

Testimony before the Human Services Committee
March 1, 2011
Support for SB 959 and HB 6360

Good morning, Senator Musto, Representative Tercyak, and members of the Human Services Committee. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). I am here today on behalf of NAMI-CT to testify in strong support of both SB 959, An Act Concerning the Transition of Youth from the Department of Children and Families to the Department of Mental Health and Addiction Services, and HB 6360, An Act Concerning Notice by the Department of Social Services of a Decision to Deny Payment for a Prescription Drug under the Medicaid Program.

From 1998 to 2007, the referrals from DCF to DMHAS rose from 41 to 1,829, an increase of almost 4500%.ⁱ DMHAS estimates that young adults account for 35% of their incoming clients with an estimated 250 referrals from DCF on an annual basis.

The issue is the lack of appropriate services and transition planning for these youth and young adults who are transitioning into the adult mental health system. Both Departments are required to create and execute transition plans for each young adult that is moving from DCF to DMHAS care. However, plans are often not written or, when they do exist, are not followed.

This bill begins a process of holding DCF and DMHAS accountable for timely transition planning and collaborative programming by seeking the data necessary to gain a full understanding of the population, and the barriers to appropriate transitioning and treatment.

The bill also prevents transitioning youth and young adults from falling through the cracks by requiring both Departments to agree that all of the elements of the youth's transition plan that directly relate to a safe and therapeutic transition have been successfully completed before DCF can terminate their services.

Youth transferred to DMHAS with successful transition plans are more likely to make positive adjustments, require fewer services, and be stable and productive. Furthermore, addressing the needs of these children and youth will avoid the more complex needs of a growing population of young adults who are failed by the DCF system.

We are not asking either of these agencies to do anything that they should not already be doing – and the increased level of attention to the population and the reporting requirements will greatly enhance the ability to identify the scope of the problem and the complex needs of this population. Furthermore, with behavioral health services for both children and adults on Medicaid now being managed through the Behavioral Health Partnership and Value Options, there is even greater ability and opportunity for data analysis and reporting on this population.

NAMI-CT is also in strong support of HB 6360, which will require same day (within 24 hours) individualized written notice of denial to a Medicaid beneficiary whenever an electronic denial at the pharmacy occurs, for lack of prior authorization (PA) or for any other reason (dosage limits, etc.), advising of appeal rights in the event of an error, of the means to obtain PA, and whether alternative drugs are available which do not require PA. The bill also requires notice by DSS or its contractor (within 48 hours) to the prescriber advising that a PA-only drug was denied at the pharmacy or that only a one-time 14-day temporary supply was provided because of lack of PA, and about the need to either request PA for the drug or prescribe a different drug that does not require PA.

Absent the pharmacist being willing and able to take time away from other customers to make a call to the prescriber and getting through to him/her to explain all of this, the prescriber often does not know their patient is going without a medication or received only a 14-day supply which will end, without a timely request for PA.

Written notice to the enrollee will at least let him/her know what is happening and the steps which may be taken to address the denial. In 2008, the Attorney General and Child Advocate wrote to DSS to inform them that this written notice to enrollees is legally required whenever drugs are electronically denied at the pharmacy for any reason- but, to date, no notices are ever issued when drugs are so denied.

Based on our work in the community and recent data from DSS's contractor, HP (Hewlett-Packard), we know that a significant number of drugs are being denied at the pharmacy counter, including after the **one-time** 14-day temporary supply has been provided and used up with no one knowing it was a temporary supply and that PA was needed, with the patient walking out with nothing and with no written notice of denial telling them that they can appeal if they think the denial was in error or how they can go about getting PA to obtain the denied drug (please see attached data). The HP data only included denials under the HUSKY program; it does not include the "aged, blind, or disabled" population, which, in general, uses more prescriptions per person and which is arguably more at risk for medication disruptions when drugs are denied at the pharmacy.

These disruptions can become extremely costly and harmful.

Recognizing that fact, DSS instituted a follow-up process for clients who are denied psychiatric medications. We applaud the Department for this effort, and for understanding the unique characteristics of mental health conditions that often come with significant functional and/or cognitive impairment, poverty, and reduced social supports. This bill extends that process to all Medicaid beneficiaries for all medication classes by enacting what the Attorney General strongly recommended in his January 2008 letter.

To give you a couple of recent examples on the scope of the problem, in a room full of twenty or more psychiatric visiting nurses, every visiting nurse agreed that the average wait for PA is one to two weeks, and that it is exceptional to get a PA approved within the same day. One community member stated that she feels like she has "one foot in the hospital and one foot out" – that medications were helping her stay out of the hospital, but then came the letter about co-pays and confusion about prior authorization. She became very confused with all the changes and ended up in the hospital again.

Lastly, PA in and of itself is proven to lead to medication disruptions for people with serious mental illnesses and Medicaid recipients. A study across ten state Medicaid programs found increases in emergency room visits, hospitalizations, incarceration, and homelessness.ⁱⁱ If we intend to continue to apply PA despite these negative consequences, we should require the basic consumer protections set forth in the Attorney General's letter to reduce the harm from medication disruptions.

Thank you for your time and attention to these important issues.

ⁱ This does not include the new young adult cases accepted directly by the adult system.

ⁱⁱ West, Joyce C., et al. Medication Prescription Drug Policies and Medication Access and Continuity: Findings from Ten States. *Psychiatric Services* 2009;60(5):601-610