

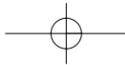


## Notes



**The Nation's Voice on Mental Illness**

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## Prior Authorization, Supplemental Rebates and Medicaid

In 2002 over two thirds of States have initiated budget reduction actions. States have used rainy day funds, drawn on unexpended reserves and enacted some new taxes. **Medicaid optional services have and will continue to be considered for cuts and restrictions in eligibility, benefits and payments.**

The key areas for cost containment in Medicaid are pharmacy, hospital, long term care and managed care. Even with cuts, most states in 2002-2003 will likely need supplemental funding for Medicaid. States are projecting Medicaid enrollment increases due to rising unemployment. Prescription drug expenditures are rising at double digit rates. Medicaid managed care cost savings are a thing of the past. Congress is considering a one time increase in the Federal share of Medicaid, but this is a short term solution at best.

The Medicaid financing crisis is occurring in an environment where general tax revenues are down significantly. Rainy day and reserve funds are being drained and net borrowing by state and local governments is at record levels. **Spending pressure on state and local governments is continuing to increase.**

Based on National Association of State Budget Officer's preliminary review of fiscal 2001 and 2002 state expenditures, total state Medicaid spending increased by 11.6% and 11.7%, respectively, and now amounts to more than 20% of total state spending. **Just as states are trying to manage the recession's fiscal fallout, Medicaid continues to exert severe pressure on state budgets.**

States in all regions continue to report that spending on prescription drugs is one of the fastest growing areas within Medicaid programs. In reaction to this trend, States are considering or have adopted a variety of strategies to control spending on pharmaceuticals. In 2002, 16 states have adopted measures to implement one or a combination of the following cost containment measures. These measures include:

- Preferred drug lists
- Prior authorization for prescriptions
- Supplemental rebates
- Generic substitution
- Prescribing and dispensing limitations
- Co-payments

Pharmacy and Therapeutics Committees have been created to advise state policymakers on formularies and cost containment strategies in Medicaid Pharmacy accounts. Most states are considering as options all of the above spending controls on medications in Medicaid. These cost containment schemes taken as a whole will mean that vulnerable persons on Medicaid will have difficulty obtaining certain drugs.

The combination of a preferred drug formulary with prior approval for all non-listed drugs within a state's Medicaid Program is a dangerous proposition for persons with mental illness. These plans have the potential to further erode a very tenuous community system of care.

In 2002, NAMI advocates in Ohio, Vermont, Indiana, Connecticut and Kansas working in coalitions have successfully used legislative strategies to carve out medications to treat mental illness from restrictive drug formularies. States such as Colorado, Washington and Oklahoma have blocked attempts at imposing prior authorization plans for medications used to treat mental illnesses. These are hard won and very important victories. They provide a roadmap for our efforts in states in 2003 and beyond.

As the 2002 legislative sessions move toward closure and the 2002 election season begins in earnest, the issues related to cost containment and pharmaceuticals moved into federal court. On July 1, 2002 the Pharmaceutical Research and Manufactures of America (PhRMA), a national trade association of prescription drug manufacturers, filed a lawsuit in the federal district court against the federal Department of Health and Human Services (HHS) and the federal Centers for Medicare and Medicaid Services (CMS). The lawsuit asks for a preliminary injunction to invalidate the Medicaid cost containment program developed by the State of Michigan and approved by HHS.

The Michigan program creates a prior authorization process and a preferred drug list. A drug is placed on the preferred drug list and is not subject to prior authorization only if the pharmaceutical manufacturer agrees to pay the state significant "supplemental rebates" beyond what the state receives from the federal government. PhRMA objects to these rules as violations of the Medicaid statute and harmful for Medicaid recipients.

We believe that the war between State governments and the pharmaceutical industry over pricing holds persons with mental illness who rely on Medicaid for medication hostage. **Access to quality care and recovery is at risk when state by state battles over cost containment and medication pricing occur.**

Supplemental rebates simply mean that persons with mental illness will in all likelihood have difficulty accessing certain drugs manufactured by a drug company which refuses to

pay these additional sums to the state. **Using vulnerable citizens in a showdown over drug pricing is both unacceptable and inexcusable.**

We understand that in these difficult financial times state governments must seek efficiencies in their budgets. **We ask that they, as Ohio, Kansas, Vermont and Connecticut have done, preserve access to medications that can be lifesaving and cost saving in the long run.**

Although we oppose the imposition of supplemental rebates and prior authorization policies, we demand that if savings on medications to treat mental illness are accrued from these schemes that these savings be allocated back into the system of care for persons with mental illnesses.

As stated in State Policy Bulletin no. 02-01, dated 4/16/2002, cost containment schemes in Medicaid that include prior authorization pose a significant threat for Medicaid recipients with mental illness. It is important that we **oppose in all cases the imposition of prior approval lists that include medications to treat mental illness.** If prior approval plans are enacted, refer to NAMI's 4/16/2002 State Policy Bulletin's Notification, Grievance and Appeal Procedures section for guidance on how to protect the rights of people with mental illnesses.

In the coming months, it is very important that we educate Medicaid Directors about the serious consequences of limiting access to medications central to the recovery of persons with mental illness. In 2003 state governments will again be faced with the choice of increasing revenues and/or cutting program costs. **We must work with policymakers to ensure that limited public dollars are used in the most effective way to protect access to the newest and most effective treatments for illnesses such as schizophrenia, bipolar disorder, major depression and severe anxiety disorders.**

**Medications make a tremendous difference. We will not tolerate pharmacy policies that depart from clinical care guidelines. Rising pharmacy costs must be understood as part of the larger picture-dramatic reductions in hospitalizations and criminalization result from access to effective medication and outpatient care.**

If you have questions, need information and/or support regarding changes to your state's Medicaid program, medication access or the PhRMA lawsuit against HHS, please contact Mike Fitzpatrick (207-353-9311) [mfitznami@aol.com](mailto:mfitznami@aol.com) or Ron Honberg (703-516-7972) [ronh@nami.org](mailto:ronh@nami.org).