternately, if the procedure is approved for one facility and the patient then finds that they can get it done sooner at a different facility, the prior auth needs to be redone for the new facility. While these re-authorizations are not typically as time consuming as the original request, they are none the less a cause for increased administrative work and time in each office.

My last point with prior authorizations is that almost all of the time, my prior authorizations are approved. If I'm ordering a medication for a patient, I can generally justify its need. If I'm ordering an imaging study, it's generally because it is medically necessary and appropriate. If I'm unsure on the appropriateness of a study, I will frequently speak to radiology or to a specialist to ask about the most appropriate next step. So the issue is not that these items are not getting approved. It's that we are dedicating tremendous amounts of staff and provider time to comb through charts, complete forms, schedule peer-to-peer reviews and write letters of justification, just to get the service that we all know is medically appropriate.

Prior authorizations and medication step therapy are certainly not the only source of administrative burden, and I harbor no illusion that H766 will eliminate all of the primary care woes we are facing. However, I truly believe that a strong foundation in primary care is essential to improving patient

outcomes and reducing system cost. We will be unable to provide that strong foundation if we don't have providers willing to join our ranks. Any effort to reduce the burden on primary care providers is welcome. Again, thank you for your attention. I'm happy to answer any questions you may have.