

KANSAS MENTAL HEALTH COALITION

.....Speaking with one voice to meet the critical needs of people with mental illness

Medicaid Medication Management and PDL

Position: The Coalition supports K.S.A. 39-7,121(b), which protects patients' rights to choice in treatment, enables recovery and saves money by exempting mental health prescription drugs from prior authorization or a preferred drug list (PDL). The Coalition opposes efforts to overturn the current statute. The Coalition also opposes the creation of a PDL, or prior authorization, for mental health drugs under the KanCare contractual agreements.

The Problem: Research supports exempting mental health drugs from restricted access. Other research identifies potential problems with preferred formularies. Many studies have reported that PDLs, which prevent access to specific medications, harm Medicaid subscribers with mental illness. Policies that include a PDL with prior authorization requirements, restrictive formularies, fail-first requirements, monthly prescription limits, or tiered co-payments, have resulted in: failure to reduce healthcare costs; prolonged suffering; and reduced potential for persons with mental illness to achieve recovery. In 2002, the Kansas Legislature exempted "medications including atypical anti-psychotic medications, conventional anti-psychotic medications and other(s)...used for the treatment of severe mental illness," from a Medicaid preferred formulary and prior authorization.

Research supports exempting mental health drugs from restricted access.

Why this matters: Many mental health consumers, like others with chronic diseases, need medication to recover, to alleviate symptoms and make the illness "manageable." Access to the full range of medications, including the newest and most effective, promotes successful treatment. Continuity of the medication regime is essential. Continuity requires open access and results in a 65% decrease in inpatient costs, a 55% decrease in emergency room costs, and an overall savings of \$166 per patient, per month. Finding and maintaining the most effective medications is often the key to a durable recovery that enables children with mental illness to attend school and graduate; enables adults to keep jobs, pay taxes, and contribute to their communities; and enables families to stay together.

The bottom line: KMHC will work with KDHE to study and promote policies that enhance patient safety and create efficiency without jeopardizing patient access to medications. A uniform formulary and medication policy for all three Medicaid managed care contractors should be in place.

Need more information? Drill deeper into this issue on the back of this page.

*Kansas Mental Health Coalition PO Box 4744, Topeka, KS 66604
February 2014*

Robert G. Bethell Joint Committee on Home and Community
Based Services and KanCare Oversight
November 18, 2014
Attachment 9

The rest of the story about mental health medications and Medicaid

Kansas is noted for having among the best state statutes related to medication for mental health conditions. KS 39-7,121 b. is lauded for specifically exempting mental health prescription drugs from prior authorization or a preferred drug list. These mechanisms are structured to reduce utilization (and, ostensibly, expense) by listing which drugs can be prescribed to patients, and/or by setting up administrative steps that patients and/or their doctors must take to get the medication that works well for them. The lists, while nominally based on clinical judgment, are generally based on cost, as the state expects to get its savings via better pricing from the manufacturers. Commonly, the more expensive drugs—usually the newer, better tolerated ones, with fewer side effects and thus greater patient compliance—are more likely to be restricted.

Countless studies, and the experience of other states, have clearly and repeatedly demonstrated that preserving full access to the complete range of medications used to treat mental health conditions saves money—both in Medicaid and in the matching State General Funds. Conversely, a plethora of data, across numerous states, has shown that restricting access to these medications drives up costs. For example:

- Restricted access to medication through PDLs in Louisiana increased Medicaid costs 4.1%
- When California forced patients with mental illness to switch to cheaper medication, it cost the state \$6,000-\$8,000 MORE per person due to increased hospitalizations

The risk of increased hospitalization (with resultant higher costs) is not inconsequential, and generally is a result of discontinuation of medication treatment, and relapse and decompensation, which can happen in as little as a few days. (*References relating to quoted research available on request.*):

- One study demonstrated that implementation of a PDL produced 82% higher odds of treatment discontinuation or noncompliance.
- Another study found that 22% of patients in a Medicare prescription drug benefit program discontinued or temporarily stopped medication because of restricted coverage or management issues. Those patients were 8 times more likely to have an emergency room visit.
- A California study of Medicaid patients with schizophrenia showed that discontinuation of treatment for as little as 1 to 10 days, doubled the risk of hospitalization (An 11-30 day gap tripled the risk, and a gap greater than 30 days quadrupled the risk).

Given that Kansas inpatient hospitalization costs range from \$428 to \$1,000 per person, per day, maintaining open access is prudent fiscal policy. Consider the cost of treating someone experiencing a psychotic break due to the unavailability of a drug. Two weeks in a hospital could cost up to \$14,000. Maintaining that person on a newer antipsychotic medication for *one year* is \$15,000. Institutional costs avoided by medication therapy are about \$73,000 a year, *per patient*.

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