Improving Psychiatric Drug Benefit Management: IV. Experiences of a Pharmacy Advisory Committee

Diane Gottlieb, M.D.
William R. Dubin, M.D.
Autumn Ning, M.D.
George C. Gardiner, M.D.

The effort to contain pharmacy costs has been a major challenge for the health care industry (1). Common cost-control strategies include open, preferred, tiered, and closed formularies (2). Recently, several notable initiatives have addressed how prescribing practices affect quality of care and financing (3–5, personal communication, Parks JJ, 2003). These strategies focus on three critical elements of prescribing practices: medication availability, cost-effective prescribing, and quality-driven medication management. This column describes the experience of the Southeastern Pennsylvania regional pharmacy and therapeutics committee in trying to maintain medication availability while addressing Medicaid's financial constraints.

In 1997 the Pennsylvania Medicaid program began transferring Medicaid recipients from a fee-for-service program to a mandated program called Health Choices that required all Medicaid patients to enroll in one of three health maintenance organizations (HMOs) of their choice. Behavioral health was carved out to three behavioral health managed care organizations (BH-MCOs). The Southeastern Pennsylvania Health Choices included the Medicaid population of Philadelphia and the counties of Delaware, Chester, Bucks, and Montgomery. The creation of a pharmacy and therapeutics committee in southeastern Pennsylvania was mandated as part of the Pennsylvania Health Choices initiative. The committee includes six psychiatrists from the practice community along with representatives from relevant state agencies, BH-MCOs, and general health HMOs. The committee meets monthly throughout the year.

From the perspective of the practice community, the psychiatrists from the Medicaid network have served two important functions on the pharmacy and therapeutics committee. First, they have promoted a pharmacy management process that is more user-friendly. Second, they have influenced the formularies to enhance the availability of medication.

Improving the pharmacy management process

In the first year of the Health Choices program, each BH-MCO was responsible for its own psychotropic drug formulary and budget. Although psychotropic medications were part of each behavioral health formulary, many primary care physicians were prescribing antidepressants, benzodiazepines, and antipsychotics. At the same time psychiatrists were prescribing anticonvulsant medications from the general health formulary for use as mood stabilizers. Patients had to carry two pharmacy cards—one for behavioral health medications and one for general health medications. It was also difficult to keep track of who was prescribing which medications to patients because the general health HMOs did not have a list of psychiatric providers and the BH-MCOs did not have a list of the HMO providers. A patient could receive prescriptions from a psychiatrist and additional prescriptions from the primary care physician. This issue was especially problematic with scheduled drugs, such as benzodiazepines. As a result, a decision was made by the Pennsylvania Department of Welfare that each general health HMO would manage its own formulary and have financial responsibility for all outpatient medications, including psychotropic medications. Inpatient medications would continue to be included in the BH-MCO per diem rates.

From the outset the HMOs protested that because they did not control the network of psychiatrists they had no leverage to control prescribing patterns or to monitor quality in the split system. The general health HMOs did not benefit financially from the purported advantages of the new and significantly more expensive second-generation antipsychotic medications, which were reported to have fewer side effects, to increase adherence, and to reduce hospitalizations. As more of these sec-

Dr. Gottlieb, Dr. Dubin, and Dr. Ning are affiliated with the department of psychiatry at Temple University School of Medicine, 1316 West Ontario Street, Room 719, Jones Hall, Philadelphia, Pennsylvania 19140 (e-mail, diane.gottlieb@temple.edu). Dr. Gardiner is with Community Behavioral Health in Philadelphia. James E. Sabin, M.D., and Alison Evans Cuellar, Ph.D., are editors of this column.

ond-generation antipsychotics became available, pharmacy costs escalated approximately 20 percent a year.

In an effort to contain costs, the HMOs began discussing, and in some instances implementing, strategies to limit which second-generation antipsychotic medications were available or to limit the dosages prescribed. This strategy was also used with the selective serotonin reuptake inhibitors (SSRIs). This plan put the goals of the HMOs in direct conflict with those of the BH-MCOs, which were trying to provide care in the least restrictive environment and to minimize hospital admissions and lengths of stay. Psychiatrists and consumers were concerned that any new medication would not be available. Even when these medications were available with preauthorization, the process was cumbersome and discouraged physicians from prescribing regimens that required authorization.

As a result of these conflicts, the pharmacy and therapeutics committee began playing a prominent oversight role by reviewing proposed formulary changes and acting as a forum to discuss HMO initiatives that were related to the authorization process. The goal was to protect patients from potentially adverse pharmacy practices and to ensure quality-driven prescribing through collaboration between community psychiatrists, the BH-MCOs, and the HMOs.

Since the creation of the committee, clinicians have consistently agreed that if the prior authorization process were simplified and uniform, then formulary restrictions would not be so onerous. Psychiatrists frequently complained that the complicated preauthorization process created impediments to prescribing nonformulary drugs. The HMOs supported the idea of a single preauthorization policy for all three HMOs. A group of clinicians developed a uniform prior authorization form and presented it to the committee for approval. The form was piloted successfully and was recently approved for use by all three participating Health Choices HMOs.

Enhancing drug availability

In 1999 the first point of contention occurred when one of the HMOs removed sertraline from its formulary for cost reasons, without prior discussion with the pharmacy and therapeutics committee. The HMO's justification was that four other SSRIs were available on its formulary. There was an immediate outcry from the psychiatric community and the Mental Health Association of Southeastern Pennsylvania. The pharmacy and therapeutics committee members reviewed the literature and conducted discussions over several months about the efficacy of and the need for sertraline among specific patient populations, such as pregnant women. Influenced by these discussions, the HMO softened its position on sertraline and made it available through the prior authorization process. Sertraline subsequently was put back on the formulary in 2002. As a result of this experience, if an HMO wants to restrict access to a drug or remove it from its formulary, it initiates a discussion with the pharmacy and therapeutics committee, which reviews the literature and comes to a consensus recommendation.

In 2000 the HMOs became concerned with the escalating costs of the second-generation antipsychotics and the practice of prescribing more than one of these drugs to a single patient, or therapeutic duplication. The HMOs imposed restrictions on the dosage and number of pills that could be prescribed each month, which paradoxically increased therapeutic duplication, because some psychiatrists prescribed one second-generation antipsychotic at the maximum dosage allowed by the HMO and then added an additional second-generation antipsychotic. As the HMOs struggled to contain costs, they were reluctant to put newly released second-generation antipsychotics on their formularies.

Discussions began about appropriate prescribing practices for these second-generation antipsychotics. In 2003 data from the state hospital system found high rates of therapeutic duplication with little or no justification in the records (personal communication, Fiorello SJ, 2003). After implementing a modified version of the Texas Medication Algorithm, the rate of therapeutic duplication decreased significantly (6). The psychiatrists supported the position of the HMOs that therapeutic duplication was generally not appropriate and that the use of two second-generation antipsychotics should be subject to preauthorization and close review. However, the psychiatrists educated the HMOs about the problems created when artificial limits on dosage conflict with emerging clinical experience. Initial drug dosage ranges are sometimes modified after extensive clinical use shows that higher or lower dosages are more effective or better tolerated. The psychiatrists also persuaded the HMOs to allow at least two months of therapeutic duplication when a patient switches from one medication to another.

When generic clozapine became available, reimbursement for Clozaril became an issue. The Health Choices program guaranteed equal access to the available psychotropics for the Medicaid population. Patients and providers had become accustomed to obtaining second-generation antipsychotics without any obstacles. At the time generic clozapine was approximately half the cost of Clozaril. However, despite literature supporting generic clozapine's efficacy, physicians expressed concern that an abrupt switch to the generic form by the outpatient pharmacies might disrupt the stability of the largely treatment refractory patients who were taking Clozaril. A subcommittee was set up that was composed of representatives from the HMOs and psychiatrists, and over the course of several meetings, guidelines were devised that supported the use of generic clozapine for patients who were beginning treatment with this medication while allowing the continuation of Clozaril for patients who were already stabilized on the medication. The discussions enabled the committee to consider the clinical and financial ramifications, issues related to competing companies that produce generic medications, and the potential risks of using generic medications that have been shown to be less efficacious or for which little evidence about efficacy is available.

Conclusions

Throughout its seven-year history the pharmacy and therapeutics committee has acted as a sounding board for the discussion of salient pharmacy issues, mediating disagreements between clinicians and the HMOs. The presence of community-based clinicians on the committee has helped keep the HMOs mindful of the realities of clinical care, while the HMOs have educated the clinicians about the importance of managing costs. These discussions have fostered the development of a best-practices model for the region. Although the authors believe that the most reasonable system would be one with a single payer that controls costs, the committee has been helpful in mediating disputes that arise as a result of the split financial responsibility, enabling the system to provide quality clinical care while saving money (7). Continuous participation by community-based psychiatrists has been crucial to the process. ♦

References

1. Huskamp H: Managing psychotropic drug costs: will formularies work? Health Affairs 22(5):84–96, 2003
2. Schreter RK: Managed pharmacy: a new direction in cost containment. Psychiatric Practice and Managed Care 6(l):4, 2000
3. Sabin JE, Daniels N: Improving psychiatric drug benefit management: I. Lessons from Massachusetts. Psychiatric Services 54: 949–951, 2003
4. Sabin JE, Daniels N: Improving psychiatric drug benefit management: II. Kaiser Permanente's approach to SSRIs. Psychiatric Services 54:1343–1349, 2003
5. Sabin JE, Daniels N: Improving psychiatric drug benefit management: III. The VA's approach to atypical antipsychotics. Psychiatric Services 55:22–25, 2004
6. Miller AL, Chiles JA, Chiles JK, et al: The Texas Medication Algorithm Project (TMAP) schizophrenia algorithms. Journal of Clinical Psychiatry 60:649–657, 1999
7. Daniels N, Teagarden R, Sabin J: An ethical template for pharmacy benefits. Health Affairs 22(1): 125–137, 2003