



*Service, Education, Advocacy*  
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Good Evening, Chairman and members of the Appropriations Committee. My name is Domenique Thornton. I am General Counsel and 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. Thank you for the opportunity to tell you why we are opposed to restrictive co-payments, alternative benefits and rate changes in the Medicaid program. We believe that it would be detrimental the health of vulnerable people and cost more money to the state to institute these proposed budget proposals.

Persons on the Medicaid program for low-income adults, (LIA) cannot afford co-payments. Vulnerable persons in need of necessary medications or medical treatment will be deterred from seeking the medical care they need if they do not happen to have \$3 in their pockets. Those persons on Medicaid or who are dually eligible for Medicaid and Medicare have no other resources to make copayments. That may not sound like a lot of money for people in this room but it can create a restrictive barrier that results in more expensive necessary care. Even Office of Policy and Management Secretary Benjamin Barnes agreed that copayments in Medicaid are not good public policy and serve as a barrier to care. In fact, a 2009, a ten (10) state Medicaid study examined restrictive medication management techniques in California, Florida, Georgia,

Michigan, Massachusetts, New York, Ohio, Pennsylvania, Tennessee, and Texas and concluded that "Medication-access problems were highly associated with utilization-management features and with adverse events. Medicaid prescription-drug-management policies that are based primarily on cost rather than clinical considerations may result in significant human, economic, and social costs." See attached. In this study, restrictive measures such as co-payments resulted in a nearly 8 times greater likelihood of experiencing an adverse event. With the requirement of co-payments Connecticut can expect to find more elderly, chronically ill, and low income adults having increased expenditures for the emergency department and hospitalizations. Imposing co-payments will cause people with serious medical condition to stop taking medications which will cause harm and result in expensive crisis intervention later on also shown in a December 2010 report by the Robert Wood Johnson Foundation also attached.

Another adverse outcome of copayments is that Medicaid health care providers may ultimately pay the cost of Medicaid copayments because they are responsible for collecting the money from patients and often will provide the needed care but never receive that portion of their payment. Once again, vulnerable people are more likely to go without care or forego some other need to pay their doctors.

We know that Connecticut was the first state to adopt the program, known as Medicaid LIA under the Affordable Healthcare Act. Although the Medicaid LIA program has concededly grown faster than may have been expected due to the recession, this program is expected to save the state money by bringing in federal dollars as the state transfers adults previously covered by 100% state-administered general assistance into Medicaid. The Mental Health Association would not be opposed to an asset test for this program because those who have no other resources LIA would be covered. We would request that all those found eligible for Medicaid receive the same benefits and services as a matter of equal protection. Thank you.

# Medicaid Rules Linked to More Adverse Outcomes in Mentally Ill, Increased Mental Health Costs

Janis Kelly

June 4, 2009 — Some state Medicaid requirements meant to save money are associated with more adverse outcomes among mentally ill patients and might actually be increasing mental-health costs, new research suggests.

Practices such as requiring a switch to generics, placing limits on the number or dosing of medication, requiring prior authorization, and requiring use of step therapy or fail-first protocols were associated with a greater number of adverse events in patients, the study authors, led by Joyce C. West, PhD, from the American Psychiatric Institute for Research and Education, in Arlington, Virginia, conclude.

The investigators also conclude that states with more prescription-drug-management practices in place had significantly higher medication-access problems. After adjusting for patient case mix, the researchers found that patients with medication-access problems had a 3.6 times greater likelihood of experiencing a significant adverse event.

"Medication-access problems were highly associated with utilization-management features and with adverse events. Medicaid prescription-drug-management policies that are based primarily on cost rather than clinical considerations may result in significant human, economic, and social costs," Dr. West, told *Medscape Psychiatry*.

The study is published in the May issue of *Psychiatric Services*.

## Ten State Programs Examined

The study looked at prescription-drug-management features in 10 state Medicaid programs, at medication-access problems among psychiatric patients in those 10 states, and at adverse events in those patients, including emergency-department visits, hospitalizations, homelessness, suicidal ideation or behavior, or incarceration.

Data were collected from 857 psychiatrists in California, Florida, Georgia, Massachusetts, Michigan, New York, Ohio, Pennsylvania, Tennessee, and Texas.

Psychiatrists in the study reported 5 common medication access problems:

- 34% of patients could not access clinically indicated medication refills or new prescriptions because Medicaid would not cover or approve them.
- 29% could not be prescribed the physician's preferred medication because of drug-coverage or approval issues or because patient could not make copayments.
- 26% of patients discontinued a drug as a result of prescription-drug-coverage or management issues or problem with copayments.
- 25% of patients were prescribed a medication not clinically preferred because clinically indicated or preferred medications were not covered or approved.
- 14% of patients had problems accessing medications because of copayments.

According to the study, patients who had problems with copayments had a nearly 8-fold greater likelihood of experiencing an adverse event. All of the access problems were associated with increased emergency visits and psychiatric hospitalizations.

## Access Problems, Adverse Events

Of the 10 states studied, New York, Texas, and California had the lowest rates of access problems, while Ohio, Florida, Massachusetts, Pennsylvania, Tennessee, Georgia, and Michigan all had higher rates.

"The bottom line in terms of implications and inferences from this study would be that those utilization-management features we were able to study — copays, prior authorizations, step therapy, etc — and the differences in the utilization-management features and the ways they were operating or functioning across the states appear to be associated with medication-access problems and adverse events," Dr. West said.

Alyce S. Adams, PhD, who is a research scientist at Kaiser Permanente in Oakland, California, who recently completed a study showing prior-authorization policies for antidepressants had no adverse effect on patient outcomes, said the current study raises some questions about the researchers' classification of states' restrictive drug policies.

"The authors have chosen an important topic and provide sobering data on persistent barriers to access among patients as reported by psychiatrists. However, the findings regarding the link between psychiatrist-reported patient outcomes and state Medicaid policies must be interpreted with caution."

### **Drug Caps an Important Omission**

"As the authors acknowledge, cross-sectional studies cannot provide evidence of causality. Further, the inclusion of psychiatrists with varying exposure to the Medicaid program and reliance on self-reports of outcomes are additional threats to the internal validity of the study findings," Dr. Adams told *Medscape Psychiatry*.

It is important to note, she added, that the investigators may have omitted 1 of the most powerful policy instruments available to states from their analysis — drug caps.

"The authors describe limits on the number of medications, which I assume to mean restrictions on days' supply of medications (eg, 30 days). Drug caps, limits on the number of drugs that the state will reimburse per month (eg, 3 per month) are a less popular but more restrictive policy used by some state medication programs to control costs. Two of the states described as less restrictive by the authors have limits on the number of reimbursable prescriptions per month," she added.

According to Dr. Adams, there is very strong evidence that caps on the number of reimbursable prescriptions per month and cost sharing reduce use of medications, even clinically essential medications, among the mentally ill.

"Given that mental illness is generally undertreated, it may make sense for states to exclude these populations from such blunt policy instruments. The utility of other mechanisms such as prior authorization may vary, depending on the patient population and the implementation strategy," she said.

Dr. Adams warned that states should consider the evidence from rigorous studies of patients with mental illness and implement monitoring policies to identify and address problems should they arise following implementation of restrictive prescription-drug policies.

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## **Authors and Disclosures**

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Janis Kelly is a freelance writer for Medscape. She has been a medical journalist since 1976, with extensive work in rheumatology, immunology, neurology, sports medicine, AIDS and infectious diseases, oncology, and respiratory medicine.