NAMI Kansas
National Alliance on Mental Illness

Senate Public Health & Welfare Committee

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Executive Director

NAMI Kansas is a statewide grassroots membership organization dedicated to improving the lives of individuals with mental illness. Our members are individuals who are living with mental illnesses and the family members who provide care and support. NAMI Kansas provides peer support through a statewide network of local affiliates. We sponsor educational programs targeted at consumers of mental health services, their family members, and the general public. We advocate for individuals who are living with mental illness to ensure their access to treatment and supportive services.

We ask that you continue to exempt psychiatric medications from requirements for prior authorization and any restricted drug formulary for participants in the Medicaid program. The temptation to achieve budget savings by establishing a Preferred Drug List is not a good public policy option. *We urge you to reject SB 123.*

Our members know from personal experience that the right medication or combination of medications for an individual can mean the difference between experiencing recovery and living successfully with a major mental illness versus experiencing devastating relapses. Unlike other illnesses, difficulties in accessing the most appropriate medications for mental illness result in emergency department visits, hospitalizations, homelessness, incarceration, and even death by suicide. The tragic consequences are all too vivid and immediate in the lives of our members and your constituents. Among individuals with bipolar disorder or schizophrenia, nearly one in ten dies by suicide.

The Kaiser Commission on Medicaid and the Uninsured has noted the distinct vulnerability of individuals with mental illness who are on Medicaid and **recommends exemptions from restrictions for all psychotherapeutic and anticonvulsive medications.**[1] Psychotropic medications—even those within the same class—have unique properties that result in different effects from one person to another. The National Institute on Mental Health (NIMH) notes that **individuals have unique responses to psychiatric medications and need more, not fewer, choices.**[2] NIMH concludes that "a medication that works well for one person with schizophrenia often doesn't work well for another. Genetic variations are thought to play a key role in this difference in response. While patients search for the right medications, their illnesses may worsen."

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Preserving access to mental health medications is a critical component of assuring appropriate care for those who live with serious mental illness. Without such access, the results can be costly and devastating. A study by the American Psychiatric Association showed that over half of dual eligible Medicare Part D patients with mental illness had problems accessing needed medications. More than a fifth had medications terminated or interrupted and about one in five were switched to a different medication because the medication on which they were stable was no longer covered or approved. [3]

The consequences of actions to restrict access to psychiatric medications include the following:

- **More than one in five patients (21.7%) reported an increase in suicidal thoughts or behaviors.**
- **Nearly one in five (19.8%) required an emergency room visit and more than one in ten (11%) required hospitalization.**
- Clinicians and staff spent almost **twice as much time on drug plan administrative issues than on direct patient care due to features like preferred drug formulary lists or prior authorization requirements.**

NAMI believes that individuals with brain disorders must have access to treatments that have been recognized as effective by the FDA and/or NIH. NAMI supports exclusions for psychiatric medications from any PDL in order to ensure that people with mental illness have open access to medications that maintain recovery. Due to the very nature of mental illnesses, a consumer's willingness to take one medication or another may not be predictable. For this reason, **open access is important in optimizing treatment adherence.**

While as a matter of policy, NAMI does not endorse any particular treatment or medication for brain disorders, our policy stipulates that decisions regarding specific medications prescribed to persons with severe mental illness should be based on the clinical judgments of treatment providers, not on economic factors.

We strongly oppose measures that limit the availability and right of individuals with brain disorders to receive treatment with "new generation" medications.

Any cost savings achieved from repealing the exemption would surely be lost as individuals experience an increase in symptoms, emergency room visits and hospitalizations following a decline in their mental health—not to mention the costly effect of scarce prescriber time being spent on red tape. A 2010 study reported in the *American Journal of Psychiatry* documented results that "mental health-specific inpatient and emergency room utilization and costs increased" from step therapy which "may have the unintended effect of reducing overall antidepressant use and increasing medical use and costs."[4]

A study of the policies adopted in the Georgia Medicaid program published in 2008[5] concluded that while prior authorization of "atypical antipsychotics was associated with significant prescription savings to the Georgia Medicaid program, among a vulnerable cohort of patients with schizophrenia, an increase in outpatient expenditures was associated with overall savings." The authors challenge policymakers who are considering similar policies to "consider carefully the potential for unintended consequences of restricted access to antipsychotic medications." The Georgia Department of Human Resources also found in their review that there was no significant increase in cost from going to open access from a restricted formulary in their state hospital facilities.

In 2003, Maine instituted a prior authorization and step therapy policy for atypical antipsychotics. Persons affected by prior authorization requirements had a **29 percent greater risk of treatment discontinuity.** Due to negative outcomes from adopting this policy including an increase in hospitalizations, the policy was suspended.

A ten state study of Medicaid prescription drug policies revealed that the use of preferred drug lists was associated with **5.4 times higher odds of medication access problems.** Individuals facing access problems were **3.6 times more likely to suffer a significant adverse event** such as an emergency room visit, hospitalization, incarceration, or suicidal behavior. Prior authorization requirements were associated with **2.2 times greater likelihood of being reported homeless** and **3.1 times greater likelihood of being hospitalized.** PDLs were associated with **1.8 times higher rates of ER visits** and **2.3 times higher rates of hospitalizations.**

Harvard University Professor Stephen Soumerai, one of the leading researchers in this field, stated the following in a 2004 article: "Given the rapid increase in the use of [prior authorization] policies and other cost-control mechanisms in Medicaid, the relative lack of data on their risks and benefits is cause for concern. It is sobering to realize that if such policies were considered for a clinical study, the possible risks of reduced access to essential medications would likely result in a failure to obtain human-subject approval from most institutional review boards."[6]

Removing the mental health exemption is a blunt instrument which will put many patients at risk of not getting the treatment that they need. We should also take action against providers to ensure the safety of consumers without restricting consumers' ability to get the medication that will best support their recovery.

Thank you for the opportunity to present our views to the Committee.

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[1] Kaiser Commission on Medicaid and the Uninsured, "Model Prescription Drug Prior Authorization Process for State Medicaid Programs," April 2003.

[2] National Institutes of Health, National Institute of Mental Health, *NIMH Perspective on Antipsychotic Reimbursement: Using Results From The CATIE Cost Effectiveness Study,* December 2006.

[3] West, Joyce C., Ph.D., M.P.P., et al, "Medication Access and Continuity: The Experiences of Dual-Eligible Psychiatric Patients During the First 4 Months of the Medicare Prescription Drug Benefit," *Am J Psychiatry; 164:789-796,* May 2007.

[4] Mark, Tami L, Gibson Theresa M., McGuigan, Kimberly and Chu, Bong Chul, "The Effects of Antidepressant Step Therapy Protocols on Pharmaceutical and Medical Utilization and expenditures." *American Journal of Psychiatry,* 167:10, October 2010.

[5] Farley, Joel F. et al, "Retrospective Assessment of Medicaid Step-Therapy Prior Authorization Policy for Atypical Antipsychotic Medications," *Clinical Therapeutics,* Vol. 30, No. 8: 1524-1539, August 2008.

[6] Soumerai, Stephen, *Health Affairs,* 2004: 23:135-46.

KANSAS MENTAL HEALTH COALITION

.....Speaking with one voice to meet the critical needs of people with mental illness

Medicaid Medication Management and PDL

Position: The Coalition supports K.S.A. 39-7,121(b), which protects patients' rights to choice in treatment, enables recovery and saves money by exempting mental health prescription drugs from prior authorization or a preferred drug list (PDL). The Coalition opposes efforts to overturn the current statute. The Coalition also opposes the creation of a PDL, or prior authorization, for mental health drugs under the KanCare contractual agreements.

The Problem: Research supports exempting mental health drugs from restricted access. Other research identifies potential problems with preferred formularies. Many studies have reported that PDLs, which prevent access to specific medications, harm Medicaid subscribers with mental illness. Policies that include a PDL with prior authorization requirements, restrictive formularies, fail-first requirements, monthly prescription limits, or tiered co-payments, have resulted in: failure to reduce healthcare costs; prolonged suffering; and reduced potential for persons with mental illness to achieve recovery. In 2002, the Kansas Legislature exempted "medications including atypical anti-psychotic medications, conventional anti-psychotic medications and other(s)...used for the treatment of severe mental illness," from a Medicaid preferred formulary and prior authorization.

Research supports exempting mental health drugs from restricted access.

Why this matters: Many mental health consumers, like others with chronic diseases, need medication to recover, to alleviate symptoms and make the illness "manageable." Access to the full range of FDA approved medications, including those that are new and those most effective, promotes successful treatment. Continuity of the medication regime is essential. Continuity requires open access and results in a 65% decrease in inpatient costs and a 55% decrease in emergency room costs. In patients with schizophrenia and bipolar, continuity saves $800 in medical costs per year. Finding and maintaining the most effective medications is often the key to a durable recovery that enables children with mental illness to attend school and graduate; enables adults to keep jobs, pay taxes, and contribute to their communities; and enables families to stay together.

The bottom line: KMHC will work with state officials to study and promote policies that enhance patient safety and create efficiency without jeopardizing patient access to medications. A uniform formulary and medication policy for all three Medicaid managed care contractors should be in place.

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The rest of the story about mental health medications and Medicaid

Kansas is noted for having among the best state statutes related to medication for mental health conditions. KS 39-7,121 b. is lauded nationwide for specifically exempting mental health prescription drugs from prior authorization or a preferred drug list. Prior authorizations, and/or preferred drug lists, are structured to reduce utilization (and, ostensibly, expense) by listing which drugs can be prescribed to patients, and/or by setting up administrative steps that patients and/or their doctors must take to get the medication that works well for them. The lists, while nominally based on clinical judgment, are generally based on cost, as the state expects to get its savings via better pricing from the manufacturers. Commonly, the more expensive drugs—usually the newer, better tolerated ones, with fewer side effects resulting in greater patient compliance—are more likely to be restricted.

Countless studies, and the experience of other states, have clearly and repeatedly demonstrated that preserving full access to the complete range of medications used to treat mental health conditions saves money—both in Medicaid and in the matching State General Funds. Conversely, a plethora of data, across numerous states, has shown that restricting access to these medications drives up costs. For example:

- Restricted access to medication through PDLs in Louisiana increased Medicaid costs 4.1%
- When California forced patients with mental illness to switch to cheaper medication, it cost the state $6,000-$8,000 MORE per person due to increased hospitalizations
- Formulary policies are estimated to increase the prison population by 2 percentage points. In 2008, this was estimated to increase nationwide prison populations by 9,920 inmates. This estimated additional cost totaled $362 million.

The risk of increased hospitalization (with resultant higher costs) is not inconsequential, and generally is a result of discontinuation of medication treatment, and relapse and decompensation, which can happen in as little as a few days. *(References relating to quoted research available on request.)*:

- One study demonstrated that implementation of a PDL increased the odds that a patient would discontinue or not comply with treatment by 82%.
- As a result of formulary restrictions, patients are required to switch medications. Switching medications was found to have a 27% increase in adverse effects, 20% increase in emergency room visits, 11% increase in hospitalizations, and a 22% increase in suicidal ideation.
- A California study of Medicaid patients with schizophrenia showed that discontinuation of treatment, for as little as 1 to 10 days, doubled the risk of hospitalization (An 11-30 day gap tripled the risk, and a gap greater than 30 days quadrupled the risk).