



Service, Education, Advocacy
Contact: Domenique Thornton at (860) 529-1970 extension 11

Good Morning Mr. Chairman and members of the Human Services Committee. My name is Domenique Thornton. I am the Director of Public Policy for the Mental Health Association of CT, Inc., (MHAC). MHAC is a 100-year old private non-profit dedicated to service, education and advocacy for people with mental health disabilities. I would like to thank you for the opportunity to speak to you in favor of both Senate Bill 281 An Act Concerning Public Participation in Meetings of the Pharmaceutical and Therapeutics (P & T) Committee and House Bill 5297 An Act Concerning the State-Wide Expansion of the Primary Care Case Management Pilot Program. Concerning public input on the P & T Committee, mental health medications have long been exempted in this state from the Preferred Drug List (PDL) in this state for good reason. Adding mental health medications to the PDL will not save the state money. One study showed that "There was a statistically significant increase in the number of outpatient hospital visits and physician visits for the test group compared with the control group in the first 6 months after PDL implementation,"¹ Requiring Prior Authorization (PA) is no guaranteed remedy for this situation. The legislature has difficult decisions to make balance the costs of care with the lives of some of the sickest and poorest residents in the state of Connecticut. But, you should consider that PA ignores the setbacks, bad experiences, symptom remission or other life problems caused by step therapy required to "fail first" for persons who have severe and chronic mental illness. One study² reports that the "PA implementation can be a barrier to initiation of non preferred agents without offsetting increases in initiation of preferred agents, which is a major concern. There is a critical need to evaluate the possible unintended effects of PA policies to achieve optimal health outcomes among low-income patients with chronic mental illness." Members of the public, health care providers and others should be

¹ Murawski MM, Abdelgawad T, Exploration of the impact of preferred drug lists on hospital and physician visits and the costs to Medicaid. The American Journal of Managed Care [Am J Manag Care], ISSN: 1088-0224, 2005 Jan; Vol. 11

² Lu, Christine Y. PhD; Soumerai, Stephen B. ScD; Ross-Degnan, Dennis ScD; Zhang, Fang PhD; Adams, Alyce S. Unintended Impacts of a Medicaid Prior Authorization Policy on Access to Medications for Bipolar Illness. PhD Medical Care: January 2010 – Volume 48 – Issue 1 pp 4-9

allowed to inform the decisions of the P & T Committee before they include or exclude any mental health medications. As another researcher voiced this eloquent conclusion:

In the current climate of tight budgets, most payers of health care have restricted coverage and reimbursement for prescription drugs in an effort to control spiraling medical costs. These efforts have relied on methods such as using a "*preferred drug list*" that includes only the cheapest drugs of a class, or requiring treatment failures before approving newer, more expensive drugs for a patient. These strategies, especially in the case of the mentally ill, are seriously flawed because they result in poorer therapeutic outcomes and may eventually cost substantially more. Serious mental illness is marked by frequent relapses that lead to brain degeneration and chronicity of symptoms. As such, relapse prevention is essential. Treatment non adherence is attributed to a variety of causes, chief among which are intolerable side effects of prescribed drugs. Therein lies the benefit of newer atypical antipsychotic drugs, which are as effective, if not more so, than older conventional drugs but have a far more tolerable side-effect profile. Though the older antipsychotics are cheaper on a pill-for-pill basis, the increased incidence of relapse due to side-effect-induced non adherence is shown to offset any short-term saving by increasing other costs of care such as re-hospitalization and increased outpatients costs. In the long run, attempt at cost control by restricting formularies and by using older, cheaper drugs is fundamentally flawed and needs to be reconsidered.³

A better way to control costs would be through utilization management to identify high users of pharmacy benefit by certain individuals. It may be possible to link the DSS database on claims now to the database compiled by DMHAS that hold information on hospitalizations, employment, substance use, current level of care and system-wide admissions and discharges. By looking at two different sets of information, high pharmacy costs and outcome data, it may be revealing to see whether the pharmacy charges are justified in achieving the goals everyone hopes for. Cost outliers could be examined and monitored in a much more person centered approach that aims to provide a balance between cost and quality. Such utilization review may also identify individuals where poly-pharmacy – numerous prescription medications given to one individual from different providers, often without coordination or knowledge among those providers – could cause medical risks to the individual. Barriers to access to mental health medications such as placing mental health medications on a preferred drug list requiring prior authorization regardless of its past success require more public input as in other states that do use a preferred drug list for mental health medications have other protections in place consisting of sub-committees, advisory boards, etc. comprised of medical professionals and academicians to inform and advise the drug selection process to ensure a robust array of choices of medications to treat effectively treat a variety of conditions. Thank you for the opportunity to speak to you. Our Association is ready to help DSS, DMHAS or other state agencies in helping Connecticut improve its system of care.

3. Verma, Kiran; Verma, Sumer; is the Cheapest Drug the best Alternative? Primary Psychiatry, Vol. 11(1), Jan,

Similarly, House Bill 5297 An Act Concerning State-Wide Expansion of the Primary Care Case Management Pilot Program is a very good idea. Medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities. Medical homes have become an important theme of health reform discussions at the federal and state levels.⁴ Medical homes are not buildings but are a coordinated and patient centered approach to attending to medical care delivery. Eight states have recognized the potential of adopting a medical home model and seven are in the process of developing a criteria to recognize medical homes.⁵ Medical home pilots and programs are operating in at least 37 states including Connecticut.⁶ The patient-centered medical home has the potential prevention as well as for better management of chronic diseases. I currently serve on the Sustinet Advisory Subcommittee for Patient Centered Medical Homes. Thank you.

⁴ PCCM: A New Option for HUSKY, CT health Policy Project, www.cthealthpolicy.org/pccm

⁵ Christopher Atchison, presentation at Building a Medical Home: issues and Decisions for State Policy Makers, NASHP, Oct. 5, 2008, Tampa, FL

⁶ Patient Centered Medical Home: Building Evidence and Momentum, PCPCC, 2008, national Academy for State Health Policy, November 2008, National Partnership for Women and Families, Sept. 2008