SB990.StepTherapy.MPhA.pdf
Uploaded by: Aliyah Horton
Position: FAV

MPhA
MARYLAND PHARMACISTS ASSOCIATION

Date: March 4, 2024
To: The Honorable Pamela Beidle, Chair
From: Aliyah N. Horton, FASAE, CAE, Executive Director, MPhA, 240-688-7808
Cc: Members, Senate Finance Committee
Re: **FAVORABLE SB 990** - Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

The Maryland Pharmacists Association (MPhA) urges a favorable report for **SB 990** - Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness.

- Patients should not be denied medication during a mental health crisis merely because a Pharmacy Benefit Manager denies it.
- This is a patient population that is particularly vulnerable and may not be able to advocate for themselves.
- Delays in providing necessary medication for patients experiencing a mental health crisis may create unnecessarily dire situations for the patient and caregivers.
- While often used as a cost-savings strategy, a disruption in medication based on a step therapy policy and not efficacy may lead to increased expenses to the state due to emergency care and emergency hospital admissions; disruptions in housing and employment; and police interventions.

SB 990_SMI Meds_FAVORABLE.pdf
Uploaded by: Dan Rabbitt
Position: FAV

Behavioral Health System Baltimore

March 6, 2024

Senate Finance Committee
TESTIMONY IN SUPPORT
SB 990 - Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 100,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.

Behavioral Health System Baltimore strongly supports SB 990 - Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness. This bill would provide crucial protections to Maryland Medicaid beneficiaries being treated for serious mental illness and help prevent costly disruptions in care.

The treatment of bipolar disorder, schizophrenia, major depression, and post-traumatic stress disorder (collectively known as 'serious mental illness') relies on the use of a variety of psychiatric medications. These medications are necessary to manage the symptoms of these illnesses, maintain social functioning, avoid adverse outcomes like justice-involvement, and ultimately achieve recovery.[1,2] Serious mental illness can be chronic and potentially disabling, so it is critical to identify the proper medication regiment. The effectiveness of psychiatric medications, however, can vary significantly from person to person.[3] An individual's symptom management and social functioning can also decline significantly if medication regiments are interrupted.[4]

As the LBHA for Baltimore City, BHSB oversees many programs to treat individuals diagnosed with serious mental illness. These programs such as Assertive Community Treatment (ACT) and Outpatient Civil Commitment (OCC) demand high-intensity services and relatively high levels of funding. This level of intensity is needed to maintain stability and medication compliance. Under no circumstances should an individual with serious mental illness have their medications disrupted due to insurance carrier preference for medications. That decision should be made between the individual and their provider and must consider the specific medications that work best for that individual. Any cost savings that could be achieved by requiring a preferred medication will be more than offset by costs due to crisis and decompensation. These conditions are too severe and the consequences of a mental health crisis too great to use fail first or step therapy approaches to psychiatric treatment.

Insurance carrier prior authorization and utilization review policies must not disrupt the medication regiment decided upon by the individual and their provider. **BHSB urges the Senate Finance Committee to support SB 990.**

For more information, please contact BHSB Policy Director Dan Rabbitt at 443-401-6142

References:

[1] Agency for Healthcare Research and Quality (AHRQ). "Treatments for Schizophrenia in Adults: A Systematic Review." AHRQ Publication No. 17(18)-EHC031-EF. October 2017. Available at https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/schizophrenia-adult_research-2017.pdf

[2] AHRQ. "Treatments for Bipolar Disorder in Adults: A Systematic Review." AHRQ Publication No. 18-EHC012-EF. August 2018. Available at https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/cer-208-bipolar-report.pdf

[3] McCutcheon RA, Pillinger T, Efthimiou O, Maslej M, Mulsant BH, Young AH, Cipriani A, Howes OD. "Reappraising the variability of effects of antipsychotic medication in schizophrenia: a meta-analysis." *World Psychiatry*. 2022 Jun;21(2):287-294. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9077611/.

[4] Semahegn A, Torpey K, Manu A, Assefa N, Tesfaye G, Ankomah A. Psychotropic medication non-adherence and its associated factors among patients with major psychiatric disorders: a systematic review and meta-analysis. Syst Rev. 2020 Jan 16;9(1):17. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6966860/.

SB0990_FAV_MedChi, GWSCSW_Medicaid & HI - Step The
Uploaded by: Danna Kauffman
Position: FAV

MedChi

The Maryland State Medical Society

1211 Cathedral Street
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www.medchi.org

Greater Washington Society for Clinical Social Work

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Clarence K. Lam

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine Krone
410-244-7000

DATE: March 6, 2024

RE: **SUPPORT** – Senate Bill 990 – *Maryland Medical Assistance Program and Health Insurance – Step Therapy, Fail-First Protocols, and Prior Authorization – Prescription Drugs to Treat Serious Mental Illness*

On behalf of the Maryland State Medical Society and the Greater Washington Society for Clinical Social Work, we submit this letter of **support** for Senate Bill 990.

This bill is narrowly drafted to prohibit both the Medicaid program and the fully insured commercial market from applying a prior authorization requirement or step therapy protocol for a prescription drug used to treat an enrollee's diagnosis of: (1) bipolar disorder; (2) schizophrenia; (3) major depression; 4) post-traumatic stress disorder; or (5) a medication-induced movement disorder associated with the treatment of a serious mental illness.

Maryland has made great strides to ensure that step therapy protocols do not unnecessarily burden or limit a patient's access to medications. However, it still must be noted that policies which restrict access to medication can cause negative outcomes. This is especially true for individuals with serious mental illness where patients may be on more than one drug to address both the illness and reactions to the medications. When patients experience delays in treatment or when access is restricted, the risk of emergency department visits, hospitalizations, or even criminal justice involvement increases, which can lead to additional medical and societal costs.

Therefore, on behalf of the above-referenced organizations and our patients, we urge a favorable vote on Senate Bill 990.

SB990.LOS.hf.20240305.pdf
Uploaded by: Heather Forsyth
Position: FAV

CANDACE MCLAREN LANHAM
Chief Deputy Attorney General

CAROLYN A. QUATTROCKI
Deputy Attorney General

LEONARD J. HOWIE III
Deputy Attorney General

CHRISTIAN E. BARRERA
Chief Operating Officer

ZENITA WICKHAM HURLEY
Chief, Equity, Policy, and Engagement

PETER V. BERNS
General Counsel

ANTHONY G. BROWN
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STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

WILLIAM D. GRUHN
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March 5, 2024

To: Pamela Beidle, Chair
Senate Finance Committee

From: Heather Forsyth, Deputy Director, Health Education and Advocacy Unit

RE: SB 990 – Maryland Medical Assistance Program and Health Insurance – Step Therapy, Fail-First Protocols, and Prior Authorization – Prescription Drugs to Treat Serious Mental Illness (**Support**)

The Health Education and Advocacy Unit writes in support of Senate Bill 990 which protects consumers with mental health disorders from review protocols which prevent or delay appropriately prescribed medication.

SB 990 would prohibit Medicaid and Maryland-regulated plans from applying fail-first or step-therapy protocols for prescription drugs used to treat mental health disorders itemized in the bill (bipolar, schizophrenia, major depression, PTSD, or a medication-induced movement disorder associated with the treatment of a serious mental illness).

Step therapy protocols pose dangers for patients generally, but are especially harmful for patients undergoing treatment for mental health disorders because of the individualized nature of mental health illness and patient response to treatment. Because many mental health illnesses are chronic, lifelong conditions and have a broad array of symptoms even among patients with the same diagnosis, step-therapy protocols limit the ability of the health care provider to provide the right medication, at the right dose, at the right time. Even a short interruption of medication which has stabilized a patient can have life-altering consequences.

Insurers will often justify the use of such protocols as cost savings measures, but denying appropriate and timely medication just shifts costs downstream and raises the overall costs of care, as well as risking patient safety and stability. These risks are magnified because currently less than 20% of the need for Mental Health Professionals is met in Maryland. Removing the burden of step therapy protocols gives mental health professionals urgently needed additional time for patient care.

For these reasons we ask the Committee to issue a favorable report for SB 990.

SB0990 Testimony.docx.pdf
Uploaded by: Jonathan Dayton
Position: FAV

Statement of Maryland Rural Health Association (MRHA)
To the Senate Finance Committee
Chair: Senator Pamela Beidle
March 5, 2024
Senate Bill 0990: Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

POSITION: SUPPORT

Chair Beidle, Vice Chair Klausmeier, and members of the committee, the Maryland Rural Health Association (MRHA), is in SUPPORT of Senate Bill 0990: Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

Removing barriers to treating certain mental illnesses or a medication-induced movement disorder associated with the treatment of a severe mental illness will improve the health and well-being of rural Marylanders.

On behalf of the Maryland Rural Health Association,
Jonathan Dayton, MS, NREMT, CNE, Executive Director
jdayton@mdruralhealth.org

_2024 SB 990 LOS MD NAPNAP.pdf
Uploaded by: Lindsay Ward
Position: FAV

National Association of Pediatric Nurse Practitioners℠
MD: CHESAPEAKE

Support: SB 990 Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

3/3/24

Maryland Senate
Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Dear Honorable Chair, Vice-Chair and Members of the Committee:

On behalf of the pediatric nurse practitioners (PNPs) and fellow pediatric-focused advanced practice registered nurses (APRNs) of the National Association of Pediatric Nurse Practitioners (NAPNAP) Chesapeake Chapter, I am writing to express our support of **SB 990 Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness.**

This legislation would prohibit the Maryland Medical Assistance Program and certain insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations from applying a prior authorization requirement, step therapy protocol, or fail-first protocol for drugs to treat certain mental illnesses or a medication-induced movement disorder associated with the treatment of a serious mental illness. These drugs would be used to treat the following disorders:

- BIPOLAR DISORDER
- SCHIZOPHRENIA
- MAJOR DEPRESSION
- POST–TRAUMATIC STRESS DISORDER
- MEDICATION–INDUCED MOVEMENT DISORDER ASSOCIATED WITH THE TREATMENT OF A SERIOUS MENTAL ILLNESS

Prior authorization—sometimes called preauthorization or precertification—is a health plan cost-control process by which physicians and other health care providers must obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage.. Step therapy (fail first therapy) is a process by which insurers (public or private) require patients to try and fail on one or more medications chosen by their insurer before they can access the optimal treatment recommended and prescribed by their healthcare provider. Sometimes the preferred drugs are cheaper to the patient and sometimes they are not. Insurers can make a higher profit on the drugs they force patients to step through, and this is sometimes why they implement the policy. Other times, fail first represents a generic drug which can be cheaper for the patient and less profitable for the insurer.

All of these regulations result in a delay in care in prescribing the medication, the patient obtaining the medication and the patient benefiting from the medication. When a patient has to fail first on a drug before being allowed to take the medication originally prescribed, the patient, physician and public health suffers.

National Association of Pediatric Nurse Practitioners℠
MD: CHESAPEAKE

This practice can result in serious negative consequences for consumers and the public health system. By limiting the medication options, both doctors and patients are forced to compromise their treatment decisions in a way that is dangerous, time consuming and more expensive in the long-term.

Often, when a patient's insurance changes, the new company requires the fail first process to start again. With no limitations, fail first wreaks havoc on the lives of patients with chronic disease and their providers.

For these reasons the Maryland Chesapeake Chapter of NAPNAP extends their support to **SB 990 Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness and requests a favorable report.**

The pediatric advanced practice nurses of your state are grateful to you for your attention to these crucial issues. The members of Chesapeake Chapter of the National Association of Pediatric Nurse Practitioners memberships includes over 200 primary and acute care pediatric nurse practitioners who are committed to improving the health and advocating for Maryland's pediatric patients. If we can be of any further assistance, or if you have any questions, please do not hesitate to contact Lindsay J. Ward, the Chesapeake Chapter President at 410-507-3642 or MDChesNAPNAPLeg@outlook.com .

Sincerely,

Lindsay J. Ward

Lindsay J. Ward CRNP, RN, IBCLC, MSN, BSN
Certified Registered Nurse Practitioner- Pediatric Primary Care
International Board-Certified Lactation Consultant
National Association of Pediatric Nurse Practitioners (NAPNAP)
Chesapeake Chapter President

Evgenia Ogordova

Evgenia Ogordova-DNP
National Association of Pediatric Nurse Practitioners (NAPNAP)
Chesapeake Chapter Legislative Chair

SB990 FAV.pdf
Uploaded by: Morgan Mills
Position: FAV

March 6, 2024

Chairwoman Beidle, Vice Chair Klausmeier, and distinguished members of the Finance Committee,

NAMI Maryland and our 11 local affiliates across the state represent a network of more than 58,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a 501(c)(3) non-profit dedicated to providing education, support, and advocacy for people living with mental illnesses, their families, and the wider community.

NAMI MD believes that all people with mental health conditions deserve access to effective medication and treatment options. Therefore, we work to ensure open access to psychiatric medication and will oppose, at all costs, 'fail first' provisions in State laws and policies. We strongly support public policies that prohibit step therapy for psychiatric medications.

Mental health medications affect people—even those with the same diagnosis—in different ways, including varying levels of effectiveness and different side effects. Because of this, it is important that a person can access the mediation that works best for them. It is crucial that medication decisions are carefully considered with a healthcare provider who has both extensive knowledge of the individual and available medication options.

Sometimes, health insurers may request or even require that patients demonstrate unsuccessful treatment on one or more insurer-preferred medications before they receive coverage for the medication that their physician recommends. This practice is known as 'fail first' or 'step therapy', meaning that the individual must 'fail' on one or more medication before they can 'step up' to another. Step therapy results in patients not being able to access the treatments they need in a timely manner.

Step therapy/fail first can be a danger to the health and well-being of the person taking the medication, and result in worsening of symptoms and undermining the decisions made between individuals and their health care providers. In fact, a 2015 study published in Psychiatric Services, a Journal of the American Psychiatric Association, shows that "Step therapy and fail-first protocols were associated with 4.7 times greater odds of a medication access or continuity problem."[i]

When a health insurer requires step therapy, it can pose serious and dangerous risks to a person taking mental health medication. Not being able to access the medication and treatment needed in a timely manner can lead to worsened symptoms. Under this bill, individuals diagnosed with bipolar disorder, schizophrenia, major depression, and post-traumatic stress disorder would be exempt from fail-first/step therapy protocols. These diagnoses are serious mental illnesses. Untreated or inadequately treated serious mental health conditions can result in unnecessary disability, emergency department visits and hospitalizations, unemployment, substance abuse, homelessness, inappropriate incarceration, increased risk of suicide, and diminished quality of life.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

NAMI MD ran a survey earlier this year and we garnered 64 responses, half of which were from individuals living with a mental health condition themselves, the other half from family members of individuals with mental health conditions or service providers. Out of the 64 responses, 43 either used Medicaid or private insurance. Of those 43, 83.7% have had a prescription denied and 67.4% were subject to step therapy/fail first protocols. In the respondent's experience, there have been instances of up to 6-month periods before they could get the medication originally prescribed to them by their provider. These delays can be deadly.

Ultimately, utilizing step therapy protocols hurts patients—their condition may worsen, or they may suffer unnecessarily in the process of failing insurer-preferred treatments.

For these reasons, we urge a favorable report.

[i] https://ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.5.601

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

HB1423 Testimony - Patricia Cully.pdf
Uploaded by: NAMI Maryland
Position: FAV

Greetings,

My name is Patricia Cully, and I am a member of NAMI. I'm from Howard County, Ellicott City, District 9B.

I'm here to advocate for the Fail Therapy/Fail First Revisions, SB990. We have three adult children with major depression and anxiety. Two have also been diagnosed with ADHD. I'm here today to ask for your support for mental health services.

Our daughters have worked very hard and received both cognitive treatment and medication therapy. Two of our daughters were admitted to the hospital for in-patient care. They assessed the illness and received medication and then were discharged. After-hospital services were managed by our family, there were not referred to any follow-on programs.

My youngest daughter had tried meds and they failed. She wanted to try transcranial magnetic stimulation aka TMS as this had been the one treatment that had worked for both of her sisters. Insurance said she would have to fail two additional times, or wait an additional 3-6 months, before they would approve her for TMS therapy. She was struggling to go to work every day and couldn't understand why she couldn't get approval for this treatment.

There are a lot of side effects with these medications, and it can take a minimum of 4-6 weeks of treatment or longer, for a doctor to determine if the medication is effective for the patient. If they must switch to another medication, many times they must come off one medication, or taper, before they can start a new one. There is a higher risk of self-harm for the first 2-3 weeks on a new medication.

We had to work with her doctor and do multiple appeals with her insurance company, while she was struggling with major depression and anxiety, to get TMS approved for our youngest daughter. During that time, additional stress was placed on our daughter as she navigated her mental illness while attempting to perform at work. She was constantly worried she would lose her job and then she would have to break her lease. Luckily, with her doctor's support, the request was approved within a couple of months and the TMS treatment was highly successful.

I'm happy to share that with their hard work and the help of professionals, they have all finished college. Two of them completed master's degrees, they are all in long time relationships and have careers.

Thank you for reading my story.
Can I count on your support for SB990, STEP therapy/fail-first revisions, and to protect mental health services—and give families the hope of recovery?

Thank you

Patricia Cully

2024 LCPCM SB 990 Senate Side.pdf
Uploaded by: Robyn Elliott
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee:	**Senate Finance Committee**
Bill:	**Senate Bill 990 - Maryland Medical Assistance Program and Health Insurance – Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness**
Hearing Date:	**March 6, 2024**
Position:	**Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports *Senate Bill 990 - Maryland Medical Assistance Program and Health Insurance – Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness.* The bill would streamline the process for prescribers in ensuring their patients could access needed medication for serious mental illnesses. The current pharmacy claims process is cumbersome, with many insurers requiring extra steps, such as step therapy and fail first protocols, for prescribers. Behavioral health providers and programs are already stretched thin in meeting the increasing need for services. We support legislation the reduces unnecessary administrative burdens to ensure providers can focus on patient care.

We ask for a favorable report. If you need any additional information, please contact Robyn Elliott at relliott@policypartners.net.

Antipsychotic Access in Medicaid.pdf
Uploaded by: Sarah Peters
Position: FAV

Antipsychotic Access in Medicaid

A review of Medicaid medical and pharmacy claims by Columbia Data Analytics[1] for patients living with serious mental illness (SMI) from 2016-2022 demonstrates that Medicaid programs offering open access to antipsychotics may realize lower overall costs. *Both patients and state budgets may benefit when Medicaid helps patients access the mental health drugs they need.*

- This analysis, funded by Otsuka Pharmaceutical Development & Commercialization, Inc., found that Pennsylvania Medicaid patients living with SMI – who face rigorous prior authorization to access antipsychotics (APs) – had higher costs (for both overall healthcare services and SMI-related ones) than did patients with SMI in Michigan, whose Medicaid program has open access to APs and respects physician-patient prescribing decisions based on clinical need.

- **Key findings:**

    - Pennsylvania's restrictive policies requiring prior authorization to access AP treatment for patients with SMI was associated with a significant economic burden on the state's budget for managing patients with SMI.

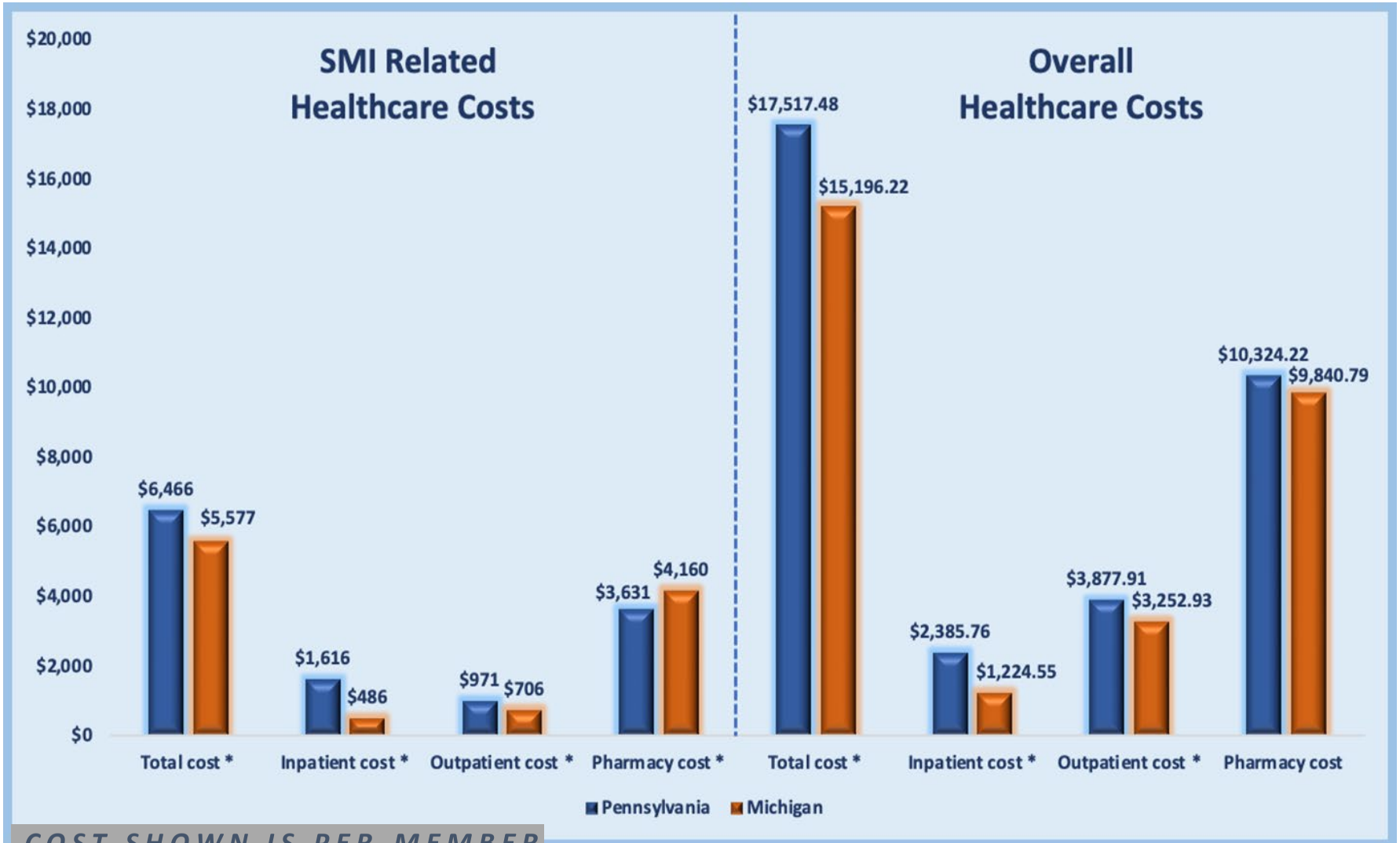
    - "Although [Michigan's] pharmacy cost was higher for preferred AP users, they had lower healthcare utilization and emergency department costs, indicating better overall patient outcomes. This is further supported by 10% fewer hospital admissions, almost four days shorter length of stay, 6% fewer ED visits, and almost 5% fewer outpatient visits."

    - "The Medicaid policy in Michigan [was associated with] lower overall and SMI-related costs, and better outcomes for patients with mental health conditions."

Creating Change: *States may improve health outcomes for patients with SMI by making legislative or regulatory changes to protect mental health drugs from utilization management processes like prior authorization and step therapy ("fail first") without impacting the overall budget.*

[1] This retrospective cohort study – sponsored by Otsuka Pharmaceutical Development and Commercialization, Inc. – reviewed claims filed in the Kythera open claims database[2] between Jan. 1, 2016 and Dec. 31, 2022 for Pennsylvania and Michigan Medicaid members age 18+ with an SMI diagnosis (i.e.: bipolar disorder, major depressive disorder, schizophrenia, related disorders). Patients were included in the study if they had at least 1 pharmacy claim for an AP and had continuous medical and pharmacy benefits for 3 months pre- and 12 months post-treatment initiation. This study is limited to two states and findings may not be representative across all states.

[2] Kythera is an open claims database, updated weekly, that contains over 330 million patients, 12.5 billion healthcare claims, 12.9 billion prescription drug claims, and represents 79% coverage of all U.S. patients.



COST SHOWN IS PER-MEMBER

* shows significant differences (p-value < .05)

SOURCE: Otsuka data on file from Columbia Data Analytics review, 2023.

MD SB990HB1423 Hearing TPs.pdf
Uploaded by: Sarah Peters
Position: FAV

SB990- Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

What other states have said about costs, utilization, etc.:

Michigan Department of Health and Human Services Psychotropic Best Practices Workgroup Report:

"After considerable discussion, the group conceptually endorses the practice of the past 14 years wherein Medicaid psychotropic prescriptions have not been subjected to administrative prior authorization. The group does not believe prior authorization tied to costs, and often done in conjunction with step therapy, is good or effective for persons with serious mental illness, their families, Michigan communities including payers or the providers who strive to serve them. Rationale for this is that persons with mental illness present with a unique set of variables that may require various efforts at psychopharmacological trials to achieve the best clinical success. Access to care issues for persons with mental illness can be more difficult than for medical illnesses. Thus, it is critical that barriers to care be as few as possible for individuals seeking treatment for their mental illness, and for providers willing to treat them. The workgroup spent a great deal of time discussing members' experience with prescribing and oversight as well as prior authorization processes. Based on this discussion, the workgroup determined the most appropriate tools to improve psychotropic prescribing, while monitoring for inappropriate prescribing, are in providing prescriber education about best practices and other steps described below.

It is also important to note that data show the vast majority of psychotropic prescriptions in Michigan Medicaid are for generics (85-87% in Fiscal Year 2017). Michigan's psychotropic carveout, in place since 2004, has not resulted in prescribers flooding Medicaid with claims for brand drugs. Additionally, while psychotropic prescriptions account for 99 percent of DHHS carveout claims, they represent only 62 percent of costs across all carveout products. The 1 percent of carveout claims for non-psychotropics now account for 38 percent of all DHHS carveout costs."

Utah DAW PDL compliance:

Utah created open access by implementing a dispense as written law for the anti-psychotic class. That was caveated by a requirement that PDL adherence remain at a certain percentage. 75% of prescriptions by July 1, 2019 needed to be in compliance with the PDL -- Compliance with the PDL at the completion of State fiscal year 2019 was 91%.

Oregon PDL compliance:

The most recent figures in Oregon for mental health medication carve out protections show that in 2023 usage of generics in the Medicaid population was 96.9% and overall PDL adherence was 92.8%

Drug Use Research & Management Program
DHS - Health Systems Division
500 Summer Street NE, E35, Salem, OR 97301-1079
Phone 503-947-5220 | **Fax** 503-947-1119

Oregon State University
College of Pharmacy

Pharmacy Utilization Summary Report: July 2022 - June 2023

Gross PMPM Drug Costs (Rebates not Subtracted)	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Avg Monthly
PMPM Amount Paid (FFS & Encounter)	$78.88	$88.27	$81.38	$81.76	$82.15	$82.56	$86.69	$79.88	$91.47	$81.34	$90.49	$87.51	$84.36
Mental Health Carve-Out Drugs	$8.39	$8.94	$8.34	$8.33	$8.34	$8.45	$8.81	$8.11	$8.06	$7.08	$7.78	$7.37	$8.17
FFS Physical Health Drugs	$41.52	$49.41	$43.67	$44.89	$44.60	$43.53	$47.73	$43.57	$51.03	$44.55	$50.65	$45.21	$45.86
FFS Physician Administered Drugs	$12.79	$11.32	$12.69	$11.09	$8.52	$8.92	$16.52	$14.21	$14.54	$14.34	$15.86	$14.02	$12.90
Encounter Physical Health Drugs	$55.66	$62.21	$57.95	$58.05	$58.21	$58.72	$60.50	$56.52	$63.97	$58.29	$64.61	$63.18	$59.82
Encounter Physician Administered Drugs	$16.38	$18.86	$16.69	$17.07	$17.58	$17.49	$18.74	$16.56	$21.17	$17.45	$19.62	$18.94	$18.05

Claim Counts	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Avg Monthly
Total Claim Count (FFS & Encounter)	1,106,008	1,202,993	1,141,967	1,179,219	1,184,623	1,180,869	1,223,411	1,116,649	1,277,819	1,189,404	1,287,183	1,236,032	1,193,848
Mental Health Carve-Out Drugs	189,732	206,349	194,268	196,514	195,984	197,022	210,579	191,974	218,492	204,162	220,533	211,391	203,083
FFS Physical Health Drugs	34,793	36,905	34,841	35,463	35,609	35,287	38,747	35,301	41,633	36,810	39,482	37,405	36,856
FFS Physician Administered Drugs	10,044	10,212	9,855	10,162	10,206	10,077	11,407	10,179	11,192	10,245	10,709	10,563	10,404
Encounter Physical Health Drugs	757,997	828,564	786,733	818,511	826,534	825,342	842,963	767,979	877,971	819,414	891,575	856,810	825,033
Encounter Physician Administered Drugs	113,442	120,963	116,270	118,569	116,290	113,141	119,715	111,216	128,531	118,773	124,884	119,863	118,471

Gross Amount Paid per Claim (Rebates not Subtracted)	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Avg Monthly
Average Paid / Claim (FFS & Encounter)	$94.31	$97.59	$95.34	$93.21	$94.00	$95.42	$97.44	$98.82	$99.44	$95.37	$98.58	$99.66	$96.60
Mental Health Carve-Out Drugs	$58.51	$57.60	$57.43	$56.96	$57.71	$58.51	$57.50	$58.36	$51.25	$48.37	$49.45	$49.09	$55.06
FFS Physical Health Drugs	$138.33	$152.26	$146.71	$150.11	$148.42	$148.93	$153.09	$146.59	$150.32	$148.65	$153.88	$147.51	$148.73
FFS Physician Administered Drugs	$147.60	$126.02	$150.78	$129.45	$98.95	$106.84	$180.02	$165.83	$159.35	$171.92	$177.65	$161.93	$148.03
Encounter Physical Health Drugs	$88.59	$91.32	$89.94	$86.94	$87.11	$88.52	$89.78	$92.93	$92.27	$90.48	$92.93	$94.81	$90.47
Encounter Physician Administered Drugs	$174.24	$189.65	$175.21	$176.44	$187.02	$192.33	$195.79	$188.06	$208.58	$186.82	$201.47	$203.14	$189.90

Gross Amount Paid per Claim - Generic-Multi Source Drugs (Rebates not Subtracted)	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Avg Monthly
Generic-Multi Source Drugs: Average Paid / Claim (FFS & Encounter)	$24.45	$24.99	$25.01	$23.64	$23.24	$23.47	$24.00	$24.12	$24.50	$24.18	$24.39	$24.23	$24.18
Mental Health Carve-Out Drugs	$17.21	$17.56	$17.29	$17.35	$17.33	$17.61	$17.83	$17.95	$17.99	$17.68	$17.90	$17.77	$17.62
FFS Physical Health Drugs	$94.81	$103.33	$106.38	$103.97	$105.68	$106.52	$102.89	$97.58	$103.93	$104.69	$107.46	$102.32	$103.30
Encounter Physical Health Drugs	$23.40	$23.73	$23.73	$22.05	$21.46	$21.67	$22.26	$22.60	$22.72	$22.52	$22.65	$22.75	$22.63

Gross Amount Paid per Claim - Branded-Single Source Drugs (Rebates not Subtracted)	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Avg Monthly
Branded-Single Source Drugs: Average Paid / Claim (FFS & Encounter)	$671.26	$698.50	$644.46	$616.56	$639.26	$673.13	$722.99	$762.26	$755.03	$736.84	$759.46	$760.53	$703.36
Mental Health Carve-Out Drugs	$1,085.19	$1,115.96	$1,147.02	$1,155.25	$1,195.38	$1,233.65	$1,241.11	$1,279.96	$1,289.12	$1,286.57	$1,319.02	$1,306.46	$1,221.27
FFS Physical Health Drugs	$348.53	$400.50	$337.78	$367.86	$355.72	$361.86	$423.95	$416.82	$408.22	$398.86	$420.70	$397.14	$386.50
Encounter Physical Health Drugs	$657.02	$682.86	$625.89	$593.50	$617.19	$651.55	$702.35	$744.75	$744.95	$726.03	$747.78	$752.00	$687.16

Generic Drug Use Percentage	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Avg Monthly
Generic Drug Use Percentage	90.7%	90.8%	90.2%	89.9%	90.2%	90.5%	91.2%	91.3%	91.5%	91.6%	91.5%	91.4%	90.9%
Mental Health Carve-Out Drugs	96.1%	96.4%	96.4%	96.5%	96.6%	96.6%	96.8%	96.8%	97.4%	97.6%	97.6%	97.6%	96.9%
FFS Physical Health Drugs	82.8%	83.5%	82.6%	82.5%	82.9%	83.4%	84.4%	84.6%	84.8%	85.1%	85.2%	84.7%	83.9%
Encounter Physical Health Drugs	89.7%	89.7%	89.0%	88.6%	89.0%	89.4%	90.1%	90.3%	90.4%	90.3%	90.3%	90.1%	89.7%

Preferred Drug Use Percentage	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Avg Monthly
Preferred Drug Use Percentage	90.49%	90.42%	90.45%	90.65%	90.48%	90.31%	90.43%	90.35%	90.37%	90.34%	90.25%	90.27%	90.4%
Mental Health Carve-Out Drugs	93.24%	93.13%	93.14%	93.07%	92.87%	92.70%	92.58%	92.51%	92.53%	92.51%	92.39%	92.42%	92.8%
FFS Physical Health Drugs	95.64%	95.77%	95.69%	95.64%	95.79%	95.85%	95.21%	95.24%	95.27%	95.44%	95.36%	95.39%	95.5%
Encounter Physical Health Drugs	89.61%	89.54%	89.59%	89.89%	89.72%	89.54%	89.72%	89.63%	89.64%	89.61%	89.53%	89.56%	89.6%

Amount Paid on the Claim = 1) Ingredient Cost ([AAAC/NADAC/WAC] x Dispense Quantity) + Dispensing Fee. If Billed Amount is lower, pay Billed Amount, 2) - TPL amount

Last Updated: January 18, 2024

Research on the issue of utilization management use for serious mental illness/anti-psychotics:

USC Issue Brief Medicaid Access Restrictions on Psychiatric Drugs: Penny-Wise or Pound-Foolish? – Summary of three peer-reviewed studies. Attached and digital copy here - Medicaid Access Restrictions on Psychiatric Drugs: Penny-Wise or Pound-Foolish? – USC Schaeffer

- *"Restricting access to antidepressants through both prior authorization and step therapy was associated with a 2.1 percentage point (8.2%) increase in the likelihood of any hospitalization and a 1.7 percentage point (16.6%) increase in the likelihood of an MDD-related hospitalization"*
- *"Previous research has shown that while atypical antipsychotics are generally effective, patients respond differently to specific atypical antipsychotic medications, often requiring changes in treatment regimens to attain desired clinical outcomes. As a result, formulary restrictions on atypical antipsychotics can disrupt treatment and affect patient adherence."*
- *"According to the study, patients with schizophrenia subject to formulary restrictions were more likely to experience a hospitalization, had 23 percent higher inpatient costs and had 16 percent higher total medical costs.. Similar results were found for patients with bipolar disorder, with those subject to formulary restrictions being more likely to be hospitalized and 20 percent higher inpatient costs and 10 percent higher total costs."*

Columbia Data Analytics:

A review of Medicaid medical and pharmacy claims by Columbia Data Analytics for patients living with serious mental illness (SMI) from 2016-2022 demonstrates that Medicaid programs offering open access to antipsychotics may realize lower overall costs. Both patients and state budgets may benefit when Medicaid helps patients access the mental health drugs they need.

• This analysis, funded by Otsuka Pharmaceutical Development & Commercialization, Inc. and conducted by Columbia Data Analytics, found that Pennsylvania Medicaid patients living with SMI – who face rigorous prior authorization to access antipsychotics (APs) – had higher costs (for both overall healthcare services and SMI-related ones) than did patients with SMI in Michigan, whose Medicaid program has open access to APs and respects physicianpatient prescribing decisions based on clinical need.

Key findings:

- Pennsylvania's restrictive policies requiring prior authorization to access AP treatment for patients with SMI was associated with a significant economic burden on the state's budget for managing patients with SMI.
- "Although [Michigan's] pharmacy cost was higher for preferred AP users, they had lower healthcare utilization and emergency department costs, indicating better overall patient outcomes. This is further supported by 10% fewer hospital admissions, almost four days shorter length of stay, 6% fewer ED visits, and almost 5% fewer outpatient visits."
- "The Medicaid policy in Michigan [was associated with] lower overall and SMI-related costs, and better outcomes for patients with mental health conditions."
- Overall healthcare costs were $2,321 per patient higher in PA, compared to MI – where open access is in place.

MDHHS - Psycotropic Carve Out.pdf
Uploaded by: Sarah Peters
Position: FAV

Provide Workgroup Recommendations

(FY2019 Appropriation Act - Public Act 207 of 2018)

March 1, 2019

Sec. 1867. (1) The department shall convene a workgroup that includes psychiatrists, other relevant prescribers, and pharmacists to identify best practices and to develop a protocol for psychotropic medications. Any changes proposed by the workgroup shall protect a Medicaid beneficiary's current psychotropic pharmaceutical treatment regimen by not requiring a physician currently prescribing any treatment to alter or adjust that treatment.

(2) By March 1 of the current fiscal year, the department shall provide the workgroup's recommendations to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget office.

MDHHS

Michigan Department of Health & Human Services

Michigan Department of Health and Human Services

Psychotropic Best Practices Workgroup

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MI Department of Health and Human Services

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Child & Adolescent Psychiatry
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Jennifer Stanley, MD
Psychiatrist serving on the Medicaid DUR Board
Community Mental Health Authority of Clinton, Eaton, and Ingham Counties

Nikhil Hemady, MD
Family Medicine
Oakland Integrated Health Network

CONSUMER/FAMILY REPRESENTATIVE

Mark Reinstein, PhD
President & CEO, Mental Health Association in Michigan
Chair, Behavioral Health Advisory Council

Meetings
(In Person/Teleconference)

1. *When:* **Thursday, March 22, 2018**
   Where: Lewis Cass Building, 320 S Walnut St, Lansing, MI 48933

2. *When:* **Thursday, April 12, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

3. *When:* **Tuesday, April 24, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

4. *When:* **Monday, May 14, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

5. *When:* **Thursday, September 13, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

6. *When:* **Friday, September 21, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

Historical Background

Psychotropic medications[1] can be broadly defined as medications that affect brain functions.[2] They are also defined as medications that affect the central nervous system, changing brain processes, such as mood, thoughts, perceptions, emotions, and behaviors.[3]

Psychotropic medications are used to treat individuals with mental disorders related to mood, anxiety, psychosis, trauma, attention-deficit/hyperactivity, cognition, and many other conditions defined in the literature. These medications can successfully alleviate mental health symptoms, treat acute exacerbations, and prevent relapse but like many medications used to treat other medical conditions, they do not serve as a "cure" per se.[4]

A 2013 study done by the Medical Expenditure Panel Survey found that roughly 1 in 6 adults in America take a psychotropic medication. This was up from a 2011 study that state 1 in 10 adults reported taking prescription medications for problems with nerves, emotions, or mental health.[5] Psychotropic medications have generally been found to be as effective in treating mental disorders as medications that are used to treat general medical disorders.[6] In 2017, additional articles published by the Kaiser Family Foundation portrayed the important role Medicaid plays in both financing and facilitating access to Mental Health Services for low-income individuals.[7] [8]

The use of psychotropic medications has been an important evolution in the treatment of mental health conditions, and the wide-spread use of these medications by prescribers has become fairly common. Although generally prescribed as indicated, there are instances of overprescribing that have called attention to their use, especially in particular populations. For example, efforts have been made to protect children, particularly those in foster care, from over prescription of psychotropic medications.[9]

Some states have issued guidelines to attempt to maximize the likelihood that psychotropic medications are being prescribed and used appropriately. Many of these guidelines and protocols are relatively new and there is still much to be learned from them. To date, the success of these efforts has not been clearly defined or established as the means to help prescribers utilize best practices in prescribing. A number of states have made changes in state-run Medicaid programs such as prior authorization and peer review, informed consent for children, distributing utilization management reports, and made efforts to educate prescribers.[10] Texas developed a guide with best practices for psychotropic medication usage in children and

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690138/
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181612/
[3] https://www.verywellmind.com/psychotropic-drugs-425321
[4] https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml
[5] https://www.scientificamerican.com/article/1-in-6-americans-takes-a-psychiatric-drug/
[6] https://psychnews.psychiatryonline.org/doi/10.1176/pn.47.9.psychnews_47_9_1-b
[7] Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured." Nov. 27, 2017.
[8] Zur, Musumeci, and Garfield. "Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals." June 2017 Issue Brief.
[9] http://waynelawreview.org/wp-content/uploads/Archives/58%20Wayne%20L.%20Rev.%20183%20-%20THE%20USE%20OF%20PSYCHOTROPIC%20MEDICATION%20IN%20MICHIGAN%20FOSTER%20CARE%20-%20Thomas%20Fuentes.pdf
[10] https://www.macpac.gov/wp-content/uploads/2015/06/Use-of-Psychotropic-Medications-among-Medicaid-Beneficiaries.pdf

youth in foster care that includes criteria for reviewing a child's clinical status.[11] Florida's best practices for psychotropic medications identified non-medication therapy interventions, prior authorization for high risk prescriptions, educational interventions, continuing education, and threats of Medicaid exclusion.[12]

While there is concern about the potential for over-prescribing these medications, there has also been concern about access to full mental health care on par with access to care and treatment for medical conditions. Limiting psychotropic medication access inappropriately or making these medications more difficult for public patients to access can have deleterious consequences on mental state.

Since 2004, Michigan has prohibited prior authorization of most Medicaid psychotropic prescriptions as an effort to ensure access to these medications. Even with this prohibition in place, the state has undertaken, and continues to work on, efforts to identify and intervene with potential problem prescriptions. The purpose of this workgroup was to again explore these issues and make recommendations in accordance with the legislative directive that this workgroup take place.

Existing Michigan Initiatives by Year

1. *National Medicaid Pooling Initiative (NMPI) [2004]:* Michigan received approval of the first-ever Multi-State Prescription Drug Pooling Program to help reduce the cost of Medicaid prescriptions by creating a Preferred Drug List (PDL) that encourages drug manufacturers to offer supplemental drug rebates to the State when their product is identified as a Preferred product.[13]

2. *MCL 400.109h [2004]:* Michigan legislation prohibiting the prior authorization of products in protected drug classes, including psychotropics. Because this law covered some, but not all, of Medicaid, it has been supplemented by department policy and, more recently, legislative budget boilerplate the past three years.[14]

3. *Medicaid Retroactive Drug Utilization Review (RetroDUR) Programs:*

    a. *Pharmacy Quality Improvement Program (PQIP) [2005]:* An educational mailing intervention program that analyzed the prescribing of mental health medications for Medicaid adult and child members and identified prescribing patterns that did not follow accepted evidence-based treatment guidelines.

[11] http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp
[12] http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml
[13] http://www.providersynergies.com/overview/default.asp
[14] Public Act 248 of 2004 excluded persons enrolled in Medicaid Health Plans (there were far fewer individuals in those plans in 2004 than is the case today). The law protected access in Medicaid to prescriptions for mental illness (including substance use disorder), epilepsy, HIV-AIDS, organ replacement therapy and cancer. Since 2004, the Department of Health and Human Services as a matter of policy has retained direct management of virtually all Medicaid drugs for mental illness, epilepsy, HIV-AIDS and organ replacement therapy. The Legislature has reaffirmed this policy in budget boilerplate the past three years.

b. *Former EnhanceMed program [2012] which then expanded to the program now called WholehealthRx [2015]:* Whole Health Rx is a clinical quality management program that uses medical diagnosis, behavioral, pharmacy claims and lab data, when available, to identify patients taking behavioral health medications who also have common co-morbid conditions such as heart disease, diabetes, asthma, etc. It then works with providers to identify and resolve potentially inappropriate prescribing, gaps in care and potential drug interactions to drive member safety and cost savings. This improved program not only included redesigned reports, but providers were also provided access to an online pharmacy portal. The portal has many services available including educational information, clinical resources, as well as the ability to request a clinical consultation. It also has a pharmacy search tool to provide access to prescription data on patients as a tool for care management activities. Providers who have secure logins to the website may access this information on patients that they are treating.[15]

4. *Foster Care -Psychotropic Medication Oversight Unit (FC-PMOU) [2014]:* Established via the ongoing partnership of staff in the Department of Health and Human Services (DHHS) Children's Services Agency and Medical Services Administration. The unit is responsible for monitoring psychotropic prescription claim trends, informed consent (DHS-1643) documentation and policy compliance and providing specific feedback to prescribing physicians based on the oversight reviews and prescription quality indicators. Reviews focus on quality indicators including prescribing multiple medications and/or duplicate therapeutic regimens, medication dosing outside of typical guidelines, and use of medications in very young children.

Context and Background Principles

As budget section 1867 relates to Medicaid services, which constitute a proportionally high percentage of care for individuals who have a mental illness diagnosis, and Medicaid prescription costs are predominantly for outpatient care, this report and its recommendations are limited to Medicaid outpatient psychotropic medications. Although care and treatment provided within a hospital community is critical, as is the care and treatment related to transitioning from hospital settings to community, this workgroup's focus does not include considerations of psychotropic usage in the hospital or the hospital to community transition. That said, the workgroup recognizes that as people move from one treatment setting such as inpatient, outpatient, corrections, skilled nursing facilities, etc., it is essential that care be seamless and integrated. Thus, the recommendations contained in this report consider best mechanisms for prescribing guidelines that will impact outpatient services related to those transitions.

This report recognizes there is always a balance between quality of care and the cost of such care, keeping in mind there is often no correlation between cost and quality. Although the

[15] https://michigan.fhsc.com/Committees/BHealth.asp

workgroup believes steps can be taken to reduce costs, it was the consensus of the workgroup that the priority is to assure the prescription of psychotropic medications that is high quality and under the direction of properly qualified medical professionals.

Comments and Current Recommendations:

After considerable discussion, the group conceptually endorses the practice of the past 14 years wherein Medicaid psychotropic prescriptions have not been subjected to administrative prior authorization. The group does not believe prior authorization tied to costs, and often done in conjunction with step therapy, is good or effective for persons with serious mental illness, their families, Michigan communities including payers or the providers who strive to serve them. Rationale for this is that persons with mental illness present with a unique set of variables that may require various efforts at psychopharmacological trials to achieve the best clinical success. Access to care issues for persons with mental illness can be more difficult than for medical illnesses. Thus, it is critical that barriers to care be as few as possible for individuals seeking treatment for their mental illness, and for providers willing to treat them. The workgroup spent a great deal of time discussing members' experience with prescribing and oversight as well as prior authorization processes. Based on this discussion, the workgroup determined the most appropriate tools to improve psychotropic prescribing, while monitoring for inappropriate prescribing, are in providing prescriber education about best practices and other steps described below.

It is also important to note that data show the vast majority of psychotropic prescriptions in Michigan Medicaid are for generics (85-87% in Fiscal Year 2017). Michigan's psychotropic carveout, in place since 2004, has not resulted in prescribers flooding Medicaid with claims for brand drugs. Additionally, while psychotropic prescriptions account for 99 percent of DHHS carveout claims, they represent only 62 percent of costs across all carveout products. The 1 percent of carveout claims for non-psychotropics now account for 38 percent of all DHHS carveout costs.

These data suggest that, if psychotropic medication costs strike some as "too great," it is because mental illness is so highly common in Medicaid. Ending the psychotropic carveout to eliminate the roughly 14 percent of prescriptions for brand products will not likely save major money. Curtailing access to psychotropics would not necessarily result in savings and could actually negatively impact quality outcomes for our general population and increase costs. The workgroup does not recommend curtailing access to appropriately prescribed psychotropic medication.

Thus, it is imperative to keep broader prescribing authority for practitioners, and the workgroup has recommendations for that, as well as other issues, below.

1. Exclude non-controlled psychotropic medications (including anti-seizure and substance use disorder medications consistent with current law) from prior authorization and amend MCL 400.109h so that it unequivocally applies the prior

authorization protections to all of Medicaid (i.e., Managed Care in addition to Fee-For-Service).[16]

This is consistent with a major recommendation of the DHHS Section 298 Facilitation Workgroup. This psychotropics workgroup recommends that the Department's Medical Services Administration review the Medicaid Health Plan pharmacy carve-out list to be consistent with the law. This workgroup recommends further evaluating the appropriateness of requiring prior authorization for controlled substances used to treat psychiatric conditions.

2. Identification of Undesirable Prescribing and Collaborative Educational Response to Positively Impact Practice

One of the key issues with psychotropic medications noted in the introduction above is the concern about inappropriate prescription of psychotropic medication which impacts patients of all ages and can have dire consequences.[17] The group noted that a key element in combating this prescription challenge is identifying undesirable prescribing among physicians and other prescribers. Using lessons learned from best practice principles and from existing models used to promulgate best practices, a mechanism should be established to allow consultations for prescribers to be provided using clinically driven, evidence-based parameters.[18] [19] The parameters that are established should account for reasonable and desirable prescribing of psychotropic medications to support quality outcomes.

The DHHS' current academic detailing program was cited as one example of the implementing actions that help curb poly-pharmacy and gaps in care to provide more safety for members.[20] Similar to the system in place for children in foster care, they contact and provide consultation for physicians that are identified for undesirable prescribing. To facilitate the implementation of such a program, Medicaid services would need to vet any contractual arrangement, costs and other parameters to ensure that the services could be available as needed and the success of such a program and its ability to collaborate with and link to the Community Mental Health system.

When contacting prescribers that have engaged in potentially undesirable prescribing, the group supported a system that establishes a peer-to-peer approach instead of an administrative ruling that passed down a condemnation or punishment. Building on the concept of communities of practice, networks of providers in different fields could work

[16] Although MCL 400.109h applies to several drug classes, the scope of this workgroup's recommendations is limited to psychotropic medications (including anti-seizure and substance use disorder medications).
[17] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2601416
[18] https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf
[19] https://www.cdc.gov/phcommunities/index.html
[20] https://michigan.fhsc.com/Committees/BHealth.asp

together to improve prescribing habits and engage physical and behavioral health in a more united approach.[21] [22] The group further advised keeping these one-on-one meetings between prescribers of a similar background, such as psychiatrist to prescriber.

3. Encourage Use of Technology to Help Improve Provider Awareness of Inappropriate Prescribing and Best Practices

Even with the additional model of identification of prescribers who may need assistance and education related to prescribing practices, an overarching theme that could help prescribers may be by the expanded use of electronic health records and e-prescribing. It should be noted that, though existing health information technology investments are still in their infancy, such a model might help inform prescribers.

Using effective e-prescribing can also help avoid potentially dangerous drug interactions.[23]

4. Explore the Potential Use of Safety Edits

The statute as written does not permit the DHHS to implement quantity, dose, or age limits to non-controlled substance psychotropic medications that appear not to align with standards of practice. In future meetings the workgroup would like to have further discussion on whether amending statute to allow for workgroup-recommended safety edits may promote safe prescribing practices and better outcomes for people taking psychotropic medications. There was some concern during ongoing workgroup discussions that this needs to be pursued thoughtfully while weighing the pros and cons of such a change.

5. Explore Future Cost Saving Opportunities

The workgroup discussed its desire to further explore future cost-saving opportunities that could be put into place to help decrease the need for State funds. The workgroup supports exploration of the DHHS' prior budget savings proposal under which psychotropic medications could be labeled as "non-preferred" without the drug being subjected to prior authorization procedures. A manufacturer could gain "preferred" status for its product by paying a supplemental rebate to Michigan. Like other states, the Michigan legislature may wish to consider pharmaceutical cost transparency and pharmaceutical lobbying/marketing laws/regulations, ultimately to help benefit persons served.

6. Continuation of the Workgroup

This psychotropic workgroup supports the continuation of its meetings for purposes of further evaluating best practice models that the State could incorporate in future years

[21] http://wenger-trayner.com/introduction-to-communities-of-practice/
[22] https://aims.uw.edu/collaborative-care
[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3995494/

and leveraging the subject matter expertise from persons served/family representatives, physicians, and pharmacists.

NPAM Support.pdf
Uploaded by: Sarah Peters
Position: FAV

NURSE PRACTITIONER
Association of Maryland

"Advocating for Nurse Practitioners since 1992"

Bill: SB 990/HB 1423- Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

Position: SUPPORT

Dear Chair, Vice-Chair, and Members of the Committee:

On behalf of the Nurse Practitioner Association of Maryland (NPAM), representing over 849 nurse practitioners throughout the state, we offer our support for SB 990/HB 1423.

As an association representing nurse practitioners who are at the forefront of patient care, we believe that this bill is crucial for ensuring timely access to appropriate medication for individuals grappling with serious mental health conditions. By eliminating unnecessary bureaucratic hurdles, this legislation empowers healthcare providers to make decisions based on clinical judgment and the individual needs of their patients.

Several members work as psychiatric nurse practitioners and have encountered a number of situations that this bill would have helped. To name a few:

- A pregnant patient diagnosed with bipolar disorder. The only safe pregnancy mood stabilizer medication was declined without prior authorization.

- A female patient diagnosed with bipolar disorder failed multiple trials of mood stabilizers. Stable on one medication for over a month and kept getting declined. It took multiple appeals to Maryland Medicaid to get approved.

- A male diagnosed with bipolar disorder who experienced a drug overdose. He was stabilized on medication. Insurance denied the medication and wanted him switched to another. The provider had to write multiple letters to get approved.

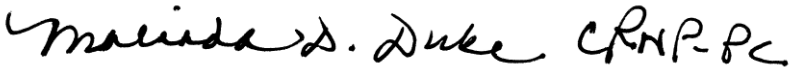
- Patient diagnosed with bipolar disorder who had Medicaid was stabilized and discharged from an inpatient admission. The medication required a PA and step therapy once he saw an outpatient provider.

- A patient was prescribed one medication, but the insurer refused with recommendation to fail on one of two other drugs first until the provider completed a peer-to-peer call.

- Patient prescribed one medication, but the insurer denied saying that they would not agree because the patient was over 18. Provider started that medication because the patient was using substances, and the provider did not want to prescribe a controlled medication. The insurer denied the prescribed medication and recommended a controlled substance.

It is our firm belief that timely access to appropriate medication is paramount in managing mental health conditions effectively.

Sincerely,



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USC Issue Brief - Medication Access Restrictions.p

Uploaded by: Sarah Peters

Position: FAV

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for Health Policy & Economics

Issue Brief

NO. 2 · FEBRUARY 2015

MEDICAID ACCESS RESTRICTIONS ON PSYCHIATRIC DRUGS: PENNY-WISE OR POUND-FOOLISH?

More than 10 million American adults suffer from serious mental illnesses, including major depression, schizophrenia and bipolar disorder. Medicaid, the state-federal health program for low-income people, is the nation's largest funding source of mental health treatment, including prescription drugs. Access to effective medication often can mean the difference between a mentally ill person living safely in the community or landing on the streets, in jail or dead. But psychiatric drugs are expensive, and state Medicaid programs face constant pressure to contain costs. Many states have restricted access to psychiatric drugs in hopes of saving money.

However, research from the USC Leonard D. Schaeffer Center for Health Policy & Economics shows that Medicaid formulary restrictions, such as prior authorization and step therapy—where patients must first try less expensive drugs—save little, if any, money on drug spending. Instead, formulary restrictions increase overall Medicaid spending for people with serious mental illnesses, especially for inpatient hospital care. Beyond the human toll of mentally ill people's increased likelihood of hospitalization, homelessness and incarceration, formulary restrictions also raise costs to society through increased spending to jail mentally ill Americans. One study, for example, found that Medicaid formulary restrictions on atypical antipsychotics for patients with schizophrenia and bipolar disorder increase state costs by an estimated $1 billion annually when factoring in both extra Medicaid spending and increased incarceration rates.

State Budgets, Medicaid Formulary Restrictions and Patient Health

Faced with rapidly growing prescription drug spending, many state Medicaid programs have adopted drug formularies—or lists of preferred drugs—that restrict access to medications to treat serious mental illnesses, including major depression, schizophrenia and bipolar disorder. Common Medicaid formulary restrictions include:

- ***prior authorization***, which requires clinicians to obtain permission from Medicaid to prescribe a specified drug, or Medicaid will not guarantee reimbursement; and
- ***step therapy***, which permits payment for a non-preferred medication only after the patient tries other selected medications—usually cheaper alternatives.

Under both policies, clinicians must make the case for why patients need non-preferred drugs. Step therapy, in particular, restricts clinical decision making by requiring the use of certain medications first even if the clinician believes the preferred drugs are less desirable—for example, because of lower tolerability, therapeutic noncompliance from adverse side effects, poor treatment outcomes or lack of improvement compared to non-preferred medications.

Growing evidence, however, indicates that Medicaid formulary restrictions save little, if any, money on drug spending for serious mental illnesses and instead contribute to worse patient outcomes, higher overall Medicaid spending, and increased incarceration rates for people with serious mental illnesses.

This Issue Brief summarizes three recent peer-reviewed studies by Schaeffer Center researchers published in the *Forum for Health Economics and Policy* and the *American Journal of Managed Care* that examined Medicaid formulary restrictions for psychiatric medications, Medicaid spending and estimated costs of increased incarceration rates for people with serious mental illnesses (see Data Source).

Prior Authorization/ Step Therapy and Major Depression

An estimated one in five adults covered by Medicaid is diagnosed with major depressive disorder (MDD), a severe and debilitating form of depression that impairs people's ability to function—for example, staying employed and interacting with other people—without

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proper treatment, including antidepressants. Medicaid spending on patients with MDD has grown rapidly from $159 million in 1991 to almost $2 billion in 2005, making it an attractive cost-containment target.

To examine the relationship between Medicaid formulary restrictions on antidepressants and health care utilization and spending, Schaeffer Center researchers used medical and pharmacy claims from 24 state Medicaid programs to identify acute-care utilization—hospitalizations and emergency department (ED) visits—and spending for 901,376 patients diagnosed with major depressive disorder between 2001 and 2008. Researchers then linked these data to formulary restrictions—prior authorization and step therapy—on antidepressants in the 24 states during the same period and examined the financial effects of prior authorization alone and prior authorization combined with step therapy.

Over the course of the study period, the proportion of patients in the study sample exposed to prior authorization for at least one antidepressant increased from 40 percent to 80 percent. The use of step therapy combined with prior authorization was not observed in the study sample until 2003 but increased to about 20 percent of patients by 2008.

After controlling for differences in patient and state characteristics, researchers compared outcomes for Medicaid patients in states with and without formulary restrictions before and after restrictions were adopted. Restricting access to antidepressants through both prior authorization and step therapy was associated with a 2.1 percentage point (8.2%) increase in the likelihood of any hospitalization and a 1.7 percentage point (16.6%) increase in the likelihood of an MDD-related hospitalization (see Figure 1).While there were significant associations between formulary restrictions on antidepressants and hospitalizations, there appeared to be little relationship between formulary restrictions and ED visits or physician office visits.

On the spending side, researchers found no evidence of any overall savings to Medicaid programs from formulary restrictions on antidepressants. The combination of prior authorization and step therapy showed a statistically significant association with higher inpatient spending, while prior authorization alone showed a statistically significant association with higher outpatient expenditures. At the same time, there was no indication that prior authorization resulted in significantly lower pharmacy spending. Considering pharmacy and non-pharmacy medical spending together, formulary restrictions were not associated with any statistically significant change in overall Medicaid spending per MDD patient, but patients with MDD were put at significantly higher risk of hospitalizations.

Atypical Antipsychotics and Formulary Restrictions

The introduction of atypical antipsychotics—also known as second-generation antipsychotics—almost three decades ago signaled a significant advance in treatment for people with schizophrenia and bipolar disorder. Compared to first-generation antipsychotics, the newer drugs are less likely to cause side effects that threaten patient adherence, such as significant movement disorders and heavy sedation.

Atypical antipsychotics accounted for more than 15 percent of all Medicaid spending in 2005 and are among the most frequently targeted drugs for Medicaid formulary restrictions. Previous research has shown that while atypical antipsychotics are generally effective, patients respond differently to specific atypical antipsychotic medications, often requiring changes in treatment regimens to attain desired clinical outcomes. As a result, formulary restrictions on atypical antipsychotics can disrupt treatment and affect patient adherence. While previous research has found that formulary restrictions on atypical antipsychotics diminish patient adherence and raise health care spending, most of the studies have focused on a small group of states.

To provide a more complete picture of potential unintended consequences of trying to contain costs by curtailing access to atypical antipsychotics, Schaeffer Center researchers used medical and pharmacy claims for people with schizophrenia and bipolar disorder from 24 state Medicaid programs between 2001 and 2008 to estimate the impact of formulary restrictions on health care spending.

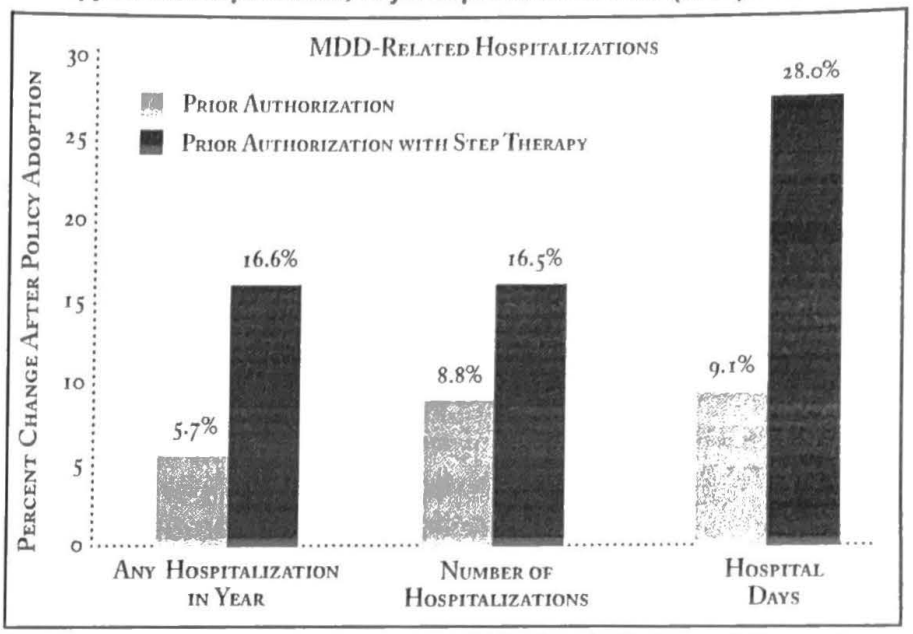
The study included 117, 908 patients with schizophrenia and 170,596 people with bipolar disorder who were newly prescribed one of five atypical antipsychotics—olanzapine, risperidone, quetiapine, aripiprazole or ziprasidone. The formulary restrictions examined were prior authorization, step therapy and quantity limits. Similar to state trends with antidepressants, Medicaid formulary restrictions on atypical antipsychotics grew quickly between 2001 and 2008.

According to the study, patients with schizophrenia subject to formulary restrictions were more likely to experience a hospitalization, had 23 percent higher inpatient costs and had 16 percent higher total medical costs (see Figure 2). Similar results were found for patients with bipolar disorder, with those subject to formulary restrictions being more likely to be hospitalized and 20 percent higher inpatient costs and 10 percent higher total costs.

Formulary restrictions were not associated with statistically significantly lower pharmacy expenditures for either group. Additionally, patients with schizophrenia subject to formulary restrictions had worse adherence, while formulary restrictions had no significant effect on bipolar patients' adherence.

Figure 1

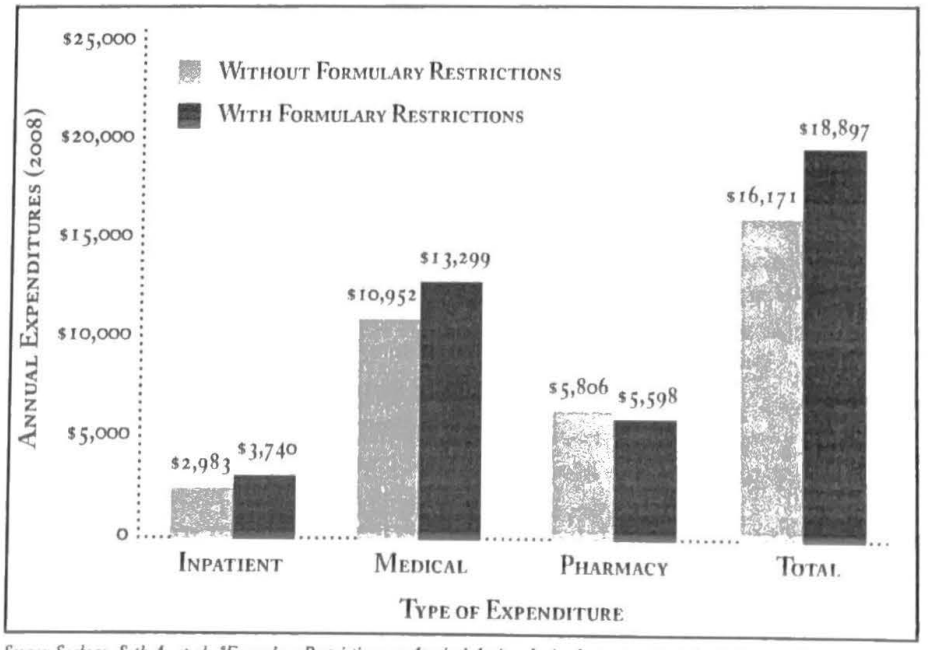
Change in Hospital Outcomes Associated with Prior Authorization and Step Therapy for Antidepressants, Major Depressive Disorder (MDD) Related



Source: Seabury, Seth A., et al., "Patient Outcomes and Cost Effects of Medicaid Formulary Restrictions on Antidepressants," Forum for Health Economics and Policy (2014).

Figure 2

Predictied Expenditures With and Without Formulary Restrictions for Atypical Antipsychotics: Patients with Schizophrenia



Source: Seabury, Seth A., et al., "Formulary Restrictions on Atypical Antipsychotics: Impact on Costs for Patients with Schizophrenia and Bipolar Disorder in Medicaid," American Journal of Managed Care, Vol. 20, No. 2 (February 2014).

Jail: The New Hospital Bed?

About 36 percent of men and 28 percent of women with serious mental illness in the United States went without treatment in 2013, according to the most recent U.S. Behavioral Health Barometer. And, each year, an estimated 356,000 Americans with serious mental illness end up in jail, another 200,000 are homeless, 108,000 are hospitalized and 34,000 die by suicide, according to a 2014 investigative series by *USA Today*.[1]

"We have replaced the hospital bed with the jail cell, the homeless shelter and the coffin," U.S. Rep. Tim Murphy, R-Pa., told *USA Today*.

The number of inpatient psychiatric hospital beds has dropped dramatically since the 1950s when a move to dein-

Data Source

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stitutionalize care for people with serious mental illnesses led to many problem-plagued state mental hospitals closing. By one 2010 estimate, there was one psychiatric bed for every 300 Americans in 1955, dropping to one psychiatric bed for every 3,000 Americans in 2005.[2] In many cases, promised community-based mental health treatment to replace inpatient beds never materialized, and state budget cuts have hit mental health services hard—an estimated $5 billion decrease between 2009 and 2012.[3]

Prior Authorization and Incarceration Rates

When people with schizophrenia miss or discontinue taking their medication, they are at high risk of an acute psychotic episode, which can lead to threatening behavior, contact with law enforcement, arrest and incarceration.

To examine the impact of formulary restrictions on the likelihood that people with schizophrenia will be arrested and incarcerated, Schaeffer Center researchers looked at drug-level information on prior authorization policies in 30 state Medicaid programs, state usage rates of atypical antipsychotics and responses from 16,844 inmates to a nationally representative survey that included detailed information about any mental health conditions.

The analysis found that people with schizophrenia in states with prior authorization for atypical antipsychotics faced a 22 percent increase in the likelihood of imprisonment. Inmates in those states also were more likely to have been previously diagnosed with schizophrenia. And, the study found that higher state-level atypical prescriptions per capita were associated with lower likelihood of psychotic symptoms and prior schizophrenia diagnosis among prisoners. The bottom line: a strong link between Medicaid prior authorization requirements for atypical antipsychotics and higher rates of incarceration of mentally ill people.

As part of the study looking at broader formulary restrictions on atypical antipsychotics, researchers estimated that the restrictions increased the number of prisoners by almost 10,000 and incarceration costs by $362 million nationwide in 2008. When researchers extrapolated the average increase in Medicaid spending for patients with schizophrenia and patients with bipolar disorder, combined with the additional prison costs, the total estimated cost to society of formulary restrictions on atypical antipsychotics exceeded $1 billion annually.

Policy Implications

Taken as a whole, the Schaeffer Center research findings related to Medicaid formulary restrictions on psychiatric drugs published in the *Forum for Health Economics and Policy* and the *American Journal of Managed Care* provide policymakers with important new information about the effectiveness of policies restricting access to medication for people with serious mental illnesses. Not only is it becoming clear that Medicaid formulary restrictions on antidepressants and atypical antipsychotics harm patients, they also likely drive up both medical and prison costs.

Formulary restrictions on psychiatric drugs are only one aspect of the mental health crisis in America. As policymakers re-evaluate Medicaid formulary restrictions, larger issues require their attention as well. A fundamental question that cannot go unanswered much longer is whether the criminal justice system will continue as the de facto solution to the millions of Americans with serious mental illness who don't receive appropriate treatment. ■

Notes

1. Szabo, Liz, "Cost of Not Caring: Mental Illness in America," *USA Today* (July 2014).
2. Treatment Advocacy Center, Arlington, Va., and National Sheriffs' Association, Arlington, Va., "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of States" (May 2014).
3. Szabo (2014).

Utah Psychotropic DAW PDL Compliance Report 11-20.

Uploaded by: Sarah Peters
Position: FAV

Report to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee

Medicaid Preferred Drug List

Psychotropic Drugs

Prepared by the Division of Medicaid and Health Financing

November 2020

UTAH DEPARTMENT OF HEALTH

EXECUTIVE SUMMARY

UCA 26-18-2.4(3) authorized a PDL for psychotropic drugs with a dispense as written override and established targets for savings from the PDL.

This report is submitted in response to the following language from UCA 26-18-2.4(3):

> (e) The department shall report to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee before November 30, 2016, and before each November 30 thereafter regarding compliance with and savings from implementation of this Subsection (3).

Implementation of a Psychotropic PDL

The statute defines psychotropic medications as:

i. Atypical Anti-psychotics;
ii. Anti-depressants;
iii. Anti-convulsant/mood stabilizers;
iv. Anti-anxiety agents; and
v. Attention deficit hyperactivity disorder stimulants

The Department's Pharmacy and Therapeutics Committee has reviewed these drug classes for inclusion on the PDL. The committee was established by UAC R414-60B-5 as a professional and technical advisory board to the Department in the formulation of a PDL. The committee is composed of physicians and pharmacists who meet regularly to consider PDL recommendations.

On July 1, 2016, the Department placed attention deficit hyperactivity disorder (ADHD) stimulants on the PDL. On October 1, 2016, the Department added atypical anti-psychotics, anti-depressants (several categories), and anti-convulsants/mood stabilizers (several categories) to the PDL. On January 1, 2017, the Department added most of the remaining anti-depressants, anti-convulsants/mood stabilizers, and anti-anxiety agents to the PDL. On January 1, 2018, the Department added anti-depressant TCA's and MAOI's to the PDL.

Savings for Fiscal Year Ended June 30, 2019

The Department achieves PDL savings by shifting utilization to less expensive drugs that are equally safe and efficacious, as well as from secondary rebates from drug manufacturers. The Department also incurs additional administrative expenses by implementing and managing the PDL which are subtracted from the PDL savings figure.

PDL savings from all psychotropic drug classes for the state fiscal year ending June 30, 2020 are $3,020,460 in General Fund.

Provider Compliance with the PDL:

UCA 26-18-2.4(3) also requires the Department to:

(ii) Determine whether care provider compliance with the preferred drug list is at least:

A. 55% of prescriptions by July 1, 2017;
B. 65% of prescriptions by July 1, 2018; and
C. 75% of prescriptions by July 1, 2019.

Compliance with the PDL at the completion of State fiscal year 2019 is 91%.

SB 990 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FAV

March 5, 2024

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building – 3 East
Annapolis, MD 21401

RE: Support – Senate Bill 990: Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

Dear Chairman Peña-Melnyk and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS strongly support Senate Bill 990: Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness (SB 990). Step therapy, also known as "fail first" protocols, is a practice used by health insurers and pharmacy benefit managers (PBMs) to control the cost of prescription medications by requiring patients to try less expensive treatments before they are allowed to receive more costly treatments. While the intention behind step therapy may be to reduce costs, it can sometimes have negative consequences for patients, especially for individuals being treated for a mental illness and/or substance use disorder. There are several reasons, therefore, why this committee should pass SB 990, and step therapy or fail-first protocols should be banned in the context of mental health treatment:

- **Delayed Treatment:** When patients are required to try less expensive treatments before being prescribed more expensive ones, it can lead to delays in treatment, which can be detrimental to patients' health. For example, suppose a patient with schizophrenia is required to try a less effective medication before being prescribed a more effective one. In that case, the patient's symptoms may worsen during this delay. When a patient with a mental health disorder decompensates, the patient could hurt himself or others, which could lead to a loss of liberty either through involuntary commitment or incarceration.

- **Adverse Effects:** In some cases, patients may have adverse reactions to the less expensive treatments they must try first. This can lead to unnecessary suffering and may even result in hospitalization or other medical complications.

- **Medical Necessity:** Step therapy protocols may not consider individual patients' unique needs. A medication that works well for one patient may not work for another, and patients may need to try multiple medications before finding one that works for them. Step therapy protocols can limit patient access to necessary medications based on cost considerations rather than medical necessity.

- **Physician Discretion:** Physicians are trained to make treatment decisions based on their patient's needs and medical history. Step therapy protocols may undermine physicians' ability to make the best patient treatment decisions.

In summary, step therapy or fail-first protocols can have negative consequences for patients, including delayed treatment, adverse effects, limitations on medical necessity, and a reduction in physician discretion. As such, MPS and WPS ask the committee for a favorable report on SB 990. If you have any questions concerning this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

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Uploaded by: Evelyn Burton
Position: FWA

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However, research from the USC Leonard D. Schaeffer Center for Health Policy & Economics shows that Medicaid formulary restrictions, such as prior authorization and step therapy—where patients must first try less expensive drugs—save little, if any, money on drug spending. Instead, formulary restrictions increase overall Medicaid spending for people with serious mental illnesses, especially for inpatient hospital care. Beyond the human toll of mentally ill people's increased likelihood of hospitalization, homelessness and incarceration, formulary restrictions also raise costs to society through increased spending to jail mentally ill Americans. One study, for example, found that Medicaid formulary restrictions on atypical antipsychotics for patients with schizophrenia and bipolar disorder increase state costs by an estimated $1 billion annually when factoring in both extra Medicaid spending and increased incarceration rates.

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Under both policies, clinicians must make the case for why patients need non-preferred drugs. Step therapy, in particular, restricts clinical decision making by requiring the use of certain medications first even if the clinician believes the preferred drugs are less desirable—for example, because of lower tolerability, therapeutic noncompliance from adverse side effects, poor treatment outcomes or lack of improvement compared to non-preferred medications.

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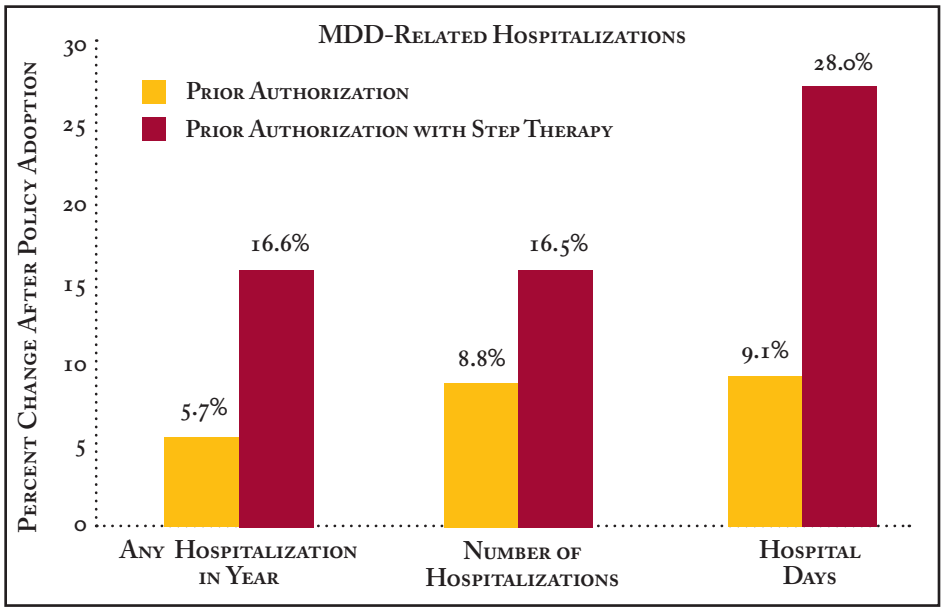
Formulary restrictions were not associated with statistically significantly lower pharmacy expenditures for either group. Additionally, patients with schizophrenia subject to formulary restrictions had worse adherence, while formulary restrictions had no significant effect on bipolar patients' adherence.

Figure 1

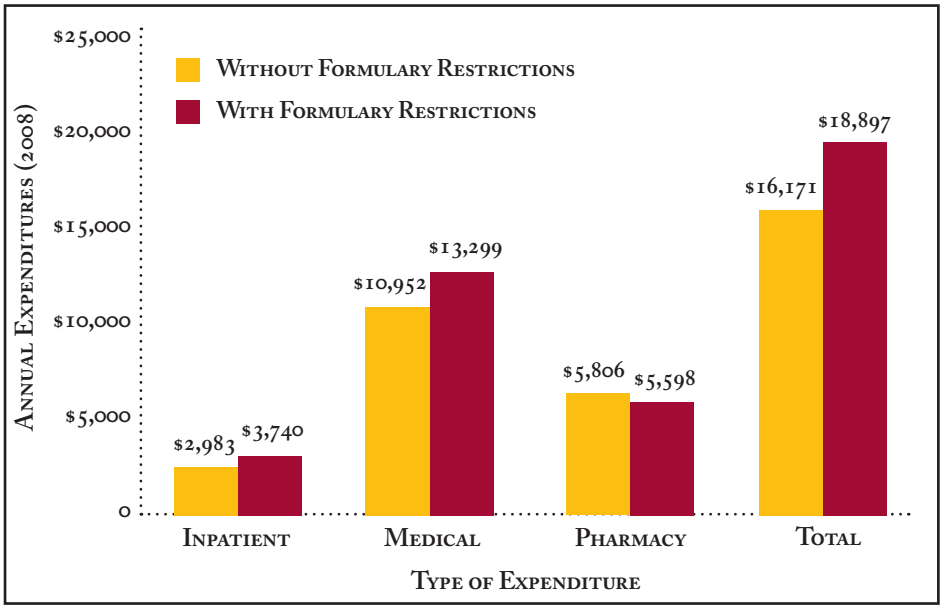
Change in Hospital Outcomes Associated with Prior Authorization and Step Therapy for Antidepressants, Major Depressive Disorder (MDD) Related



Source: Seabury, Seth A., et al., "Patient Outcomes and Cost Effects of Medicaid Formulary Restrictions on Antidepressants," Forum for Health Economics and Policy *(2014).*

Figure 2

Predictied Expenditures With and Without Formulary Restrictions for Atypical Antipsychotics: Patients with Schizophrenia



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Policy Implications

Taken as a whole, the Schaeffer Center research findings related to Medicaid formulary restrictions on psychiatric drugs published in the *Forum for Health Economics and Policy* and the *American Journal of Managed Care* provide policymakers with important new information about the effectiveness of policies restricting access to medication for people with serious mental illnesses. Not only is it becoming clear that Medicaid formulary restrictions on antidepressants and atypical antipsychotics harm patients, they also likely drive up both medical and prison costs.

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1. Szabo, Liz, "Cost of Not Caring: Mental Illness in America," *USA Today* (July 2014).
2. Treatment Advocacy Center, Arlington, Va., and National Sheriffs' Association, Arlington, Va., "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of States" (May 2014).
3. Szabo (2014).

SB990_S&PAA_FAV_WITH_AMEND.pdf
Uploaded by: Evelyn Burton
Position: FWA

SB990 Testimony
From: Evelyn Burton, Maryland Advocacy Chair, Schizophrenia & Psychosis Action Alliance
Position: SUPPORT WITH AMENDMENTS

As families of those with the psychiatric brain disorders of schizophrenia, bipolar disorder, and major depression that can result in psychosis if not effectively treated, we too often see tragic outcomes of incarceration, homelessness, violence and even deadly results. On average, those with all mental illnesses are no more dangerous than the average population. However, according to Dr. Thomas Insel, a past director of the National Institute on Mental Health (NIMH), "An active psychotic illness is associated with irrational behavior and violence can be part of that….There is a 15 fold reduction in risk of homicide, with … treatment."[1] Research shows nonadherence to antipsychotic treatment results in a "fourfold increase in the risk of suicide…and increased rates of hospitalization, use of emergency psychiatric services, arrests…[and] greater substance use."[2]

Any delay in effective medication prescription for a psychotic illness, including delays from prior authorization or step therapy requirements, seriously risk the life of the patient as well as others. Unlike a condition like high cholesterol which does not cause adverse effects quickly, active psychosis is unpredictable and can result in violence and other adverse consequences at any time. When someone is taken off effective medication for a psychotic illness, because of step-therapy requirements, the psychosis and tragic consequences can occur within days. In addition, requiring step therapy risks the individual refusing to take any medication if intolerable side effects from a non-optimal medication are experienced.

With psychotic illnesses, there may be only one window of opportunity to prescribe the most effective and tolerable medication for an individual before extremely adverse consequences occur. Only an individual's physician can best judge which medication is most likely to be effective, is compatible with the individual's comorbid conditions and which the individual is most likely to tolerate and agree to take.

Untreated and ineffectively treated psychosis is a major driver of criminalization of those with serious mental illness (SMI.) The delusions and hallucinations and cognitive impairments of psychosis often result in the inability to comply with the law. The Maryland Secretary of Health recently testified that approximately 25 percent of people in Maryland jails have serious mental illness.

Research has found that prior authorization and step-therapy dramatically increased overall state costs. According to the attached Issue Brief from the Scheffer Center for Health Policy & Economics,[3] "Medicaid formulary restrictions, such as prior authorization and step therapy…save little, if any, money on drug spending. Instead, formulary restrictions increase overall Medicaid spending for people with serious mental illnesses, especially for inpatient hospital care. … formulary restrictions also raise costs to society through increased spending to jail mentally ill Americans." (See charts below)

Allowing the Department of Legislative Services to abruptly re-institute prior authorization and step-therapy for those already stabilized on effective medications is tantamount to a death sentence for some by suicide or violence and incarceration for others. Such discontinuation should be carefully considered by the legislature.

We ask for a favorable report on SB990 with the following amendments to require consideration of total Medicaid costs and also prevent the tragedies of suicide, death and incarceration from the delay and interruption of effective medication treatment of psychotic illnesses.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) On or before January 31, 2026, and each January 1 thereafter through 2030, the Maryland Department of Health shall report to ~~the Department of Legislative Services AND~~ THE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE AND THE FINANCE COMMITTEE on any cost increase to the Maryland Medical Assistance Program from the immediately preceding fiscal year that results from the implementation of Section 1 of this Act.

(b) CALCULATION OF COSTS IN THIS SECTION SHALL INCLUDE CONSIDERATION OF ANY REDUCTION IN HOSPITAL COSTS FOR INDIVIDUALS AFFECTED UNDER SECTION 1 OF THIS ACT COMPARED TO THEIR HOSPITAL COSTS BEFORE IMPLEMENTATION OF SECTION 1 OF THIS ACT.

~~(b) On or before April 30 of the year in which a report is submitted under subsection (a) of this section, the Department of Legislative Services shall determine, based on the report, whether the implementation of Section 1 of this Act resulted in a cost increase to the Maryland Medical Assistance Program of more than $2,000,000 from the immediately preceding fiscal year~~

~~(c) If the Department of Legislative Services determines that the implementation of Section 1 of this Act resulted in a cost increase to the Maryland Medical Assistance Program of more than $2,000,000 from the immediately preceding fiscal year, with no further action required by the General Assembly, at the end of April 30 of the year the determination is made, Section 1 of this Act shall be abrogated and of no further force and effect.~~

References:

1. DJ Jaffe. *insame consequences*. Pg 33
2. DJ Jaffe. *insame consequences*. Pg 77
3. USC Schaeffer. Medicaid Access Restrictions on Psychiatric Drugs: Penny Wise or Pound Foolish? Issue Brief No. 2 February 2015.

Figure 1[3]

Change in Hospital Outcomes Associated with Prior Authorization and Step Therapy for Antidepressants, Major Depressive Disorder (MDD) Related

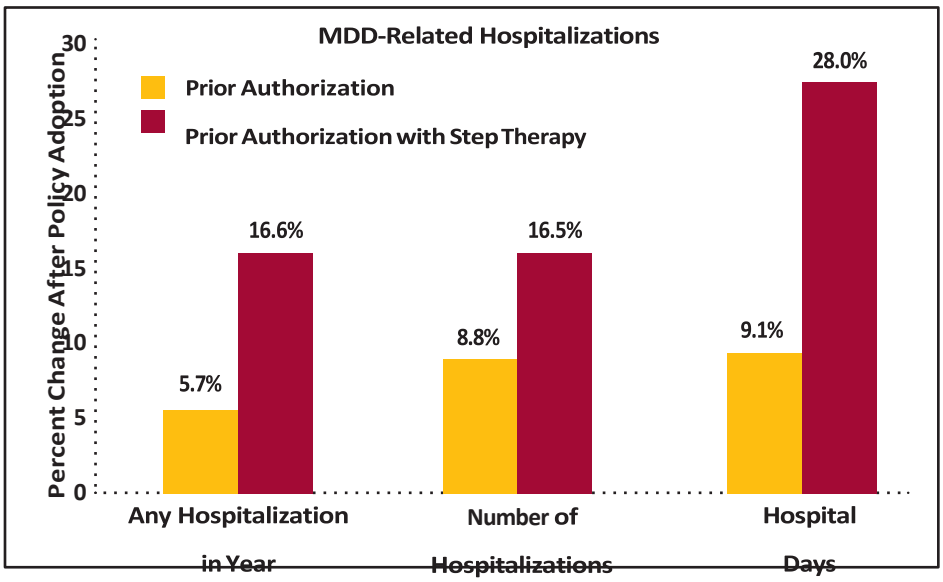
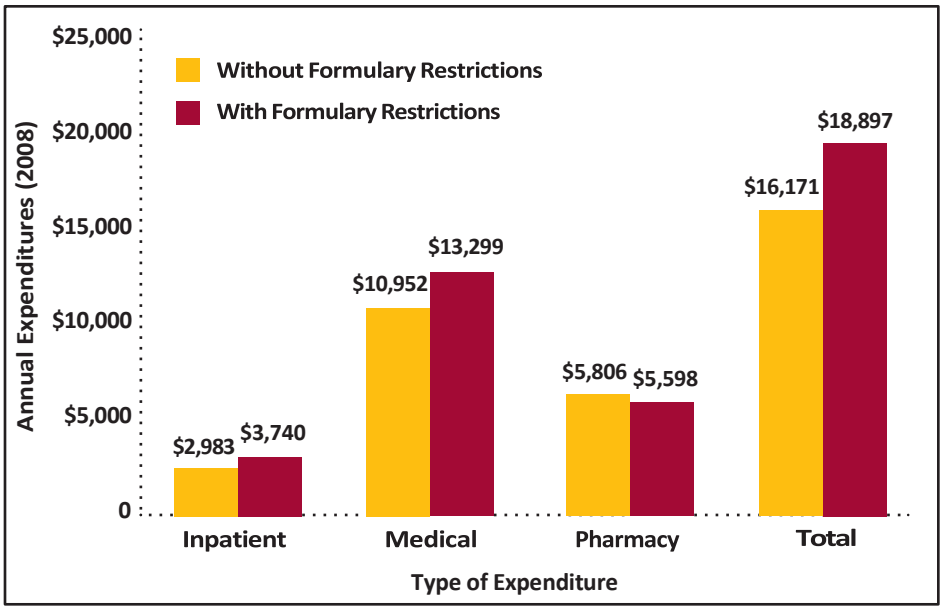


Figure 2[3]

Predictied Expenditures With and Without Formulary Restrictions for Atypical Antipsychotics: Patients with Schizophrenia



SB 990 Moran Testimony.pdf
Uploaded by: Mary Moran
Position: FWA

SB 990, Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness
Senate Finance Committee
Date: March 6, 2024
From: Mary Ellen Moran, Bowie, MD 20716 (District 23)
Position: SUPPORT WITH AMENDMENTS

As an individual with bipolar disorder and a son with schizophrenia, I am pleased to support SB 990. This Bill would ensure that persons with serious mental illnesses receive the medications that their mental health care providers prescribe because, in their professional opinions, the prescribed drug will work.

My son was subjected to step therapy and twice he had serious relapses.

He was taking a brand that worked well and was required to take a less expensive, lower tier brand.

After a period of time on the new drug, at sunrise he walked out to a large cul de sac, took off his clothes and started worshiping the sun. Fortunately I was able to talk him into putting on his bathrobe and going back in the house. His psychiatrist had recommended that some of the brand name medication that worked be saved in the event of an emergency. Also, the doctor had an emergency number to call and when I called he said to start giving my son the brand that worked. This action kept him out of the hospital.

However, had no medicine that worked been immediately available, he would have required hospitalization.

It is concerning that SECTION 1 would be abrogated on the basis of a determination by the Department of Legislative Services that the cost to the Maryland Medical Assistance Program increased by more than $2,000,000 with no consideration of the potential additional cost of relapses which could result in hospitalizations, incarcerations, homelessness and suicide. Such discontinuation should be carefully considered by the legislature.

Therefore, I respectfully request that you amend SB 990 as shown below and give it a favorable report.

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SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) On or before January 31, 2026, and each January 1 thereafter through 2030, the Maryland Department of Health shall report to ~~the Department of Legislative Services AND~~ THE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE AND THE FINANCE COMMITTEE on any cost increase to the Maryland Medical Assistance Program from the immediately preceding fiscal year that results from the implementation of Section 1 of this Act.

(b) CALCULATION OF COSTS IN THIS SECTION SHALL INCLUDE CONSIDERATION OF ANY REDUCTION IN HOSPITAL COSTS FOR INDIVIDUALS

AFFECTED UNDER SECTION 1 OF THIS ACT COMPARED TO THEIR HOSPITAL COSTS BEFORE IMPLEMENTATION OF SECTION 1 OF THIS ACT.

~~(b) On or before April 30 of the year in which a report is submitted under subsection (a) of this section, the Department of Legislative Services shall determine, based on the report, whether the implementation of Section 1 of this Act resulted in a cost increase to the Maryland Medical Assistance Program of more than $2,000,000 from the immediately preceding fiscal year~~

~~(c) If the Department of Legislative Services determines that the implementation of Section 1 of this Act resulted in a cost increase to the Maryland Medical Assistance Program of more than $2,000,000 from the immediately preceding fiscal year, with no further action required by the General Assembly, at the end of April 30 of the year the determination is made, Section 1 of this Act shall be abrogated and of no further force and effect.~~

MMCOA Letter of Information on SB990 - Step Therap

Uploaded by: Joseph Winn

Position: INFO

MMCOA
MARYLAND MCO ASSOCIATION

Senate Bill 990 - Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness

Letter of Information

Senate Finance Committee
March 6th, 2024

Thank you for the opportunity to submit this letter of information for Senate Bill Bill 990 - Maryland Medical Assistance Program and Health Insurance - Step Therapy, Fail-First Protocols, and Prior Authorization - Prescription Drugs to Treat Serious Mental Illness.

The Maryland Managed Care Organization Association (MMCOA), which is comprised of all nine MCOs that serve Medicaid, is committed to ensuring access to the prescription drugs and therapies that our members depend on for their health and wellbeing.

Importantly, a majority of the drugs prescribed for the conditions referenced in Senate Bill 990 are not currently covered by the MCOs. These drugs are carved out of the HealthChoice program and the Medicaid enrollees that are seeking care for Serious Mental Illness (SMI) receive these drugs via Fee-For-Service through the Behavioral Health ASO.

Utilization management of prescription drugs is an important aspect of any Medicaid program. These tools help determine the therapeutic appropriateness of a drug, monitor for over utilization, possible therapeutic duplications, drug contradictions and interactions, and appropriate dosing.

Given the unique needs of Medicaid members seeking treatment for SMI it would be worthwhile to consider including these issues in Senate Bill 212. Among other things, Senate Bill 212 tasks the Commission on Behavioral Health Access and Treatment to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health services in Medicaid in coordination with the council.

Thank you for considering this letter of information and please do not hesitate to reach out to MMCOA should you have any questions.

Please contact Joe Winn, Executive Director of MMCOA, with any questions regarding this testimony at jwinn@marylandmco.org.

SB990_MDH_INFO
Uploaded by: Sarah Case-Herron
Position: INFO

Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

March 6, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 990 – Maryland Medical Assistance Program and Health Insurance – Step Therapy, Fail-First Protocols, and Prior Authorization- Prescription Drugs to Treat Serious Mental Illness – Letter of Information

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of information for House Bill (SB) 990, *Maryland Medical Assistance Program and Health Insurance – Step Therapy, Fail-First Protocols, and Prior Authorization – Prescription Drugs to Treat Serious Mental Illness*. SB 990 prohibits prior authorization requirements, fail-first protocol, or step therapy protocol for a prescription drug used to treat a participant's diagnosis of bipolar disorder; schizophrenia; major depressive disorder; post traumatic stress disorder; or a medication induced movement disorder associated with the treatment of a serious mental illness. Additionally, HB 1423 includes a reporting requirement for Maryland Medicaid.

SB 990 will result in a financial impact to the Department. Overall, the implementation of SB 990 will require $651.8 million in total funds ($325.9 federal funds, $325.9 State general funds) over the next five fiscal years and $125.3 million annually ($62.6 federal funds, $62.6 State general funds).

The Department anticipates that the prohibition of prior authorization, step therapy, or fail-first protocol would lead to a shift in the utilization of medications within these four classes from generic to name drugs, or from brand name drugs with a lower net cost to other brand name drugs with a higher net cost, with a significant increase in the cost per prescription. Medicaid also anticipates a decrease in revenue from supplemental rebates as manufacturers will no longer have an incentive to offer supplemental rebates to have their brand name drugs included on the preferred drug list. Removing the prior authorization requirements would also pose operational challenges to Medicaid, as prescriptions do not include diagnosis information, and so a given drug cannot be authorized for only certain conditions. Therefore, Medicaid would have to authorize the prescription whenever these classes of drugs are prescribed, leading to an increase in the number of prescriptions being filled, and in the cost to Medicaid.

MDH further notes that the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act[1] (Public Law 115-217) passed in 2018 requires states to implement claims review processes for individuals prescribed opioids and antipsychotics, as well as monitor appropriate prescribing of antipsychotic medications to children, and report on monitoring activities for children under 18 or in foster care. Maryland Medicaid's current prior authorization policies are in compliance with the federal SUPPORT Act. The changes required by SB 990 may impact the State's compliance with the SUPPORT Act, putting federal matching dollars at risk.

If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron, Director of Governmental Affairs at sarah.case-herron@maryland.gov or (410) 260-3190.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

[1] https://www.govinfo.gov/content/pkg/PLAW-115publ271/pdf/PLAW-115publ271.pdf