Testimony to Senate Committee on Public Health and Welfare on SB 123

February 11, 2015

Madame Chair and members of the committee, thank you for allowing me to appear before you today. My name is Eric Atwood and I am a child & adolescent psychiatrist and serve as Medical Director for Family Service & Guidance Center, a CMHC for children here in Topeka. I also chair the organization that represents the psychiatrists, nurses and other medical professionals serving our Kansas CMHCs. On behalf of this group of medical professionals, I'm here to voice our great concern and opposition regarding SB 123 which would repeal the protections for open access to medications used to treat serious mental illness.

The medical professionals who serve the most seriously ill of our state's mentally ill population want to point out extensive research from around the county that indicates limiting or delaying access to psychiatric medication has negative implications for our patients and does not ultimately save the state money. While medication is by no means the "be all and end all" of psychiatric treatment, for most mentally ill clients, the right medication at the right time is an essential foundation for the full range of services they may need. It is for this reason that professional medical organizations, including the American Psychiatric Association and the American Academy of Child & Adolescent Psychiatry, strongly advocate open access to psychiatric medication. References to well done, respected research that has looked at the experience of states that have implemented various forms of limitations on mental health medications are provided with my testimony; these findings show increased adverse events, and cost shifting to either more expensive forms of care or cost burdens associated with incarceration. It's important to also note that in severe illnesses, including schizophrenia and bipolar disorder, relapse is associated with loss of brain function, aggravation of other functional deficits and worsening of the course of the disease, further limiting prospects for a productive, satisfying life for the patient.

We believe there are far better strategies than restrictive formularies or preferred drug lists to address concerns that may exist around cost and patient safety, strategies that allow for individualized treatment decisions to be made for the patient and their provider, improve patient outcomes, and save money. Such strategies include behavioral pharmacy management systems, treatment algorithms and disease management programs. These are all strategies that have proven to be effective in other states, helping to control overall costs while enhancing quality care. For example, the Behavioral Pharmacy Management System pioneered in Missouri, and implemented briefly in Kansas a few years ago, has shown clear evidence of reducing the growth of Medicaid pharmacy spending while also improving quality measures. Programs like this are particularly helpful for rural states like Kansas where primary care physicians are often put in a position to prescribe psychotropics due to lack of psychiatrists in many areas. We believe the best way to positively impact cost is by focusing on quality, which these types of interventions do.

This is a complex topic that is difficult to adequately summarize in brief testimony. We feel any proposed change to an issue with such far reaching consequences should be very carefully studied by all involved stakeholders, including the patients who will be impacted. The CMHC system stands ready to productively participate in any process to evaluate the impact of this proposed change before it is considered for passage by the legislature. Thank you.

References:

1. “Medicaid Prescription Drug Policies and Medication Access and Continuity: Findings From Ten States” Psychiatric Services, May 2009, Vol. 60, No. 5
2. “Medication Access and Continuity” American Journal of Psychiatry, May 2007, Vol. 164, No. 5
3. Letter from APA to CMS, Re: Comments to Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, March 7, 2014
4. Parks, J. J., & Surles, R. (2004). “Best practices: using best practices to manage psychiatric medications under Medicaid” Psychiatric Services, 55(11), 1227-1229
5. 2007 APA Institute on Psychiatric Services, Poster 112 “Applying Evidence-Based Medicine to Prescribing Practices in Community Mental Health Centers” with George Oestreich, PharmD; Harold Carmel, M.D.; Paul Stuve, Ph.D.; New Orleans, LA , 10/12/07
6. "Effect of Prior Authorization of Second-Generation Antipsychotic Agents on Pharmacy Utilization and Reimbursements" Psychiatric Services 59(5), pp. 540-546
7. "Short-Term Impact of Preferred Drug List Changes on Health Care Use and Medicaid Costs: Injectable Risperidone" , Psychiatric Services 61(9), pp. 937–939
8. “An empirical analysis of cost outcomes of the Texas Medication Algorithm Project” Psychiatric Services 57:648-659, 2006
9. “Benefits and risks of increasing restrictions on access to costly drugs in Medicaid” Health Affairs 23:135-146
10. “Medicaid policies to contain psychiatric drug costs” Health Affairs 24:536-544

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