Don't Block medication access -
Kansas already has effective ways of reducing medication costs

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Testimony on Kansas Senate Bill 123

I, Corinna West, am a person who has successfully been treated for schizophrenia and schizoaffective disorder. I am now a tax paying Kansas citizen working full time. I have taken 29 different psychiatric medications including the 5 antipsychotics Haldol, Abilify, Risperdal, Seroquel, and Geodon. I no longer need any of these medications or any kind of mental health treatment. This is not because of the medications, but because I had social supports and was not suddenly denied access to medications.

Denying or delaying access to medications is hugely dangerous. People don't understand the difficulty of cold turkey psych med withdrawal. The withdrawal effects are very similar to traumatic brain injury (Journal of Psychiatry and Neuroscience, 2000: 23: 237). My friends who helped me safely get off medications taught me to do it slowly, gradually and carefully. With a proactive plan and by replacing the medication with wellness strategies. It took me five years to get off all the medications I was on. When advocates say slowly, we mean very, very slowly. A successful taper is roughly 10% dose reduction per month, one medication at a time. This is why it took me five years. (Am J Psychiatry Baldessarini et al; 2010) I'm afraid that SB 123 will not give people this kind of time and support even though it actually costs less.

People who come off medications abruptly have three times the relapse rate of people who do a gradual withdrawal (Arch Gen Psychiatry. 1997;54:49). I was a pharmaceutical chemist before I was a mental health patient so I know the research. Now I am back to work full time as a grant writer, entrepreneur, and employer. I am an Entrepreneurial Scholar at UMKC for businesses like that are projected to bring in over $1 million of revenue by year 5. It wasn't the medications that helped me recover from "schizophrenia," but by staying on medications consistently instead of dropping on and off the prescriptions, my odds were three times better.

You might want to reduce costs, but you will increase hospitalization. Studies in California showed that when a restricted like the one proposed was lifted, hospitalization and nursing home rates went down. Health Care Financing Review, 25(3), 35–53. I often struggled to get my prescriptions filled but I managed because I was a college educated person who is used to piles of paperwork. Legislators are good at handling paperwork too, and generally live stable lives. So what seems like a small barrier to you might be insurmountable to other people. Remember, who might be a victim of domestic violence, or homeless, or suffering from traumatic brain injury, or overwhelmed in poverty.

Please don't pass Senate Bill 123. Instead, please talk to advocates about more effective, more evidence-based ways to reduce drug costs.

Here is a list of ways that already work to reduce costs that have less chance to harm people: 1. Form peer based medication reduction teams in mental health centers to help people through planned medication withdrawals. 2. Work slowly with advocates to develop medication edits. 3. Review the medication system and address just the problem patterns. 4. Remove bad doctors. 5. Add more certified peer specialists.

Why SB 123 won't reduce costs and what proven ways would reduce costs

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Please do not pass SB 123 – restricting access only increases costs:

- NOT preferred drug lists - in Louisiana these increased Medicaid costs 4.1%
- NOT fail first / stepped plans - 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
- NOT prior authorizations - Continuity requires open access and results in a 65% decrease in inpatient costs and a 55% decrease in emergency room costs. (See Kansas Mental Health Coalition for references)

These cost saving measures work for other medication types. Why NOT for psych meds? What's the difference?

- **Biological Differences** are greater with psych meds – Most heart meds or headache meds work about equally across the category for all people. With psych meds its trial and error to see exactly which meds will work and which don't. When people find the right med they need to stay with it. The meds simply don't substitute the same way as in other medical areas. (Journal of the American Medical Association, 286(23), 3003–3004). SB 123 ignored the fact that psych meds actually are biologically different than other types of medications.
- **Carve out** – If we pay separately for mental health and physical health, we are just balancing drug costs vs. hospital costs instead of really weighing in how much money social support would save on both types of costs. SB 123 plays a shell game shifting money from drug costs to hospital costs when we could reduce all the cots together.
- **Withdrawal syndromes** – These are caused by limiting access to drugs like SB 123 would do. Abrupt psych med withdrawal is immensely dangerous, causing symptoms like brain injury that can last up to two years (Psychother Psychosom 2012;81:386–388). **People who come off medications abruptly have three times the relapse rate** of people who do a gradual withdrawal (Arch Gen Psychiatry. 1997;54:49). This is become of the traumatic brain injury caused by the brain getting used to the drug and then suddenly not having it. This is quite similar to the way that cold turkey heroin and alcohol withdrawals can endanger lives.
- **Long term stability** – Most physical health issues do not cause biochemical crises when meds are withdrawn. People who suddenly got dropped off psych meds were stable less than a third as long as people who were able to gradually taper off ((Am J Psychiatry Baldessarini et al.; AiA:1–8). SB 123 greatly endangers people by causing even short delays in medication access.

So what does work for psych med cost reduction?

1. Peer/doctor evidence based medication reduction teams - The best way to predict whose medication are working is to simply ask people if they like taking their medication. If people tell you that their medications are not working, then in the long term they tend to not show a response to them, either. So, helping people reduce their medication use may both reduce their treatment costs and improve their recovery outcomes. A careful, slow, considered medication reduction is absolutely necessary, though, and hindered by medication access restrictions.

Recommendation: State officials can immediately ask each community mental health center to form a volunteer team to help people use good evidence based medication withdrawal techniques. Then any

time a person asks about reducing medication use, they should be referred to this team. Since this uses existing staffers and treatment protocols, it would not incur any additional costs and would save money immediately.

2. Medicaid good prescribing limitations as in Missouri - Missouri put in place limitations to Medicaid drug costs where doctors who prescribe medications outside of evidence based practices have to explain the exception to a pharmacist before the prescription is filled. The prescription is not blocked, but just delayed until the doctor provides a justification. These are not conservative limits. In Missouri the clinical edits are things like:

6 or more psychotropic medications at once
greater than 2 SSRI antidepressants
SSRI antidepressants in children under 5 years old
use of multiple atypical antipsychotics at the same time
use of atypical antipsychotics in children under 5 years old
use of SNRI antidepressant for more than 30 days in children under 18 years old
More than two tricyclic antidepressants at the same time

Recommendation: Work with advocates to develop a long term regulation process, don't just strip the protections all in one go.

3. Prescribing reviews: Texas also cut their medication costs in half according to a video published on PBS video when they added in these kind of evidence based limitations. North Carolina has similar limitations, with a table showing that even the FDA and the drug manufacturers do not recommend prescribing certain antipsychotics off label to children. If the drugs have so little effect that even a drug company doesn't recommend them, this would be an excellent place to cut our budget.

The reason limits like that are important is that there is no evidence base for any of the above prescribing practices. None of the atypical antipsychotics have an indication in children under 5, and only two of them have an official clinical indication for children under 10. However, in Missouri, the HealthNet Psychology Program Unit collected data on atypical antipsychotic use in children 6 years of age and younger for the full 2007 calendar year. They found that 443 kids under age 7 were given antipsychotics during the year at a cost of $1.4 million to the state. Kansas will have similar stats. Again, keep in mind that this would fund 28 peer support centers of 15 respite care homes, and that's just one drug category for one age group.

Recommendation: Review medication patterns and address places of concern, not the whole system all at one go. The MCO's should find this in their best interests so there should be no new costs to the state or little program implementation time.

4. Reach out to ineffective doctors: Rhonda Driver, the director of Missouri's Medicaid monitoring program, said, "What we've found is that there is just a small number of doctors violating these practices, but.... they are kind of like...frequent flyers. Often they don't even bother to put in a justification when the prescription is denied."

Cindi Keele, the director of NAMI Missouri said, "Well, maybe we can reach out to the people whose prescriptions have been denied."

I said, "Well, maybe we can reach out to these doctors who don't seem to understand evidence based medicine." These clinical edits are not very conservative. If a doctor repeatedly violates the guidelines, either they are trying to heroically rescue a lot of people with huge doses of medications, or they have not kept up to date with medicine. Removing these doctors from the Medicaid prescribing pool should produce the following cost savings:

Est. 2000 clinical edit violations per year X $300 per psych med prescription X 2.5 factor for giving someone a better chance at recovery X 2 for reducing hospitalization needs due to

overmedication = $3 million dollars per year.

Recommendation: State officials should cut our budgets by immediately questioning doctors who repeatedly violate evidence based prescribing practices and remove them from Medicaid prescribing eligibility. The MCO's should find this in their best interests so there should be no new costs to the state or little program implementation time.

5. **Peer supporters as 10% of staff in mental health centers** to build wellness strategies NOT risk avoidance measures. 3X the recovery rates. Peer support has a huge evidence base of effectiveness and the staff costs much less than academically trained professionals. A research article showing that peer staff is less invalidating than traditional staff, and when people need to be challenged, peers can often do this in a way that is not invalidating to service recipients. (Psychiatric Services November 2008 Vol. 59 No. 11).

The benefits of increased levels of peer support implementation include:

- **Increased morale:** Nursing students instructed by a peer academic professional had lower levels of burnout. Archives of Psychiatric Nursing 27 (2013) 161–165
- **Improved outcomes and cost savings:** Mental health peer services are able to achieve outcomes beyond traditional services. Peer coaching produces cost savings in substance use treatment. (BRSS – TACS, 2012 Expert Panel Meeting Report)
- **More revenue:** the Medicaid Billing Rate is $45 per hour in KS, $80 per hour in Missouri although candidates earn $12 per hour on average. If we can employ large numbers of peer specialists but keep supervision and billing costs low, we can make a strong business model.
- **Better workforce capacity:** SAMHSA's 2007 Action Plan for Workforce Development had two relevant goals listed as #1 and #2, increasing the capacity of communities to help with emotional distress, and increasing the peer workforce.
- **More suicide prevention:** "The Way Forward," (2013) was the first suicide prevention action plan to significantly include input from people with lived experience. It called for increasing peer services in planning, treatment, and crisis intervention.

Recommendation: State officials should immediately implement policies boosting the number of peer supporters in mental health centers. Because this should be a revenue stream for mental health centers,