The Nation's Voice on Mental Illness

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Deborah Perfetto
U.S. Pharmacopeia
12601 Twinbrook Parkway
Rockville, MD 20852

Dear Ms. Perfetto:

On behalf of the 210,000 members and 1,200 affiliates of the National Alliance on Mental Illness (NAMI), I am pleased to submit the following comments on the revised U.S. Phamacopeia (USP) Model Guidelines for the Medicare Part D drug benefit. As the nation's largest organization representing individual with severe mental illnesses and their families, NAMI is pleased to have this opportunity to share our views on these important revised guidelines.

USP Model Guidelines & Access to Medications Under the Part D Drug Benefit

In 2004, NAMI offered comments on the initial set of Model Guidelines for Medicare Part D, raising concerns that the relatively short list of therapeutic categories provided a significant opening for Part D prescription drug plans to limit the scope of breadth of coverage. When coupled with requirements in the law, the original Model Guidelines would have allowed a plan to pick two older medications within a number of the broad classifications and thereby permit plans to avoid covering newer more effective medications with superior side effect profiles and a stronger support among treating physicians. NAMI was especially concerned about the impact these Guidelines would have had on the most vulnerable Medicare beneficiaries living with severe disabilities and chronic illnesses for which access to a specific regimen of medications is critical.

In response to these original Model Guidelines, the Centers for Medicare and Medicaid Services (CMS) developed binding guidance for drug plans requiring broad coverage of medications within 6 therapeutic categories -- mandating coverage of "all or substantially all" of the drugs within these classes. These classes included 3 categories essential to the treatment of mental illness: anti-psychotics, anti-depressants and anti-convulsants (in addition to anti-retrovirals, immuno-suppressants and oncology drugs). In the justification for this formulary guidance, CMS made clear that the medications within these classes are associated with serious chronic conditions and not readily interchangeable among individual patients. As such CMS felt that Part D drug plans should not be allowed to limit coverage of these medications.

In NAMI's view, CMS was (in many respects) forced to go beyond the standard set forth by USP in the original draft Model Guidelines because they would have allowed a drug plans a "safe harbor" from the very strong anti-discrimination standard in the Medicare Modernization Act (MMA). Part D drug plans (both free-standing PDPs and Medicare Advantage MA plans) would

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have been allowed to include as few as 2 medications within these classes and be largely immune from any challenge of having limited coverage to discourage enrollment by beneficiaries with chronic or serious illness. Fortunately, CMS took the steps necessary to ensure that drug plans were not able to limit their formularies in a discriminatory manner. This in turn meant that the overly short and inadequate initial set of USP Model Guidelines were largely superseded by the "all or substantially all" guidance.

Revised Model Guidelines Fall Short

In NAMI's view, it is unfortunate that these USP Revised Model Guidelines appear to largely follow the pattern set forth in the initial Model Guidelines. In fact, the Revised Model Guidelines appear to take a major step backwards by eliminating an entire column. This limits the Guidelines to 41 therapeutic categories for which Part D drug plans would be required to at least 2 drugs in each class. In only 32 classes are there "associated" classes -- with a total of 137 pharmacologic classes. However, it is important to note that under the MMA, a drug plan need not cover any medications within these 137 classes. Instead a drug plan could cover as few as 82 medications on their formulary (2 drugs within each of the 41 categories) and be allowed a "safe harbor" from scrutiny on the basis of discriminatory benefit design. This is deeply troubling to NAMI given how critically important the Part D benefit will be for the most vulnerable low-income Medicare beneficiaries with severe disabilities and chronic illnesses.

NAMI would urge USP to expand these Revised Model Guidelines and reclassify the "associated pharmacologic classes" and "key formulary drug types" as therapeutic categories. This would help ensure that drugs plans offer coverage of medications on their formularies that is broad and adequate to meet the complex treatment needs of the Medicare population.

Further, the Revised Model Guidelines cite “clinical non-distinction” as justification for many of its decisions in assigning critical pharmacologic treatments to particular categories or classes, as well as revising the classification system itself. Unfortunately, the Revised Guidelines fail to define this terminology or describe its analysis in application to each section. At minimum, USP appears to be inconsistent in its application of criteria by confusing therapeutic effect and pharmacological effect in the collapse of categories and classes within specific illness categories. As a consequence, treatment options for individuals with severe chronic diseases and disabilities are severely restricted and inadequate. This is particularly notable with respect to severe mental illnesses.

USP Revised Model Guidelines & Coverage of Medications to Treat Mental Illness

Medicare beneficiaries with severe mental illness are particularly vulnerable, because most have important disease-related cognitive impairments as well as limited social and financial support. Anti-psychotics, anti-depressants, and bipolar medications are critically important in controlling acute episodes and preventing recurrence. NAMI continues to support open, unrestricted access to medications to treat mental illness to maximize both quality health outcomes for individual patients, as well as to provide the most cost-effective total healthcare strategy.

In drafting the MMA, the House-Senate Conference Committee was explicit in their expectation of pharmaceutical coverage for patients with mental illness:

> *"It is the intent of the Conferees that Medicare beneficiaries have access to prescription drugs for the treatment of mental illness and neurological diseases resulting in severe epileptic episodes under the new provisions of Part D. To fulfill this purpose the Administrator of the Center for Medicare Choices shall take the appropriate steps before the first open enrollment period to ensure that Medicare beneficiaries have clinically appropriated access to pharmaceutical treatments for mental illness, including but not limited to schizophrenia, bipolar disorder, depression, anxiety disorder, dementia, and attention deficit disorder/attention deficit hyperactivity disorder and neurological illnesses resulting in epileptic episodes."* H.Rpt. 108-39, p 769

It is this specific direction from Congress that helped establish the basis for CMS to go beyond the USP Guidelines and include anti-psychotics, anti-depressants and anti-convulsants in the "all or substantially all" coverage guidance for the 6 vulnerable classes. This direction from Congress should also provide the needed justification for USP to expand the categories for medications to treat mental illness.

NAMI would like to make the following specific recommendations with respect to 3 therapeutic categories: anti-psychotics, medications to treat bipolar disorder and anti-depressants.

<u>Collapsing of Anti-Psychotic Categories is Not Justified</u>
The Revised Model Guidelines set forth only two Pharmacologic Classes for anti-psychotic medications to treat schizophrenia: Atypicals (#56) and Non-Atypicals (#57). This is contrast to the initial Model Guidelines from 2004 which contained three separate categories of anti-psychotic medications: phenothiazines (#54), non-phenothiazines (#55) and non-phenothiazines/atypical antipsychotics (#56). This change is justified in the Revised Model Guidelines as a "nomenclature clarification."

This is troubling for several reasons. First, if the purpose of the change from the Initial Guidelines to the Revised Guidelines is simply a nomenclature clarification, why has is resulted in the number of therapeutic categories being reduced from three, down to two. From NAMI's perspective, this is more than simply a nomenclature change since it will result in a Part D drug plan being able to meet the standard for safe harbor by covering only four anti-psychotic medications, instead of six.

Again, this standard is in stark contrast to the requirement established by CMS in the "all or substantially all" guidance noted above that mandates broad coverage anti-psychotic medications. As noted previously, CMS adopted this required approach because of the complex nature of schizophrenia and negative consequences of forced switching of medications. In NAMI's view, moving from this "all or substantially all" requirement to the standard in these Revised Model Guidelines would disastrous for vulnerable Medicare beneficiaries living with schizophrenia. NAMI would therefore urge that the Revised Guidelines be expanded to include additional therapeutic categories for anti-psychotics.

Research has demonstrated that different anti-psychotic medications impact distinct portions of the brain and affect the brain in very different ways. Atypical anti-psychotics, in particular, are

highly individualized. Further there is growing evidence that there may be as many as 3 distinct types of atypical anti-psychotics that are each associated with distinct chemical structures, mechanisms of action, and clinical outcomes. These categories of atypical medications include "pines," "dones," and "partial agonists." Unfortunately, the Revised Model Guidelines fail to draw any distinction between the 3 categories.

It should also be recognized that the older, typical anti-psychotic medications are also distinct and often associated with pervasive and disabling side effects evident in as many as 40 percent of patients (e.g., muscle spasms resulting in abnormal and usually painful body positions, tremors and muscle rigidity, involuntary repetitive movements often of the face, mouth, or hands, and painful muscular restlessness requiring the person to move constantly).

Given the critical differences between all of these medications, it is extremely important that beneficiaries have access to the full array of anti-psychotics. Reducing coverage to only two categories -- USP is proposing here -- will further increase the risk that Medicare beneficiaries will be forced to switch to medications that are less effective for their individualized clinical circumstances. This poses enormous risk of compromising the clinical progress and recovery for these Medicare beneficiaries, many of whom already frequently face multiple challenges including severe disability and advanced age. Forcing these vulnerable beneficiaries to switch medications can result in dangerous drug interactions, harmful relapses in symptoms and psychiatric crises. NAMI therefore urges that USP amend the Revised Guidelines to expand the anti-psychotic categories.

Anti-Depressant Categories Need Expansion

In NAMI's comments on the original Model Guidelines, we highlighted the fact that the proposed model guideline structure was overly restrictive for anti-depressants. Specifically there was too much grouping of dissimilar drugs in large non-uniform classes. The revised Model Guidelines appear to take a very different approach by expanding the number of categories. However, the revised Model Guidelines continue to place dissimilar medications into a single category.

Specifically, the Revised Guidelines separate the “Reuptake Inhibitor” Pharmacologic Class into three distinct Formulary Key Drug Types: Selective Serotonin Reuptake Inhibitors (SSRIs), Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs), and Tricyclics. Monamine Oxidase Inhibitors (MAOIs) and “Antidepressants, other” category are also recognized as distinct classes. In NAMI's view, this classification falls short of what is needed and fails to recognize important pharmacological differences among agents within groups and subgroups.

NAMI is disturbed that the Revised Guidelines further contract the classification by combining the SSRIs and SNRIs into one Pharmacologic Class, while elevating the tricyclics to Pharmacologic Class status. The stated justification for this contraction is “FKDT reduction for clinical non-distinction.” This is troubling for two reasons: 1) it ignores a large body of evidence demonstrating clinically important differences among these classes and individual agents within these classes; and 2) the resulting formulary structure would result in enormous inconsistencies, especially for vulnerable Medicare beneficiaries who prescribed anti-depressants.

First, on the issue of clinical distinction, there is an extensive body of clinical research demonstrating differences between SSRIs and SNRIs in the treatment of depression. In judging the adequacy and appropriateness of a formulary structure of categories and classes it is obviously important to look at the specific needs of the population to be served by the resulting formulary as well as the implication of decision rules imposed by CMS on participating plans developing formularies. Part D formularies primarily affect both the elderly beneficiaries and non-elderly beneficiaries with disabilities (including those dually eligible for both Medicare and Medicaid).

The proposed Revised Model Guideline structure for anti-depressants has four pharmacologic classes: MAOIs, reuptake inhibitors, tricyclics, and the heterogeneous "other" class. While MAOIs are believed to act on both serotonin and norepinephrine, MAOIs are rarely used especially in the elderly because they are poorly tolerated and subject to frequent potentially dangerous drug-drug interactions. Tricyclics, many of which are believed to act on both serotonin and norepinephrine, are proposed to be a different category from SNRIs or SSRIs**.**

However, one major difference between TCAs, SNRIs and SSRIs is that TCAs are especially poorly tolerated and can even be dangerous in the elderly who are susceptible to their sedation, orthostatic hypotension and other anticholinergic effects, as well as and cardiac toxicity. Despite this, tricyclics were actually promoted to Pharmacologic Class status in the Revised Model Guidelines and plans would thus have to list two MAOIs and two tricyclics. The "other" group of antidepressants is a heterogeneous group with each agent having a relatively distinct mechanism of action. Again, individual agents in this group are relatively infrequently used in the elderly, but at least two of them would have to be included in a formulary.

The result is a "mega class" of "reuptake inhibitors" which make up the vast majority of antidepressant prescriptions in the elderly as well as other populations because of their unmatched track record of demonstrated effectiveness and tolerability. However, by the proposed guidelines, a plan would only need to list two agents in combined SSRI/SNRI Pharmacologic Class. Extensive research has demonstrated the heterogeneity of response to SSRIs and to SNRIs, even among agents with the similar profile.

Data from the IMS on the use of anti-depressants among the elderly (over age 65) reveals that fewer than 15% are prescribed tricyclics and less than 1% are prescribed MAOIs. By contrast, 15% are prescribed SNRIs and 58% are prescribed SSRIs. In other words, USP is proposing to collapse six drugs in classes used by for 27 percent of senior anti-depressant prescriptions, and as few as two drugs from the classes used by 73 percent of seniors. SNRIs are used as frequently as tricyclics, more frequently than the entire "other" category, and much more frequently than MAOIs. Based on actual use patterns and clinical differentiation, it is clear that SSRIs and SNRIs should be separate therapeutic classes.

For the non-elderly disabled Medicare population (many of whom are dually eligible for Medicare and Medicare) there is a separate issue. This population includes a disproportionate number of individuals with severe mental illness. Clinical experience has demonstrated that treating these individuals requires the maximum flexibility in choosing agents to reach efficacy.

Thus, the proposed structure would therefore discriminate against this population and not serve the needs of either group.

Bipolar Drug Listings Inadequate

In the Revised Model Guidelines, the Bipolar Agents (#68) contains several important omissions. Further, the Key Formulary Drug Types list only four of the nine agents currently FDA-approved as treatments for bipolar disorder (also known as manic-depression). Bipolar Disorder is a cyclical, debilitating mental illness, characterized by episodes of mania, depression, and normal mood. The FDA has recognized the cyclical and episodic nature of bipolar disorder and has granted approval to medications that have proven safety and efficacy for specific phases of bipolar disorder, by approving specific indications for bipolar mania, bipolar depression, and bipolar maintenance.

Despite that, only lamotrigine has been added to the Revised Model Guidelines. NAMI recognizes that CMS has made clear that this drug listing is not comprehensive. Further, the Revised Model Guidelines now contain a column "disclaimer" stating that the listing includes "examples." However, it seems inconsistent that the listing for most therapeutic categories is relatively exhaustive, while the Bipolar Agents listing is both brief and dramatically incomplete.

NAMI is especially concerned that this inconsistency could have negative consequences for patients. It is reasonable to assume that Part D drug plan sponsors may be relatively unfamiliar with current bipolar therapy and may assume that the list is complete or reasonably complete. This could result in leaving out important therapeutic options for a complex illness known to be relatively treatment refractory. Alternatively, a plan could mistakenly assume that the listed agents were "preferred" agents -- a finding far beyond the scope of the Revised Guidelines.

NAMI would therefore urge that the Key Formulary Drug Type column under category Bipolar Agents (#68) be expanded to encompass all of the FDA approved treatments for the three major indications of the illness: bipolar mania, bipolar depression and bipolar maintenance.

Process for Development of the Model Guidelines Has Been Flawed and Inadequate

Finally, NAMI is compelled to comment in the process by which the USP developed and brought forward these Revised Model Guidelines. We are especially disturbed by the absence of meaningful public input into the development of these proposed Revised Model Guidelines. The very brief duration of the comment period simply does not permit the extent and depth of public discussion necessary to develop Model Guidelines that best meet the needs of Medicare beneficiaries living with chronic disease or disability. NAMI would urge that in the future USP consider a much more transparent and open process that takes additional measures to ensure meaningful public input from Medicare beneficiaries, especially groups representing beneficiaries living with chronic illnesses and disabilities. This should include representation from such organizations on any and all advisory panels that USP establishes to assist in development and refinement of the Guidelines.

Conclusion

NAMI appreciates the opportunity to comment on the Revised Model Guidelines. It is critically important that USP work to revise these Guidelines to make them more responsive to the treatment needs of Medicare beneficiaries living with chronic illness and disability. Thank you for your attention on these important issues.

Sincerely,

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Executive Director
NAMI