

Medicaid Managed Care Regional Forums  
For Individuals with Mental Health and  
Substance Abuse Disorders

Report

*December 28, 2007*

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# Report

## *Background*

Over 250 people participated in six Medicaid Managed Care forums which were held around the state between September and November, 2007. Session sites included Athens, Lebanon, Columbus, Bowling Green, Canton and Cleveland.

The purpose of the forums was to provide individuals with mental health and substance abuse disorders and their families the opportunity to learn about the transition to Medicaid Managed Care and to understand how this change impacts their healthcare. Attendees also had the opportunity to express concerns about the new system and receive answers to questions about their benefits.

The forums were co-sponsored by NAMI Ohio; Ohio Department of Job and Family Services; Ohio Association of Health Plans; Ohio Department of Mental Health; Ohio Department of Alcohol and Drug Addiction Services; and the Coalition for Healthy Communities.

## *Issues Raised*

Consumers, families and other participants raised several issues during the forums. For the most part, these concerns related to one of the following themes:

- Appropriate access to atypical antipsychotic and other mental health and substance use treatment medications
- Providers listed on managed care plan (MCP) panels often are not accepting new patients
- Responsibility for and access to transportation to behavioral health appointments
- Receiving approval from MCPs to gain access to psychiatric hospital beds
- Understanding the difference between case management services provided by MCPs and the community mental health and alcohol and other drug services system
- Getting questions answered from MCP Helplines in a timely fashion
- Service availability and coverage responsibilities for those who are dually eligible for Medicare and Medicaid – there is considerable confusion among this population.

## *Observations and Recommendations*

Representatives from the cosponsoring organizations participated in each of the forums. Based on the experiences and concerns shared by forum attendees, the following observations and recommendations are being offered to address those concerns.

Coordination issues within the delivery system and inadequate communication between and among all the parties involved in the provision and the receipt of services appears to have led to consumers and family members experiencing difficulties in accessing behavioral healthcare services. To address these issues, we offer the following recommendations:

1. Ramp up efforts to simplify access to care for consumers served by the Medicare and/or Medicaid programs by improving the coordination of services through out the delivery system so that consumers can receive services through any access point; and, address those systemic issues that result in limitations on the availability of providers and hospital beds.
2. Improve system communication by:
  - a. MCPs (with the assistance of advocacy organizations) providing specialized training to their staff members who have direct contact with clients with behavioral health disorders to educate them about these disorders, help in recognizing common behaviors associated with these disorders, help in distinguishing if someone is in crisis, and provide tips on how to communicate effectively with someone with a behavioral health disorder. Also, training should include information regarding local behavioral health resources, such as hotlines and warm lines, so staff can be helpful in redirecting clients who may need assistance due to their illness but it is not related to their insurance benefits.
  - b. ODJFS, with assistance from ODMH and ODADAS, developing an easy to understand benefits comparison guide which provides clarification regarding the different policies for accessing atypical antipsychotic medications. The guide should be posted on the Department's website and updated regularly.
  - c. ODJFS, with assistance from ODMH and ODADAS, developing an easy to understand Behavioral Health Benefits comparison chart which includes information regarding the available services and medication policies of each of the eight MCPs. The benefits guide should include, but not be limited to, policy information regarding transportation services, and hospital access for both emergency and non-emergency situations. The guide should be posted on the Department's website and updated regularly.
  - d. Behavioral healthcare providers and Boards meeting with MCPs to review health plan procedures for prior authorization of services, medications and coordination with health plan case managers.
  - e. ODMH and ODADAS, with support from ODJFS, providing user-and health plan-friendly information on certified providers by provider site in addition to organizational grouping.

# Medicaid Managed Care Public Forum

## Southwest Ohio

### Lebanon, OH

#### Make Up of Audience

- There were 36 people total who participated, including approximately 3 consumers, 12 family members, 2 agency reps, 2 board reps, 3 state employees, and 14 MCO reps.
- Hamilton, Butler, Clermont, Warren and Greene Counties were represented.

#### Identified Issues and Concerns

##### 1) Dual Eligibility

- There was a question posed regarding service availability to people who had both Medicare and Medicaid coverage. The sense was that being dually eligible was actually a liability.
- There was a question whether it is acceptable to turn down eligibility for Medicare. Overall, there seems to be considerable confusion at all levels about how dual eligibles are served by and in the new system.
- One participant noted that his son receives SSDI, and takes Risperdal Consta. He said he is afraid that if his son gets a job, he will lose his SSDI and will not be able to pay for his medication.
- It was noted that in some states, dual eligibles participate in managed care.

##### 2) Medication

- There were several questions and comments raised regarding medication access. Attendees wanted to know what the requirements for medication prior authorization will be after January 1, 2008. The MCPs tried to assure participants that they are committed to “doing the right thing” and do not plan to switch clients who are stable on a particular medication.
- One person questioned whether her daughter would have access to Invega which she needs because she has a liver condition. She was told that it would require prior authorization by Medicaid (or the MCP if her daughter was a member of one) and that as part of the process, someone would ask for the medical reasons why Invega needs to be prescribed.
- The question was asked whether consumers will be notified when (or if) an MCP places a medication on the list to be prior authorized. They were told that the

MCP will contact them in writing at least 30 days before a medication is placed under prior authorization or a medication's preferred status is changed.

- One person expressed concern that doctors may not take the time to prior authorize a medication.

### **General Comments/Questions**

- There was a question regarding what is considered when determining if someone qualifies for case management.
- A member of the audience asked what the major differences were between the three plans. She was told that due to the state's regulations, the plans have many things in common. Some differences were outlined including different provider panels, different hospital availability, and different medication formularies. It was pointed out by the MCPs that one of the real advantages to the new system is that MCPs will be able to coordinate health and behavioral health care which will result in better outcomes for clients.
- It was noted by a member of the panel that there is a 1-3% roll over rate in Covered Families and Children (CFC) enrollment each month that could result in an MCP's membership turning over up to 40% each year.
- There were several questions regarding the enrollment process which were all satisfactorily answered.
- There were general questions regarding emergency room usage.
- There was a question about how often someone can change their medical home.

### **Evaluations**

- Six evaluation forms were completed. The questions on the form are:
  - Was the information presented what you expected? Yes    Somewhat    No
  - Did you find the information presented helpful? Yes    Somewhat    No
  - Were you able to get your questions answered? Yes    No    NA
  - Do you have any suggestions for improving the forum format?
  - How did you find out about the forum?
  - Other comments:
- 100% of the comments were favorable. Most people heard about the forum through their local NAMI or from the Mental Health Association.

# Medicaid Managed Care Public Forum

## Southeast Ohio

### Athens, OH

#### Make Up of Audience

- There were 41 people total who participated, including approximately 7 consumers, 3 family members, 5 agency reps, and at least 4 state employees
- Hocking, Athens, Vinton, Meigs and Jackson Counties were represented
- Aside from the panel, which consisted of one provider, one board rep, and 3 managed care reps, the rest of the attendees included representatives from the Southern Consortium for Children or were either Managed Care reps or Coalition for Healthy Community reps

#### Identified Issues/Concerns

##### 1) Transportation Services

- There was considerable confusion around transportation services and which entity is responsible for what type of service, including emergency, non-emergency, after hours, out-of-state appointments.
- When told they have a choice, members of the audience questioned how they would know that they have a choice. Also, there were questions about who transports the client if they are behaving aggressively.

##### 2) Accessing Plans after Hours

- It was stated that the person answering the nurse hotline was not able to answer the question posed and did not get back to the caller with the required information.

##### 3) Hospitalization:

- There were several questions regarding the authorization of hospitalizations for children in crisis.
- There is considerable confusion about whether there has to be prior authorization. When told that only notification is required within the first 72 hours, but that prior authorization is not, agency staff found this difficult to believe. It was noted that sometimes the hospital will not accept the child without the authorization and other times the child does not meet the hospital's criteria for admission even though the MCP has approved the hospitalization.
- Many noted that the approval process often takes several hours. One woman in the audience noted that her son waited in the waiting room for so long that he

wore himself out, and was so lethargic when they got to him that they refused to accept him.

- There was consensus among the audience that the process for getting a child hospitalized has become difficult since MCP expansion began. Many attributed this to poor communication and lack of established relationships.
- It was noted that in many instances kids are being sent to Lexington, KY or Youngstown, OH because the plan has a contract with hospitals in those areas, even though it is very inconvenient for families.
- It was observed that MCPs do not understand the dynamics of kids in crisis and their families.
- One gentleman raised the concern that gaining access to emergency AOD services through the ER, hospital is much more difficult today than it was ten years ago.

#### 4) Medication

- Someone was told he had to switch from Seroquel to Risperidal even though he was stable on the Seroquel. There were additional side effects with the new drug and overall the patient did not feel as well as he did on the original medication, but he was not given the option of returning to the original medication. The primary concern noted was that it appeared MCPs were not taking into account quality of life when reviewing a patient's condition during the prior authorization process.
- There were questions about how MCPs will respond after the moratorium is lifted on atypicals in the ABD population.
- A provider expressed frustration in dealing with MCP pharmacists who are not trained in psychiatry.

#### 5) Eligibility

- It was reported that a child was cut from Medicaid Managed Care because of a payment the family received from the Child Support Enforcement Agency.

### **General Comments**

- The system is complicated and convoluted, especially for someone who is eligible to receive both Medicare and Medicaid. The notices that consumers receive in the mail are hard to follow and contribute to the stress levels of those who already struggle with issues as a result of their mental illness.
- Some of these problems will be worked out over time as relationships are established and providers/families learn who they need to call with their questions.

- Overall, it seems like the mental health system is much less responsive today than it was 10 years ago. Then, hospitals accepted patients readily who were in a psychiatric emergency, but today that does not seem to be the case.

### **Pending Questions**

What percentage of people in Southeast Ohio selects their MCP as compared to the percentage who is being assigned to a plan? How does this compare with other parts of the state? (Steve Trout, Southern Consortium)

# Medicaid Managed Care Public Forum Central Ohio Columbus, OH

## Make Up of Audience

- There were a total of 47 participants, including approximately 7 consumers, 12 family members, 11 state agency reps, 9 managed care reps, 2 board reps, 1 provider rep, 3 Coalition members, and 2 pharmaceutical representatives.
- Franklin, Licking, Delaware, and Marion Counties were represented.

## Identified Issues/Concerns

### 1) Case Management

- The question was asked about what type of mental health disorders qualify an individual for case management services. It was explained that it is not the type of disorder that qualifies someone for case management, but the intensity of the services that they require. There is no mental health condition excluded. Individuals seeking case management services should contact their MCP and request it.

### 2) Hospitalization

- It was questioned whether wellness/exercise programs are covered under managed care. The woman asking the question explained that her child has difficulty with weight gain due to the medication that he taking. She is concerned about his weight and the possibility of his getting diabetes. She was told that wellness per say is not covered, but case managers can help connect clients to exercise programs available in the community.
- There was a request for clarification regarding the difference between free standing psychiatric hospitals and general hospitals which include psychiatric services. It was noted that Medicaid does not cover free standing hospitals (including state mental health hospitals) for individuals between the ages of 18 – 65. It was noted that this is a federal law.
- The panel was asked about cost-shifting for hospitalization. Several Boards have seen an increase in Medicaid eligible consumers admitted to State Hospitals. The question was asked regarding what protocols were in place to prevent cost-shifting from MCPs to the community behavioral health system. The MCPs were unaware of the increase in the number of Medicaid eligible consumers in State Hospitals and did not know what to attribute the increase to, but one of the plans mentioned that they were working to develop more rapid step-down units and that this would be an issue they would further consider.

### 3) Eligibility and Medical Home

- It was questioned whether case managers can help a client apply for SSI. It was noted that a caseworker at the county Department of Job and Family Services would be the most appropriate place to seek help.
- There was a question about how primary care providers are selected. The response was that members may select anyone in the network. If they don't select one, one will be selected for them.
- If your PCP is not enrolled in your network, clients should let their physicians know that they would like their doctor to sign on to the panel. PCPs can sign up for as many plans as they like.
- There was a question whether a psychiatrist can be considered a medical home. The answer is yes, if you are enrolled in an MCP that participates in Aged, Blind and Disabled (ABD) managed care program.

### 4) Medication Access

- There was a question raised as to what would happen after January 1, 2008 after the moratorium on prior authorization for atypical antipsychotics is lifted. The answer was that the Department does not know yet.
- There was a concern expressed that MCPs are not looking at the big picture when they make decisions to deny medication. An example was given of a child who was prescribed a medication for ADHD that could be absorbed through a patch. The reason the doctor wanted to dispense it in that form was because the child was refusing to go to the school office to get his medication because he was being teased by the other students. The MCP denied the medication because the doctor could not claim that the child had a fear of swallowing pills.
- The panel was asked what the turn around time is for a prior authorization determination. By rule and federal requirements, MCPs must respond to prescription medication authorization requests within 24 hours. It was observed by the questioner that many clients in the community mental health system "are long gone" by then and cannot be reached.
- One audience member expressed concern that her friend switched MCPs and was told that she would no longer be able to access a medication that she needed. It was recommended that folks check the MCP's preferred drug lists before switching to a new plan. The list is available on line.
- There was a question as to the availability of methadone for pain management for individuals with Sickle Cell. It was stated that methadone for pain management is covered.

## 5) Transportation

- There was a question about how quickly someone can expect to have access to the county's NET transportation service. The general answer is that NET programs can require up to 9 days advance notice for a transportation request. However, exceptions can be made for emergencies. It was questioned whether having a prescription filled would be considered an emergency and the response was that it could be.
- It was noted that MCPs may also provide extra transportation services to members as an additional health plan benefit. Members should contact their MCP member services department or case manager to find out more about the service and what is provided by the MCP.

## 6) Medicaid Buy-In

There was a question regarding Medicaid Buy-In candidates and whether they would be eligible for Managed Care or Fee for Service. They were told that the final decision had not yet been made, but it is likely that they will be in the traditional or Fee-for-Service Medicaid program

## 7) Other

- It was questioned whether chiropractic services are covered. The response was that such services are "very limited" and the service is "very narrowly defined".
- One person said she contacted the 24-hour after hours number to ask a question. She called back later and asked for the person who helped her the first time and was told there was no one there by that name.
- It was questioned whether service providers were being educated about managed care, particularly with regard to the emergency room admittance policy. It was noted that there still seems to be a lot of providers who are under the misunderstanding that the MCP must prior authorize all hospital admissions, including emergencies.
- There was a question about maintaining relationships with out-of-network primary care providers. The MCPs stated that they would work to include the providers in their network so that there could be consistency in care. There is no limit on the number of panels to which a primary care physician can belong.

# Medicaid Managed Care Public Forum

## Northwest Ohio

### Bowling Green, OH

#### Make Up of Audience

- There were a total of 34 participants, including approximately 3 consumers, 11 family members, 3 state agency reps, 7 managed care reps, 4 board reps, 2 provider rep, 4 Coalition members.
- Lucas, Wood, Seneca, and Mercer Counties were represented.

#### Identified Issues/Concerns

##### 1) Medication Access

- There was a question regarding the amount of time that Managed Care can take to approve or deny a prior authorization request. The answer was 24 hours, but many plans take less. If a prior authorization cannot be issued within that timeframe, a 3-day supply of medication must be dispensed to cover the patient during the review period.
- There were some questions regarding the appeal process if the prior authorization request is denied.
- One MCP noted that they deny approximately 3% of the requests.
- The question arose as to what consumers can expect after the Dec. 31 moratorium on atypical antipsychotics is lifted. The answer was that no decision had been made and that the issue was currently under study at the department. .”
- It was noted by an MCP that regardless of what happens; consumers who are stable are unlikely to be switched to a new drug. When asked how MCPs will determine if someone is stable, it was stated that “the consumer and the physician will let us know.”

##### 2) Dual Eligibility

- One gentleman asked several questions regarding the spend down process. He observed that “circumstances seem a lot better if you aren’t dual eligible.” He expressed concern of being dropped from Medicaid spend down if he does not meet his spend down requirements, yet he cannot afford his monthly medication.
- There was considerable frustration expressed that when trying to get answers from Medicare, they send you to Medicaid, and vice versa. When you do finally get an answer out of one of them it usually conflicts with what the other tells you.

##### 3) Provider Panels

- On woman shared that her daughter is on Anthem and “no one in Wood County accepts Anthem.” After being referred to several doctors by Anthem, who all told her they did not accept that plan, she finally found a doctor 23 miles away.

#### 4) Case Management

- It was noted that case managers can help clients locate a provider.
- Someone questioned whether an MCP case manager could attend an appointment with a client. The response was that most MCP case management is done over the phone, but that arrangements could be made to have a face to face meeting.
- It was questioned what conditions are covered by case management. The response was that it is not solely a person’s behavioral health condition that determines whether a case manager is assigned, but rather their level of need. It was stated that MCPs welcome requests from people requesting a case manager.
- It was questioned whether doctors are educated about managed care. Many in the area do not accept any plans. It was shared that all providers have been contacted and offered the opportunity to learn more about managed care. It was noted that providers who are on the panel agree to serve a certain number of the plan’s clients.

#### 5) Help Line

- When calling for help, it is impossible to speak to the same person twice.

#### 6) Enrollment

- It was asked what percentage of people is automatically enrolled in an MCP? The answer was “approximately 60%.”
- When questioned about satisfaction rates, it was noted that there is currently no way to measure if someone is satisfied with a plan because the statewide expansion is so new. It generally takes about 12 months of experience before meaningful information on consumer satisfaction is available statewide. Consumer satisfaction with MCPs has been measured by ODJFS for a long time. The Department uses an independent contractor to assure the independence of the results. Previous consumer satisfaction surveys are available to review at <http://jfs.ohio.gov/ohp/bmhc/mhcri.stm> . Simply click on “Reports”.

#### 7) Hospitalization

- The question was asked whether prior authorization is required for hospitalization. The answer was yes, except in emergency situations, in which the hospital will contact the MCP within the first 48 hours.

## **Evaluations**

- Six evaluation forms were completed.
  - 100% of the comments were favorable.
  - Most people heard about the forum through their local NAMI.
  - All the suggestions centered on the need to do a better job getting the word out about the forums and to provide transportation to consumers.

# Medicaid Managed Care Public Forum North Central Ohio Canton, OH

## Make Up of Audience

- There were a total of 32 participants, including approximately 3 consumers, 5 family members, 5 state agency reps, 8 managed care reps, 3 board reps, 3 provider reps, 4 Coalition members, 1 pharmaceutical rep.
- Stark, Summit and Medina Counties were represented.

## Identified Issues/Concerns

### 1) General

- There was a question related to Medifax, and how a provider knows which MCP is responsible for payment.
- There was a question about what questions had come up in previous meetings. The answer was: Dual Eligibility, Hospital Admission, and Medication Access.

### 2) Medication Access

- There was a question regarding the accessibility of atypical antipsychotic medication after December 31, 2008. It was noted that there will be a provider agreement draft available soon which will outline how these medications will be handled. (The new policy was issued on Nov. 9, 2007.)
- There was a question regarding the how MCPs will educate consumers when a medication is added to the list of meds for which prior authorization is required. It was noted that the contract requires the MCPs to notify consumers and providers on their panels at least 30 days in advance of any changes to the MCP's prior authorization requirements or the preferred status of any prescription medication.
- There was a question regarding copays, and which plans require them. The answer was that no plans currently require copays.

### 3) Help Line

- One person said that she called her MCP's help line and was placed on hold for 30 minutes. She was told that under the agreement, all calls must be answered within 30 seconds. If members have difficulty reaching their member services department, the member should file a complaint with the MCP. If the problem persists, the member can also file a complaint with ODJFS at [bmhc@odjfs.state.oh.us](mailto:bmhc@odjfs.state.oh.us) or by calling the Bureau of Managed Health Care at (614) 466-4693.

## Evaluations

- Three evaluation forms were completed.
  - 100% of the comments were favorable.
  - Most people heard about the forum through their local NAMI.
  - All the suggestions centered on the need to do a better job getting the word out about the forums, provide transportation to consumers, and offer the forums during a different time frame.

# Medicaid Managed Care Public Forum

## Northeast Ohio

### Cleveland, OH

#### **Make Up of Audience**

- There were a total of 49 participants, including approximately 5 consumers, 4 family members, 3 state agency reps, 9 managed care reps, 5 board reps, 14 provider reps, 3 Coalition members, 3 pharmaceutical representatives, 1 Congressional aide, 2 college students
- Cuyahoga, Portage, Lorain, and Lake Counties were represented.

#### **Identified Issues/Concerns**

##### 1) Medication Access

- The concern was expressed by a local provider that his staff is struggling with reaching MCPs to get approval for medication. He stated that the time spent trying to reach MCPs is very costly to the agency and upsetting to the staff, particularly when clients are forced to take a generic over a preferred name brand medication. He indicated that he knew of one client who is currently suffering because he was denied a name brand medication. The following responses were offered by members of the panel:
  - A MCP representative stated that plans are required to respond within 24 hours. She indicated that the most efficient method of communication is fax, the second most efficient method is sending a request via the website, and the least efficient method is via telephone. Providers were reminded to include the medical necessity for the medication and all other relevant medical information on the request.
  - The ODJFS representative stated that if it takes longer than 24 hours to receive a response, the individual should report a complaint to ODJFS. Complaint forms are on line at <http://jfs.ohio.gov/ohp/bmhc/pro-man-care.stm>. Click on “Provider Complaint Form”.
  - It was noted by one MCP that case managers can help when there is a problem getting approval for a particular medication by working proactively with internal staff.
- One person stated that he had spent a full afternoon researching the MCPs websites trying to track down information regarding the Prior Authorization requirements on seven specific medications. He said that it was very difficult to navigate all the sites as they are each set up much differently from one another. It was suggested that there be a standard format so consumers are not forced to go through what he went through to try to learn if their medication is covered. The ODJFS representative stated that he would bring the suggestion back to the

Department. He did state, however, that the Department tries to provide MCPs with administrative flexibility whenever possible.

- A member of the audience asked the MCP reps whether they work collaboratively to identify opportunities to make their systems more user friendly. The answer was “not really.”
- There was some confusion over the policy that a person can receive a three day supply while the MCP is reviewing the PA request. It was noted that many pharmacists are not familiar with this policy because it is not being utilized. There was a question regarding the educational outreach to pharmacists to ensure that they are aware that they can give out the three day supply. The ODJFS rep noted that it is the responsibility of the MCPs to reach out to pharmacists and educate them about this policy. He did state, however, that the state did provide a managed care expansion overview to the state pharmacy association in April, 2006. The Board rep observed that Boards could take responsibility for educating the pharmacists in their respective areas. There was some discussion about providing a prompt to pharmacists when they place a prior authorization request on line. It was noted that this would be difficult due to space limitations on the pharmacy network.
- The question was asked, “What is the purpose of prior authorization? How can a doctor who is not a mental health professional who lives 400 miles away know what is better for a consumer than their own doctor?” The response that was provided is that prior authorization helps to ensure the client safety because the MCP has the ability to view all the medications that a client may be taking and it helps to control costs.
- There was a question about the future status of atypical antipsychotics after the moratorium is lifted on Jan. 1, 2008. It was noted that ODJFS will be hosting a conference call for advocates on Nov. 8<sup>th</sup> to announce its intention with regard to this language.

## 2) Case Managers

- There was discussion between the panelists and audience members about the role of case managers in the effort to integrate physical and behavioral health care. Participants noted that there are many advantages to having a case manager including: supportive integration between the community mental health system, the MCP and the medical home; the MCP can help consumers locate a medical home, the MCP can help arrange transportation to treatment, the MCP can help coordinate pharmacy benefits, and finally the MCP can help consumers navigate their way through the health care maze. There are also limitations, including: the consumer not knowing who his/her case manager is, and the fact that case managers must get permission from their clients to reach out to providers to discuss their care. Also, some case managers do not know where their clients are so they cannot reach out to them and offer them their services.

- It was noted that many of these responsibilities overlap with the responsibilities of the community mental health system's case managers. The response was that communication between the two case managers is imperative to avoid duplication.

### 3) Medicaid Buy-In

- A member of the audience asked what the impact of Medicaid Buy-In would be. The answer is that the details are not yet worked out but that it is likely that they will stay in traditional Medicaid or be switched to it if they are currently enrolled in an MCP.

### 4) General Questions

- It was asked how long the contracts extend. The answer is that they are renewed annually on the first of the state fiscal year (July 1).
- It was asked how long after a person enrolls in an MCP will they receive their packet of information and their membership card. Generally, a person will receive their enrollment information before their enrollment in the MCP begins.

### Evaluations

- Thirteen evaluation forms were completed.
  - 100% of the comments were favorable.
  - Most people heard about the forum through an e-mail from either the Mental Health Advocacy Coalition or the Cuyahoga County Mental Health Board. One person said he read about it in the newspaper.

## Appendix A

The following list of questions was provided in writing by a participant at the Central Ohio Forum.

- When a patient is assessed for psychiatric hospitalization after hours, is it necessary for the clinician to call the company for approval that night or can the patient go into the unit and the call is made during regular business hours? Does this policy vary from company to company?
- Locally, one of our larger physician groups decided not to do business with Molina. This significantly restricts the choice for Marion County residents, since two of the local psychiatrists are part of this group (MIPA). How does this impact someone with Molina who needs hospitalization?
- Seroquel - This medication is classified as an atypical antipsychotic and is used in dosages of 300 to 600 mg for patients suffering from schizophrenia. It is prescribed in low dosages (25 to 50 mg) for ADHD children at bedtime to help them settle their thoughts so that they can sleep. When attempting a prior authorization, the diagnosis of bipolar disorder or schizophrenia is necessary. We are told that the approved recommendation is Trazadone or Ambien or Ristoral or other Benzodiazepine/sedatives. However, we are concerned about prescribing Benzodiazepines and have found that the Seroquel works better with many children.
- Daytrana Patch - this ADHD medication offers a more consistent delivery throughout the day. Parents can apply the patch in the am, even before the child awakens, and the am tasks are much easier to accomplish. The child also has the benefit of not having the stigma of going to the office to get their medication during the day. When we have tried to get this approved we have had problems and have been told that the child must have an actual swallowing problem to justify this med.
- Vyvanse - this newer med for ADHD has the quality of activation only after it has been ingested - which deters much of the medication abuse. It has a sustained treatment level, which allows the child to be able to go the entire school day without additional dosages. We are having significant difficulty getting this approved. We are told that the child has to have a trial of a less expensive generic medication. The potential for abuse by older patients or by people other than the child is higher with the short acting generic meds. Companies do not seem to be considering the benefits of this long acting medication.
- In general, there is significant time being spent on the phone to get approval for medication. Often, this is not a new medication but not something on the companies 'preferred' list. Many times it ends up being approved but the time spent on this activity is significant.

