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Resource Paper

Helping Families Enrolled in Medicaid Get Prescription Drugs

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What are the Rules on Coverage of Prescription Drugs in Medicaid?

Prescription drugs are actually an optional benefit in Medicaid, meaning that states can choose whether or not to cover them. But, every state covers prescription drugs.

In general, most FDA-approved drugs are covered under Medicaid, not only for children but adults as well.[1] However, more and more states are trying to control the rising costs of prescription drugs by requiring special approval for a person on Medicaid to get certain drugs. This is often called a prior authorization (PA) process.

When families with Medicaid coverage get to the pharmacy and cannot get a prescription filled, it is usually because prior approval has not been requested or has not been granted. The physician or other health provider may have written a prescription but (a) he or she did not know to request PA or (b) no action may have been taken to authorize the PA request.

Federal rules require that state Medicaid programs respond to prior authorization requests within 24 hours and also require that Medicaid enrollees who submit a prescription to the pharmacy without prior authorization receive a 72-hour temporary supply in an emergency. Families also should receive a formal Medicaid notice if prior authorization is denied. These precise procedures do not apply to Medicaid managed care programs, but PA requests must be acted on with "reasonable promptness," and families should receive notice if PA is denied. State Medicaid managed care contracts may also require that temporary supplies be given to enrollees.

What about SCHIP?

The purpose of this paper is to assist community-based organizations that are working with families on Medicaid who have had problems obtaining prescription drugs. Families with children in separate state SCHIP programs may have similar difficulties, but the Medicaid rules and protections, which are discussed in this paper, do not apply to separate state SCHIP programs. However, there may be contract provisions between the state and managed care organizations providing services to children enrolled in SCHIP and there may be state laws that apply to SCHIP.

[1]Federal Medicaid law provides that states can choose not to cover certain types of drugs, including but not limited to drugs for anorexia, weight loss or weight gain, drugs for the symptomatic relief of coughs and cold, and drugs used to promote smoking cessation. In addition, states can limit the number of prescriptions that adults receive each month and can also limit the number of refills and the quantity of medication in each prescription.

How Should Prior Authorization Work and What Can Go Wrong?

The key ingredients of a successful PA system are:

- Health care providers who know which drugs are on the various formularies of managed care organizations and/or the state Medicaid program's own formulary or preferred drug list, who know which drugs require PA, and who know how to request PA.

- Pharmacists who understand that Medicaid covers most FDA-approved drugs, who know when to give a family a temporary supply of a medication, and who regularly contact the health care provider when a family presents a prescription requiring PA when PA has not been obtained.

- An efficient PA system that is available 24 hours a day/7 day a weeks with sufficient phone and fax lines for receiving and acting on inquiries.

- Technology that supports effective communication between health care providers, pharmacies, managed care organizations, and other entities involved in the PA process, including the provision of prompt written notice when PA is denied.

Why Are States Requiring Prior Authorization?

The rise in prescription drug costs has led states to use a variety of strategies to keep the cost of the drugs they pay for with Medicaid funds as low as possible. A number of the most common strategies are implemented through a system of prior authorization or approval.

Both states and managed care organizations may require PA for certain categories of drugs. In addition, many states and managed care organizations have lists of drugs ─ sometimes called formularies or preferred drug lists ─ that are covered without prior authorization, while other drugs for the same purpose may require PA. For example, the state may select a given drug or a few drugs as the preferred choice for a particular condition, such as high blood pressure. These drugs are often (although not always) less costly to the state than other drugs for the same purpose. An alternative drug for the same condition would only be available when medically necessary through the PA process. A provider would be required to justify that the drug is medically necessary.

Most states also require use of generic drugs when available. PA may then be required to obtain a brand name drug when use of a generic substitute is not appropriate.[2]

[2] In some states, brand name drugs may be obtained without PA if the physician writes "no substitution" or "brand name necessary" on the prescription.

Even though there are rules that govern the PA process, many things can go wrong in busy provider offices and pharmacies that are dealing with multiple health plans and programs each with their own drug formularies or preferred drug lists:

- Health care providers may have difficulty keeping up with multiple formularies that frequently change.

- Pharmacists may not understand the special rules for Medicaid, and they may not have the time to contact physicians or managed care plans when a prescription is not authorized.

- Phone lines may be busy or may not be answered at all hours.

- Procedures for granting temporary supplies may be inadequate, unclear, or not widely known.

What Can Community-Based Organizations Do?

A. Find Out the Rules:

Before deciding how to address the problems experienced by families unable to obtain prescription drugs, community-based organizations need to have a clear understanding of the rules in their states and how those rules are being implemented in their local areas.

The following questions can be answered through interviews with state officials, health plan staff, health care providers, and pharmacists and through review of state managed care contracts:

1. Are prescription drugs provided through a managed care plan, through a state contract with a pharmacy benefits manager, or by pharmacies that bill the state on a fee-for-service basis?

2. When is prior authorization required? Does the state have a preferred drug list or formulary? Do managed care plans use formularies? Is there a policy for mandatory substitution of generic drugs and if so, how can a brand name drug be obtained?

3. How do the contracts between the state and the Medicaid managed care organizations address the provision of prescription drugs? Are there time limits for PA and rules requiring temporary supplies? Is notice required when PA is denied?

4. In Medicaid fee-for-service programs, how has the state implemented the requirement that a temporary supply be granted in an emergency? Are their rules defining the circumstances for dispensing a temporary supply? Who decides whether there is an emergency situation? How are these rules working? Are pharmacists aware of the rules and are they assured of payment when they provide a temporary supply? What happens if a PA request is not decided within the required time frame?

5. How are PA systems working? Is there access to the entity responsible for deciding PA requests 24 hours a day, 7 days a week? Are there adequate phone lines and fax lines or do health providers experience frequent busy signals? Is there an easy way for pharmacists to contact the state or the managed care organizations when a family presents without PA? How long does it usually take to get PA?

6. How do health care providers find out about drugs that require PA? How are changes communicated? Is the information available on the web or only on paper? Are health care providers aware of the rules and the PA process?

7. How are Prior Authorization procedures explained to Medicaid beneficiaries? Are families notified when prior authorization is denied? Who sends the notice and what does it say? Are providers notified when a prescription is not filled because PA has not been obtained?

B. Find Out What Is Happening

The best information on whether the PA system is working in your state or local area can be obtained from families who use the system. But asking families whether they were able to fill their prescriptions is only a first step. Here are some questions to ask families who had problems getting medications:

1. Do you know what "Prior Authorization" means? Was it ever explained? If so, how?
2. What was the medication?
3. What did the pharmacist tell you?
4. Did you talk to your doctor about this?
5. What did your doctor say?
6. Were you offered a temporary supply?
7. Did you get any written notice?

Ask the families for copies of any notices, and ask whether you can call the pharmacist or the doctor with them to find out more about what happened.

Your goal in asking these questions should be to identify the point at which the system may have broken down. Did the physician not know the drug was on the PA list? Did the managed care company not respond to a request for prior authorization? Or was the request denied? (These are very different situations, as a denial should result in a notice to the family. But, if there is no response, the family and/or doctor may not know what has happened.) You will be most successful in working with your state partner organization and state Medicaid agency if you get precise details about what is working well and what is not.

Conclusion

Answering these questions should provide an understanding of the systemic problems that may be causing some families to have difficulty obtaining prescription drugs and should guide community-based organizations toward strategies to improve prescription drug access. For example, the state may have a contract provision that requires temporary supplies, but pharmacists may not be aware of the requirement or may not be able to override the health plan's automated denial in order to issue the supply. In the alternative, there may not be any requirement for a temporary supply. Depending on the circumstances, there may be a need for changes or clarifications in the rules and procedures, for education of providers, pharmacists, and families, for better notice to families and providers, or for other changes such as web-based access to formularies and standardized PA request forms.

Resources:

S. Somers, J. Perkins, Model Prescription Drug Prior Authorization Process for State Medicaid Programs, Kaiser Commission on Medicaid and the Uninsured, April 2003 (available at www.kff.org).

J.S. Crowley, D. Ashner, L. Elam, Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003, Kaiser Commission on Medicaid and the Uninsured, December 2003 (available at www.kff.org) (Includes survey responses from all CKF-AI states except for Oregon).