Nevada White Paper on Medicaid Drug Benefit
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Executive Summary

Though Nevada has a history of protecting access to medications and care services for Medicaid clients living with mental illness, epilepsy, and other serious chronic conditions, those protections have eroded significantly over time. The increased penetration of managed care within the Medicaid program and lack of consistency in coverage for medicines between managed care companies and the state fee for service program make access to stable coverage for medications extremely difficult, place a significant added burden on providers navigating different formularies and access restrictions, and leave patients vulnerable to the consequences of poor management of their conditions. Costs to the state accrue both within the medical system from avoidable increased utilization and outside the medical system from added costs of homelessness, incarceration, educational needs, and unemployment. These challenges will grow with the expansion of the Medicaid population in Nevada.

The vast majority of states have patient protections in place within Medicaid to facilitate open access to medications for certain serious chronic conditions, including epilepsy and mental illness. Nevada’s erosion of such protections has resulted in the state’s consistent ranking at or near the bottom of surveys on access to care for people living with mental illness and epilepsy compared to the rest of the nation. The most recent Request for Proposals for managed care plans for Nevada Medicaid recognizes these shortfalls and includes recommendations to address these problems. More is needed, however, to improve access for Nevada’s most vulnerable citizens, reduce overall costs of mental illness and epilepsy to the state, and lessen the burden of poor health to the people served by Medicaid.

This white paper examines the burden the current system places on patients, providers, and the state; explores how other state Medicaid programs address these issues; and includes options for how Nevada can, as the Request for Proposals states, balance purchasing and providing “quality health care services to low-income Nevadans...at an affordable cost to the taxpayers of Nevada.”1
Introduction

Nevada Medicaid has a history of protecting access to medications for some of the state’s most vulnerable citizens, including those living with neurological conditions, like mental illness and epilepsy and seizure disorders. These protections derive from widely accepted clinical recommendations that people living with these conditions need access to a broad range of treatment options to manage their health. Prior to June 2010, Nevada law required the Department of Health and Human Services to develop a list of preferred prescription medicines for use in the Medicaid program. The law provided patient protections by excluding certain classes of medicines from access restrictions imposed on the list of preferred medicines overall. Those protected classes included certain antipsychotics, anticonvulsants, immunosuppressants (antirejection medications for organ transplants), antidiabetics, antihemophilic medications, and medications to treat HIV or AIDS. During the economic recession, Nevada passed Senate Bill 4 in June 2010, which suspended existing protections for access for antipsychotic, anticonvulsant, and antidiabetic medications. Although the law was scheduled to sunset on June 30, 2011, the suspension remains in place.

In the meantime, managed care penetration has grown and exacerbated access issues for medicines, particularly when comparing fee for service coverage and managed care coverage. Specifically, compared to fee for service coverage and each other, the managed care organizations deploy limited formularies, fail first policies, and prior authorization processes, placing substantial obstacles in front of particularly vulnerable enrollees and adding administrative burdens for prescribers.

Medicaid expansion and the transitory nature of income-based eligibility means that people will transition between Medicaid and health exchange coverage, may transition between fee for service Medicaid and managed Medicaid, and even between managed Medicaid plans, making continuity of care a significant challenge. Access issues are exacerbated by the high prevalence of new Medicaid enrollees with a mental illness.
Care transitions for these populations also occur between hospitalizations, other in-patient or residential care facilities, and the corrections system, adding to the need for continuity of care and maintaining clinical control of health. Stability of health status is particularly critical for people with living with mental illness and seizure disorders.

Though federal law establishes minimum standards for Medicaid coverage, each state’s Medicaid program is a unique mix of eligibility requirements, financing mechanisms (fee for service, managed care, and combinations), and covered benefits. Like the vast majority of Medicaid programs across the U.S., Nevada Medicaid sets minimum requirements for Medicaid coverage and carves out certain coverage from managed care contracts to be paid directly and exclusively by the state.

Nevada’s Request for Proposals (RFP) for Medicaid managed care plans released July 2016 includes several coverage “carve-out” examples and language encouraging better access to medicines to match that provided in the fee for service program.

Though not mandatory, the language is a clear recognition of the need to improve the continuity of coverage for medicines between programs and the shortfalls in the existing system as noted by patient advocates in the community.
Like their colleagues across the U.S., policymakers in Nevada regularly revisit its Medicaid program to ensure it balances the need to be good stewards of public funds while meeting the healthcare needs of its most vulnerable citizens. Although part of the Nevada Division of Health Care Financing and Policy’s (DHCFP) mission is to “promote equal access to health care at an affordable cost to the taxpayers,” many in the patient community have raised concerns that variations in coverage, particularly relating to access to medication therapies for mental health and epilepsy, create unequal access that compromises patient health.\(^7\)

Medicaid expansion under the Affordable Care Act has increased Medicaid rolls significantly in Nevada, raising the total lives covered under Nevada Medicaid to 614,054 as of March 2016 and providing access to regular coverage for the first time to many. In light of existing challenges with Nevada Medicaid, patient advocates have raised serious questions requiring careful consideration on how well equipped the current system, particularly managed care, is to meet the health needs of this population.\(^8\)

Given the significant changes the Nevada Medicaid program faces in terms of an influx of new entrants, access issues within the program, and the opportunities for improving health and lowering state costs, now is an ideal time to revisit policies relating to medication access, particularly for serious chronic conditions associated with significant medical and non-medical costs. This white paper examines different benefit control and financing mechanisms that states currently employ for Medicaid pharmacy benefits and considers the advantages and downfalls of each.
Burden of Mental Illness and Epilepsy in Nevada

Mental Illness in Nevada
In any discussion on managing costs, it is important to recognize that:

Medicaid spending is highly concentrated with 5 percent of enrollees accounting for almost half of spending.9

Within Nevada's top Medicaid-only utilizers, 65 percent – or nearly two out of three “super-utilizers” – had a mental health condition.10 Overall, almost 4 percent of the adult population in Nevada – about 91,000 people - experienced serious mental illness in a year.11 Depression is the third most prevalent condition for women and the suicide rate in Nevada is nearly double the national average.12 Every year, about 20,000 adolescents (ages 12-17) in Nevada experience a major depressive episode.13 Mental health comorbidities are common for people with chronic conditions, which contribute to lower health outcomes and higher costs when poorly managed. For example, people with type-2 diabetes have a one-in-four chance of having depression, and depression affects as many as 70 percent of people with diabetic complications.14

Across all enrollee age groups, total Medicaid spending nationally was nearly $10,000 more for enrollees with a behavioral health condition than for enrollees with no behavioral health condition.15 The top three spending categories for Nevada’s Medicaid super-utilizers were: hospital care (25%), acute care services (22%), and other support services (20%).16 Nationally, for children covered by Medicaid, mental and behavioral health disorders accounted for the second highest share of hospital admissions and the highest readmission rate.17

According to a 2014 national survey of psychiatrists:

• More than half cited formulary restrictions, prior authorizations, and fail first policies as the most frequent barriers to access to medicines for their patients;
• Three out of four reported that limited medication access resulted in patients having lower medication compliance and suboptimal health outcomes; and
• Sixty-two percent said patients experienced increased emergency department visits, hospitalizations, and healthcare costs from poor access to medicines.18

Of new nursing home admissions in Nevada, 2.9 percent involved a schizophrenia or bipolar diagnosis.19 Nursing home admissions involving mental illnesses other than dementia were also more than twice as likely to involve a long-term stay of more
than ninety days. In Nevada, nearly half of those admitted with a mental illness stayed longer than ninety days.\textsuperscript{20}

Costs to the state extend well beyond the medical expenses involved and, accordingly, accrue outside of Medicaid. These larger potential costs are important considerations in designing and implementing Medicaid coverage, particularly since managed care companies do not bear these expenses.

\textbf{In Nevada, there are 9.8 times more people with a serious mental illness in jail or prison than in a hospital, meaning that a Nevadan with serious mental illness is almost 10 times more likely to be incarcerated than hospitalized.}\textsuperscript{21}

The average annual cost per prisoner in Nevada was $20,656 in 2012.\textsuperscript{22} While long-term institutional care in any setting is highly undesirable, the costs associated with criminal justice involvement are more than just financial. Prisoners with serious mental illness have higher rates of misconduct and accidents while incarcerated, serve longer sentences and have higher recidivism rates than those without mental illness.\textsuperscript{23}

Mental health issues affect the juvenile justice system at even higher rates. Nationally, 70 percent of youth in juvenile justice systems have at least one mental health condition and one in five live with a serious mental illness.\textsuperscript{24} The cost of one year of incarceration for youth in Nevada’s most expensive correctional facility was more than $195,000 in 2014.\textsuperscript{25} According to the National Association of Counties suspension rather than termination of Medicaid benefits for inmates is a key cost saver although Nevada currently chooses termination.

Mental illnesses have become the only chronic conditions that, as a matter of public policy, are not treated until stage 4, and even then often only through incarceration.\textsuperscript{26} Owing to lack of access, many states have increasingly relied on court orders for treatment.\textsuperscript{27} Nevada instituted Assisted Outpatient Treatment, a program enabling court-ordered treatment.\textsuperscript{28} For the limited number of people who meet that criteria, the success of mental health treatment depends upon access to qualified mental health providers, finding treatment that works for the individual, and having stable coverage and access to that treatment. Even with such a program in place, only a small percentage of those in need, including super-utilizers, would be reached.

Other costs are associated with the immediate and long-term consequences of mental illness among youth, particularly those with lower income status served by Medicaid. Over half of lifetime mental health conditions begin in childhood or adolescence. For example, though inmates have a high prevalence of depression and other mental health conditions, research shows that some of the most common psychiatric disorders among former inmates emerge during childhood and adolescence, and therefore, predate incarceration.\textsuperscript{29} Almost four-in-ten students
(ages 14-21) with a mental health condition served by special education drop out of school, increasing the likelihood of unemployment and marking the beginning of what is known as the school-to-prison pipeline. Adolescent girls who have lower incomes and are experiencing long-term psychological stress have a higher risk of teenage childbearing and are more likely to have long-term patterns of psychological distress, including depression. Research on mental health issues among children in foster care found a higher prevalence of behavioral health conditions both near- and long-term. For example, foster children ages 14-17 experienced general anxiety disorder and major depressive disorder at more than and nearly twice the rate as their peers.

**Epilepsy and Seizure Disorders in Nevada**

For people living with epilepsy and other seizure disorders, finding and adhering to a treatment regimen that controls seizures with minimal side effects can have a profound effect on their ability to work, attend school, drive a car, and otherwise maintain their independence. A seizure can mean the difference between being able to drive and losing driving privileges, which in a predominantly rural state like Nevada without many public transportation options seriously limits employment opportunities and independence. In general, the unemployment rate for people with epilepsy is two to three times higher than that of the population overall.

According to the Institute of Medicine, 1 in 26 – or more than 110,000 Nevadans – will develop epilepsy at some time in their lives. More than four million adults have had a diagnosis of epilepsy or seizure disorder nationally. Within Medicaid and the State Children’s Health Program, 1.1 percent of children report currently having epilepsy or seizure disorder. Epilepsy and other seizure disorders are highly heterogeneous, with many different types of seizures, causes, and treatments. Determining the appropriate anti-convulsant medication to achieve seizure control involves a number of factors, including the type and frequency of seizures, age, gender, tolerance of side effects, interactions with other treatments, and other health-related variables. These medications are not interchangeable and individuals often respond differently to available treatments. Even differences in the therapeutic range allowed between brand and generic medications with the same active ingredients have been linked to breakthrough seizures. Side effects may affect people’s ability to adhere to treatment, making access to the full range of treatments available particularly important. The RANSOM study, a study of nonadherence and outcomes for people with epilepsy, followed more than 30,000 patients over a five-year period.

**Nonadherence to seizure medication was associated with higher rates of serious clinical consequences, including:**

- Fifty percent higher incidence of Emergency Department visits;
- Eighty-six percent higher incidence of hospitalizations;
- Significantly higher incidence of fractures and motor vehicle accidents; and
• **Three-hundred percent higher increase in risk of death.**

Recognizing the risks, the American Academy of Neurology (AAN) has developed evidence-based clinical guidelines and policy statements that strongly support prescriber autonomy in determining the appropriate use of anti-convulsants for people with epilepsy.\textsuperscript{39} The Epilepsy Foundation also opposes policies that hinder access to treatment, including prior authorization, step therapy and fail-first policies for people with epilepsy.\textsuperscript{40}

## Health Economic Outcome Research

There is a large and growing body of evidence showing that restrictions on access to medicines to treat serious mental illness and epilepsy may lead to negative clinical, economic, and societal consequences, including treatment nonadherence and discontinuation, increased emergency room (ER) visits and hospitalizations, increased total medical costs, and increased rates of incarceration – all while having little or no impact on pharmacy costs.\textsuperscript{41}

West et al. found that Medicaid patients with treatment access barriers 3.6 times higher likelihood of experiencing adverse events, including ER visits, hospitalizations, homelessness, and incarceration. And, state drug formulary policies, including PAs, ST, and PDLs, were significant contributors to access issues.\textsuperscript{42}

![Graph: Association Between Treatment Access Problems and Adverse Events](image)

*Source: West, Medicaid prescription drug policies and access (2009).*

Seabury et al. conducted a retrospective analysis of medical and pharmacy claims data across 24 state Medicaid programs.\textsuperscript{43} Compared to states without formulary restrictions on Atypical Antipsychotics, patients with schizophrenia and bipolar disorder in states with formulary restrictions were 13.4 percent and 7.3 percent more likely to be hospitalized, respectively. Patients in states with formulary restrictions also had higher total medical costs and lower adherence rates. And, notably, formulary restrictions were not associated with any significant pharmacy cost savings.
From a broader societal perspective, Seabury et al. also estimated that restrictive formulary policies increase the overall prison population by 2 percent, due to more mentally ill patients being arrested, thereby increasing the number of prisoners by nearly 10,000 and incarceration rates costs by over $350 million nationwide in 2008. Applying these estimates to Nevada specifically, formulary restrictions on AAPs would have increased the number of prisoners by over 250 and incarceration costs by over $9.6 million in 2008.

Finally, Rajagopalan et al. recently conducted a literature review of fifteen studies that analyzed the impact of formulary restrictions to AAPs among patients with schizophrenia and bipolar disorder. Findings were highly consistent across the studies, indicating that restricted access was associated with unintended negative consequences including increased treatment discontinuation and nonadherence, increased healthcare utilization, increased total healthcare costs, and increased administrative costs. Rajagopalan et al. concluded that any initial pharmacy cost savings from formulary restrictions were likely shifted to other parts of the healthcare system.

An extensive body of research also shows that formulary restrictions on anticonvulsants or antiepileptic drugs (AEDs) cause a multitude of medical problems and are inconsistent with recommendations from established epilepsy organizations. The American Epilepsy Society (AES) Position Statement on Access to Epilepsy Care emphasizes that “people with epilepsy must have access to and insurance coverage for all AEDs in all their formulations without formulary restrictions.”

Consistent with these recommendations, Labiner and Drake recently published an independent article on the impact of formulary restrictions for patients with epilepsy. These epilepsy experts clearly indicate that “formularies must include all access to all AEDs, both generic and branded, in order to improve seizure control and quality of life.” The article further highlights a landmark study showing that 53 percent of patients with epilepsy do not respond to their initial AED and over 30 percent of patients have refractory seizures. Thus, many patients require switching to a different medication, or a combination of medications, due to side
effects or a lack of efficacy. The experts emphasize that only an “unrestricted formulary” makes this switching and augmentation process possible, as it assures availability of the widest variety of AEDs to help obtain seizure freedom as quickly as possible.\textsuperscript{50}

A growing body of HEOR evidence also suggests that formulary restrictions on AEDs may have negative clinical and economic consequences, including increased healthcare resource utilization and total healthcare costs.

Divino et al. conducted a retrospective study of 462 patients with epilepsy to assess the economic impact of delaying a switch or adjunctive therapy regimen in the six months following a first-line treatment failure.\textsuperscript{51} Findings showed that patients who delayed initiation of second-line treatment had higher all-cause and epilepsy-related medical costs, which were not offset by pharmacy cost savings. Thus, potential barriers to accessing AED treatment, such as PA or ST, may result in significant negative clinical and total healthcare cost outcomes.

Luciano et al. conducted a study of 155 patients with uncontrolled chronic epilepsy to examine the effect of adding a new (previously unused) AED to their existing treatment regimen.\textsuperscript{52} By the end of the study, nearly one-third of patients were rendered seizure free by the introduction of one or more new AEDs. Applying a previously estimated cost of $381 per seizure avoided to those findings, the annual
cost savings for a patient who became seizure free would be $27,579.\textsuperscript{53} Taken together, these findings highlight the clinical and economic importance of unrestricted access to AEDs.

Finally, the Epilepsy Foundation recently published an article titled “Access to Newer AEDs and Specialists Are Key to Seizure Control”, and this article highlights findings from a real-world health outcomes study with policy implications related to restricting access to newer AEDs.\textsuperscript{54} Specifically, Faught et al. conducted retrospective claims analyses of Medicaid and commercial databases and found that patients taking at least one second-generation AED reduced their risk of hospitalization due to epilepsy complications by 31 percent compared to those taking a first-generation AED.\textsuperscript{55} In addition, patients who had their medication regimen modified following their hospital stay were less likely to experience seizure-related complications that led to readmission, especially when they were switched from a first-generation AED to a second-generation AED.

And, as a companion to the Faught et al. publication, the Epilepsy Foundation released state-by-state scorecards for discussions with state policymakers about the value of meaningful access to care.\textsuperscript{56} Notably, Nevada received a “C” for “relative utilization of newer AEDs” and an “F” for “access to neurologists,” highlighting substantial access challenges that exist for patients with epilepsy in Nevada. These challenges would likely worsen if MCOs were allowed to develop and implement PDLs at the local plan level. In fact, the Nevada scorecard also outlines specific steps the state can take to protect and improve access to new AEDs, including limiting the use of “fail-first” policies, such as prior authorization and step therapy, and limiting high cost-sharing policies (e.g., co-payments and deductibles).
## Nevada Medicaid Drug Benefit Coverage

Nevada currently administers both fee for service benefits and contracts with two managed care companies, HPN SmartChoice and Amerigroup, for Medicaid coverage. Unlike most states, Nevada Medicaid does not mandate access or require patient access protections based on a disease state or medication class other than requiring access to all over-the-counter and prescription treatments for smoking cessation regardless of coverage type. As a result, Nevada Medicaid enrollees are subject to three different drug formularies – fee for service, HPN Smartchoice, and Amerigroup – each of which has different restrictions on access, including “fail first” policies and prior authorization requirements.57

Typically, new Medicaid enrollees are enrolled in fee for service Medicaid for a few months and then must choose or are assigned to a managed care plan, if they live in Clark or Washoe County and are not exempted by law.58 Accordingly, three patients with serious mental illness, for example, who start on a covered brand medicine in fee for service that is not a preferred medicine under managed care would have three very different experiences:

<table>
<thead>
<tr>
<th>Remains in fee for service</th>
<th>Transferred to MCO A</th>
<th>Transferred to MCO B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient stabilized on Medication 1</td>
<td>No coverage for Medication 1</td>
<td>No coverage for Medication 1</td>
</tr>
<tr>
<td></td>
<td>Switched to preferred Medication 2 (typically a generic)</td>
<td>Switched to preferred Medication 2</td>
</tr>
<tr>
<td>Month 2-3: Fails Medication 2</td>
<td>Month 2-3: Fails preferred Medication 2</td>
<td></td>
</tr>
<tr>
<td>Month 3: Switched to preferred Medication 3 (typically a generic)</td>
<td>Month 3: Doctor files prior authorization paperwork noting failure of Medication 2 and requesting access to Medication 1</td>
<td></td>
</tr>
<tr>
<td>Month 3-4: Fails Medication 3</td>
<td>Month 4: If approved, patient restarts Medication 1</td>
<td></td>
</tr>
<tr>
<td>Month 4: Doctor must file prior authorization paperwork; must share medical records documenting two failures and request coverage for Medication 1</td>
<td>Month 5: Patient stabilized on Medication 1</td>
<td></td>
</tr>
<tr>
<td>Month 5: If approved, patient restarts Medication 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 6: Patient stabilized on Medication 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table describes highly optimistic scenarios assuming continuity in both access to and use of provider, self-advocacy on the part of the patient with serious mental illness to pursue treatment, and access to medical records showing medication failures. The table also does not include interruptions and costs associated with Emergency Room visits, hospitalizations, incarceration, or other care settings, which
a ten state Medicaid study shows is almost four times more likely to happen with prior authorization policies for access to these medicines.59 For these reasons and others:

**Mental Health America calls “fail-first” or step therapy requirements “inherently objectionable in that they restrict access to medically necessary medications.”**60

Access also depends on provider knowledge of the different policies and documentation required, availability of medical records, and provider capacity and willingness to pursue approval.

**Access barriers in Nevada have resulted in the state receiving poor scores in independent rankings on mental healthcare (ranked 49th overall and 51st on access in 2014) and epilepsy care (rated “C” on access to newer medicines and “F” on access to neurologists).**61
Medicaid Access Protections in Other States

The vast majority of states provide patient access protections to medications, regardless of financing model. Nevada Medicaid is one of only 11 states nationwide that does not protect patient access, either through use of a statewide, universal formulary and/or by requiring coverage to commonly protected classes of medicines (GA, IL, KY, MA, NV, NM, PA, RI, SC, VA, WI). Even some of these states employ certain access protections for the atypical antipsychotic (AAP) and anticonvulsant (AED) medication classes. Overall, the majority of states (28), regardless of managed care penetration, have at least a common formulary that applies across the state Medicaid programs regardless of the state’s financing model.

Twelve states operate under a fee for service model (AL, AK, AR, CT, ID, ME, MT, NC, OK, SD, VT, WY). In these states, there is one Preferred Drug List that is set by the state for all Medicaid patients. Many contract with Pharmacy Benefit Administrators to help administer the drug benefit. Two of these states, Connecticut and Montana, recently transitioned back to fee for service after trying managed care, because of concerns that quality standards were not met. As a March 18, 2016 Wall Street Journal article relates, since Connecticut made the switch to “managed fee for service” in 2012, the average cost per patient per month dropped from $718 to $670, doctor participation increased by 7 percent and administration costs fell from 12 percent to 5 percent. Legislation has passed in Alabama and North Carolina to move to a managed Medicaid model, but both states will require that managed care organizations follow a single universal formulary.

Among the thirty-nine states (including D.C.) with Medicaid managed care, nearly all elect to exclude or “carve-out” certain services from the MCO contracts. Many, for example, carve-out all or some behavioral health-related services.
Some states also explicitly exclude certain beneficiaries from participating in traditional MCOs or allow them to opt out, including Aged, Blind, and Disabled enrollees, those with serious mental illness, or those requiring long-term care services. In 2015, Arizona and New York joined Florida in carving out individuals with serious mental illness (SMI) from traditional MCO contracts. Arizona and New York are instead implementing specialized, integrated behavioral and physical health plans for people with SMI.67 Nevada, by contrast, does not allow people receiving services in an Intermediate Care Facility for Individuals with Intellectual Disabilities to receive managed care coverage and allows people who have been diagnosed with a Severe Mental Illness (SMI) to opt out of Managed Care.68

Most Medicaid managed care states (33 out of the 39) include or “carve-in” most of their pharmaceutical benefits for the populations covered by their managed care contracts. Some of these states have carve-outs for certain drug classes, such as drugs to treat HIV/AIDS, hepatitis C, and mental health conditions. Three states Iowa, Missouri, and Nebraska carve-out pharmacy benefits entirely, delivering those benefits on a fee for service basis. Additionally, Tennessee reported that all drugs, except for certain physician-administered medications, are carved-out and delivered through a contracted pharmacy benefit manager. Two states, Indiana and Wisconsin, reported that pharmacy benefits are carved-in under certain managed care programs, but carved-out for others.

Overall, the vast majority of managed care states include patient protections for medication access.

• Fourteen MCO states require use of a common, statewide formulary seen as a floor to benefits. The terms vary as to whether the state or the MCO pays for medications (AZ, CO, DE, IA, FL, KS, LA, MI, MN, MS, NH, TX, VT, WV). Of these states, at least four (AZ, LA, MN, NH) expressly encourage MCO plans to contract directly with providers and pharmaceutical manufacturers to enhance their benefits and view the common formulary as the minimum
required. Nevada has included similar language to encourage use of the fee for service formulary in the Medicaid RFP issued July 1, 2016, although the language is permissive, not mandatory. In addition, many of the states choose to pay for certain medications out of fee for service as a way of managing capitation rates.

- Eleven states allow some independence in formulary development, but include state protections and oversight to assure patient access. Those protections include state approval of formulary; mandates on certain classes of medications through carve-outs, open access requirements, and other payment/coverage arrangements for certain protected classes of medications; and/or prescriber prevails legislation that streamlines the access process (CA, DC, HI, IN, MD, NJ, NY, OH, OR, UT, WA). For example, in California, Ohio, and Washington, the state must approve the formulary and requires it to be comparable to the state fee for service formulary. In Ohio, the MCO’s formulary must be at least 80 percent consistent. The most common requirement is the coverage of certain classes of medications. In Maryland, Oregon and Utah, the state mandates open access for all mental health medications (atypical antipsychotics, antidepressants, and anti-convulsants) and pays for these medications through their fee for service program.

- Eleven states allow managed care full control over the drug benefit (IL, KY, MA, ND, NV, NM, PA, RI, SC, VA, WI). The health plans set formularies, prescribing guidelines, and cost containment measures. North Dakota does this only for their Medicaid expansion population. Notably, the majority of these states rank in the bottom half of the nation in patient advocacy rankings for access to medicines and overall care.69
Nevada Drug Benefit Options for Better Access

The mission of Nevada’s Medicaid program is to “purchase and provide quality health care services to low-income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to the taxpayers of Nevada.” Unequal access is a serious issue, however, with inconsistent access to medications depending on where a person lives and whether he or she is in fee for service or a particular managed care plan. Adopting policies that promote equal access to medications regardless of payor would help achieve that mission for Nevada’s most vulnerable citizens. Several states have adopted policies for pharmacy benefits that promote equal access and care consistency, reduce administrative burden on providers, and take advantage of savings from rebates, larger purchasing pools, and mid-year patent losses on branded medicines.

An analysis by Magellan Pharmacy Solutions, a leading pharmacy benefit manager, noted several benefits for states exercising more control, including:

- Better care through continuity of therapy and consistent interpretation of clinical criteria;
- Significantly reduced burden on providers;
- Economies of scale to reduce costs and enable implementation of clinical management programs targeting populations with limited size and high costs; and
- Maximizing savings for Medicaid by capitalizing on all rebates available to the state, including those available exclusively to the state.70

Tactics States Use to Manage High FFS Drug Spend and Utilization (Insight from one-on-one interviews with State Medicaid Directors)

Source: Health Strategies Group, Contracting in the Medicaid Fee For Service Environment (October 2015).
Adoption of Statewide, Universal Formulary
A statewide, universal preferred drug list (U-PDL) provides efficiencies by maximizing rebates and minimizing pharmacy reimbursement costs.

If state administered, states get the benefit of state supplemental rebates and OBRA rebates otherwise missed when responsibility transfers to MCOs.

States lower costs by placing preferred branded medicines on preferred lists when brands, because of rebates, are less expensive than generics or provide better outcomes, including overall savings.

Shortages in the number of providers accepting Medicaid patients, particularly in urban areas served by MCOs in Nevada, are a significant issue. A recent study by the American Medical Association found a direct relationship between the use of multiple formularies and a prescriber's negative view of a program due to the complexity of dealing with different coverage arrangements. Adopting a universal prior authorization process further reduces the administrative burden on providers, and provides predictability for patient access and reduces variability in interpretations of clinical appropriateness for the patient. In Ohio, requirements of high consistency with the state's formulary and a standard prior authorization form drove a 70 percent reduction in the volume of prior authorizations submitted by prescribers. In a fifty-state survey covering FY2015 and FY2016, eleven states indicated that they were standardizing prior authorization clinical criteria across both fee of service and managed care.

Maximizing rebates on brand drugs and improving care coordination are key tactics for states to control FFS drug utilization and reimbursement.
- PBAs, drug purchasing pools, and U-PDLs give states the opportunity to achieve preferable pricing.
  - A new negotiating pool with 25 states was created in January 2015 and is only targeted at high cost, specialty drugs, such as for hep-C.
  - A U-PDL gives states the opportunity to buy brand products at a price below the generic.

[With a single U-PDL] we’re paying about 3% higher cap rates but we’re collecting hundreds of millions of dollars in rebates. [MCOs] would like to be able to manage the pharmaceutical benefit more....They would do more generic substitution. ...For example, when they’re paying $100 of a brand name drug, when they know there is a generic they could pay $30 or. What they don’t know is that we’ve negotiated $75 in rebates. So it’s only netting the taxpayers a $25 cost. So we’re doing something cheaper...but they don’t see that.

– Deputy State Medicaid Secretary

A U-PDL also allows for greater continuity of therapy as patients move from fee for service to managed care or between managed care plans. Encouraging continuity between the exchange plans and the state U-PDL would promote even greater continuity among Medicaid expansion populations likely to transition between exchange and Medicaid coverage because of fluctuating income levels.

Efficiencies of scale could also lower costs to the state. With a statewide U-PDL,
states take advantage of larger purchasing pools, can capture all data needed to collect all federal and state rebates, and balance the portfolio of medications as new generic medications enter the market.

With annual managed care contracts, states never realize any of the savings for new generic entries that occur during the course of the contract year. Many major medicines went off patent in 2015 and are going off patent in 2016 and in the years to come, including those in commonly protected classes such as medicines for mental health conditions, HIV, and cancer.

A U-PDL allows the state to realize immediate savings from generic entries when they occur during the plan year instead of waiting until the next contract negotiation period.

![Image](image-url)


Magellan Pharmacy Solutions highlighted many of advantages of adopting a unified state formulary, including:

- Better patient care resulting from continuity of therapy and therapeutic preferences developed, reviewed and approved by the Medicaid Pharmacy and Therapeutics Committee;
- Reduced burden on providers; and
- Maximized savings by leveraging manufacturers rebates available exclusively to the state and optimizing the formulary to take advantage of economics of rebates uniquely available to the state.74
<table>
<thead>
<tr>
<th>Issue</th>
<th>Universal PDL</th>
<th>Carve-Out Setting</th>
<th>Carve-In Setting</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee continuity of therapy</td>
<td>Enrollees have access to same medications regardless of MCO, FFS, or location in the state. Extending to exchanges can reach enrollees expected to cycle between Medicaid and exchange coverage.</td>
<td>Enrollees have access to same medications regardless of location in the state. May be extended to exchanges to improve coverage continuity.</td>
<td>Without a universal PDL, continuity of therapy is a challenge for patients to achieve and providers to manage.</td>
<td>Significant churn in Medicaid hinders continuity of therapy. Churn may be between MCOs, MCO and FFS, or in and out of Medicaid.</td>
</tr>
<tr>
<td>Provider administrative burden</td>
<td>Assists with consistency in drug list, but prior authorization requirements and hurdles may vary based on payor.</td>
<td>Providers rely on single list of approved medications and have one prior authorization form, process, etc.</td>
<td>Providers must know enrollee’s plan, each plan’s current formulary, use different forms for prior authorization, and adhere to different policies (such as fail first, etc.)</td>
<td>Churn from moving in and out of Medicaid eligibility can aggravate problems.                                                                isses.</td>
</tr>
<tr>
<td>Rebate optimization</td>
<td>State manages PDL and can collect all rebates directly with MCO (TX) or otherwise (FFS).</td>
<td>State manages PDL and collects all rebates. Allows a state to concentrate purchasing power on both FFS and MCO-covered lives. State has rapid, accurate access to utilization data.</td>
<td>MCOs can collect federal rebates, but do not collect state supplemental rebates. State access to and accuracy of pharmacy data from MCOs can hinder rebate optimization.</td>
<td>Because of state supplemental and OBRA rebates, branded medicines may be cheaper than generics to the states. MCOs do not have access to all rebates.</td>
</tr>
<tr>
<td>Care integration/data analytics</td>
<td>Universal PDL enables all Medicaid providers to work from the same list of covered medications and facilitates care continuity of medication therapy between care settings, providers, and payors.</td>
<td>MCOs have to rely on state to provide access to pharmacy data to help in coordinating care. States do not have problems getting complete and accurate data from CMOs to collect drug manufacturer rebates.</td>
<td>MCOs have access to pharmacy data (collected in-house or most often by PBM and supplied to plan).</td>
<td>Most MCOs and states contract with same organizations offering PBM or PBA pharmacy services, making data access issues manageable when built into state contracts.</td>
</tr>
</tbody>
</table>
Nevada Medicaid’s recently released Request for Proposals (RFPs) marks a step forward toward a U-PDL by encouraging managed care to “mirror or exceed FFS” pharmacy benefits, and provides an incentive in terms of a higher proposal score during RFP evaluation. The RFP does not require adoption of the fee for service PDL or universal adoption of its prior authorization processes.

Any arrangement has benefits and challenges. The table below addresses those and common issues raised by managed care organizations arguing against U-PDLs and other patient access protection.

### Universal PDLs Financing Models

By law, Texas adopted a statewide preferred drug list, contracts with MCOs to manage the drug benefits, but the state maintains the PDL and collects all the rebates. The state law also establishes a standard prior authorization process to enhance predictability and reduce prescriber burden. Nine additional states have adopted this approach since Texas first introduced it in 2013 (AL (2016), AZ (2015), CO (2015), DE (2015), KS (2014), MS (2014), NC (2016), NH (2013), WV (2014)).

Tennessee deploys a U-PDL, but carves out medications from managed care contracts and pays for them directly. Missouri and Nebraska use a similar model for Medicaid drug benefits. The states often contract with a Pharmacy Benefit Administrator to negotiate and administer the PDL for the state. Most major Pharmacy Benefit Managers, the organizations with which most Medicaid managed care organizations contract for managing drug benefits, also offer pharmacy benefit administrator services that many states use for Medicaid drug benefits.
Protecting Certain Classes of Medications

Carving Out Certain Medication Classes
Some states exclude or “carve out” coverage of certain classes of medications from managed care contracts and require that managed care follow the state fee for service formulary for these classes. For example, Oregon carves out mental health medications and immunosuppressants from managed care contracts. Medicaid enrollees with these conditions have complete open access to medications via a “Voluntary Formulary” and the state pays for these medicines directly for all Medicaid clients. Utah just adopted this model for all mental health medications (antipsychotics, antidepressants, ADHD, anti-anxiety and anticonvulsant medications) in 2016. California carves out atypical antipsychotics, substance abuse, HIV and blood coagulates from its managed care contracts. Maryland also has carved out coverage for atypical antipsychotics, antidepressants, medicines for ADHD, and anticonvulsants from its managed care contracts.

Requiring Access for Certain Medication Classes
Several states require managed care companies at risk for the drug spend either to have open access for certain classes of medications or to follow the state preferred drug list to assure consistent coverage. For example, Arkansas, Hawaii, Indiana, Kansas, Michigan, Minnesota, and New Jersey require open access for atypical antipsychotics for all managed care patients. Illinois, Indiana, Michigan and New Jersey also require open access for anti-convulsants. Washington requires MCOs to follow the state formulary for atypical antipsychotics and does not allow substitutions on epilepsy medications regardless of formulary.

Summary of State Protections for Access to Mental Health and Epilepsy Medications

<table>
<thead>
<tr>
<th>State</th>
<th>Access Protections</th>
<th>Policy Basis</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>Open access for antipsychotics &amp; anticonvulsants</td>
<td>AL 9455-2013 /560-X-16.06, 20. Part of annual state budget</td>
<td>Antipsychotics &amp; anti-epileptic meds do not count against 4 prescription limit.</td>
</tr>
<tr>
<td>AR</td>
<td>All atypical antipsychotics available.</td>
<td>Department policy</td>
<td>Prescription limit per patient reviewed on individual basis.</td>
</tr>
<tr>
<td>CA</td>
<td>MCOs follow FFS formulary for atypical antipsychotics, substance abuse, blood coagulents, &amp; HIV.</td>
<td>Department policy</td>
<td>Medicines are reimbursed by FFS.</td>
</tr>
<tr>
<td>CT</td>
<td>Prior authorization not required for any mental health drug that’s been filled or refilled at least one time in the previous year. Also restricts step therapy.</td>
<td>SB 394- 2014</td>
<td></td>
</tr>
<tr>
<td>HI</td>
<td>No restrictions or coverage limitations on antipsychotics. Also restricts step-therapy on antidepressants and anti-anxiety drugs.</td>
<td>HRS § 346-59.9</td>
<td></td>
</tr>
<tr>
<td>IN</td>
<td>Open access to atypical</td>
<td>IC 12-15-35.5-3</td>
<td>Covers both FFS and Managed</td>
</tr>
<tr>
<td>State</td>
<td>Policy</td>
<td>Reference</td>
<td>Notes</td>
</tr>
<tr>
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<tr>
<td>KS</td>
<td>Exempts mental health meds from prior authorization or a PDL.</td>
<td>K.S.A. 39-7, 121</td>
<td>Exemption covers all Medicaid plans including KanCare.</td>
</tr>
<tr>
<td>MN</td>
<td>Requires plans providing drug coverage to cover antipsychotics whether or not on the plan’s formulary.</td>
<td>Minn Stats. 62Q.527</td>
<td></td>
</tr>
<tr>
<td>NC</td>
<td>Open access to anticonvulsants for patients with epilepsy or seizure diagnosis.</td>
<td>Department Policy</td>
<td></td>
</tr>
<tr>
<td>NH</td>
<td>Suspended prior authorization for community mental health programs for medications used to treat severe mental illness.</td>
<td>Chap. 2015-199</td>
<td>Suspension is up for renewal in 2017.</td>
</tr>
<tr>
<td>NJ</td>
<td>Requires coverage of any atypical antipsychotic or anticonvulsant drug regardless of formulary or treatment plan of the MCO.</td>
<td>Department Policy</td>
<td>Medicine can be ordered by a participating or non-participating provider to be covered regardless of formulary or treatment plan of the MCO.</td>
</tr>
<tr>
<td>ND</td>
<td>Open access for atypical antipsychotics in FFS population.</td>
<td></td>
<td>Expansion population is managed by MCOs without these protections.</td>
</tr>
<tr>
<td>NY</td>
<td>Prescriber prevails prohibits prior authorization to atypical antipsychotics prescribed by a psychiatrist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OH</td>
<td>State-registered psychiatrists can prescribe atypical antipsychotics and antidepressants without restrictions.</td>
<td>Ohio 5111.172</td>
<td>Covers Medicaid FFS and Managed Medicaid plans.</td>
</tr>
<tr>
<td>OR</td>
<td>“Voluntary formulary” for mental health meds, including anticonvulsants. No prior authorization for these meds by any MCO.</td>
<td>ORS 414.325 and 414.334</td>
<td>Prior authorization on refills for anticonvulsants are prohibited regardless of the managed care formulary.</td>
</tr>
<tr>
<td>TX</td>
<td>Access to anticonvulsants not restricted in Managed Medicaid.</td>
<td>HHSC DUR Board requirements</td>
<td></td>
</tr>
<tr>
<td>UT</td>
<td>Mental health medications placed on a “voluntary formulary” that can be overridden with “Dispense as Written”. Not subject to prior authorization.</td>
<td>SB 437-2016</td>
<td>Mental health medications include atypical antipsychotics, antidepressants, anticonvulsants, and antianxiety medications.</td>
</tr>
<tr>
<td>WA</td>
<td>MCOs must follow state formulary for antipsychotics.</td>
<td>RCW 69.41.190</td>
<td>Prior authorization requirements cannot require more than failing on</td>
</tr>
</tbody>
</table>
Prescriber Prevails and Prior Authorization Prohibition Laws

To allow the clinical judgment of the provider to prevail over medication access restrictions, several states have enacted provisions that allow the prescriber to override those restrictions in certain circumstances. Both New York and Ohio have adopted “prescriber prevails” provisions for their Medicaid programs. Under prescriber prevails, the professional opinion of medical care providers of the patient is the final determination for approval of coverage of a prescription medicine in disputes over coverage with Medicaid managed care organizations. New York’s law covers antidepressants, antipsychotics, antirejection, seizure and epilepsy, endocrine, hematologic, immunologic, and antiretroviral medications.\textsuperscript{80} By law in Ohio, physicians registered as psychiatrists with the state Medicaid program are exempt from prior authorization requirements for antidepressants and antipsychotics.\textsuperscript{81} Connecticut, Kansas, Oregon, and Washington also have laws prohibiting prior authorizations for refills of these medications regardless of current formulary status.

Opportunities to Lower Costs by Optimizing Appropriate Medication Use

Several states have taken a more holistic approach to medication use and worked to lower the total cost of care through better medication management. For example, Minnesota’s deployment of medication therapy management services reduced overall medical spending and resulting in 31 percent reduction in total health expenditures per patient.\textsuperscript{82} In 2009, Connecticut has tested a medication management program involving pharmacists within primary care settings within Medicaid and realized an estimated annual savings of $1,500 per patient on medication and other medical expenses.\textsuperscript{83}

Other Opportunities to Improve Health

Access to medically necessary treatments is critically important to people living with serious chronic conditions, including mental illness and epilepsy. In addition to providing consistent access to medications deemed medically necessary by the patient’s healthcare provider, the state can take other steps to improve care. Short of adopting a U-PDL and common prior authorization process, establishing specific circumstances under which a provider may request an override of a managed care organization’s rejection of coverage would be helpful.

Assuring that Medicaid managed care clients have access to specialists who treat serious mental illness or epilepsy would also help to improve outcomes for these patients.\textsuperscript{84} For example, specifying neurologists as a required network provider specialist within Medicaid managed care options would help facilitate access for epilepsy patients. Including anticonvulsants in mental health services for the purposes of assuring parity in coverage and access, and in meeting quality
standards could greatly improve access to care for these patients.
Conclusion

With its limited access protections in place for its citizens served by Medicaid, Nevada ranks near the bottom in access to care for mental health and epilepsy. The majority of states have adopted policies that promote access and care consistency for Medicaid clients, placing Nevada among a small minority of states without these protections. These protections not only help patients achieve and maintain better health, but also reduce the administrative burden on providers. The cost of poor health affects state budgets in a multitude of ways both inside and outside the healthcare system. This reality uniquely resides with the state and places greater urgency and responsibility on the state to adopt policies that assure access to care that promote health for the state's most vulnerable populations.
CITATIONS

1 Nevada Request for Proposals 3260 (July 1, 2016), http://purchasing.nv.gov/Solicitations/Documents/RFP3260/.
10 Ibid.
14 Mental Health America, Co-Occurring Disorders and Depression, http://www.mentalhealthamerica.net/conditions/co-occurring-disorders-and-depression.


National Alliance on Mental Illness, Mental Health by the Numbers, https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers#sthash.XoaoTHiE.dpuf.


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42 West JC et al, Medicaid prescription drug policies and medication access and continuity: findings from ten states, Psychiatr Serv 2009;60(5):601-610.


45 Nevada Department of Corrections. Fiscal Year 2013 Annual Statistical Report, http://doc.nv.gov/uploadedFiles/docnvgov/content/About/Statistics/Annual_Abstracts_by_Fiscal_Year/fy2013.pdf; Nevada Medicaid Incarceration Cost Calculation: Nevada’s prison population in 2008 was 13,269, an increase of 2%, or 265 prisoners. According to Seabury’s rate of $36,491.94/prisoner, this equates to an increase of $9,684,231.04.


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50 Labiner DM, Drake KW, Formularies, costs, and quality of care: Formulary restrictions are the not the answer, especially for epilepsy, Neurology Clinical Practice 2013;3(1):71-74.

51 Divino V, et al, Healthcare resource utilization and costs of immediate versus delayed second-line treatment initiation among patients with epilepsy, Poster presented at the 68th Annual American Epilepsy Society Meeting (December 5-9, 2014), Seattle, WA.


54 Ibid.


58 State of Nevada Department of Health and Human Services, Medicaid Managed Care Frequently Asked Questions (May 5, 2015), http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/MCO%20FAQ'S%20letterhead.pdf.


63 Note: These states may still use specialized formularies in addition like the ADAP program.
Pharmacy Benefit Administrators (PBAs) administer the claims and provide other administrative tasks for the states. In comparison, Pharmacy Benefit Managers (PBMs), with which most Medicaid health plans outsource drug benefit management, perform administrative tasks and will set formularies, access policies, and procedures for health plans. Most PBMs also provide PBA services.


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