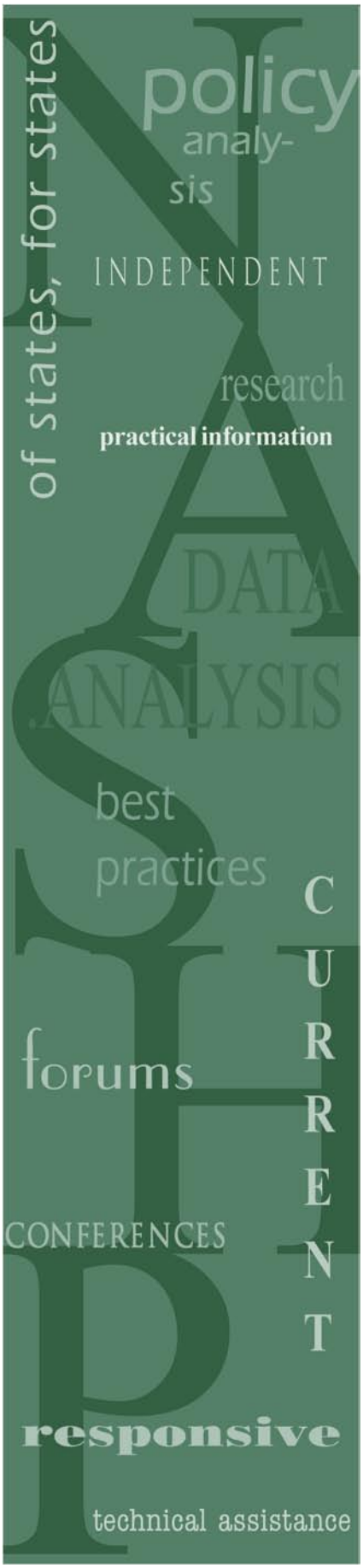

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State Efforts to Manage The Behavioral Health Pharmaceutical Benefit

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Behavioral Health Pharmaceuticals

In recent years, states have begun to consider ways to better manage behavioral health pharmaceuticals because of both increases in cost and shifts in utilization, factors that are driving cost increases for other pharmaceuticals as well. Medicaid agencies in the site visit states reported that pharmaceuticals used to treat mental illnesses consume a greater percent of their Medicaid pharmaceutical budget than drugs for any other disease category. For example, Florida reported that, of the $2.6 billion spent on pharmaceuticals in Medicaid fee-for-service in 2003, behavioral health pharmaceuticals cost more than $500 million—just below 20 percent of the total. And while behavioral health pharmaceuticals are made up of many drug classes—including antineuroleptics (drugs that treat the neurological hyperactivity that causes spasms, seizures, and tics), anxiolytics (antianxiety drugs) and hypnotics, and stimulants—states report that antipsychotics and antidepressants are their greatest concern. In particular, the cost implications of providing broad access to atypical antipsychotics (AAPs, such as Risperdal and Zyprexa) and second-generation antidepressants (such as Paxil, Prozac, or Zoloft), have raised concerns among some states.

AAPs and second-generation antidepressants are among the more expensive and widely used drugs. Most of these drugs have come on the market in the last 15 years, and some are still protected by original patents. However, many have recently become available in generic form. Site visit states also report that utilization of AAPs and second-generation antidepressants has increased dramatically over the same time period, as prescribing patterns have shifted utilization away from "typical" antipsychotics like haloperidol and older-generation antidepressants like monoamine oxidase inhibitors and tricyclics. The high cost and increasing utilization of these psychotropic medications have made them one of the largest cost centers for Medicaid pharmacy programs. AAPs in particular are driving much of the cost, as nationally they comprise more than 90 percent of the national market for antipsychotics, a class which cost Medicaid programs more than $3 billion in 2004.[1]

However, site visit states also report that psychotropic medications work well and are cost-effective, particularly the AAPs and second-generation antidepressants. As a general rule, AAPs (clozapine, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole) are believed to treat serious conditions like schizophrenia with fewer side effects—particularly the irreversible tardive dyskinesia—than older, "typical" antipsychotic medications.[2] Similarly, second- generation antidepressants, including Prozac (fluoxetine) and other selective serotonin reuptake inhibitors (SSRIs), are considered at least as effective as older generation antidepressants and often have fewer side effects.[3]

However, these newer medications do not work for all beneficiaries. In some cases, older AAPs and antidepressants are more appropriate, which, in part, is why states have been reluctant to engage in access management strategies. However, a recent study indicated that people with psychotic disorders are no more likely to adhere to a medication regimen of AAPs than typical antipsychotics, and that physicians may be able to reduce the incidence of side effects like tardive dyskinesia by using lower doses of older medications. It is too soon to tell if states will use this new evidence to promote the use of older, typical antipsychotics, as many people predict.[4]

Managing behavioral health pharmaceuticals

The site visit states generally have not acted aggressively to manage access to behavioral health pharmaceuticals, in part because they believe that psychotropic medications require individual adjustments. States reported that they see the use of psychotropic drugs as more of an art than a science, and that they must be managed to reflect the range of individual responses and tolerance for side effects. As a result site visit states were concerned that the use of a preferred drug list (PDL) might inadvertently lead to psychiatric destabilization[5] and more costly acute or inpatient care. These more intensive forms of care are significantly more expensive for states, as federal Medicaid funds cannot be used to pay for services provided to beneficiaries between the ages of 22 and 65 in institutions for mental diseases (IMDs).[6]

However, cost and quality of care were not the only reasons states have eschewed management of behavioral health pharmaceuticals. Every site visit state reported that, within their respective states, strong advocacy coalitions for behavioral health issues—including the National Alliance for the Mentally Ill, Mental Health Associations, community mental health agencies, psychiatrists, and consumer groups—have made it politically difficult to manage access. Missouri, for example, encountered stiff resistance to a seemingly minor change that required consumers to switch from Clozaril to its generic equivalent.

Most stakeholders in the site visit states feared state efforts to manage behavioral health pharmaceuticals would hinder access to needed medications. These groups asserted that psychotropic drugs require sensitive adjustments to account for individual responses and tolerance of side effects. These issues, they argue, are not easily addressed through pharmacy management efforts like a PDL that can hinder access to these drugs.

Some states have already begun to examine behavioral health pharmaceuticals more closely, and many states expect to pay more attention to them in the future. DERP released its first report on second-generation antidepressants in November 2004 in the midst of our six site visits. They have since released an initial report on AAPs and an update to the report on second-generation antidepressants. Site visit states believed that these reports would be instrumental in making an evidence-based case for managing behavioral health pharmaceuticals. For example, Washington reviewed the report on second generation antidepressants in December 2004 and February 2005. This data was used to produce a PDL of five preferred generic drugs that was implemented in July 2005. Washington's P&T Committee is scheduled to review AAPs in 2006.

Implementation of the Medicare prescription drug benefit in 2006 will dramatically alter state efforts to manage the pharmacy benefit in Medicaid and may cause states to consider strategies to manage behavioral health

drugs. After Medicare coverage goes into effect, Medicaid agencies will no longer manage the pharmacy benefit for dual eligibles (enrollees of both Medicaid and Medicare). Many state staff interviewed anticipated that removing the dual eligibles from their pharmacy management programs would lead them to consider strategies to address the remaining high-cost therapeutic classes, including drugs used to treat behavioral health conditions. CMS data confirms that they will be a large cost center once the Medicare drug benefit takes effect. Antipsychotics and antidepressants accounted for about 17 percent of the total Medicaid pharmacy costs for enrollees other than dual eligibles in 1999[7].

What have site visit states done?

States reported a number of ways to manage behavioral health pharmaceuticals, only some of which were currently being used. Few of the site visit states used PDLs and other types of front-end strategies to manage these drugs. Most reported that instead they had used back-end strategies, such as drug utilization review.

Managing beneficiary access

States reported on four access management strategies, none of which were widely used, as shown in Table 1. Two of these—PDLs and caps on the number of prescriptions a beneficiary can have filled each month—are not specific to behavioral health pharmaceuticals. An early iteration of Michigan's PDL included AAPs and second generation antidepressants, but this was dropped shortly after implementation because of pressure from consumers and advocates. Both California and Florida reported that they had capped the number of prescription drugs that can be obtained without prior approval, though Florida specifically exempted prescriptions for behavioral health drugs.[8] The Texas Medication Algorithm Program (TMAP) that is specifically designed for some serious mental illnesses[9] and the fail-first strategy are access management strategies with a specific application in behavioral health pharmaceuticals. These initiatives were widely discussed in site visit states. However, California is the only site visit state to report any experience with TMAP, and no state used the fail-first strategy.

Table 1: Management of behavioral health pharmaceuticals in site visit states

	California	Florida		Michigan	Missouri	Washington*
Exemption of psychotropics from a PDL or other access management strategies.	Established administratively (only some psychotropic drugs are exempt)	No	No	None, then established administratively, then legislatively	Legislative	N/A
"Grandfather" clause**	No	Yes	No	Yes	No	Yes
Limit on total number of prescriptions per month	6	4 (MH drugs exempt)	No	No	No	No
TMAP***/Fail-First strategy	TMAP	None	None	None	None	None
DUR process for MH drug issues (eg. poly-pharmacy)	Yes	No	Yes	Yes	Yes	No

* At the time of our visit, Washington had not reviewed AAPs and was considering using a fail-first methodology for second generation antidepressants. They have since established a PDL for second-generation antidepressants with five generic drugs, and expect to address AAPs in 2006.

** A "grandfather" clause exempts people already stabilized on a medication regimen from any of the state's management strategies.

*** TMAPis the Texas Medication Algorithm Project, a method specifically designed for schizophrenia, major depressive disorder, and bipolar disorder.

Improving physician practices

Four of the six site visit states reported having reviewed physician prescribing patterns for behavioral health pharmaceuticals. Kansas, Missouri, Michigan, and California all use their federally-required drug utilization review (DUR) programs[10] to manage behavioral health pharmaceuticals. These states' DUR programs seek to change the practices of physicians who have a history of suboptimal prescribing patterns for behavioral health pharmaceuticals. Missouri and California both reported that they specifically address issues of polypharmacy—prescriptions for more than one drug in the same class—for AAPs. Of states using drug utilization review, Missouri has the most aggressive process for identifying and trying to change physicians; suboptimal prescribing patterns.

The Missouri Mental Health Medicaid Pharmacy Partnership Program

Of the site visit states, Missouri engaged in the most extensive effort to address the use and cost of behavioral health pharmaceuticals. In 2003, Missouri's Department of Mental Health and the Medicaid agency developed the Missouri Mental Health Medicaid Pharmacy Partnership Program (MHMPP) in conjunction with Comprehensive NeuroScience (CNS), a health care consulting company from White Plains, NY. The pharmaceutical company, Eli Lilly, funded the MHMPP in its first two years and Missouri began funding the program in 2005.

MHMPP uses encounter, beneficiary, and prescription data to compare Medicaid physician prescribing practices to nationally recognized, standardized guidelines. Physicians that deviate from the guidelines are then notified that their prescribing practice does not conform to the standard of practice, and sent appropriate educational materials. MHMPP does not sanction physicians that continue to deviate from the guidelines, though the contact with the physician exerts strong pressure to change practice. MHMPP also identifies beneficiaries who are receiving the same (or similar) prescription from multiple providers, and then works to eliminate unnecessary prescriptions.

Missouri reports that these efforts have reduced anticipated 2004 Medicaid costs by $7.7 million. Furthermore, the MHMPP led to:

- A 98 percent reduction in beneficiaries receiving the same prescription from multiple providers;
- A 64 percent reduction in beneficiaries on multiple drugs within the same class;
- A 43 percent reduction of children on three or more behavioral health drugs; and
- A 40 percent reduction in the number of beneficiaries receiving medication doses that exceed guideline recommendations.[11]

Stakeholders—including pharmaceutical manufacturers and consumer advocates—report that they are satisfied with the work of the MHMPP and view it more favorably than access restrictions.

How does MHMPP work with physicians?

CNS begins by reviewing encounter data to identify physicians that deviate from standard practice guidelines that address polypharmacy, maximum dosage levels, and rapid switching from drug to drug. They review guidelines from a number of external sources, including the American Psychiatric Association. CNS does not identify a single standard to which physicians must adhere, so long as it is clear that a standard is being followed.

Physicians who deviate from the guidelines are then targeted with a program of peer education. MHMPP has created three levels of nonbinding interventions with physicians.

Initially the Medical Director of the Missouri Department of Mental Health (DMH) sends the physician a letter, detail sheets for all relevant beneficiaries (including information on which drugs, dates, and dosages), and educational materials on the standard of practice.
After 5-6 months, if the physician has not improved, MHMPP sends a letter that identifies the physician's rank among worst offenders in the state in the relevant area of prescribing practice: e.g., "You have the third highest number of patients with multiple prescriptions for atypical anti-psychotics in Missouri." Missouri state staff report that this changes behavior in most cases.
If the suboptimal prescribing practice continues, the Department of Mental Health calls the physician and offers to establish a call or in-person meeting with a well-respected physician in Missouri to review the specific case.

Missouri reported that these efforts are successful because they use peer education and are targeted only to those physicians who deviate from standards of practice.

Missouri reported that MHMPP's peer education effort has no power to sanction physicians, and that letters sent emphasize that the information is only advisory. Physicians therefore face no consequences if they decide to deviate from the standards of practice. Nonetheless, Missouri reports that the peer pressure involved is quite substantial and that the nonbinding nature of the guidelines is a key to success. Further, physicians generally appreciate an approach that emphasizes education.

Missouri also reports that peer education is efficient because it allows state officials to concentrate on working with a limited number of providers. Their data shows that 5 percent of prescribing physicians account for more than 50 percent of the costs associated with deviations from standard guidelines.

Conclusion

Behavioral health pharmaceuticals are a substantial portion of state pharmacy costs in Medicaid. As beneficiaries that are dually eligible for Medicaid and Medicare begin to receive the Medicare drug benefit, the portion of state pharmacy costs attributable to AAPs, second generation antidepressants, and other behavioral health pharmaceuticals is expected to rise. With this increase, states may pay even more attention to managing behavioral health pharmaceuticals in Medicaid.

While states generally see behavioral health pharmaceuticals as cost effective—particularly considering the expense of alternatives—many have begun initiatives intending to trim costs and optimize quality. Despite the generally light approaches to managing behavioral health pharmaceuticals, site visit states nonetheless report principles that will guide future efforts. Among these:

- Consumers and advocates have voiced strong opposition to efforts that would restrict access to behavioral health pharmaceuticals. They are particularly concerned with efforts such as a PDL that they perceive as arbitrary.
- States have generally not used front-end interventions to manage access to behavioral health drugs.
- Drug utilization review has not incurred the ire of consumers and advocates because it is viewed as encouraging quality of care and permitting physicians to use their clinical expertise.
- Missouri reports that in 2004, its DUR effort produced a cost savings of $7.7 million and an increase in the quality of care for people with mental illnesses.

Notes

[1] "Little difference found in schizophrenia drugs" *New York Times,* September 20, 2005.
[2] "*Drug Class Review on Atypical Antipsychotic Drugs*" DERP (January 2005)
[3] "*Drug Class Review on Second Generation Antidepressants*" DERP (July 2005)
[4] "Little difference found in schizophrenia drugs" *New York Times,* September 20, 2005.
[5] Decompensation is the process of psychiatric destabilization that leads to an episode of psychological imbalance.
[6] §435.1008 (a)(2) of Title 42
[7] http://www.cms.hhs.gov/researchers/projects/medicaid_rx/USA_main.pdf (9/30/2005)
[8]This has bearing on access to behavioral health medications for two reasons: most second-generation antidepressants and AAPs are still protected by intellectual property rights. Consequently, there are no generic alternatives available for these medications. At the same time, stakeholders in these states observed that mental health consumers tend to have multiple health problems for which brand-name drugs may be appropriate. The confluence of these two phenomena could therefore impede access to needed behavioral health medications.
[9] For more information on the Texas Medication Algorithm Program see http://www.dshs.state.tx.us/mhprograms/TMAPtoc.shtm.
[10] §1927(g) of the Social Security Act specifies the requirements for DUR programs.
[11] Press Release "*Missouri sees $7.7 million in mental health services savings,*" December 9, 2004 (accessed from http://www.dmh.mo.gov/newsreleasesevents.htm 9/20/2005).

About the Series

Medicaid agencies report that pharmacy costs are a major driver of overall spending growth in Medicaid programs.[1] Many states believe tools such as preferred drug lists and prior authorization can help curtail pharmacy costs (while ensuring beneficiaries have access to needed prescription drugs) and that using clinical evidence for these tools can make them more credible. These states recognize that prescription drugs—even expensive ones—can be cost effective and improve quality of life.

In 2004, the Commonwealth Fund funded the National Academy for State Health Policy and Georgetown University to conduct a series of site visits to examine state efforts to manage the pharmacy benefit in Medicaid programs. With input from a broad-based advisory group of state officials and other experts, researchers selected six states (California, Florida, Kansas, Michigan, Missouri, and Washington) where they met with multiple groups of stakeholders, including agency staff, pharmacy vendors, pharmacists, physicians, drug utilization review (DUR) and pharmacy and therapeutic (P&T) committee members, and advocates for consumers.

This brief, the fourth of four, smmarizes the experience of site visit states regarding the management of the behavioral health pharmacy benefit. The other briefs in this series examine state efforts concerning Pharmacy and Therapeutics Committees, Prior Approval processes, and the role of the Drug Effectiveness Review Project (DERP) in providing states with systematic evidence-based reviews of pharmaceuticals. Our observations indicate that states face critical issues in designing and

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