**HB No. 5250 AN ACT PROHIBITING REQUIREMENTS FOR PRESCRIBING CLININCALLY INAPPROPRIATE QUANITIES OF OUTPATIENT PSYCHOTROPIC DRUGS**

**INSURANCE AND REAL ESTATE COMMITTEE**

Public Hearing: February 27, 2020

Testimony: **IN SUPPORT**

**Representative Sean Scanlon, Senator Matthew Lesser, Senator Joan Hartley, Representative Lucy Dathan, Senator Kevin Kelly, Representative Cara Pavalock-D Amato, and Honorable Members of the Committee**:

I am Danielle Morgan, MSN, CNS, Family PMHNP, APRN a board-certified Family Psychiatric Nurse Practitioner, and I have provided psychotherapeutic and psychopharmacologic services for persons with mental illness in Connecticut since completing my nurse practitioner training at Yale University in 2000. I have a private practice with offices in Hamden and Guilford where I treat approximately 1000 patients. Additionally, I am a member of the medical staff of a methadone clinic in New Haven where we treat a whole range of substance use and psychiatric disorders for patients presenting in our clinic daily.

Thank you for the opportunity to provide feedback on Bill 5250, on behalf of the over 1500 psychiatric APRNs providing care to the citizens of CT. We are happy to see this bill providing support for the prescribing providers' medical decision making while outweighing the 90-day convenience of health insurers.

The psychiatric APRNs of CT appreciate the language in this bill as it appears to apply to all types of group, individual, and state funded/state employee health insurance policies and their prescription coverage of psychotropic medications. As there is currently no oversight body that can regulate the current problems surrounding this issue, psychiatric providers come to the legislature to seek corrective action.

For the past several years it has become increasingly common for pharmaceutical benefits to compel prescribers to dispense 90-day fills after an initial 30-day prescription has been written for a psychotropic medication. This means that anyone writing that initial 30-day prescription – PCP, OBGYN, pediatric NP, geriatric PA, or psychiatrist, to name only a few – must then write for a 90-day supply of the psychotropic medication or the coverage

will be denied at the pharmacy and what may have been a $5 or $30 copay becomes a fully priced pharmaceutical costing the beneficiary hundreds to thousands of dollars a month.
We may choose to fight this denial of benefit decision, through an appeals process, but I can tell you in my 20 years of experience, I have never been successful. With arguments such as recent inpatient hospitalization for suicide attempts by overdose or opioid crisis in the state, third party payor systems have denied me over and over again. This sets up a very negative relationship between patient and provider, as we make these seemingly unfavorable decisions daily.

These decisions are based on complex assessments and medical decision making as we evaluate the patient sitting in our office, the family context they are living within, and the community that the family shares residence with. There are many variables that determine whether or not a 90-day supply of sometimes several psychotropics (many of our patients are stabilized, for better or worse, on polypharmaceutical regimes) is a safe and prudent idea. This is data that is not available to a pharmacy or a third-party payor. Yet they compel those of us responsible for collecting this data and making these decisions to dispense what they mandate: absurd quantities of potentially dangerous medications.

Indeed, many of the very medications that save our most vulnerable citizens from the symptoms that drive them into their deepest despair, can be lethal in quantities as small as 14-day supplies. I often choose to prescribe these in short supplies when a patient has recently discharged from a hospital or when a family member may be suicidal to ensure patients' safety. No pharmacy benefit would be privy to this data.

The appreciation for the complexity of psychiatric care is also lost with patients when inappropriate 90-day dispensing is encouraged. Many patients take this as a "pass go" on appointment attendance when medication management is not the "whole" and therapy, however brief, is needed. This can lead to non-compliance, treatment failure, poor outcomes, and illness that never reaches remission not because it was not successful, but because patients were welcomed away from their treaters, having been given a 90-day supply of medication and not asked to attend to all the psychosocial stressors that surround their mental illness as well. This is the "medicalization of mental illness" at its best and we know this does not work. Study after study demonstrate that medication plus therapeutic intervention is the key to illness remission.

Illness remission, the goal of treating clinicians, is not the goal of the insurance industry. We have learned that this 90-day fill standard has been born out of studies like that published in *Medicare & Medicaid Research Review* (2012, Vol 2 No 3) that aimed, through retrospective observation at one retail pharmacy chain in CA, to assess adherence, wastage, and cost among their Medicaid population. In looking at four drug classes, SSRIs showed the lowest adherence in the 90-day dispense at 74%, the highest wastage (14.4), and the lowest persistency (228 average days of therapy). This mimics the data we have known for years – the number one reason for depression relapse is that 65% of people stop their meds by the 6$^{th}$ week of treatment. The way you curb that data

is with increased provider contact and increased psychoeducation. The number one barrier to achieving this is transportation issues, particularly among the Medicaid population. Dispensing 90-day supplies of psychotropic medication will not remove these barriers and will only add to the danger of potential overdose and increased numbers of unnecessary pharmaceuticals in the community.

As prescribers of these agents that have the great capacity to heal, we are happy to dispense 90-day supplies when clinically indicated to make fiscally sound decisions. But psychiatric treatment offers variables not well accounted for by other chronic illness management. We need to stop looking at this through the lens of hypercholesterolemia, hypertension, and diabetes, and see psychiatric illness for all the unique challenge it brings to our patients and providers.

I, again, laud Representatives Doucette, Cook, and Steinberg for introducing the bills last year that address this concept and I thank Rep Scanlon and the committee for raising Bill 5250 for further action.
Additionally, I ask that final authors be mindful that all third-party payors who offer pharmacy benefits in CT be held to the standards set forth by this language. This should not be isolated to just Medicaid, or to just state employee funded plans, or just Medicare beneficiaries – no pharmacy benefit should dictate the quantity supply of a psychotropic medication that a prescriber must dispense.

I am happy to respond to any questions or concerns.

Respectfully submitted,
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