

Submitted via electronic submission

May 5, 2020

Dear House Commerce Committee Members,

My name is Dr. Sheldon Berkowitz. I am a Pediatrician at Children's Minnesota and the Medical Director for Case Management and Utilization Management. I am also President – Elect of the MN Chapter of the American Academy of Pediatrics. Thank you for the opportunity to submit comments in support of House File 3398, changes to health care utilization and prior authorization requirements.

While I understand the desire to lower and control health care costs and the role of prior authorization in addressing that goal, I am also very aware of the roadblocks this can present to a clinician wanting to provide the best care for his or her patients and the roadblocks that both patients and families endure while waiting for the prior authorization to be approved in a timely manner. I also believe that the requirement that the person making these prior authorization determinations be a physician with experience treating patients with similar conditions is an important requirement, particularly as it relates to pediatrics.

One example where this can create delays is in our Cardiovascular Intensive Care Unit (CICU) where we often receive denials and delays in getting a medication called sildenafil approved for our patients. The generic name, Viagra, often prompts immediate denials as UROs don't understand the needs for our pediatric patients. This drug is commonly used to treat pulmonary arterial hypertension, a condition where increased blood pressures due to lung disease can damage the heart. The medication helps to reduce that pressure. The lack of understanding from UROs delays treatment and discharge from the hospital. Having either a pediatric specialist cardiologist, intensivist or neonatologist reviewing the request would expedite the response and most likely lead to approval.

Below are some other common examples we experience with the current prior authorization processes:

Title continued ...

Page 2

1. Pediatric patients being discharged from the hospital often need to go home on liquid medicines, rather than a tablet or capsule, however, some UROs will only approve tablet forms. While it is common sense that infants and young children cannot swallow pills, we receive regular denials for liquid forms of medication.
2. We have experienced denials receiving approval for durable medical equipment, such as feeding pumps, where some UROs have told us it could take up to a month to get approval. This puts the family in a difficult position of choosing to either pay out of pocket and hope to get reimbursed or keep their child in the hospital until approval is obtained.
3. We have also experienced problems on evenings, weekends and holidays getting prior authorizations approved leading to delays in discharge. Hospitals and health care needs don't close down at 5 pm on Friday. Prior authorization processes shouldn't either.
4. And finally, UROs sometimes require a patient to come into the clinic to sign a release of information so that we can appeal a denial on their behalf. This is just another undue burden we place on families during a time of stress.

These are but a few examples of prior authorization problems we encounter every week. Attempts to streamline and improve the process is a step in the right direction and the right thing to do for our pediatric patients.

Lastly, a consequence of prior authorization has been that individual clinician offices as well as hospitals have had to hire additional personnel to handle prior authorization issues which adds to the overall administrative costs of healthcare, without necessarily improving the quality of care. If you also look at the amount of time that clinicians have to spend trying to get prior authorization requests approved instead of caring for patients, I think we all would agree this is time not well spent.

Thank you for your consideration.

Dr. Sheldon Berkowitz

Title continued ...
Page 3