



NAMI-NEW YORK STATE

National Alliance on Mental Illness - New York State

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Testimony for the Senate Finance & Assembly Ways and Means On 2009-2010 Executive Budget for Health/Medicaid

Submitted by National Alliance on Mental Illness of New York State
Presented by Trix Niernberger, Executive Director
Monday, February 2, 2009

The National Alliance on Mental Illness of New York State (NAMI-NYS) is a grassroots organization of 26 years, providing education, support and advocacy. Through our 56 local chapters, NAMI-NYS represents thousands of families. Most of our members either have a mental illness or have a loved one with a mental illness. It is their hopes and fears that form the foundation of our testimony related to the Executive Budget for Medicaid.

MEDICAID & EPIC PHARMACY INITIATIVES WE OPPOSE

- **Expand Medicaid Preferred Drug List to Include Antidepressants**
This provision is included in the Deficit Reduction Plan, but the Governor lists NO savings associated for it for the current year. Please reject this proposal.

New York's Medicaid program currently employs a Preferred Drug List (PDL) for certain medications. If a physician wants to prescribe a non-preferred drug, Medicaid reimbursement is denied unless prior authorization is obtained. Currently, antidepressants are exempt from the Preferred Drug List.

Antidepressants are used for a broad range of illnesses, often in combination with other medications. The narrowing of therapeutic options could cause serious consequences for patients and their families, including the discontinuation of therapy, more hospitalizations and suicides.

To say medications are equivalent, according to the National Institute of Mental Health, is not to say they are identical. People have unique responses to psychiatric medications and need more, not fewer, choices. Persons of various heritages, particularly African, Asian and Hispanic, may be affected by genetic differences in drug metabolism that can lead to severe side effects. Options in treatment are critical.

Although Governor Paterson says there are no savings this year and \$3.3 million next year, this latter number does not include all the costs associated with the unintended consequences of switching the medications of thousands

of persons with serious mental illness. It is likely that the costs will far exceed the predicted savings. What will happen when the medications of thousands, who have been stabilized on medication regimens that have taken many months or years of trials, changes? According to a May 2007 study published in the American Journal of Psychiatry, almost 20% of patients required an emergency room visit when psychiatric medications were switched. In addition, 11% of patients required hospitalizations.

Here is a recipient of mental health service's personal story:

After taking Effexor XR for about four years, I switched to Venlafaxine HCL which is the generic form. I experienced nausea and waves of fatigue throughout the day and was in a continuous state of excessive nervousness, obsessive thoughts and apprehension. I had never experienced side effects with Effexor XR. These conditions interfered with my ability to focus to do work, limited the time I was able and willing to drive my car, motivation to exercise, and more. I became irritable, angry (not my nature) and depressed. A month later, I returned to using Effexor XR again. These symptoms gradually subsided and within two weeks I was feeling well again. There were no significant changes in my life other than the change to the generic form of the antidepressant so it was apparent that the side effects were related to my taking the Venlafaxine. I am now back to my healthy routines.

Although this member's story involves a positive ending after she was returned to her prior drug regimen, this is not always the case. Others have found that returning to a prior regimen may not work as well as it did prior to a switch.

Please do not place obstacles in the way of effective treatment. Prescribing decisions must be made by physicians and their patients, not bureaucracies. We hope you will act now to preserve access to these life-sustaining medications. We are attaching a summary of studies providing support to our testimony on page four herein.

- **Establish Prospective Drug Utilization Review for Anti-Psychotics**
This new provision will stop pharmacists from filling prescriptions ordered by physicians if the prescription does not meet standards developed by the Office of Mental Health. We strongly oppose this initiative.

We are in favor of retroactive drug utilization review which is how the Office of Mental Health is using their standards. When OMH sees that a physician is prescribing more anti-psychotics than the standard, they inform the physician. This is done through their electronic PSYCHES system. We have no problem with this methodology of changing physician practices. However, when doing

this prospectively which is proposed, the patient is punished while they wait for a response from the physician.

The Department of Health will tell you they do this with other drugs. However, antipsychotics are not like other drugs. Stopping an anti-psychotic until a doctor can be contacted when a prescription cannot be filled, could cause hallucinations to return causing great harm to a mentally ill patient. The patient could end up in the emergency room or hospital as a result.

- **Require Use of Brand Name Drugs When Less Costly**
We are opposed to this idea for the same reasons we are opposed to requiring antidepressants on the Preferred Drug List.
- **Limit Quantity, Frequency & Duration of Certain Dispensed Medications**
People with mental illnesses often have complex drug regimens. This would interfere with the patient-physician relationship and causes delays in medications.
- **Eliminate EPIC Wrap-Around Coverage for Non-Medicare Part D Drugs**
The Medicaid wrap-around pays for four specific categories of drugs— atypical antipsychotics, antidepressants, anti-retrovirals and anti-rejection drugs, when Medicare doesn't cover them. Folks in the Part D “doughnut hole” will be particularly hit hard. This is a critical safety net for poor elderly and those with mental illnesses. Do not deny prescription medications to our most vulnerable New Yorkers.

THANK YOU

Thank you so much for your consideration of our concerns. If you have questions, please contact me.

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See next page: Summary of studies related to restricting access to antidepressants.

Antidepressants: 1, 2 or Even 3 Do Not Fit All

- While antidepressants in a class may have similar effectiveness overall, they have specific mechanisms that affect each person differently. Antidepressants vary in transmitters they affect, potency of their action and side effects, including metabolism of other medications, sedation, increased appetite, agitation and even psychosis. Since people have different symptoms and often have more than one diagnosis, choosing the right medication is vital.
(American Psychiatric Assn, Office of Healthcare Systems & Financing, *Maximizing Pharmacology in Treatment of Major Depression*, 3/2004)
- About one-third of participants in the *STAR*D* depression treatment study became largely symptom-free after treatment with an antidepressant. Two out of three individuals will need to keep trying different treatment regimens or combinations to get better.
(NIH, NIMH, *Switching to a Third Antidepressant Medication May Prove Helpful to Some with Treatment-resistant Depression*, 2006)
- Persons of various racial and ethnic backgrounds, particularly African, Asian and Hispanic heritage, may be affected by genetic differences in drug metabolism that can lead to severe side effects. Options in medications and dosing are critical.
(American Psychiatric Assn, Office of Healthcare Systems & Financing, *Maximizing Pharmacology in Treatment of Major Depression*, 3/2004)
- National Institute of Mental Health states that to say medications are equivalent is not to say they are identical. People have unique responses to psychiatric medications and need more, not fewer, choices. (NIH, NIMH, *NIMH Perspective on Antipsychotic Reimbursement: Using Results from CATIE Cost Effectiveness Study*, 12/2006)
- Behavior problems and abdominal symptoms were significantly worse for patients switched from one antidepressant to another in same class. (Erder, et al, *Impact of Switching from Escitalopram to Citalopram during Antidepressant Drug Treatment of Elderly Nursing Home Patient-Areas of Potential Deterioration due to Formulary Decisions*, 6/2007)
- 19.8% of patients required an emergency room visit, 11% required hospitalization, & staff spent twice as much time on administrative issues when psychiatric medications switched.
(West, Joyce C., PhD, MPP, et al, *Medication Access & Continuity: Experiences of Dual-Eligible Psychiatric Patients during First 4 Months of Medicare Prescription Drug Benefit*, Am J Psychiatry, 5/2007)
- Antidepressants are used to treat major depressive disorder, obsessive compulsive disorder, bulimia nervosa, panic disorder, social anxiety disorder, posttraumatic stress disorder and diabetic peripheral neuropathic pain.

Major Depressive Disorder (MDD)

- Depression is responsible for up to 70% of psychiatric hospitalizations. (NIH, NIMH, *Questions & Answers about the NIMH Sequenced Treatment Alternatives to Relieve Depression STAR*D Study—Background*, 2006.)
- Each year, 9.5% or 20.9 million American adults will struggle with MDD, which is a recurring illness, frequently returning for two or more episodes lasting often two years or more. (*Ibid.*)
- More than 90% who kill themselves have depression or another diagnosable mental or substance abuse disorder, often in combination with other mental disorders. (OMH, *Suicide Questions & Answers*)
- Workers with depression cost employers an estimated \$44 billion per year in lost productive time--\$31B more than the cost of all other causes combined. (JAMA, June 18, 2003)
- Treatment reduces the likelihood of another depressive episode by over half.
(American Psychiatric Assn, Office of Healthcare Systems & Financing, *Maximizing Pharmacology in Treatment of Major Depression*, 3/2004)