California AB-1437 - Frequently Asked Questions

What is the purpose of this bill?
AB 1437 will improve access to crucial medications for Medi-Cal patients with Serious Mental Illnesses (SMI) by removing unnecessary barriers.

What specific problem does the bill aim to fix?
Medications can be essential for an individual with SMI to avoid disruptions in their every-day activities, making it important for these patients to adhere to their recommended drug regimens. According to the California Department of Health Care Access and Information, "in 2020, 24% of diagnoses in the emergency department and inpatient settings were mental health disorders, substance use disorders, or co-occurring disorders." Additionally, "Medi-Cal patients present the highest percentages of mental health and substance use disorder diagnoses in the emergency department" and the unhoused population presents much higher percentages of mental health and substance use disorder diagnoses when compared to the housed population."[i] Revising prior authorization requirements to mental health drugs to ensure such restrictions have clinical value will reduce the incidence of individuals experiencing a mental health crisis, which often lead to hospitalizations, homelessness and worse.

What qualifies as a Serious Mental Illness (SMI)?
A SMI may include, but is not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, a major affective disorder, and any other severely disabling mental disorder. Adults with serious mental health needs are a population of focus in DHCS' implementation of California Advancing and Innovating Medi-Cal (CalAIM). According to the DHCS Research and Analytic Studies Division, "Mental illness of any kind had a treatment prevalence of 59% and serious mental illness (SMI) had a treatment prevalence of 45%.[ii]

Why does this address medication access only for those with serious mental illness (SMI)?
Patients with serious mental illness who have been stabilized on medication are particularly likely to have negative outcomes if they experience disruptions in their medication. A study of 10 state Medicaid programs comparing drug access problems among psychiatric patients found patients who experienced treatment access problems were 360% more likely to experience a negative outcome including emergency visits, hospitalizations, homelessness, suicidal ideation, or incarceration. In California, the study found that 57.9% of patients with a psychiatric diagnosis experienced an access problem leading to a negative outcome.[iii]

Would this bill help people experiencing homelessness?
It could. A 2014 study of treatment adherence among individuals experiencing homelessness found that refill non-adherence rate was 47.1% for psychiatric medications. Non-adherence rates for individuals experiencing homelessness were higher with drugs used in schizophrenia, with around 70% of individuals unable to follow their regimen[iv]. To prevent negative outcomes and provide greater support to individuals experiencing homelessness, the state must revise the existing process Medi-Cal patients are forced to navigate to obtain the mental health medications that have already been prescribed and approved through the prior authorization process.

How many people would be directly affected by this change?
According to data provided to the Global Medi-Cal Drug Use Review (DUR) Board in February 2021, there were approximately 600,000 adults in Medi-Cal who were prescribed a medication to address serious mental illness in the 2020 fiscal year. At any point in time one of these individuals could be denied or delayed a refill due to the existing prior authorization requirement.

What precise changes would this bill make to current Medi-Cal policy?
AB 1437 makes the following changes:

- Removing the prior authorization from being required for any drug prescribed for the treatment of an SMI and
- Automatically approving a prescribed drug for the treatment of SMI if there is a record of a paid claim that documents a diagnosis of a SMI within 365 days before the date of that prescription.

- Ensuring these changes apply only to prescriptions for a person 18 years of age and older who is not under the transition jurisdiction of the juvenile court.

Why is an automatic approval if a record of a paid claim that documents a diagnosis of a SMI within 365 days important?

Treatment for persons with serious mental illness is often a series of trial and error between the prescribing provider and the patient. However, once a patient experiences a positive treatment response, maintenance treatment is typical. As an example, in patients with schizophrenia, experts recommend "first-episode patients [are] treated for at least 1 year, while those with multi-episodes should have treatment for at least 5 years." Other state Medicaid programs also use a 365 day lookback for these types of drugs to include continuity of care, including Colorado, Missouri and Virginia.

This bill recommends 365 days because it aligns with typical dosage periods for these types of treatments. Similarly, to ensure uninterrupted care for certain kinds of patients, Medicare recently finalized a rule for Part B drugs changing the threshold from 108 to 365 days.

This bill does not change the frequency at which a patient sees their health care provider, or whether a prescriber and patient working together might decide to change a medication during the year. It only seeks to remove the requirement for additional authorizations once a medication is started and the patient and prescriber want to continue to that treatment path.

Will this bill change the protections Medi-Cal currently has in place for children and youth?

The existing Medi-Cal program rules, alerts and clinical guidelines related to medication interactions with certain drugs and antipsychotics, concomitant use with anticholinergic medications, restrictions on prescriptions for patients under 18 years of age, and for patients over 65 years of age who reside in skilled nursing facilities, will not be altered by this bill.

This bill is narrowly focused on the ambulatory population over the age of 18 who are not under the transition jurisdiction of the juvenile court, who are being prescribed a drug for the treatment of a serious mental illness.

For example, the current Medi-Cal policies requiring an approved Prior Authorization Request for any antipsychotic medication for all Medi-Cal beneficiaries 0 – 17 years of age and requiring an approved Prior Authorization Request for beneficiaries residing in skilled nursing facilities (SNFs) would not be affected by this bill.

Don't the changes happening through Medi-Cal Rx address this issue?

Before Medi-Cal Rx was proposed, mental health medications were "carved-out" of Medicaid managed care contracts, along with a few other types of therapy. Because these medications are already handled on a fee-for-service basis by Medi-Cal, the policy changes being implemented by Medi-Cal Rx do not pertain to this category of medications. Because the managed care plans do not manage mental health services for the severely mentally ill, this bill is not affected by Medi-Cal Rx, and is still needed in order to ensure access to prescribed SMI medications for adult patients.

What entities have voiced their support of this bill?

The following organizations or people have voiced their support of this bill:

- California Access Coalition (Co-Sponsor)
- Psychiatric Physicians Alliance of California (Co-Sponsor)
- Alliance for Patient Access (Co-Sponsor)

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[i] HCAI, Mental and Behavioral Health Diagnoses in Emergency Department and Inpatient Discharges by Healthy Places Index Ranking, 2023.

[ii] DHCS, Understanding Medi-Cal's High-Cost Populations. March 2015.

[iii] West, Joyce C., et al. "Medicaid Prescription Drug Policies and Medication Access and Continuity: Findings From Ten States." Psychiatric Services, 13 Jan. 2015, ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.5.601#jt07t3.

[iv] Unni, Elizabeth J., et al. "Medication Non-Adherence in the Homeless Population in an Intermountain West City." INNOVATIONS in Pharmacy, vol. 5, no. 2, Jan. 2014, doi:10.24926/iip.v5i2.342.