Prior Authorization for Psychotropic Medications

Summary of Research

1. Prior Authorization policies for psychotropic medications in Medicaid psychiatric patient populations have led to poor outcomes.
   1. Increased medication discontinuation, lapses in care (around 26% of patients)
   2. Amongst those with lapses in care, around 80% experience adverse consequences (a rate of 3.6 times more) such as:
      i. Increased utilization of emergency/crisis services
      ii. Homelessness
      iii. Incarceration
      iv. Lost wages
      v. Higher medical costs

2. Placing the burden of obtaining prior authorization for psychotropic medications on psychiatric prescribers further stretches an already scarce resource.
   1. 75% of NC counties have LESS THAN HALF the number of prescribers they need to meet county needs.
   2. NC is short nearly 1,000 prescribers to fill this gap
   3. Because of this shortage, psychiatric prescribing is frequently performed by primary care physicians. A prior-authorization requirement adds to the burden of taking care of this vulnerable population and will likely reduce the likelihood that primary care physicians will be willing to fill this prescriber gap, further worsening access to psychotropic medication management for this population.

3. NC has other tools to effectively manage psychotropic medications in the Medicaid population.
   1. A+KIDS and ASAP are programs which require registration/monitoring for patients on antipsychotics medications and provides ample data to assist in identifying physicians with prescribing practices which may not be cost effective.
   2. MCOs and CCNC can retrospectively analyze the prescribing patterns of psychiatric prescribers and primary care prescribers respectively. MCOs can work with prescribers to reward cost saving prescribing patterns and can require plans of correction for those whose prescribing practices fall outside of the standard of care. CCNC can identify prescribers who need targeted education around drug selection.
Research

Association Between Prior Authorization for Psychiatric Medications and Use of Health Services Among Medicaid Patients With Bipolar Disorder

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Abstract

Background
Prior authorization policies are commonly used by Medicaid programs to control psychotropic drug expenditures. This study examined the association of a prior-authorization policy for atypical antipsychotic and anticonvulsant agents with medication discontinuation and use of health services among patients with bipolar disorder.

Methods
A pre-post-with-historical-comparison-group design was used to analyze Maine Medicaid and Medicare claims data. Newly treated patients were identified during the policy (Jul 2003–Feb 2004; N=946) and a comparison group from the pre-policy period (Jul 2002–Feb 2003; N=1,014). Patients were stratified according to their pre-initiation visits to community mental health centers (CMHCs) that target those with the most serious mental illness: CMHC-attenders (at least 2 visits) and non-attenders (fewer than 2 visits). Changes in rates of medication discontinuation, outpatient, emergency room and hospital visits before and after drug initiation were estimated.

Results
CMHC-attenders had substantially higher rates of comorbidity and use of medications and health services than non-attenders. The policy was associated with increased medication discontinuation in both groups; reductions in psychiatric visits after discontinuing medication among CMHC-attenders (~64/100 patients/month; p<.05); and increases in emergency room visits after discontinuing medication among non-attenders (16/100 patients/month; p<.05). During the 8-month follow-up, the policy had no detectable impact on risk of hospitalization.

Conclusion
The Maine prior-authorization policy was associated with increased medication discontinuation and subsequent changes in use of health services. Though small, these unintended policy effects raise quality of care concerns for a group of very vulnerable patients. Long-term consequences of prior-authorization policies on patient outcomes warrant further investigation.
Estimate of the Net Cost of a Prior Authorization Requirement for Certain Mental Health Medications

Prepared by Driscoll & Fleeter for NAMI Ohio- The National Alliance on Mental Illness
Revised August 2008

Background
Executive Summary
The Ohio Department of Jobs and Family Services (ODJFS) has under consideration a requirement for prior authorization for the prescription of certain psychotropic drugs for patients with schizophrenia, bipolar disorder, and other serious forms of mental illness. This report is an update of a previously released report assessing the likely impact of such a policy. This revised report reflects modifications to the prior authorization policy currently under consideration by ODJFS, data on the number of severely mentally ill patients in Ohio provided to the researchers by ODJFS, and clarification of Maine’s prior authorization policy which acts as a benchmark for the analysis reported here.

Alleged Savings
Originally, ODJFS claimed that a prior authorization policy applicable to Medicaid Managed Care patients considered for inclusion in the FY08-09 biennial budget would save $47 million in Medicaid costs. After two revisions, ODJFS now claims that a prior authorization policy applicable to Medicaid fee-for-service patients will save $6 million. This figure, which has not been documented in any way by ODJFS, includes savings from 8 atypical antipsychotic medications and 44 other medications. Therefore, the savings from prior authorization of the psychotropic drugs will be less than $6 million.

Documented Costs
Much research has focused on the costs caused by the implementation of prior authorization requirements for drugs prescribed for the mentally ill in other states. Application of this research to Ohio enables the quantification of millions of dollars of additional costs as an unintended outcome of a prior authorization program for psychotropic drugs.

Maine’s experience with prior authorization provides an important benchmark for assessing the likely impact of such a policy in Ohio. As ODJFS is currently proposing in Ohio, Maine’s prior authorization initiative allowed established users of single therapy atypical antipsychotics to be grandfathered, and identified some atypicals as preferred drugs. One difference is that Maine did not provide an exemption for prescriptions written by psychiatrists. This difference is accounted for in the estimates detailed below.

Estimates of the number of persons with schizophrenia and bipolar disorder in the Ohio Medicaid program suggest that approximately 36,000 persons with such diagnoses would be affected by prior authorization requirements. 2) Research by the Harvard Medical School supports an estimate that prior authorization will increase the number of lapses in care for this population by 6%. 3) Other research shows that 80% of persons whose care lapses suffer expensive adverse consequences. 4) These adverse consequences include higher medical costs, hospitalization, lost wages, homelessness, and incarceration.
Medicaid Medication Access Problems and Increased Psychiatric Hospital and Emergency Care
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General Hospital Psychiatry xx (2010) xxx–xxx

Abstract
Objectives: To quantify the extent to which Medicaid programs may incur increased psychiatric emergency department and hospital use associated with clinically unintended medication discontinuations, gaps, switches and other access problems attributed to prescription drug coverage and management.

Method: This study uses clinically detailed, physician-reported data. A total of 4866 psychiatrists in 10 states were randomly selected from the AMA Masterfile; 62% responded and 32% treated Medicaid patients and reported on 1625 systematically selected Medicaid patients. Propensity score multivariate models assessed predicted probabilities and mean number of emergency department visits and hospital days.

Results: Many patients (46.0%, S.E.=1.3%) had medication access problems reported during the past year, including discontinuing or switching medications or inability to obtain clinically indicated prescriptions because of drug coverage or management. The expected number of emergency department visits was estimated to be 73.8% higher among patients with medication access problems reported compared to matched patients without access problems reported. Among acute stay inpatients, the expected number of hospital days was 71.7% higher for patients with medication access problems reported.

Conclusions: Medication access problems may have significant implications for Medicaid programs. The potential indirect costs of these policies in psychiatric and social services utilization should be considered in addition to direct pharmacy costs. © 2010 Elsevier Inc. All rights reserved.

West JC, Wilk JE, Rae DS, Muszynski IS, Stipec MR, Alter CL, Sanders KE, Crystal S, Regier DA.
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Source
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Abstract
OBJECTIVES:
The aims of this study were to compare medication access problems among psychiatric patients in ten state Medicaid programs, assess adverse events associated with medication access problems, and determine whether prescription drug utilization management is associated with access problems and adverse events.

METHODS:
Psychiatrists from the American Medical Association’s Masterfile were randomly selected (N=4,866). Sixty-two percent responded; 32% treated Medicaid patients and were randomly assigned a start day and time to report on two Medicaid patients (N=1,625 patients).

RESULTS:
A medication access problem in the past year was reported for a mean+/-SE of 48.3%+/-2.0% of the patients, with a 37.6% absolute difference between states with the lowest and highest rates (p<.001). The most common access problems were not being able to access clinically indicated medication refills or new prescriptions because Medicaid would not cover or approve them (34.0%+/-1.9%), prescribing a medication not clinically preferred because clinically indicated or preferred medications were not covered or approved (29.4%+/-1.8%), and discontinuing medications as a result of prescription drug coverage or management issues (25.8%+/-1.6%). With patient case mix adjusted to control for sociodemographic and clinical confounders, patients with medication access problems had 3.6 times greater likelihood of adverse events (p<.001), including emergency visits, hospitalizations, homelessness, suicidal ideation or behavior, or incarceration. Also, all prescription drug management features were significantly associated with increased medication access problems and adverse events (p<.001). States with more access problems had significantly higher adverse event rates (p<.001).

CONCLUSIONS:
These associations indicate that more effective Medicaid prescription drug management and financing practices are needed to promote medication continuity and improve treatment outcomes.
Part D and Dually Eligible Patients with Mental Illness: Medication Access Problems and Use of Intensive Services.

*Psychiatr Serv.* 2009 Sep;60(9):1169-74. doi: 10.1176/appi.ps.60.9.1169.
Huskamp HA, West JC, Rae DS, Rubio-Stipec M, Regier DA, Frank RG.

**Source**
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**Abstract**

**OBJECTIVE:**
This study examined the occurrence of medication access problems and use of intensive mental health services after the transition in January 2006 from Medicaid drug coverage to Medicare Part D for persons dually eligible for Medicaid and Medicare benefits.

**METHODS:**
Psychiatrists randomly selected from the American Medical Association’s Physicians Masterfile reported on experiences of one systematically selected dually eligible patient (N=908) in the nine to 12 months after Part D implementation. Propensity score matching was used to compare use of psychiatric emergency department care and inpatient care between individuals who experienced a problem accessing a psychiatric medication after Part D and those who did not.

**RESULTS:**
Approximately 44% of dually eligible patients were reported to have experienced a problem accessing medications. The likelihood of visiting an emergency department was significantly higher for those who experienced an access problem than for those who did not (mean odds ratio=1.75, mean p=.003). There was no difference in number of emergency department visits or hospitalizations for those who had at least one.

**CONCLUSIONS:**
Many dually eligible patients had difficulty accessing psychiatric medications after implementation of Part D. These patients were significantly more likely to visit psychiatric emergency departments than patients who did not experience difficulties. These findings raise concerns about possible negative effects on quality of care. Additional study is needed to understand the full effects of Part D on outcomes and functioning as well as treatment costs for this population.
Use of Atypical Antipsychotic Drugs for Schizophrenia in Maine Medicaid Following a Policy Change


Source
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Abstract
More than one-third of Medicaid programs and Medicare Part D plans use prior authorization (PA) policies to control the use of atypical antipsychotics (AAs). We used Medicaid and Medicare claims data to investigate how Maine’s PA policy affected AA use, treatment discontinuities, and spending among schizophrenia patients initiating AA therapy. Patients initiating AAs during Maine’s policy experienced a 29 percent greater risk of treatment discontinuity than patients initiating AAs before the policy took effect; no change occurred in a comparison state. AA spending was slightly lower in both states. Observed increases in treatment discontinuities without cost savings suggest that AAs should be exempt from PA for patients with severe mental illnesses.
North Carolina’s Mental Health Workforce: Unmet Need, Maldistribution, and No Quick Fixes
Kathleen C. Thomas, Alan R. Ellis, Thomas R. Konrad, Joseph P. Morrissey

**Background**
Recent data show a maldistribution of psychiatrists in North Carolina and critical shortages in some areas. However, only 11 entire counties have official mental health professional shortage designation.

**Methods**
This paper presents estimates of the adequacy of the county-level mental health professional workforce. These estimates build on previous work in 4 ways: They account for mental health need as well as provider supply, capture adequacy of the prescriber and nonprescriber workforce, consider mental health services provided by primary care providers, and account for travel across county lines by providers and consumers. Workforce adequacy is measured at the county level by the percentage of need for mental health visits that is met by the current supply of prescribers and nonprescribers.

**Results**
Ninety-five of North Carolina’s 100 counties have unmet need for prescribers. In contrast, only 7 have unmet need for nonprescribers, and these counties have inadequate numbers of prescribers as well. To eliminate the deficit under current national patterns of care, the state would need about 980 more prescribers.

**Limitations**
Data limitations constrain findings to focus on percentage of met need rather than supplying exact counts of additional professionals needed. Estimates do not distinguish between public and private sectors of care, nor do they embody a standard of care.

**Conclusions**
North Carolina is working to develop its mental health prescriber workforce. The Affordable Care Act provides new opportunities to develop the mental health workforce, innovative practices involving an efficient mix of professionals, and financing mechanisms to support them.