Senate Public Health & Welfare Committee

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NAMI Kansas is the state organization of the National Alliance on Mental Illness, a grassroots organization whose members are individuals living with mental illnesses and their family members who provide care and support. NAMI Kansas provides programs of peer support and education by and for our members through a statewide network of 15 local affiliates. We advocate for individuals who are living with mental illness to ensure their access to treatment and supportive services.

We urge you to adopt SB 316 and to move this bill forward to the full Senate to establish a comprehensive and barrier-free tobacco cessation program for all KanCare beneficiaries.

For the past two years with financial support from the Kansas Health Foundation, NAMI Kansas and six other behavioral health organizations have been engaged in programs of work focused on reducing the impact of tobacco among the behavioral health population.

Smokers with mental illness and addiction are becoming a sizeable percentage of individuals who are continuing to use tobacco. 40 percent of tobacco use is accounted for by the behavioral health population. Individuals living with serious mental illness face an increased risk of having chronic medical conditions.[1] Adults living with serious mental illness die up to 25 years earlier than other Americans, largely due to treatable medical conditions like heart disease, cancer, and respiratory diseases – most of which are linked to smoking.[2] [3] Smoking is the number one cause of death in people with mental illness or addiction. 50% of deaths among individuals with schizophrenia, depression and bipolar disorder are attributed to tobacco.[4] Tobacco use is one of the most preventable causes of morbidity and mortality in Kansas, causing an estimated 3,900 preventable deaths in our state every year.

Tobacco use reduces the efficacy of psychiatric medications. Individuals with mental illness can take less medication and achieve better symptom reduction by taking less medication when they quit tobacco. This represents better health and quality of life outcomes for individuals as well as savings to health care systems.

Kansas is among the five states with the lowest utilization rates of quit-smoking medication among Medicaid beneficiaries. This bottom tier of states provides medication support for only 1% to 6.5% of Medicaid recipients who smoke.

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Currently, the annual Medicaid costs caused by smoking in Kansas is estimated to be $237.4 million with 36% of Kansas Medicaid participants reporting use of tobacco products. Use of cessation benefits among these participants is very low – for example, an analysis of 2013 claims data found that only 3% of estimated smokers filled a prescription for a quit smoking medication. Likewise, an analysis of 2010-2013 Kansas claim data found that less than 1% of estimated pregnant smokers had claims for counseling for smoking cessation.

There are numerous barriers to accessing tobacco cessation treatment for existing KanCare participants. Lifting the limit on quit attempts per year is a simple way to improve utilization and thereby outcomes. Kansas Medicaid currently covers some cessation treatment options – but participants are limited to 1 quit attempt per year. Moreover, combination nicotine replacement therapy (NRT)—which is now the standard of care because it is more effective than solo NRT—is not permitted. In addition, individual and group counseling are only available for pregnant women. This means that any time that providers spend on counseling non-pregnant beneficiaries is not reimbursable. This probably accounts, at least in part, for the low rates of claims for cessation medications because providers aren't reimbursed for the time it takes to treat tobacco dependence – including the time it takes to appropriately prescribe medications.

By removing limits on medications and opening the codes for cessation counseling for all Medicaid recipients, more Kansans will have access to the type of longitudinal, dynamic treatment that is the most effective for helping people quit and stay tobacco free. These changes will also incentivize providers to initiate treatment, because the changes will remove guesswork related to patient access to medications. Lastly, providers will be able to get reimbursed for the time they take to help their patients through the quitting process.

There is strong evidence from other states that this change will quickly yield savings and improved health. Medicaid programs that cover all medications without barriers substantially reduce tobacco use, tobacco related disease, and healthcare costs among Medicaid enrollees. Increasing cessation coverage maximizes the number of smokers who attempt to quit, use evidence-based cessation treatments, and successfully quit by removing cost and administrative barriers that prevent smokers from accessing cessation counseling and medications.

From the experience of other states, it is clear that Medicaid programs that cover all medications without barriers substantially reduce tobacco use, tobacco related disease, and healthcare costs among Medicaid enrollees. By strengthening cessation coverage – through eliminating limits on quit attempts, permitting combination pharmacotherapy, and broadening coverage for counseling - KanCare can improve health, yield substantial cost savings, and bring enhanced federal matching funds**.** Under current law, the state would be eligible for an enhanced match of 1% for providing these benefits to the standard Medicaid population.

We have provided you with a copy of a study commissioned by NAMI Kansas and co-authored by Dr. Tami Gurley-Calvez whose testimony on this bill you will be hearing. Her report shows significant economic returns for Kansas based on enacting a comprehensive tobacco cessation program for the behavioral health population. We believe that the return on investment will be even greater for the Medicaid population as a whole.

Thank you for your consideration.

[1] Colton, C.W. & Manderscheid, R.W., (2006, April). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight States.
Preventing Chronic Disease: Public Health Research, Practice and Policy, 3(2), 1-14. Available at www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=16539783.
[2] Manderscheid, R., Druss, B., & Freeman, E. (2007, August 15). Data to manage the mortality crisis: Recommendations to the Substance Abuse and Mental Health Services Administration.
Washington, D.C.
[3] National Association of State Mental Health Program Directors Medical Directors Council, July 2006; Miller et al., 2006
[4] Callaghan, RC et al, Patterns of tobacco-related mortality among individuals diagnosed with schizophrenia, bipolar disorder, or depression. https://www.sciencedirect.com/science/article/pii/S0022395613003063