NAMI
The Nation's Voice on Mental Illness

STATE POLICY BULLETIN
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Strategies for Responding to Threats to Limit Access to Medications in Medicaid and Other Mental Health Financing Systems

In 2002, states are struggling with the fallout of the bleakest economy in a decade. Most states are grappling with very large budget deficits. *Medicaid represents one of the largest cost centers for states — and the fastest growing cost item within state budgets.* Medicaid is now a major economic factor in many segments of the health care marketplace. States report that spending on prescription drugs is *one of the fastest* growing areas within Medicaid programs. So, states are considering or have adopted a variety of strategies to control spending on drugs. At the same time, states are trying to address the needs of growing numbers of uninsured persons by expanding Medicaid eligibility to populations previously ineligible for Medicaid. This is stressing the budgets of states even further, and heightening the pressures on states to cut back on services for those already eligible for Medicaid.

To control pharmaceutical spending, a number of states have adopted or are considering restrictions on access to certain types of more expensive medications in their Medicaid programs, including psychotropic medications. States are attempting to improve their capacity and cost effectiveness as purchasers of medications in one or more of the following ways:

- By coordinating bulk purchasing across all state agencies and joining purchasing collaboratives with other states;
- By forming Pharmacy and Therapeutics Committees to advise Governors and Medicaid Departments on policy and programmatic issues related to Medicaid and prescription drug benefits;
- By using preferred drug lists and requiring supplemental rebates from pharmaceutical companies;
- By limiting the number of prescriptions per month an individual can fill without prior authorization;
- By requiring mandatory substitution of generic drugs; and
- By placing certain drugs on a list requiring prior authorization before dispensing.

All of these options are being given serious consideration by states as they struggle to control Medicaid expenditures on pharmaceuticals. These prior authorization proposals have appeared in legislation, appropriations bills or regulations. **They pose significant threats for Medicaid recipients with mental illnesses trying to access medications prescribed by their treating physicians.**

NAMI's Policy:

It is NAMI s policy, adopted by the NAMI Board of Directors, that decisions regarding specific medications prescribed to persons with mental illnesses should be based on the clinical judgements of treatment

providers, not on economic factors. NAMI strongly opposes measures that limit the availability and right of individuals with mental illnesses to receive treatment with psychotropic medications **such as atypical antipsychotics or selective serotonin reuptake inhibitors.**

Advocacy Strategies:

NAMI advocates in certain states have worked successfully with other advocates to exempt (carve out) psychotropic medications from restrictions in Medicaid programs.

- For example, NAMI-Connecticut partnered with other health and disability organizations to carve out psychotropic medications from prior authorization requirements in that state s Medicaid plan. A summary of the language recently approved by a vote of the Connecticut Legislature s Appropriations Committee reads as follows:

The proposed revisions to the state s pharmacy program exempt all anti-psychotics, antidepressants, anticonvulsants and HIV related antiretroviral agents from prior authorization restrictions. These drugs are to be included on the state s preferred drug list.

It should be noted that Depakoate, prescribed for the treatment of bipolar disorder, is classified as an anticonvulsant.

- In Kansas, the legislature is considering the following language developed by NAMI-Kansas in partnership with other groups.

No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available without restriction for persons with mental illnesses include antipsychotic medications, conventional antipsychotic medications, and other medications used for the treatment of serious mental illnesses.

This language also includes a grandfather clause, i.e. a provision that no one currently receiving a medication will be required to change medications.

How should your state respond?

If you are facing potential restrictions on access to psychotropic medications in your state, you and your members must decide what advocacy strategies will work best for you. As a general principle, it is always best to start with an approach that will benefit the largest numbers of people with mental illnesses.

- In the context of Medicaid drug formularies, this means promoting carve-outs for all classes of psychotropic medications as a starting point, including anti-psychotic, anti-depressant, anti-anxiety and anti-convulsant medications.

- A narrower carve-out, e.g. anti-psychotic medications only, should be considered only as a last resort, when a broader approach is not politically or economically feasible.

Notification, Grievance and Appeals Procedures

If efforts to exempt psychotropic medications from restrictions in Medicaid formularies are unsuccessful, your efforts should focus on ensuring that procedures are in place to protect Medicaid recipients with mental illnesses and other disabilities from harm. For example, you should advocate for:

- Informed clinicians must be involved in the development of formularies and in making prior authorization determinations. All Pharmacy and Therapeutics Committees must include at least one practicing psychiatrist;

- A simple and fully accessible system must be created for requesting prior authorization by phone or fax, including the broad dissemination of easy to use prior authorization forms to all participating prescribers;

- A short turnaround time for obtaining a response to requests for prior authorization (two hours) must be operational, with the full amount originally prescribed automatically approved, if the Department is not able to make oral contact with the prescriber within two hours of the request for prior authorization having been submitted;

- In appeals of decisions to deny medications, a limited (ten day) supply of the original prescribed drug must be provided while contact with the prescriber is made and the appeal is decided; and

- An expedited appeal procedure must be followed whenever an appeal is filed following the denial of a particular medication. All appeals should be decided within 10 days of the date the appeal is filed.

We anticipate that state governments will continue to work to reshape the Medicaid Program in 2003. In 2002 they have used rainy day funds, tobacco settlement monies, freezes and delays in program and construction startups along with minor program adjustments to avoid deep cuts. Once the legislative sessions startup after the 2002 elections, state governments will again be faced with significant deficits, after having used many of their one time options to fill revenue gaps in 2002. This will again place Medicaid and the general fund allocations to the mental health system at risk.

Please contact Mike Fitzpatrick (207-353-9311) mfitznami@aol.com or Ron Honberg (703-516-7972) ronh@nami.org regarding the above Policy Alert and any support we can give you in the Policy Arena.

Notes

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