Using a Clinical and Evidence-Based Strategy to Preserve Access to Psychiatric Medications

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Pharmacy expenses are the fastest growing component of Medicaid budgets across the nation. As state revenues continue to decline and health care expenses continue to rise, policy makers have been forced into action to avert a feared meltdown of state Medicaid programs. In Massachusetts, the Medicaid pharmacy expenditures for the state's Medicaid population of 940,000 reached $950 million in fiscal year 2002. Medications considered to be primarily psychiatric medications account for 47 percent of the entire pharmacy budget.

In our roles as medical directors of the Massachusetts Department of Mental Health and Division of Medical Assistance (Massachusetts Medicaid), we are responsible for clinical standards and for prudent use of resources. We are required to ensure that our patients and members receive adequate care within resource limits specified by the state government. To watch passively while pharmacy expenditures grow without intervention would guarantee substantive—possibly harmful—limits on the pharmacy benefit as a result of budgetary pressures.

Clinicians seek the best treatment for their individual patients. However, as policy makers we are obligated to calculate the effect of prescribing practices on an entire population of vulnerable individuals and to steward the resources used in obtaining these effects. In Massachusetts, we are attempting to use clinical expertise to protect access to medications while using our policy-making role to influence and even change some questionable pharmacological practice patterns.

We have chosen to focus our efforts on three proliferating polypharmacy practices for which there is limited or no evidence base: routine and concomitant use of more than one atypical antipsychotic for more than a reasonable crossover period (60 days), use of two selective serotonin reuptake inhibitors for more than 60 days, and concomitant use of five or more psychotropic medications (1).

In our dual roles as clinicians committed to individual patients and stewards of public resources (2), we are seeking cost containment strategies guided by clinical wisdom and an ethical framework to avoid the more draconian and less clinically and ethically guided alternatives (3). We began our planning process with eight basic premises:

♦ Much of the growth in pharmacy expenditures is positive. It represents improved access to psychiatric treatment, which is an indirect measure of reduced stigma associated with psychiatric disorders.

♦ Some of the growth in expenditures is a function of rising medication costs. We advocate for the lowest possible cost for these medications.

♦ Many strategies, such as tiered copayments and restricted formularies, common in commercial health insurance plans, are not available to Medicaid programs, which must adhere to the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) in their pharmacy benefit programs or risk losing both federal dollars and pharmacy rebates.

♦ Substantial copayments for indigent persons with psychiatric illness will generate access problems without providing a significant revenue stream, clearly a lose-lose strategy.

♦ Under federal law for Medicaid programs, prior authorization is the primary tool available to Medicaid programs for utilization management.

♦ Requiring prior authorization for psychiatric medications on the basis of cost alone, as has been attempted recently in some states, is a poor strategy. It is not based on clinical reasoning and has been reported to increase costs in other parts of the system.

♦ The Medicaid population frequently faces greater educational, linguistic, and cultural barriers in obtaining services than commercially insured populations.

♦ Policy changes can affect the number of physicians who are willing to accept Medicaid patients into their practices.

The Massachusetts Medicaid Pharmacy Program has long used prior authorization to manage both utilization and clinical aspects of care. To make the system user-friendly, Massachusetts has developed the MassHealth Drug List, which lists all drugs and whether prior authorization is required. Clinical experts participate in the development of the list. Because persons with psychiatric illnesses are

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often less able to advocate for themselves and because individual responses to medications vary, we have elected to retain maximal initial access to drugs while discouraging the use of individual medications and combinations of medications for which there is minimal or no evidence base.

The clinical work group we assembled included leading psychopharmacologists, members of the Massachusetts Psychiatric Society, and representatives of the Department of Mental Health, the Division of Medical Assistance, the State Pharmacy Program, and the Alliance for the Mentally Ill. The group's charge was to evaluate clinical practices in Massachusetts and make recommendations for managing the psychiatric portion of the pharmacy budget. We consulted with the Consumer Advisory Council and the Family Advisory Council of the Massachusetts Behavioral Health Partnership, the Medicaid carve-out vendor during the early stages of the project (4,5). We found that as of January 2002, more than 2,200 adults received more than one atypical antipsychotic at a time for more than 60 days, at a cost of $24 million; that almost 5,000 Medicaid recipients were taking more than one selective serotonin reuptake inhibitor for more than 60 days, at a cost of more than $4.5 million; and that more than 1,100 MassHealth recipients were receiving five or more psychiatric medications in January 2002, often from multiple prescribers. These data were supported by information gathered during case conference presentations throughout the state.

To make changes in the system, we needed to identify the forces that encourage polypharmacy. One such force is time. Inpatient stays are short, and psychiatrists feel pressured to stabilize patients rapidly. There is rarely time for medication "washouts," which could allow assessing a patient's status in a drug-free state. And, typically, short outpatient visits may not allow the kinds of information gathering that is necessary for adjusting postdischarge medication regimens.

Another factor that encourages polypharmacy is faulty clinical reasoning. Patients and clinicians are eager to see results and may attribute improvement to a newly added medication when the causative factor might actually be placebo effect, other psychosocial factors, or the gradually emerging impact of the original medication. Clinical culture is another contributor. Psychiatrists are eager to see their patients improve and often "push the envelope" by adding new agents to a regimen. And practitioners frequently are not aware of the cost of the regimen and the impact of cumulative costs on the Medicaid budget and access to care. Finally, optimism encourages polypharmacy. U.S. culture reveres new technologies, including new medications. Pharmaceutical industry marketing to physicians and consumers abets these attitudes.

Our hope is that by educating prescribers and applying prior authorization procedures to polypharmacy practices for which there is minimal or no evidence base, we will be able to improve care and moderate increases in expenditures for psychiatric medications. We have begun a campaign to educate all prescribers about the actual cost of prescribing patterns and the threat that escalating pharmacy costs pose to Medicaid's ability to sustain good access for the insured population. We have identified the relatively small number of physicians—"outliers"—who use polypharmacy routinely and will engage them in dialogue to review their prescribing practices and the evidence base as it relates to the patients they treat. Polypharmacy is surely crucial for some patients, and we must ensure that these patients have continued access to the regimens that are helping them. We will not require alteration of any regimens without allowing ample time for evaluation, consultation, and establishment of new approaches. Finally, we are seeking to engage consumers and family members in the process by consulting with them about our plans and offering education. Educated patients and families can be more effective partners with the prescribing physician in establishing and monitoring evidence-based regimens.

By focusing on expensive and untested practices, we hope to encourage more thought about polypharmacy regimens. We recognize that patients are complex, are often challenging diagnostically, and typically come with multiple medical and social problems. We also know that our doctors often do not have time to listen to patients as extensively as they would like. In these circumstances they may instead add drugs to the regimen. They may also lack time to pursue more evidence-based strategies. We are evaluating the possibility of longer inpatient visits to accomplish these aims.

Massachusetts, like other states, is facing severe financial problems in its Medicaid program. Drug costs are a highly visible and rapidly escalating component of overall costs. We have observed a proliferation of prescribing practices that create an opportunity to constrain costs and that may promote a more evidence-based prescribing culture.

We intend to evaluate the impact of this initiative on patients and prescribers through ongoing review of clinical outcomes and service use. As clinicians with administrative responsibilities we hope to engage our colleagues in a statewide dialogue about the culture of care and the evidence base for prescribing practices. We will work with the Massachusetts Psychiatric Society, the Massachusetts Medical Society, experts in psychopharmacology, consumers, and family members to build support for public policies that promote evidence-based practice and rational psychopharmacology. Such a strategy will increase our state's ability to promote better outcomes for needy, vulnerable citizens by sustaining access to effective, cost-attentive psychopharmacology. ♦

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