

## A Dilemma for State Medicaid Programs:

A look at the methods of addressing the rising pharmaceutical expenditures for treatment of mental health disorders

### KEY POINTS

- Mental health drug costs are rising rapidly within the Florida Medicaid program and elsewhere.
- Patients with mental health diagnoses are often clinically complex. Therefore, physicians require flexibility in prescribing drug regimens.
- Some studies indicate that providing mental health drug benefits may lead to higher costs in the long-term.
- Efforts to specifically address drug costs should be only one component of a broad reform effort that would include addressing utilization patterns, marketplace incentives, and accessibility of the relevant data.

In the past three years, state Medicaid programs have seen an average price increase of 37% for all classes of prescription drugs.<sup>1</sup> Reasons for this include escalating prices, an increase in the number of prescriptions per patient, and swelling Medicaid enrollment as a result of the expansion activities that have occurred over the past decade.

Mental health care drugs represent as much as a quarter of overall prescription drug costs within state Medicaid programs. Recent innovations in mental health medications have positively impacted the treatment of mental health patients. New generation drugs include antipsychotics such as Zyprexa and Risperdal, as well as selective serotonin reuptake inhibitors (SSRIs), such as Prozac, Zoloft, and Lexapro, which are commonly used to treat depression and other mental disorders. The popularity of these new drugs is explained

by the fact that they have fewer side effects and, in some cases, improved efficacy compared with some of the traditional drugs.<sup>2</sup> But these improvements have come at a price. A result of their effectiveness has been a rapid growth in their utilization and a matching increase in drug expenditures.

Over the course of the last several decades, Medicaid has become a major source of funding for patients with mental health disorders. In fact, nationally more than 60% of all expenditures for mental health benefits come from the Medicaid program,<sup>3</sup> and there is growing concern that without major programmatic changes, mental health drug expenditures will not slow in their rate of growth. Since Medicaid programs pay for more than half of the national expenditures that go towards antipsychotic, antidepressant, anticonvulsant and other psychotropic

#### DEFINITIONS: MENTAL HEALTH DRUGS

- ❖ **Antipsychotics**  
'Atypical' antipsychotics (dopamine and serotonin antagonists) and older antipsychotics
- ❖ **Antidepressants**  
Tricyclic antidepressants, serotonin-selective reuptake inhibitors (SSRIs), Monoamine Oxidase Inhibitors (MAOs)
- ❖ **Anxiolytics**  
benzodiazapines
- ❖ **Barbiturates, sedatives, hypnotics**  
barbiturates and non-barbiturate sedatives and hypnotics
- ❖ **Antimania** lithium

## Mental Health Expenditures in Florida

- Of the top 20 Medicaid drugs, ranked by total annual dollars spent, mental health drugs hold 7 of those positions—with the number one spot held by Zyprexa, an atypical antipsychotic.
- Medicaid spending on mental health drugs grew by 35% annually from 2000–2002, compared to 11% for all other drugs.
- In recent years, the growth in spending for mental health drugs is outpacing total pharmacy budget growth by nearly 20% per year.
- More than \$4,000,000 was spent on mental health drugs in 2003, representing nearly 25% of the total pharmaceutical expenditures in Medicaid.

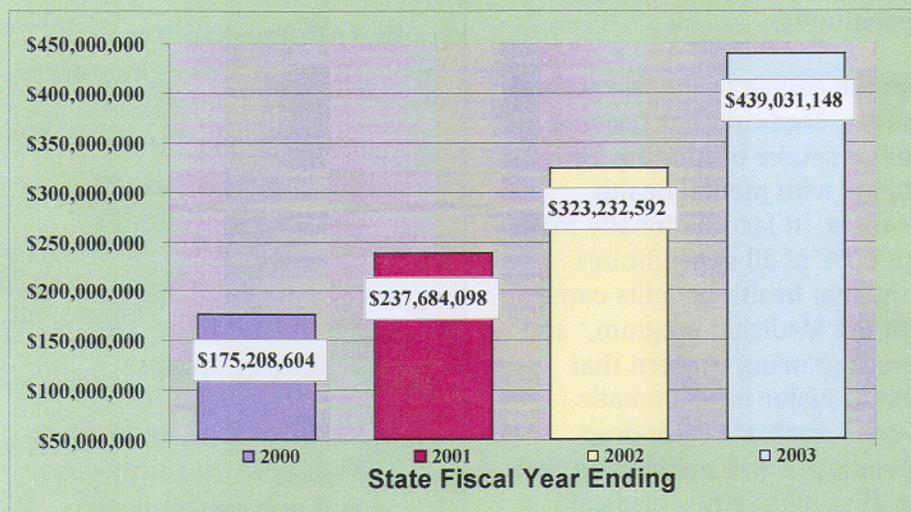
Sources: Agency for Health Care Administration. (2003). <http://www.fdhc.state.fl.us/Medicaid/index.shtml> ; Agency for Health Care Administration. (2004). "Medicaid Mental Health Drug Recommendations." *Governor's FY 2004–05 Budget Recommendations* to Senate Health and Human Services Appropriations Subcommittee, March, 2004; McCombs, Jeffrey S. Mulani, P., Gibson J. "Open Access to Innovative Drugs: Treatment Substitutions or Treatment Expansion?" *Health Care Financing Review*. Washington: Spring 2004. Vol.25, Iss. 3; pg. 35, 19 pgs.

### Fiscal Year 2002–03 Florida Medipass Claims Analysis

An analysis of claims from Florida Medicaid's Primary Care Case Management Program revealed:

- Over 500,000 MediPass (Medicaid's Primary Care Case Management Program) recipients, or more than 50 percent of individuals enrolled in the MediPass program, had one or more paid claims for a mental health medication.
- Depression was the most common mental health diagnosis among MediPass patients with paid psychotropic claims, numbering in excess of 126,000 throughout the year.
- The "newer" atypical antipsychotics (ziprasidone, risperidone, quetiapine, olanzapine, clozapine) accounted for \$210 million in drug expenditures.

**TOTAL MEDICAID EXPENDITURES FOR MENTAL HEALTH DRUGS**



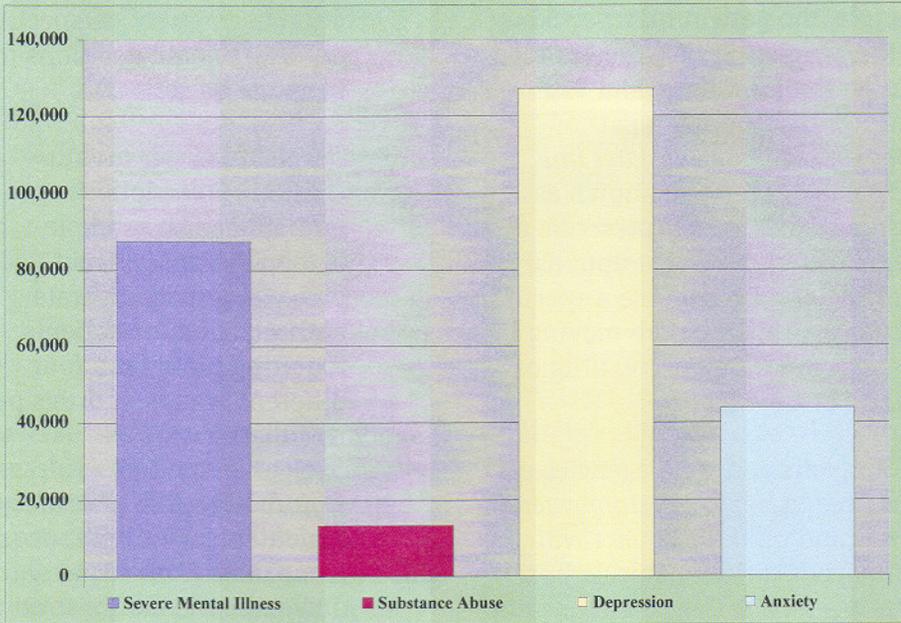
Source: Governor's FY 2004–05 Budget Recommendations presented to the Senate Health and Human Services Appropriations Committee (Sharpe, 2004; Agency for Health Care Administration).

medications, states have begun paying closer attention to the utilization of these specific drugs.

### Policy Tradeoffs

The challenges of managing a heterogeneous and complex population of individuals utilizing psychotropic medication has convinced many states that restricting or cutting mental health benefits and/or drugs must be done carefully. States have eliminated preventive services only to see increases in more expensive categories. States have focused on pharmacy expenses without addressing the full continuum of care. Several states' experiences are worth noting:

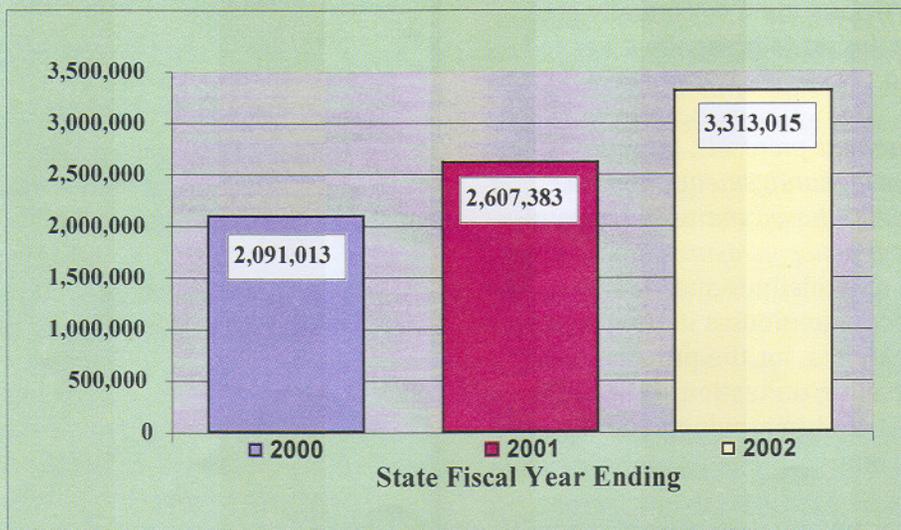
### TOTAL FLORIDA MEDICAID PRESCRIPTION CLAIMS FOR MENTAL HEALTH DRUGS



Source: Governor's FY 2004-05 Budget Recommendations presented to the Senate Health and Human Services Appropriations Committee (Sharpe, 2004; Agency for Health Care Administration).

### FY 2002-03 TOTAL NUMBER OF FLORIDA MEDIPASS MENTAL HEALTH DIAGNOSES.

(Note: MediPass is Florida's Primary Care Case Management Program that cares for nearly half of the State's enrollees).



Source: Agency for Health Care Administration (2004)

- One study of 1,600 mental health patients in San Diego revealed that 20% of the patients filled their medication too frequently. These "excessive fillers" cost California's Medicaid program \$3,500 more per patient per year than patients who were considered "adherent" to their treatment.<sup>4</sup>
- In California, when MediCal provided 'open-access' to previously restricted new generation drugs, two of the new antipsychotic brands soon became the most expensive drugs for the entire Medicaid program. However, access to the drugs also reduced costs for other high cost patients, giving the lawmakers conflicting expense implications of the policy.<sup>5</sup>
- When Tennessee carved out its mental health benefits in a way that significantly restricted the patients' options, the transitions that were imposed on the mental health patients led to negative outcomes with respect to adherence and continuity of care.<sup>6</sup>
- After Texas eliminated coverage for licensed psychologists, social workers, and other advanced mental health practitioners, there was an increase in crisis center visits—a more expensive treatment option.<sup>5</sup>
- In Colorado, nonspecific cuts in Medicaid services resulted in increased visits to the emergency room for recipients with mental health disorders.<sup>7</sup>

These experiences show that it is important to recognize the potential increase in costs that can accompany restricting mental health services. A reduction in, or limits on, mental health drugs may result in more hospital inpatient stays and more visits to the emergency room.

## Methods of Managing Pharmaceutical Expenditures

Health plans and Medicaid agencies have employed a variety of methods aimed at reducing pharmaceutical expenditures. However, both states and managed care organizations have had difficulty in identifying which types of measures are best able to address costs.

A *formulary* limits access to only those medications identified on a preferred drug list. It saves money by reducing the range of available drugs to patients. Formularies can be used in tandem with tiered co-payments, prior authorization requirements, and treatment protocols as a means to encourage patients and their providers to select cheaper drugs. The use of formularies has been shown to effectively reduce costs by shifting prescription patterns to cheaper drugs and increasing bargaining power with drug manufacturers as a consequence of the higher and more predictable volumes for a standard set of drugs.

The use of *generic medication* is one of the simplest strategies for managing pharmaceutical costs. On average, generic medications cost one-third less than brand name medications.<sup>8</sup> However, there has been considerable price inflation in recent years for generic drugs, offsetting some of the positive benefits of using generics.

Generics are often a part of *tiered formularies* and *first-line therapies*.

Tiered formularies involve the use of separate co-payments for more expensive types of drugs. For example, the patient may pay \$5 for the generic, \$10 for the branded drug on the formulary, and \$20 for drugs that are not a part of the preferred drug list. *First line treatments* (otherwise known as “first fail” treatments) prescribe a chronology of treatment options, requiring enrollees to use a specific drug or treatment before moving to the next, more expensive, drug or method of treatment.

Health plans and state agencies are often able to negotiate *supplemental rebates* and other discounts with pharmaceutical companies whose drugs are selected to be included on the formulary or preferred list. The potential increase in sales volume can enhance a state’s bargaining power with drug firms.

*Prior authorization* is often used as a complement to a formulary or preferred drug list. Typically, physicians are required to gain authorization from the health plan for drugs that are not on the formulary or that exceed other limits. This strategy can be effective in reducing costs but it may act as an obstacle to care for patients if physicians must continually seek permission to prescribe a needed drug.

*Treatment protocols, algorithms, disease management programs, evidence based management and best practice measures* involve the use of guidelines and standards that direct practitioners in their treatment of patients, for the purpose of managing utilization, controlling costs, and improving patient outcomes.

Other potential measures, many of which are often interwoven into the above strategies, include:

- The use of a pharmacy and therapeutics committee (P&T committees) to provide a multidisciplinary perspective on drug-related decisions to be made by states;
- Per member per month (PMPM) prescription limitations. An example is the Florida Medicaid policy requiring separate authorization for patients requiring more than four different brands of drugs per month;
- Contracting with pharmacy benefits management companies (PBMs) to outsource the administrative tasks of managing drug programs;
- Value-added programs,

Expand the four-brand limit to include mental health drugs

• **Rejected**

Expand PDL prior authorizations program to include mental health drugs

• **Rejected**

Limit use of Zyprexa to one dose per day

• **Adopted**

Adopt Florida Best Practice Algorithm Project

• **Adopted**

Shift mental health patients to managed care

• **Adopted**

which solicit discounts or cash investments from drug manufacturers in exchange for the states placing their drugs on the preferred drug list; and

- Provider profiling, which is a means of incentivizing physicians to change treatment behavior by providing feedback about their relative prescription patterns.

Several states have used the above measures and others to specifically reduce mental health drug related expenditures. The following are some of the programs that are being considered or have already been implemented:

- Oregon has eliminated outpatient mental health, alcohol and drug benefits, and a 24-hour local crisis hotline;<sup>9</sup>
- Kentucky excluded Zyprexa from its preferred drug list;<sup>4</sup> and
- New Hampshire, Missouri, and California are considering removing mental health drugs from their existing exemption status.<sup>4</sup>

## FLORIDA'S RESPONSE

In the 2004 legislative session, five proposals from Florida Medicaid were presented to the Florida legislature that relate to mental health drug costs. The options were:<sup>5</sup>

The expansion of the four brand limit to mental health drugs and the expansion of the prior authorization requirement were rejected in the '04 session due to concerns voiced by mental health advocacy groups and other interested parties.

One measure that was adopted was the one-dose limit on Zyprexa, an antipsychotic medication. The measure was drafted in response to reports by the Florida Agency for Health Care Administration (AHCA)

### DEFINITIONS: MENTAL HEALTH DIAGNOSES

❖ *Severe mental illness (SMI)*  
schizophrenia or psychotic disorders

❖ *Substance abuse (SA)*  
any type of substance abuse or dependence (e.g., alcohol, illicit drugs)

❖ *Depression (DEP)*  
major depression, bipolar disorder, dysthymia, or adjustment disorder with depressed mood

❖ *Anxiety (ANX)*  
panic disorder, post-traumatic stress disorder, generalized anxiety disorder, social anxiety disorder, or phobias

that approximately 30% of Medicaid recipients taking Zyprexa were receiving multiple doses per day. Current medical practice standards dictate that this drug should be taken once daily, and adherence to the treatment regime, which is a concern in individuals with severe and persistent mental illness, can be improved with single daily doses.

Another measure adopted in '04 is the Florida Algorithm Project (FALGO), an industry-sponsored project that includes financial support from a variety of pharmaceutical companies toward creating evidence-based best practices. The project, which has developed treatment guidelines for depression, bipolar disorder, and schizophrenia, includes guaranteed savings to the state of around \$34 million, according to AHCA's

pharmacy director. FALGO will need continued monitoring for its impact on the quality of health care services and effectiveness in reducing mental health expenditures.

Finally, as a general method of reducing overall costs for the population, Florida's Medicaid mental health patients will see a shift to managed care organizations in the coming months and years. As a consequence of a provision that was included in the state's budget, mental health patients will soon begin shifting to HMOs and community health centers in several Florida counties.

## Are Pharmaceutical Cost-Reduction Measures For Mental Health Drugs Effective?

Several factors contribute to the difficulty of reducing drug benefits as a means to lower Medicaid spending:

- 1) medical complexity and heterogeneity of patients suffering from mental disease is significant,
- 2) the actual effectiveness of mental health drugs is often uncertain, and
- 3) evaluations of cost reduction measures are often difficult to perform.

### Patient Complexity

One problem that state officials face when considering ways to reduce expenditures associated with mental health drugs is the complexity of the population treated. More so than other patient groups, the mental health population is considered to be extremely heterogeneous,<sup>9</sup> making it difficult to standardize their treatment. Within Medicaid, patients who benefit from mental health drugs include those who suffer from severe mental illness, substance abuse, depression, or anxiety disorders. Mental health drugs are critical to the well being of

a wide array of patients with unique sets of potential complications and comorbidities that need to be carefully weighed in their treatment, making it a significant challenge to uniformly address their treatment. Further exacerbating the issue, mental health patients tend to have high noncompliance rates, making them a difficult group to effectively treat.

Doctors will often use trial and error in prescribing for mental health patients, because it is often impossible to predict which combination of drugs will be most effective for each patient. The primary care doctors, psychiatrists, and other specialists who care for patients with mental disorders have continually urged managed care organizations and state Medicaid programs to give them the flexibility to individualize their treatment to the unique characteristics and circumstances of each of the mental health patients who come through their doors. Since mental health drugs serve such an important function in the lives of people with serious mental illness, often meaning the difference between psychotic and appropriate behaviors, there is significant risk associated with formulary approaches in this population. Limits on prescription drugs for this population have the potential to increase the chance of negative outcomes in the form of poorer quality of life and increased emergency visits, incarcerations, and homelessness. Providers maintain that restrictive formularies and other policies limit their ability to “individualize” pharmaceutical regimens.

Some advocates have recommended that all mental health drugs be exempt from restrictive state policies, pointing to the negative health outcomes that can be experienced when such restrictions

are in place.<sup>10,11,12,13</sup> For this reason many states have chosen to carve out their mental health benefits or to exempt mental health benefits from restrictions that are implemented on other drug benefits.

### Effectiveness of Some Drugs is Uncertain

The difficulty in implementing cost-reduction measures is compounded by the fact that many of the new-generation mental health drugs have not yet provided the medical community with a clear advantage of one drug over another. As one expert stated:

At this point we do not fully understand the mechanisms of action for various antidepressant medications, nor can we predict which drug will be the best match for a given patient, because of the lack of specific biological markers to distinguish the different subtypes.<sup>14</sup>

Such lack of clarity greatly inhibits efforts to standardize treatments or develop best practices that will be adopted by clinicians. Costs are thus much more difficult to address by uniform measures, in the face of an abundance of treatment options

### Program Evaluation is Difficult

Evaluating the effectiveness or appropriateness of restrictive measures for mental health drugs is not an easy task. There are several challenges to effectively monitoring the effectiveness of cost-reduction strategies:

- States need rational and comparable data by which to judge the effectiveness of such policies. To date, few states have endeavored to create longitudinal data sets that produce such information. States will have to develop better capabilities for understanding,

organizing, and accessing appropriate information. The generally disorganized and nonstandard nature of utilization, clinical outcomes, and cost data makes it difficult to effectively conduct program evaluations. Pharmaceutical costs should be carefully tracked, but only as a component of evaluating costs associated with treating the diagnosis over the full continuum of care. If at all possible, contractual arrangements with HMOs, PBMs, and physicians should include arrangements that provide the states with access to meaningful data in a standardized fashion.

- Case mix differences, severity variances, comorbidities, and other complications are important issues to consider in the design and collection of relevant data. Not appropriately adjusting for differences in disease severity can lead to erroneous conclusions.
- The longer-term implications of various strategies should be carefully considered. Specifically, evaluations should be framed in terms of the potential cost-savings to pharmacy programs, but also must consider other aspects of the delivery system. For example, will restrictions on psychotropic medications lead to increased hospitalizations and emergency room use?

## Conclusion

At this point, there is little evidence of a single best approach to managing Medicaid psychotropic pharmacy costs. The inherent complexity of the mental health population has made it hard for lawmakers to make decisions towards the best course of action. In addition, finding a link between a policy strategy and positive outcomes is difficult, because understanding the true nature of the costs associated with that decision is particularly challenging. Solutions for managing the costs associated with treating mental health problems involve taking a broader and systemic perspective, making sure to consider the variety of incentives that currently permeate the health care industry.

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Established in 2000, the Florida Center for Medicaid and the Uninsured is dedicated to the improvement of health care in Florida through multidisciplinary collaboration of academic and policy-making experts. The Center is located at the University of Florida within the College of Public Health and Health Professions.

The primary mission of the Center is to foster and develop research and analysis on issues related to access to quality health care for Florida's low-income populations. Center faculty and staff study issues related to the Medicaid program and other delivery systems for vulnerable populations. Critical to the Center's mission is the timely dissemination of information to policy makers, providers, and health care advocates.

**Florida Health Insurance Study**

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