voice/tdd
401.737.1238
fax
401.737.3395

mail
400 Bald Hill Road, Suite 515
Warwick, RI 02886

email
riddc@riddc.org

www.riddc.org

RHODE ISLAND
Developmental Disabilities Council
Charting a New Course

Testimony on Senate Bill 2385

An Act Relating to Human Services – Medical Assistance – Prescription Drugs

March 26, 2026

Dear Chairperson Murray & Members of the Senate Committee on Health & Human Services:

The Rhode Island Developmental Disabilities Council would like to thank Senator Bissaillon for sponsoring this bill.

As this topic has been before this Committee numerous times before, most of you are aware that step therapy policies require insured individuals to try and fail alternative treatments specified by a health plan, sometimes with adverse effects, before the health plan will cover the prescribed treatment as a cost containment strategy. When step therapy is used appropriately, it can steer patients towards less risky and lower cost treatments as first-line treatment options. Unfortunately, in some cases, step therapy policies are inconsistent with sound scientific and clinical evidence, requiring patients to try and fail the same treatment multiple times. In such instances, step therapy can interfere with the physician-patient relationship, cause extended delays in care, and severely impact the quality of life for individuals with intellectual/developmental disabilities (I/DD), especially those being prescribed drugs to address frequent or severe seizure activity.

Senate Bill 2385 attempts to resolve these issues.

If enacted, Senate Bill 2385 would help to ensure individuals who are treated for behavioral health or epilepsy are able to obtain effective medications in a timely manner, provide continuity of care, as well as avoid unnecessary hospitalizations, disruptions to their daily routines and extreme impacts on their quality of life.

As it has been successfully implemented in 24 other states, it is an attempt to balance the need for cost control with the impact on patients' lives. I have attached to this testimony documentation of other states efforts and success.

Thank you for your consideration. Please feel free to contact us if you have any questions.

Sincerely,

Robert Marshall
Policy Consultant
401.683.7503
mrshassoc@aol.com

Attachments: Open Access to Antipsychotics in State Medicaid Programs: Effect on Healthcare Resource Utilization and Costs Among Patients With Serious Mental Illness

Enacted Mental Health Open Access Laws

2020 MDHHS Psycotropic Workgroup Findings

Patel R, Baser O, Waters HC, et al. Open access to antipsychotics in state Medicaid programs: effect on healthcare resource utilization and costs among patients with serious mental illness. *JHEOR*. **2025:12(1):222-229.** doi:10.36469/jheor.2025.137909

Journal of Health Economics and Outcomes Research

Psychological Conditions

Check for updates

Open Access to Antipsychotics in State Medicaid Programs: Effect on Healthcare Resource Utilization and Costs Among Patients With Serious Mental Illness

Rashmi Patel[1]*, Onur Baser[2,3], Heidi C. Waters[4], Daniel Huang[4], Leigh Morrissey[4], Katarzyna Rodchenko[5], Gabriela Samayoa[5]

[1]University of Cambridge, Cambridge, UK
[2]Graduate School of Public Health, City University of New York, New York, USA
[3]Department of Economics, Boğaziçi University, Istanbul, Turkiye
[4]Otsuka Pharmaceutical Development & Commercialization, Inc., Princeton, New Jersey, USA
[5]Columbia Data Analytics, New York, New York, USA

ARTICLE INFORMATION

Accepted May 9, 2025

Keywords: Medicaid, open access, antipsychotics, serious mental illness, cost, utilization

**Corresponding author:*
Email address: rkrp2@cam.ac.uk

➢ Supplementary Material

ABSTRACT

Background: The restrictive consequences of Medicaid formulary restriction policies on antipsychotic medications may lead to higher healthcare utilization and costs among beneficiaries with serious mental illness (SMI).

Objectives: This study compared outcomes among patients with SMI accessing antipsychotic medications through state Medicaid programs with open access (OA) policies (Michigan) vs 5 states without Medicaid OA policies (California, Colorado, Florida, Illinois, Wisconsin).

Methods: A retrospective analysis was conducted using Kythera Labs Medicaid data (Jan. 1, 2016–Dec. 31, 2023). Outcomes were assessed for patients with SMI (>18 years of age, ≥1 antipsychotic medication claim during the identification period (Jan. 1, 2017–Dec. 31, 2022), ≥1 SMI claim in the 12-month baseline). Continuous medical and pharmacy benefits were required for 12 months pre- and post-index date. Outcomes included SMI-related hospital admissions, length of hospital stay, emergency department and outpatient visits, and associated costs.

Results: A greater proportion of beneficiaries with SMI resided in Michigan than in the other states. After matching, significantly more antipsychotics users experienced SMI-related hospitalizations in California (18.25% vs 9.47%, $P<.0001$), Colorado (11.41% vs 7.33%, $P=.0004$), Florida (19.70% vs 10.17%, $P<.0001$), Illinois (23.57% vs 8.79%, $P<.0001$), and Wisconsin (15.21% vs 10.02%, $P=.0046$) than in Michigan. Length of stay was lower in Michigan than in California, Colorado, and Illinois. Inpatient costs related to SMI were significantly lower in Michigan, yet pharmacy costs were higher. Total SMI-related costs were higher in all non-OA states than in Michigan, except Colorado.

Discussion: State Medicaid programs without OA to antipsychotics were associated with higher rates of SMI-related resource utilization and costs vs Michigan.

Conclusions: Policy makers should consider the potential downstream cost implications of restrictive access policies and evaluate whether OA could result in improved health outcomes for patients and savings for Medicaid programs.

INTRODUCTION

Medicaid, the federal-state health insurer for low-income individuals, now provides coverage for more than one-fifth of Americans with mental health disorders.[1] Recently, growth in Medicaid prescription drug expenditures has outpaced trends observed in other healthcare services, emerging as one of the primary contributing factors to overall increases in program costs.[2] Net spending on Medicaid prescription drugs increased by 47% between 2017 and 2022, from $29.8 billion to $43.8 billion.[3] To address the challenges associated with funding prescription medications, some state Medicaid programs often implement prior authorization and step therapy as utilization management strategies.[4] Prior authorization allows reimbursement for medications only if the prescriber requests and secures advance approval from Medicaid.[5] Step therapy is a payer-developed regimen of "steps" that requires patients to use and demonstrate a lack of response to

lower-cost medications before use of non-preferred, more costly medications is approved.[5]

Given rising healthcare costs and increasing pressure on budgets, "atypical" or second-generation APs and other psychotherapeutic drugs are increasingly subject to these restrictions. For example, since 2015, 31 state Medicaid programs implemented prior authorization for antipsychotic medications (APs) prescribed to Medicaid-enrolled youth, and 15 states incorporated clinical review and other quality monitoring programs.[6]

Colorado, Florida, California, Illinois, and Wisconsin have some of the most restrictive Medicaid pharmacy programs for patients with SMI, imposing utilization management strategies such as age limits, quantity caps, dose optimization, as well as prior authorization and/or step therapy. In contrast, Michigan's Medicaid program does not impose restrictions and instead provides open access (OA) to psychiatric drugs.

The expanded implementation of these restrictions imposes challenges on both physicians and patients. A 2023 survey of 1000 practicing physicians across various specialties revealed that, on average, they completed 43 prior authorizations for medications and procedures per week, dedicating approximately 12 hours to this task. Another report indicated that 55% of patients reported delays in therapy due to a medication requiring prior authorization.[9] The impact is pronounced for patients with SMI, who often require multiple medication adjustments involving polypharmacy to find the most effective treatment due to individual variability in response and side effects.[10,11] This complex treatment process, combined with prior authorization requirements, may explain why the implementation of utilization management on prescription drugs indicated for conditions such as diabetes, depression, schizophrenia, and bipolar disorder has been correlated with a deterioration in disease status and an increase in hospitalization rates and overall net medical expenditures.[12,13]

Since half of Medicaid beneficiaries with SMI report unmet needs,[14] the purpose of this study is to demonstrate to stakeholders the fiscal benefits of open utilization of APs among patients with SMI. This study compared differences in health costs and outcomes between the less restrictive (OA) Medicaid policies in Michigan and the more restrictive (non-OA) policies in states such as Colorado, Florida, California, Illinois, and Wisconsin. It is hypothesized that non-OA AP policies would not only be associated with worse clinical outcomes for individuals with SMI but would also increase the long-term costs to Medicaid plans.

METHODS

Data Sources

We employed a retrospective cohort design to analyze Kythera Medicaid files from January 2016 to December 2023. Kythera data encompass medical and pharmacy claims and represent coverage of 79% of the US patient population.[15] The data set includes both open and closed versions, encompassing approximately 310 million patients, 6.1 million practitioners, 1.6 million organizations, and 1.4 million facilities that collectively generate 40 billion healthcare claims.[16] Kythera contains commercial, Medicare, and Medicaid claims. We utilized the Medicaid closed portion, which contains data for 44 470 509 patients and 901 136 733 claims. The data set includes de-identified patient ages, genders, types of insurance (fee-for-service vs managed care), zip codes, diagnoses according to the *International Classification of Diseases*, *Tenth Revision* (ICD-10), Current Procedural Terminology codes, and National Drug Codes for medications. Each patient is assigned a unique identifier that links their encounters, allowing for longitudinal analysis. Details of the data have been published elsewhere, and the healthcare outcomes derived from these data have been compared with other data sets for validity and consistency.[17,18,19]

Handling of Missing Data

Patients included in the Kythera databases are generally complete and rarely have missing data. In the event of missing information, patients are benchmarked based on their characteristics and enrollment status and cross-referenced with other data sources to ensure accuracy. Claims with missing elements, such as gender or birth year, are retained only if these omissions do not impact the study outcomes. Any remaining missing data that could affect the analysis are excluded from the study.

The raw data set on which this study is based is available through a commercial data licensing agreement with Kythera Labs. Kythera data have been expertly determined by Datavant's Privacy Hub (Mirador) to comply with statistical de-identification required by the Health Insurance Portability and Accountability Act (HIPAA) and associated regulations. The analysis of de-identified, publicly available data does not constitute human subjects research as defined by US Department of Health and Human Services, 45 CFR § 46.102, and does not require Institutional Review Board (IRB) review.

Study Design and Population

Retrospective claims were used to examine primary outcomes related to healthcare costs and utilization. During the follow-up period, both all-cause and SMI-specific healthcare costs were calculated, encompassing outpatient, inpatient, emergency department (ED), and pharmacy expenses. These costs were adjusted to 2023 US dollars using the medical care component of the Consumer Price Index. Healthcare utilization for both all-cause and SMI-specific cases was assessed by measuring the number of inpatient admissions, ED visits, outpatient visits, and length of hospital stay (LOS).

The study period was from January 1, 2016, through December 31, 2023. The date of the first prescription claims for AP treatment (index date) during the identification period, from January 1, 2017, through December 31, 2022, was considered the first-line treatment initiation. Continuous health plan enrollment for 12 months pre- and 12 months post-index was required. Eligible patients were required to be at least 18 years of age.

The population with SMI in each of the selected states was defined by a diagnosis of schizophrenia or its related spectrum disorders, including schizoaffective disorder, schizophreniform disorder, bipolar disorder, mania and associated disorders, major depressive disorder with recurrent episodes, and specific personality disorders 1 year pre−index date. Patients were excluded if they were prescribed any AP during the baseline period, were prescribed clozapine during the study period, or were dually eligible for Medicaid and Medicare.

Analysis

The study utilized propensity score matching (PSM) to compare healthcare utilization and outcomes, consisting of the Michigan Medicaid program with a mental health OA policy, and the case cohort, comprising the non-OA Colorado, Florida, California, Illinois, and Wisconsin Medicaid programs. Propensity score matching is widely employed in observational studies for causal inference.[20] The propensity score represents the estimated probability of being a member of the case cohort, given a specific covariate pattern.[21] Each subject in the case cohort was matched one-to-one with a subject in the control cohort with the closest propensity score. The matching process utilized patient demographics, claims-based measures of patient health, and medication characteristics at baseline as covariates.

The Kythera Medicaid data provided fundamental demographic information, including age and gender. The status of the index AP as preferred or non-preferred was determined based on each state's Medicaid formulary. Given the variability in Medicaid formularies across states, APs listed as preferred agents on the preferred drug lists in the non-OA states were categorized as preferred, while those listed as non-preferred were categorized accordingly for each state. To facilitate comparison between AP users in Michigan and those in non-OA states, Michigan was assigned the same sets of APs as the comparison state. The preferred and non-preferred APs included in the states' preferred drug lists are detailed in **Supplemental Tables S1-S5**.

To account for variations in comorbidities among patients, we utilized 3 comorbidity indices: the revised Charlson Comorbidity Index (CCI), the Chronic Disease Score (CDS), and the Elixhauser Index. The CCI, developed to predict long-term mortality, has been adapted for use with various data sources, including ICD-9 and ICD-10 codes, and is known for its reliability and validity in diverse clinical populations.[22] The CDS, a drug-based index, stratifies patients based on prescription data to predict health outcomes.[23] The Elixhauser Index categorizes comorbidities using ICD codes and is widely used for risk adjustment in health services research.[24] The application of these indices within a matching algorithm has been demonstrated to enhance the robustness of estimators. We also controlled for mental and systemic comorbidities.

Covariates were subjected to descriptive analysis. For categorical variables, frequencies and percentages were reported, while for continuous variables, means and SD were calculated. To determine statistically significant differences between the cohorts, *t*-tests were applied to continuous variables, and Pearson's χ^2 tests were used for categorical variables, with a significance threshold set at the 5% level. Standardized differences were computed for each variable. Post-PSM, it is anticipated that there will be no significant differences in all pre-index measures between the 2 patient cohorts. All analyses were conducted using Pyspark and SparkR on Databricks and R.

RESULTS

After applying inclusion and exclusion criteria, the analysis included 7129 patients with SMI using APs from California, 4233 from Colorado, 2369 from Florida, 3558 from Illinois, 1374 from Wisconsin, and 4066 from Michigan (**Supplemental Figure S1**).

The percentage of Medicaid beneficiaries with SMI varied. Michigan had a higher percentage of Medicaid beneficiaries with SMI than other states, and the percentage of Medicaid beneficiaries with SMI increased from 2016 to 2023 in all states except Florida (**Supplemental Figure S2**).

Michigan had the youngest patient cohort, and California and Florida had the oldest. Michigan also exhibited the highest proportion of female beneficiaries with SMI, followed by Wisconsin. California recorded the highest CCI score, indicating a more significant burden of physical comorbidities. Michigan had the highest CDS, suggesting an elevated medication burden. Furthermore, California had the highest Elixhauser Index score, reflecting more comorbidities. California's beneficiaries were found to have more physical comorbidities, while Wisconsin exhibited higher rates of specific mental health comorbidities. Additionally, Michigan and California had the highest rates of non-preferred AP use among patients with SMI, surpassing the rates observed in Illinois, Wisconsin, Colorado, and Florida (**Table 1**).

Following PSM, the number of patients with SMI using APs matched with Michigan was 3726 in California, 2550 in Colorado, 1838 in Florida, 2423 in Illinois, and 1308 in Wisconsin.

Regarding all-cause healthcare resource utilization, patients with AP use in Michigan demonstrated significantly lower hospital admission rates and shorter average hospital stays than those in California. Conversely, AP users in Colorado exhibited higher rates of hospital admissions but lower proportions of ED and outpatient visits than those in Michigan. Furthermore, Michigan AP users were less likely to be hospitalized than Florida users, and compared with Illinois, Michigan AP users had lower rates of ED visits and hospital admissions, and shorter average LOS. Finally, Michigan AP users exhibited a lower overall hospital admission but a higher proportion of outpatient visits than those in Wisconsin (**Figure 1**).

Compared with California, Michigan AP users were significantly less likely to experience SMI-related hospital admissions and ED visits. Conversely, AP users in Colorado were more likely to be hospitalized for SMI-related reasons and had longer hospital stays but exhibited a lower proportion of ED visits and outpatient visits than the Michigan cohort. Michigan AP users also had lower rates of SMI-related hospital admissions than those in Florida and Wisconsin. Additionally, Michigan AP users demonstrated significantly lower SMI-related HCRU than those in Illinois, including hospital admissions, LOS, ED, and outpatient visits (**Figure 2**).

State Medicaid programs without OA to APs were associated with higher rates of SMI-related resource use and cost than Michigan, including a higher proportion of hospital admissions (**Supplemental Figure S3**).

In an analysis of all-cause healthcare costs, Michigan demonstrated significantly lower expenditures than California across several categories: inpatient costs, outpatient costs, and ED costs. Despite Michigan incurring slightly higher pharmacy costs, the overall healthcare costs remained significantly lower. Compared with Colorado, there were no significant differences in total, inpatient, and pharmacy costs, although Michigan's outpatient and ED costs were higher. Patients residing in Michigan also incurred lower inpatient and total costs than Florida, along with reduced ED and pharmacy costs. Compared with Illinois, Michigan's inpatient, outpatient, and ED costs were lower, although pharmacy costs were slightly elevated. Nevertheless, Michigan's overall costs were significantly lower. Lastly, Michigan's healthcare costs were lower than Wisconsin's in inpatient, outpatient, pharmacy, and total costs (**Figure 3**).

In terms of SMI-related costs, Michigan patients incurred significantly lower SMI-related expenditures than those in California, with reduced costs across inpatient, ED, and outpatient services, resulting in notably lower total costs. Michigan patients also incurred reduced inpatient and total costs compared with Florida. Compared with Illinois, Michigan had lower inpatient, ED, and outpatient costs, although pharmacy costs were slightly higher. Total SMI-related costs remained lower in Michigan than in Illinois. Furthermore, inpatient and total costs were lower in Michigan than in Wisconsin (**Figure 4**).

DISCUSSION

This study assessed outcomes among patients with SMI who were using APs within a state Medicaid program that implements OA policies for APs (Michigan) against those in states without such policies (California, Colorado, Florida, Illinois, and Wisconsin). We found that patients prescribed atypical AP medications experienced significantly poorer outcomes in states without OA policies. Specifically, these patients faced an increased risk of both overall and SMI-related hospitalizations, as well as higher overall and SMI-related medical costs.

These findings are consistent with an expanding body of evidence indicating that formulary restrictions can lead to unintended consequences, including burdens on provider and patient time, increased

Table 1. Baseline Demographic and Clinical Characteristics

Characteristics	California (N = 7129)	Colorado (N = 3749)	Florida (N = 2036)	Illinois (N = 2851)	Wisconsin (N = 1316)	Michigan (N = 4066)
Mean age (SD)	42.31 (14.8)	39.35 (12.9)	42.23 (14.5)	41.88 (13.9)	40.03 (12.9)	39.01 (13.0)
Female (%)	3926 (55.1)	2209 (58.9)	1142 (56.1)	1585 (55.6)	802 (60.9)	2571 (63.2)
Non-preferred AP use (%)	1810 (25.4)	424 (11.3)	166 (8.2)	592 (20.8)	159 (12.1)	1062 (26.1)
Comorbidity scores (SD)						
CCI score	1.04 (1.5)	0.48 (0.9)	0.83 (1.3)	0.89 (1.3)	0.77 (1.2)	0.83 (1.3)
CDS	2.35 (2.8)	2.49 (2.7)	2.39 (2.9)	2.67 (2.9)	2.94 (3.1)	3.58 (3.1)
Elixhauser Index score	4.02 (3.2)	2.60 (2.1)	3.71 (2.9)	3.74 (2.9)	3.57 (2.88	3.43 (2.8)
Comorbidities						
Mental health comorbidities						
Depression	131 (29.9)	794 (21.2)	629 (30.9)	983 (34.5)	494 (37.5)	1559 (38.3)
Substance use disorder	2407 (33.8)	1329 (35.5)	656 (32.2)	1046 (36.7)	532 (40.4)	1332 (32.8)
Substance-induced psychotic behavior	95 (1.3)	43 (1.2)	29 (1.4)	28 (1.0)	14 (1.1)	18 (0.4)
Specific personality disorder	137 (1.9)	97 (2.6)	69 (3.4)	75 (2.6)	69 (5.2)	103 (2.5)
Borderline personality disorder	299 (4.2)	204 (5.4)	74 (3.6)	217 (7.6)	116 (8.8)	234 (5.8)
Post-traumatic stress disorder	961 (13.5)	907 (24.2)	246 (12.1)	527 (18.5)	370 (28.1)	645 (15.9)
Severe agitation	67 (0.9)	27 (0.7)	12 (0.6)	22 (0.8)	16 (1.2)	76 (1.9)
Dementia	185 (2.6)	33 (0.9)	46 (2.3)	52 (1.8)	18 (1.4)	57 (1.4)
Delirium	201 (2.8)	52 (1.4)	38 (1.9)	75 (2.6)	24 (1.8)	79 (1.9)
Systemic comorbidities						
Type 2 diabetes	1255 (17.6)	278 (7.4)	320 (15.7)	473 (16.6)	180 (13.7)	527 (13.0)
Other specified diabetes mellitus	53 (0.7)	7 (0.2)	18 (0.9)	34 (1.2)	15 (1.1)	34 (0.8)
Viral hepatitis	387 (5.4)	92 (2.5)	118 (5.8)	124 (4.4)	46 (3.5)	176 (4.3)
Constipation	629 (8.8)	191 (5.1)	175 (8.6)	195 (6.8)	81 (6.2)	345 (8.5)
Parkinson's disease	51 (0.7)	5 (0.13)	12 (0.6)	8 (0.3)	3 (0.2)	12 (0.3)
Chronic obstructive pulmonary disease	714 (10.0)	209 (5.6)	241 (11.8)	315 (11.1)	114 (8.7)	416 (10.2)
Chronic pain syndrome	413 (5.8)	149 (4.0)	114 (5.6)	87 (3.1)	69 (5.2)	217 (5.3)
Atrial fibrillation	185 (2.6)	29 (0.8)	50 (2.5)	58 (2.0)	16 (1.2)	75 (1.8)
Hypertension	2414 (33.9)	617 (16.5)	766 (37.6)	1014 (35.6)	373 (28.3)	1284 (31.6)
Coronary heart disease	387 (5.4)	58 (1.6)	133 (6.5)	182 (6.4)	54 (4.1)	185 (4.6)
Peripheral vascular disease	120 (1.7)	22 (0.6)	44 (2.2)	45 (1.6)	19 (1.4)	82 (2.0)

Abbreviations: AP, antipsychotic; CCI, Charlson Comorbidity Index; CDS, Chronic Disease Score.

rates of treatment discontinuation, and reduced overall quality of care. For instance, one study reported a 50% increase in the risk of mental health hospitalization following a missed prescription refill for individuals with schizophrenia.[25]

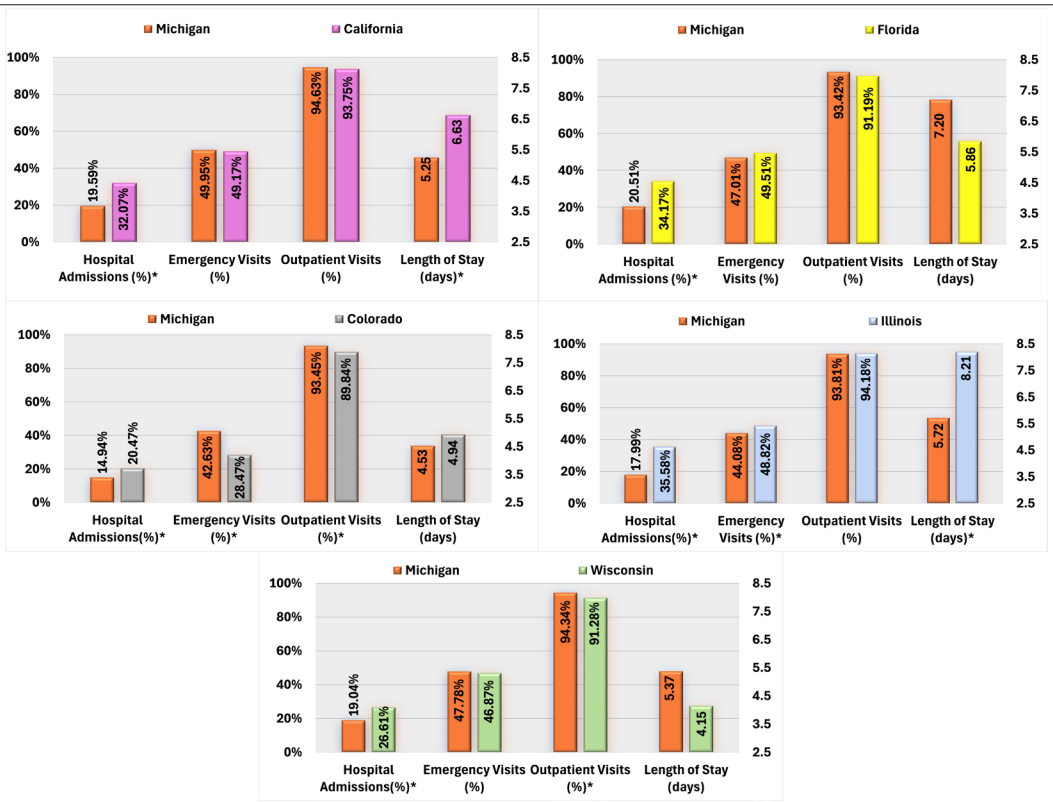
This study found that, following the implementation of formulary restrictions, California and Illinois experienced modest cost savings, while Colorado demonstrated no significant difference in pharmacy spending. These results align with previous research, which has consistently shown that formulary restrictions for APs lead to minimal reductions in pharmacy expenditures [26,27] or have no discernible impact on overall pharmacy costs,[16,28] yet also lead to more significant increases in HCRU and treatment discontinuation.[29] Our study showed that, even in states that experienced modest savings in pharmacy costs, these savings were outweighed by increased expenditures in inpatient, outpatient, and emergency care services.

Interestingly, the Colorado cohort had a significantly higher proportion of SMI-related inpatient costs, but not total SMI or all-cause costs compared with Michigan. While Colorado does not have OA policies for oral APs, all long-acting injectable APs are on the state's preferred drug list,[30] which may have led to some of the similarities between Colorado and Michigan. Administrative costs and the potential loss of additional rebates from manufacturers for branded medications due to non-OA formulary policies may further exacerbate the financial burden on states. From a global perspective, individual US states allocate a significantly larger portion of their health expenditures to administrative tasks than nearly any other country.[31]

Given the observational nature of this study, causality cannot be definitively established. Alternative explanations for cost and utilization differences may include variations in mental health provider availability, state-level mental health infrastructure, or other Medicaid-related policy differences not directly accounted for, such as differences in provider reimbursement rates.

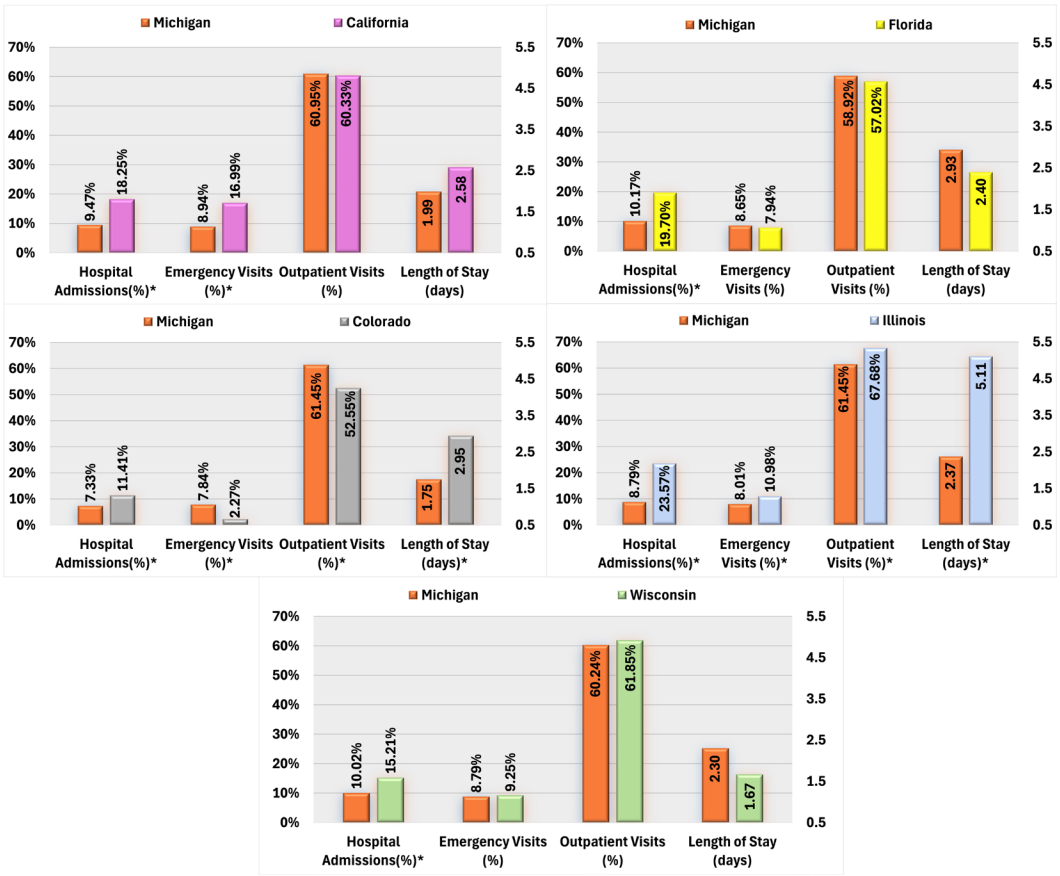
While open access to APs can reduce barriers to medication access and potentially improve outcomes, it is also important to consider potential unintended consequences. For instance, increased medication access might inadvertently lead to higher rates of off-label prescribing or polypharmacy, a common concern within Medicaid populations.[8,32]

Figure 1. PSM-Adjusted Comparison of All-Cause HCRU Among Medicaid Beneficiaries With SMI Using AP in Michigan vs California, Colorado, Florida, Illinois, and Wisconsin



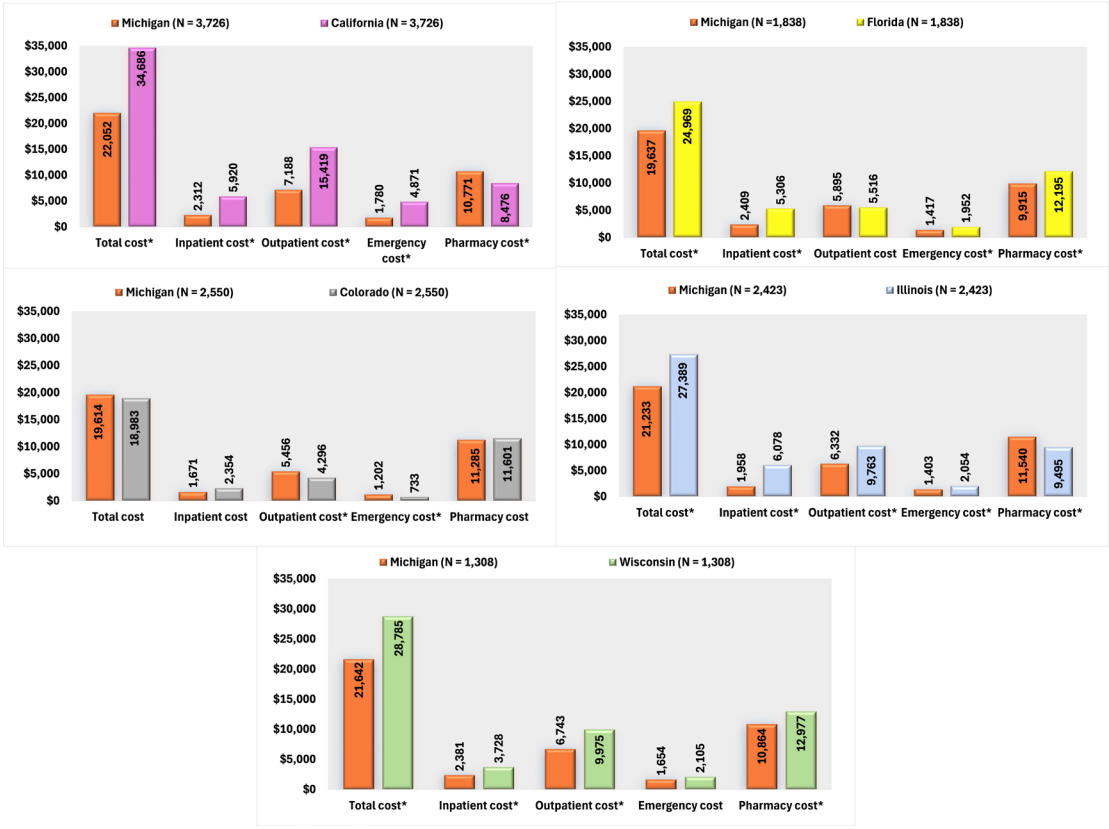
Abbreviations: AP, antipsychotic; HCRU, healthcare resource utilization; SMI serious mental illness.
*Significant at $P < .05$.

Figure 2. PSM-Adjusted Comparison of SMI-Related HCRU Among Medicaid Beneficiaries Using AP in Michigan vs California, Colorado, Florida, Illinois, and Wisconsin



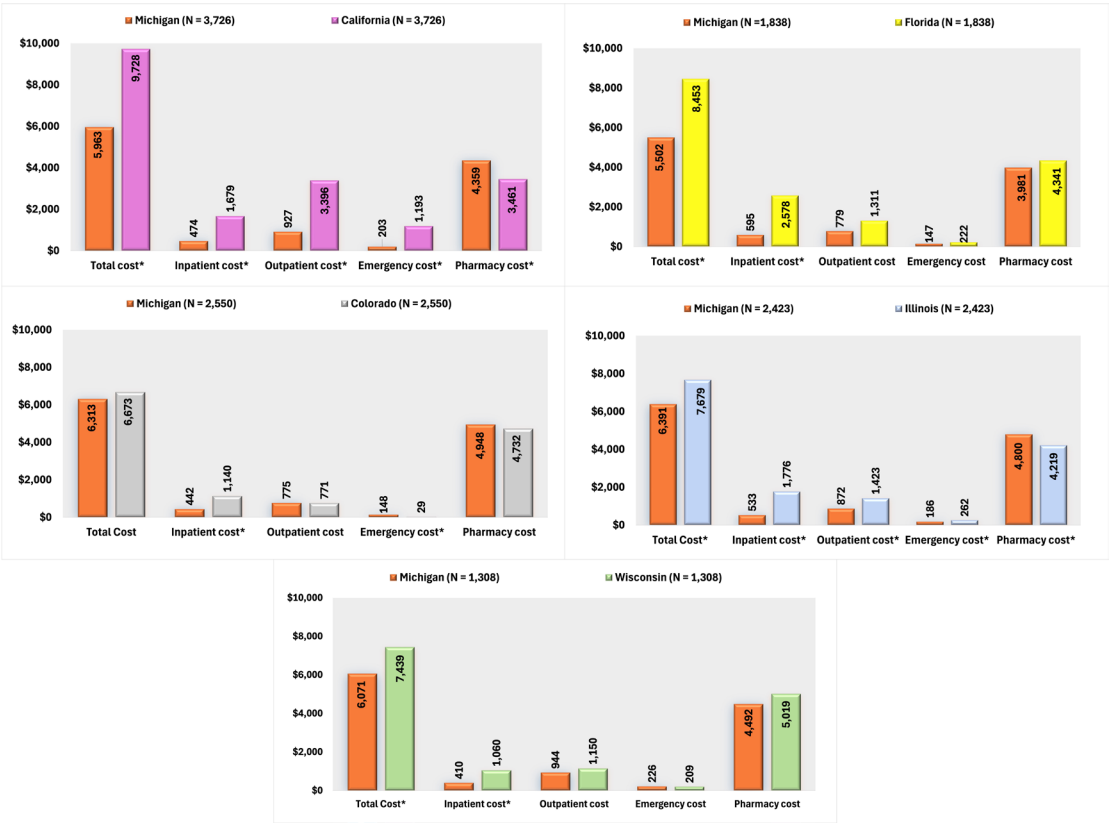
Abbreviations: AP, antipsychotic; SMI, serious mental illness.
*Significant at $P < .05$.

Figure 3. PSM-Adjusted All-Cause Costs Among Medicaid Beneficiaries With SMI Using AP in Michigan vs California, Colorado, Florida, Illinois, and Wisconsin



Abbreviations: AP, antipsychotic; SMI, serious mental illness.
*Significant at $P < .05$.

Figure 4. PSM-Adjusted SMI-Related Costs Among Medicaid Beneficiaries Using AP in Michigan vs California, Colorado, Florida, Illinois, and Wisconsin



Abbreviations: AP, antipsychotic; SMI, serious mental illness.
*Significant at $P < .05$.

Future research should investigate the prevalence and impact of these phenomena in states with OA policies.

Several factors could explain the relationship between worse patient outcomes and formulary restrictions. First, the substantial barriers imposed by these restrictions can hinder patients from acquiring their initially prescribed medications. The lack of transparency in frequently changing formularies and prior authorization requirements often leaves prescribing physicians uncertain about which treatment options will be filled without delays. When patients attempt to retrieve their prescribed medications at pharmacies, they may unexpectedly find that further steps must be taken by their physicians to secure health plan approval. This marks the beginning of an intricate process that entails interactions with health plans, initial denials, formal written appeals, and "peer-to-peer" discussions with adjudicators who may lack familiarity with the specific disease or the medication in question, and who may propose unsuitable alternatives. [33] According to one report, during this complex process of navigating formulary restrictions and prior authorization requirements, a staggering 37% of prescriptions that are initially rejected at the pharmacy are ultimately abandoned, never to be collected by the patients who need them.[34] Second, atypical APs are a well-differentiated class of medications with varying mechanisms of action and side effect profiles.[35] This variation necessitates personalized treatment plans to optimize efficacy and minimize adverse effects. Formulary restrictions that limit access to specific atypical APs can disrupt these personalized treatment plans. When patients are unable to access the most appropriate medication, they may experience suboptimal therapeutic outcomes, leading to increased rates of nonadherence and treatment discontinuation.

Limitations

This study has several limitations that should be considered when interpreting the results. First, potential administrative costs and rebates associated with implementing and managing formulary restrictions were not accounted for. These costs could offset some of the savings from reduced pharmaceutical expenditures in California and Illinois and should be considered in a comprehensive evaluation of the policy's impact. Second, the study considered the impact of formulary restrictions only on users of atypical APs. This focus excluded the potential broader effects of such restrictions on patients who might be deterred from initiating atypical AP therapy due to the restrictions. As a result, the study may underestimate the overall negative consequences of formulary restrictions. Third, the data used in this retrospective analysis were not nationally representative, which may limit the generalizability of the findings to other states or populations not included in the sample. The study focused on Medicaid beneficiaries from six states, and outcomes could potentially differ in states that were not part of the analysis. Fourth, the exclusion of dually eligible patients (eligible for both Medicare and Medicaid) could further limit the generalizability of the results. Dual-eligibility patients often have different healthcare needs and utilization patterns than those solely on Medicaid, which may influence the impact of formulary restrictions on healthcare outcomes and costs. Lastly, the analysis relied on claims data, which inherently have limitations such as potential inaccuracies in coding and the inability to capture all relevant clinical details. Claims data do not provide information on medication adherence or whether patients took the prescribed medications as directed, which could affect the observed outcomes.

Despite limitations, our claims data, which reflect the actual healthcare environment and capture real-world patient experiences and practices, encompass a vast cohort of patients using recent Medicaid data. This allowed us to effectively demonstrate the impact of formulary restrictions within the rapidly evolving landscape of atypical APs.

CONCLUSION

State Medicaid programs that do not implement OA policies for APs are associated with higher rates of SMI-related HCRU and costs than Michigan, which has such policies. Policymakers should consider whether combining OA policies with additional measures, such as care coordination programs or adherence monitoring interventions, might maximize benefits while mitigating risks. Future policy development should address not only the financial aspects but also the holistic management of patients with SMI to improve both economic and health outcomes.

Disclosures: H.C.W., D.H., and L.M. are employees of Otsuka; R.P. is a consultant to Otsuka. O.B. has no conflict of interest. K.R. is an employee of Columbia Data Analytics, which is a paid consultant to Otsuka. G.S. was an employee of Columbia Data Analytics at the time of the study.

Funding: This study was funded by Otsuka Pharmaceutical Development and Commercialization, Inc., Princeton, New Jersey.

REFERENCES

1. Rudowitz R, Garfield R, Hinton E. 10 things to know about Medicaid: setting the facts straight. Kaiser Family Foundation. Accessed August 2, 2024. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/
2. Tichy EM, Hoffman JM, Suda KJ, et al. National trends in prescription drug expenditures and projections for 2021. *Am J Health System Pharm*. 2021;78(14):1294-1308.
3. Sachs RE, Gavulic KA, Donohue JM, Dusetzina SB. Recent trends in Medicaid spending and use of drugs with US Food and Drug Administration accelerated approval. *JAMA Health Forum*. 2021:e213177-e213177.
4. Resneck JS. Refocusing medication prior authorization on its intended purpose. *JAMA*. 2020;323(8):703-704. doi:10.1001/*JAMA*.2019.21428
5. Vogt WB, Joyce G, Xia J, Dirani R, Wan G, Goldman DP. Medicaid cost control measures aimed at second-generation antipsychotics led to less use of all antipsychotics. *Health Affairs*. 2011;30(12):2346-2354.
6. Candon M, Shen S, Fadeyibi O, Smith JL, Rothbard A. Trends in antipsychotic prescribing for approved and unapproved indications to Medicaid-enrolled youth in Philadelphia, Pennsylvania between 2014 and 2018. *BMC Psychiatry*. 20211022 2021;21(1):524. doi:10.1186/s12888-021-03533-3
7. Illinois Medicaid Preferred Drug List. Effective October 1, 2023. Illinois Department of Healthcare and Family Services. Accessed January 11, 2023. https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/pdl10012023.pdf
8. Preferred Drug List (PDL). Effective October 1, 2023. Colorado Department of Health Care Policy and Financing. Accessed January 11, 2023. https://hcpf.colorado.gov/sites/hcpf/files/10-01-23%20PDL-V4.pdf
9. Medi-Cal Rx Contact Drug List. 01/01/2024. California Department of Health Care Services. Accessed Accessed January 11, 2023. https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdfCalifornia
10. Wisconsin Medicaid, BadgerCare Plus Standard, and SeniorCare Preferred Drug List – Quick Reference. Wisconsin Department of Health Services. Accessed September 6, 2024. https://www.

forwardhealth.wi.gov/wiportal/content/provider/medicaid/pharmacy/resources.htm.spage#

11. 2023 AMA prior authorization physician survey. American Medical Association. Accessed Accessed August 8, 2024. www.ama-assn.org/system/files/prior-authorization-survey.pdf
12. Electronic Prior Authorization. CoverMyMeds. Accessed August 7, 2024. https://insights.covermymeds.com/medication-access-report/2020/electronic-prior-authorization
13. Maidment I, Sud D, Chew-Graham C. Challenge of optimising medication in people with severe mental illness. *BMJ Quality Safety*. 2022;31(5):337. doi:10.1136/bmjqs-2021-013847
14. Carolan A, Keating D, Strawbridge J, Ryan C. Optimising prescribing for patients with severe mental illness: the need for criteria. *Evidence Based Mental Health*. 2019;22(4):139. doi:10.1136/ebmental-2019-300099
15. Bergeson JG, Worley K, Louder A, Ward M, Graham J. Retrospective database analysis of the impact of prior authorization for type 2 diabetes medications on health care costs in a Medicare Advantage Prescription Drug Plan population. *J Managed Care Pharm*. 2013;19(5):374-384.
16. Seabury SA, Goldman DP, Kalsekar I, Sheehan JJ, Laubmeier K, Lakdawalla DN. Formulary restrictions on atypical antipsychotics: impact on costs for patients with schizophrenia and bipolar disorder in Medicaid. *Am J Managed Care*. 2014;20(2):e52-60.
17. Medicaid and CHIP Payment and Access Commission. June 2021 report to Congress on Medicaid and CHIP. Washington (DC). Accessed August 7, 2024. https://www.macpac.gov/publication/june-2021-report-to-congress-on-medicaid-and-chip/
18. Gibbons JB, Cram P, Meiselbach MK, Anderson GF, Bai G. Comparison of social determinants of health in Medicaid vs commercial health plans. *Health Aff Sch*. 2023;1(6):qxad074.
19. Kythera Labs. Kythera Labs. Accessed July 29, 2024. https://www.kytheralabs.com
20. Baser O, Samayoa G, Yapar N, Baser E, Mete F. Use of open claims vs closed claims in health outcomes research. *J Health Econ Outcomes Res*. 2023;10(2):44.
21. Baser O, Isenman L, Baser S, Samayoa G. Impact of semaglutide on osteoarthritis risk in patients with obesity: a retrospective cohort study. *Obesity Sci Pract*. 2024;10(3):e762.
22. Baser O, Samayoa G, Rodchenko K, Isenman L, Baser E, Yapar N. The association between weight loss medications and cardiovascular complications. *Obesity*. 2024;32(7):1401-1409.
23. Rosenbaum PR, Rubin DB. The central role of the propensity score in observational studies for causal effects. *Biometrika*. 1983;70(1):41-55. doi:10.1093/biomet/70.1.41
24. Baser O. Too much ado about propensity score models? Comparing methods of propensity score matching. *Value Health*. 2006;9(6):377-385.
25. Glasheen WP, Cordier T, Gumpina R, Haugh G, Davis J, Renda A. Charlson Comorbidity Index: ICD-9 update and ICD-10 translation. *Am Health Drug Benefit*. 2019;12(4):188.
26. Putnam KG, Buist DS, Fishman P, et al. Chronic disease score as a predictor of hospitalization. *Epidemiology*. 2002;13(3):340-346.
27. Elixhauser A, Steiner C, Harris DR, Coffey RM. Comorbidity measures for use with administrative data. *Med Care*. 1998;36(1):8-27.
28. Zhang Y, Adams AS, Ross-Degnan D, Zhang F, Soumerai SB. Effects of prior authorization on medication discontinuation among Medicaid beneficiaries with bipolar disorder. *Psychiatr Serv*. 2009;60(4):520-527.
29. Soumerai SB, Zhang F, Ross-Degnan D, et al. Use of atypical antipsychotic drugs for schizophrenia in Maine Medicaid following a policy change. *Health Affairs*. 2008;27(suppl 1):w185-w195.
30. Law MR, Ross-Degnan D, Soumerai SB. Effect of prior authorization of second-generation antipsychotic agents on pharmacy utilization and reimbursements. *Psychiatric Serv*. 2008;59(5):540-546.
31. Frois C, O'Connell T, Pesa J, Fastenau J. The impact of Medicaid preferred drug lists on utilization and costs of antipsychotic medication. *J Health Econ Outcomes Res*. 2013;1(1):54.
32. Rajagopalan K, Hassan M, Boswell K, Sarnes E, Meyer K, Grossman F. Review of outcomes associated with restricted access to atypical antipsychotics. *Am J Manag Care*. 2016;22(6):e208-14.
33. Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. *JAMA*. 2018;319(10):1024-1039.
34. Radley DC, Finkelstein SN, Stafford RS. Off-label prescribing among office-based physicians. *Arch Intern Med*. 2006;166(9):1021-1026. doi:10.1001/archinte.166.9.1021
35. Feng X, Tan X, Riley B, Zheng T, Bias T, Sambamoorthi U. Polypharmacy and multimorbidity among Medicaid enrollees: a multistate analysis. *Popul Health Manag*. 20170706 2018;21(2):123-129. doi:10.1089/pop.2017.0065

Enacted Mental Health Open Access Laws

Last updated August 13, 2025

24 States with Laws Eliminating Prior Authorization (PA) and/or Step Therapy (ST) for Mental Health (MH) Drugs, Antipsychotics (APs), or Specific SMI Conditions

#	State	Category	Detailed Description	Citation
1.	AL	No PA for APs	Antipsychotics are exempt from the prior authorization requirement in the Medicaid pharmacy services; Part of annual budget.	Ala. Code 22-6-122
2.	AR	No ST for APs	The statute prohibits an insurance policy from "limit[ing] or exclud[ing] coverage under a health benefit plan for a drug . . . that is on the prescription drug formulary of the insurance policy by mandating that a covered person undergo step therapy if the insurance policy provides coverage for the treatment of (1) Psychosis and serious mental illness through antipsychotic prescription drugs."	Ark. Code § 23-99-1114(a)
3.	CO	No PA for APs	Antipsychotics are exempt from prior authorization if during the preceding three hundred sixty-five days, the adult was prescribed and unsuccessfully treated with an antipsychotic prescription drug that is included on the preferred drug list. Electronic attestation by the prescriber confirming trial and failure is required.	C.R.S. 25.5-5-517
4.	CT	No PA for MH drugs	Prior authorization not required for any mental-health-related drug filled or refilled, at least one time in prior one-year period.	Conn. Gen. Stat. 17b-274d
5.	DE	No PA for MH drugs	The Medicaid statute authorizing emergency access to certain mental health drugs mirrors the commercial statute, protecting drugs used to treat “serious mental illness,” defined as “any of the following biologically based mental illnesses: schizophrenia, biopolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo affective disorder, and delusional disorder.”	Del. Code Ann. tit. 31 § 525(b)

#	State	Category	Detailed Description	Citation
6.	FL	No PA for SZ medications	Prescriptions for the treatment of schizophrenia or schizotypal or delusional disorders are exempt from prior auth if drug was dispensed to patient in past 12 mos.	Fla. Stat. Ann. § 409.912
7.	GA	No PA for MH drugs	Prescriptions for mood disorders with psychotic symptoms, including, but not limited to, bipolar disorders, schizophrenia and schizotypal, or delusion disorders is exempt from prior authorization if prior use	Ga. Code § 49-4-152.6
8.	HI	No PA for APs	No restrictions or coverage limitations on antipsychotics	HI HRS_statutes_346-59-9
9.	KS	No PA for MH drugs	No requirements for prior authorization or other restrictions on medications used to treat mental illnesses may be imposed on Medicaid recipients	K.S.A. § 39-7-121 (b)
10.	LA	No PA if SZ	The statute prohibits the Department of Health from "restrict[ing] by prior authorization" a drug if "[t]he request is in accordance with federal requirements" and all of the following apply: 1. The patient is an adult, 2. The patient's prescribing practitioner determined that the drug is necessary for the treatment of schizophrenia and schizotypal or any delusion disorders, and 3. Either of the following conditions are met: o During the preceding year, the patient was prescribed and unsuccessfully treated with a preferred drug, or o The patient has previously been prescribed and obtained prior authorization for the nonpreferred prescription drug.	La. Stat. Ann. § 46:153.3(C)(2)
11.	ME	No PA for APs	Maine law requires a carrier to approve PA requests for drugs on the carrier's formulary that are prescribed to assess or treat serious mental illness. State law also requires a carrier to grant a step therapy override exception, effectively prohibiting step therapy, for drugs intended to assess or treat serious mental illness. Prior authorization and step therapy mental health protections apply to "carriers" defined in Me. Stat tit. 24-A § 4301-A(3) as: HMOs, PPOs, fraternal benefit society, multiple-employer welfare arrangement,	Me. Stat tit. 24-A § 4304(2-C)

#	State	Category	Detailed Description	Citation
			self-insured employer, and ACA plans (though ERISA employer plans are not subject to the requirements).	
12.	MI	No PA for MH drugs	Central nervous system drugs are exempt from prior auth in Medicaid FFS	MCL 400.109h
13.	MN	No PA for APs	Atypical antipsychotics for treatment of mental illness with no generic are exempt from prior authorization	Minn. Stat. § 256B.0625 (13f)
14.	MO	No PA for APs	No restriction to access shall be imposed on atypical antipsychotics for the treatment of schizophrenia, bipolar disorder, or psychosis associated with severe depression	Mo. Rev. Stat. § 208.227
15.	MT	No PA for long-acting injectable APs	The statute prohibits commercial plans from performing prior authorization on benefits for "any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic."	MCA § 33-32-211
16.	NC	No PA for MH drugs	"The Department shall provide immediate coverage under the Medicaid program of a new prescription medication approved by the Food and Drug Administration that becomes available to the public if (i) the manufacturer of that medication is enrolled in the federal Medicaid Drug Rebate Program and (ii) the medication is approved for the treatment of any of the following conditions, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders: (1) Bipolar disorders, hypomanic, manic, depressive, and mixed. (2) Childhood and adolescent depression. (3) Major depressive disorders, single episode or recurrent. (4) Obsessive-compulsive disorders. (5) Paranoid personality disorder and other psychotic disorders. (6) Schizo-affective disorders, bipolar or depressive. (7) Schizophrenia."	N.C.G.S.A § 108A-68.1B (eff. Oct. 3, 2023)
17.	ND	No PA for MH drugs	Antipsychotics, antidepressants & anticonvulsants are exempt from prior authorization for adults 21 years and older	N.D. Cent. Code §50-24.6-04
18.	NE	No PA for MH drugs	Antidepressant, antipsychotic & anticonvulsant prescriptions are exempt from PA if prior use or prescriber documents	Neb. Rev. Stat. § 68-955
19.	NM	No PA for MH drugs	No prior authorization if a prescriber "[C]ertifies medical necessity in writing by noting 'brand medically necessary' or 'brand	N.M. Stat. Ann. § 59A-46-57

#	State	Category	Detailed Description	Citation
			necessary' on the prescription," and "[M]aintains supporting documentation in the Member's medical record indicating that a generic or alternative medication does not meet the therapeutic needs of the Member."	
20.	NV	No PA for APs	No prior authorization for any typical or atypical antipsychotic medication that is not on the list of preferred prescription drugs upon the demonstrated therapeutic failure of one drug on that list to adequately treat the condition of a recipient of Medicaid. No prior authorization or step therapy for antipsychotics prescribed to treat a psychiatric condition of a recipient of Medicaid, if prescribed by a psychiatrist, a physician assistant under the supervision of a psychiatrist, or an advanced practice registered nurse who has psychiatric training.	NRS 422.4025 and NRS 422.403
21.	OH	No PA for APs	Psychiatrists, NPs, and CNSs are granted prior authorization exemptions for atypical antipsychotics & antidepressants	ORC 5167.12
22.	OR	No PA for MH drugs	Prohibits prior authorization for mental health medications	OR Chp 544, Oregon Laws 2019
23.	TX	No PA for APs	Prior authorization not required for antipsychotic with 14-day trial and failure, or previous prior authorization granted	Tex. Govt. Code 531.073 (a-3)
24.	UT	No PA for APs	Non-preferred psychotropic medication classes listed on the preferred drug list may bypass the non-preferred drug prior authorization if a prescriber writes "dispense as written" on a prescription	Utah Code 26-18-2.4

Provide Workgroup Recommendations

(FY2020 Appropriation Act - Public Act 67 of 2019)

March 1, 2020

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

FACILITATOR

Debra A. Pinals, MD
Medical Director, Behavioral Health and Forensic Programs
MI Department of Health and Human Services

PHARMACISTS

Santreis Cook, PharmD, BCGP
Strategic Clinical Pharmacist Consultant
Magellan Rx Management

Farah Jalloul, PharmD, MBA
State Pharmacy Emergency Preparedness Coordinator
Michigan Pharmacists Association

PHYSICIANS

Scott Monteith, MD
Past President, Michigan Psychiatric Society
Regional Medical Director, Michigan/Beacon Health Options

Angela Pinheiro, MD, JD
Medical Director, Community Mental Health for Central Michigan
Immediate Past President, Michigan Psychiatric Society

Jeanette Scheid, MD, PhD
Child & Adolescent Psychiatry
DHHS Consultant, Children's Services Agency Child Welfare Medical Unit

Jilian Danitz, DO
Child & Adolescent Psychiatry
Community Mental Health for Central Michigan

Jennifer Stanley, MD
Psychiatrist serving on the Medicaid DUR Board
Medical Director, 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
Consultant, Mental Health Association in Michigan
Member, Behavioral Health Advisory Council

Meetings
(In Person/Teleconference)

1. *When:* **Friday, January 31, 2020**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

Current Recommendations

The Psychotropics Best Practices Workgroup reconvened on January 31, 2020. The workgroup performed a comprehensive review of the prior year report and had no change to its recommendations. **The FY2019 report is attached for reference—See Attachment A.**

Attachment A

Report Authorization
Public Act No. 207 of 2018, Sec. 1867

(1) The department shall continue 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.

Michigan Department of Health and Human Services

Psychotropic Best Practices Workgroup

FACILITATOR

Debra A. Pinals, MD
Medical Director, Behavioral Health and Forensic Programs
MI Department of Health and Human Services

PHARMACISTS

Crystal Henderson, PharmD, BCPP
Senior Director, Behavioral Health Pharmacy Solutions
Magellan Rx Management

Eric Liu, PharmD, MBA
Director of Professional Affairs
Michigan Pharmacists Association

PHYSICIANS

Scott Monteith, MD
Immediate Past President
Michigan Psychiatric Society

Angela Pinheiro, MD, JD
Medical Director
Community Mental Health for Central Michigan
President
Michigan Psychiatric Society

Jeanette Scheid, MD, PhD
Child & Adolescent Psychiatry
DHHS Contractor and Consultant
Foster Care Psychotropic Medication Oversight Unit

Jilian Danitz, DO
Child & Adolescent Psychiatry
DHHS Contractor & Consultant
Foster Care Psychotropic Medication Oversight Unit

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 in an 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

---

[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 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 in 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

[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, MDHHS 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.

for Medicaid adult and child members and identified prescribing patterns that did not follow accepted evidence-based treatment guidelines.

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 & 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 take into account best

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

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 workgroup believes steps can be taken to reduce costs, it was the consensus of the workgroup that the first 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 that 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 FY-17). 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% of MDHHS carveout claims, they represent only 62% of costs across all carveout products. The 1% of carveout claims for non-psychotropics now account for 38% of all MDHHS 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% 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 MDHHS 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 Department's 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.

[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

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 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 Department 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 that will help decrease the need for State funds. The workgroup supports exploration of the Department's 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

[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/

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