Provide Workgroup Recommendations

(FY2019 Appropriation Act - Public Act 207 of 2018)

March 1, 2019

Sec. 1867. (1) The department shall convene a workgroup that includes psychiatrists, other relevant prescribers, and pharmacists to identify best practices and to develop a protocol for psychotropic medications. Any changes proposed by the workgroup shall protect a Medicaid beneficiary's current psychotropic pharmaceutical treatment regimen by not requiring a physician currently prescribing any treatment to alter or adjust that treatment.

(2) By March 1 of the current fiscal year, the department shall provide the workgroup's recommendations to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget office.

MDHHS

Michigan Department of Health & Human Services

Michigan Department of Health and Human Services

Psychotropic Best Practices Workgroup

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CONSUMER/FAMILY REPRESENTATIVE

Mark Reinstein, PhD
President & CEO, Mental Health Association in Michigan
Chair, Behavioral Health Advisory Council

Meetings
(In Person/Teleconference)

1. *When:* **Thursday, March 22, 2018**
   Where: Lewis Cass Building, 320 S Walnut St, Lansing, MI 48933

2. *When:* **Thursday, April 12, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

3. *When:* **Tuesday, April 24, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

4. *When:* **Monday, May 14, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

5. *When:* **Thursday, September 13, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

6. *When:* **Friday, September 21, 2018**
   Where: Capitol Commons Center, 400 S Pine St, Lansing, MI 48933

Historical Background

Psychotropic medications[1] can be broadly defined as medications that affect brain functions.[2] They are also defined as medications that affect the central nervous system, changing brain processes, such as mood, thoughts, perceptions, emotions, and behaviors.[3]

Psychotropic medications are used to treat individuals with mental disorders related to mood, anxiety, psychosis, trauma, attention-deficit/hyperactivity, cognition, and many other conditions defined in the literature. These medications can successfully alleviate mental health symptoms, treat acute exacerbations, and prevent relapse but like many medications used to treat other medical conditions, they do not serve as a "cure" per se.[4]

A 2013 study done by the Medical Expenditure Panel Survey found that roughly 1 in 6 adults in America take a psychotropic medication. This was up from a 2011 study that state 1 in 10 adults reported taking prescription medications for problems with nerves, emotions, or mental health.[5] Psychotropic medications have generally been found to be as effective in treating mental disorders as medications that are used to treat general medical disorders.[6] In 2017, additional articles published by the Kaiser Family Foundation portrayed the important role Medicaid plays in both financing and facilitating access to Mental Health Services for low-income individuals.[7] [8]

The use of psychotropic medications has been an important evolution in the treatment of mental health conditions, and the wide-spread use of these medications by prescribers has become fairly common. Although generally prescribed as indicated, there are instances of overprescribing that have called attention to their use, especially in particular populations. For example, efforts have been made to protect children, particularly those in foster care, from over prescription of psychotropic medications.[9]

Some states have issued guidelines to attempt to maximize the likelihood that psychotropic medications are being prescribed and used appropriately. Many of these guidelines and protocols are relatively new and there is still much to be learned from them. To date, the success of these efforts has not been clearly defined or established as the means to help prescribers utilize best practices in prescribing. A number of states have made changes in state-run Medicaid programs such as prior authorization and peer review, informed consent for children, distributing utilization management reports, and made efforts to educate prescribers.[10] Texas developed a guide with best practices for psychotropic medication usage in children and

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690138/
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181612/
[3] https://www.verywellmind.com/psychotropic-drugs-425321
[4] https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml
[5] https://www.scientificamerican.com/article/1-in-6-americans-takes-a-psychiatric-drug/
[6] https://psychnews.psychiatryonline.org/doi/10.1176/pn.47.9.psychnews_47_9_1-b
[7] Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured." Nov. 27, 2017.
[8] Zur, Musumeci, and Garfield. "Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals." June 2017 Issue Brief.
[9] http://waynelawreview.org/wp-content/uploads/Archives/58%20Wayne%20L.%20Rev.%20183%20-%20THE%20USE%20OF%20PSYCHOTROPIC%20MEDICATION%20IN%20MICHIGAN%20FOSTER%20CARE%20-%20Thomas%20Fuentes.pdf
[10] https://www.macpac.gov/wp-content/uploads/2015/06/Use-of-Psychotropic-Medications-among-Medicaid-Beneficiaries.pdf

youth in foster care that includes criteria for reviewing a child's clinical status.[11] Florida's best practices for psychotropic medications identified non-medication therapy interventions, prior authorization for high risk prescriptions, educational interventions, continuing education, and threats of Medicaid exclusion.[12]

While there is concern about the potential for over-prescribing these medications, there has also been concern about access to full mental health care on par with access to care and treatment for medical conditions. Limiting psychotropic medication access inappropriately or making these medications more difficult for public patients to access can have deleterious consequences on mental state.

Since 2004, Michigan has prohibited prior authorization of most Medicaid psychotropic prescriptions as an effort to ensure access to these medications. Even with this prohibition in place, the state has undertaken, and continues to work on, efforts to identify and intervene with potential problem prescriptions. The purpose of this workgroup was to again explore these issues and make recommendations in accordance with the legislative directive that this workgroup take place.

Existing Michigan Initiatives by Year

1. *National Medicaid Pooling Initiative (NMPI) [2004]:* Michigan received approval of the first-ever Multi-State Prescription Drug Pooling Program to help reduce the cost of Medicaid prescriptions by creating a Preferred Drug List (PDL) that encourages drug manufacturers to offer supplemental drug rebates to the State when their product is identified as a Preferred product.[13]

2. *MCL 400.109h [2004]:* Michigan legislation prohibiting the prior authorization of products in protected drug classes, including psychotropics. Because this law covered some, but not all, of Medicaid, it has been supplemented by department policy and, more recently, legislative budget boilerplate the past three years.[14]

3. *Medicaid Retroactive Drug Utilization Review (RetroDUR) Programs:*

    a. *Pharmacy Quality Improvement Program (PQIP) [2005]:* An educational mailing intervention program that analyzed the prescribing of mental health medications for Medicaid adult and child members and identified prescribing patterns that did not follow accepted evidence-based treatment guidelines.

[11] http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp
[12] http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml
[13] http://www.providersynergies.com/overview/default.asp
[14] Public Act 248 of 2004 excluded persons enrolled in Medicaid Health Plans (there were far fewer individuals in those plans in 2004 than is the case today). The law protected access in Medicaid to prescriptions for mental illness (including substance use disorder), epilepsy, HIV-AIDS, organ replacement therapy and cancer. Since 2004, the Department of Health and Human Services as a matter of policy has retained direct management of virtually all Medicaid drugs for mental illness, epilepsy, HIV-AIDS and organ replacement therapy. The Legislature has reaffirmed this policy in budget boilerplate the past three years.

b. *Former EnhanceMed program [2012] which then expanded to the program now called WholehealthRx [2015]:* Whole Health Rx is a clinical quality management program that uses medical diagnosis, behavioral, pharmacy claims and lab data, when available, to identify patients taking behavioral health medications who also have common co-morbid conditions such as heart disease, diabetes, asthma, etc. It then works with providers to identify and resolve potentially inappropriate prescribing, gaps in care and potential drug interactions to drive member safety and cost savings. This improved program not only included redesigned reports, but providers were also provided access to an online pharmacy portal. The portal has many services available including educational information, clinical resources, as well as the ability to request a clinical consultation. It also has a pharmacy search tool to provide access to prescription data on patients as a tool for care management activities. Providers who have secure logins to the website may access this information on patients that they are treating.[15]

4. *Foster Care -Psychotropic Medication Oversight Unit (FC-PMOU) [2014]:* Established via the ongoing partnership of staff in the Department of Health and Human Services (DHHS) Children's Services Agency and Medical Services Administration. The unit is responsible for monitoring psychotropic prescription claim trends, informed consent (DHS-1643) documentation and policy compliance and providing specific feedback to prescribing physicians based on the oversight reviews and prescription quality indicators. Reviews focus on quality indicators including prescribing multiple medications and/or duplicate therapeutic regimens, medication dosing outside of typical guidelines, and use of medications in very young children.

Context and Background Principles

As budget section 1867 relates to Medicaid services, which constitute a proportionally high percentage of care for individuals who have a mental illness diagnosis, and Medicaid prescription costs are predominantly for outpatient care, this report and its recommendations are limited to Medicaid outpatient psychotropic medications. Although care and treatment provided within a hospital community is critical, as is the care and treatment related to transitioning from hospital settings to community, this workgroup's focus does not include considerations of psychotropic usage in the hospital or the hospital to community transition. That said, the workgroup recognizes that as people move from one treatment setting such as inpatient, outpatient, corrections, skilled nursing facilities, etc., it is essential that care be seamless and integrated. Thus, the recommendations contained in this report consider best mechanisms for prescribing guidelines that will impact outpatient services related to those transitions.

This report recognizes there is always a balance between quality of care and the cost of such care, keeping in mind there is often no correlation between cost and quality. Although the

[15] https://michigan.fhsc.com/Committees/BHealth.asp

workgroup believes steps can be taken to reduce costs, it was the consensus of the workgroup that the priority is to assure the prescription of psychotropic medications that is high quality and under the direction of properly qualified medical professionals.

Comments and Current Recommendations:

After considerable discussion, the group conceptually endorses the practice of the past 14 years wherein Medicaid psychotropic prescriptions have not been subjected to administrative prior authorization. The group does not believe prior authorization tied to costs, and often done in conjunction with step therapy, is good or effective for persons with serious mental illness, their families, Michigan communities including payers or the providers who strive to serve them. Rationale for this is that persons with mental illness present with a unique set of variables that may require various efforts at psychopharmacological trials to achieve the best clinical success. Access to care issues for persons with mental illness can be more difficult than for medical illnesses. Thus, it is critical that barriers to care be as few as possible for individuals seeking treatment for their mental illness, and for providers willing to treat them. The workgroup spent a great deal of time discussing members' experience with prescribing and oversight as well as prior authorization processes. Based on this discussion, the workgroup determined the most appropriate tools to improve psychotropic prescribing, while monitoring for inappropriate prescribing, are in providing prescriber education about best practices and other steps described below.

It is also important to note that data show the vast majority of psychotropic prescriptions in Michigan Medicaid are for generics (85-87% in Fiscal Year 2017). Michigan's psychotropic carveout, in place since 2004, has not resulted in prescribers flooding Medicaid with claims for brand drugs. Additionally, while psychotropic prescriptions account for 99 percent of DHHS carveout claims, they represent only 62 percent of costs across all carveout products. The 1 percent of carveout claims for non-psychotropics now account for 38 percent of all DHHS carveout costs.

These data suggest that, if psychotropic medication costs strike some as "too great," it is because mental illness is so highly common in Medicaid. Ending the psychotropic carveout to eliminate the roughly 14 percent of prescriptions for brand products will not likely save major money. Curtailing access to psychotropics would not necessarily result in savings and could actually negatively impact quality outcomes for our general population and increase costs. The workgroup does not recommend curtailing access to appropriately prescribed psychotropic medication.

Thus, it is imperative to keep broader prescribing authority for practitioners, and the workgroup has recommendations for that, as well as other issues, below.

1. Exclude non-controlled psychotropic medications (including anti-seizure and substance use disorder medications consistent with current law) from prior authorization and amend MCL 400.109h so that it unequivocally applies the prior

authorization protections to all of Medicaid (i.e., Managed Care in addition to Fee-For-Service).[16]

This is consistent with a major recommendation of the DHHS Section 298 Facilitation Workgroup. This psychotropics workgroup recommends that the Department's Medical Services Administration review the Medicaid Health Plan pharmacy carve-out list to be consistent with the law. This workgroup recommends further evaluating the appropriateness of requiring prior authorization for controlled substances used to treat psychiatric conditions.

2. Identification of Undesirable Prescribing and Collaborative Educational Response to Positively Impact Practice

One of the key issues with psychotropic medications noted in the introduction above is the concern about inappropriate prescription of psychotropic medication which impacts patients of all ages and can have dire consequences.[17] The group noted that a key element in combating this prescription challenge is identifying undesirable prescribing among physicians and other prescribers. Using lessons learned from best practice principles and from existing models used to promulgate best practices, a mechanism should be established to allow consultations for prescribers to be provided using clinically driven, evidence-based parameters.[18] [19] The parameters that are established should account for reasonable and desirable prescribing of psychotropic medications to support quality outcomes.

The DHHS' current academic detailing program was cited as one example of the implementing actions that help curb poly-pharmacy and gaps in care to provide more safety for members.[20] Similar to the system in place for children in foster care, they contact and provide consultation for physicians that are identified for undesirable prescribing. To facilitate the implementation of such a program, Medicaid services would need to vet any contractual arrangement, costs and other parameters to ensure that the services could be available as needed and the success of such a program and its ability to collaborate with and link to the Community Mental Health system.

When contacting prescribers that have engaged in potentially undesirable prescribing, the group supported a system that establishes a peer-to-peer approach instead of an administrative ruling that passed down a condemnation or punishment. Building on the concept of communities of practice, networks of providers in different fields could work

[16] Although MCL 400.109h applies to several drug classes, the scope of this workgroup's recommendations is limited to psychotropic medications (including anti-seizure and substance use disorder medications).
[17] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2601416
[18] https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf
[19] https://www.cdc.gov/phcommunities/index.html
[20] https://michigan.fhsc.com/Committees/BHealth.asp

together to improve prescribing habits and engage physical and behavioral health in a more united approach.[21] [22] The group further advised keeping these one-on-one meetings between prescribers of a similar background, such as psychiatrist to prescriber.

3. Encourage Use of Technology to Help Improve Provider Awareness of Inappropriate Prescribing and Best Practices

Even with the additional model of identification of prescribers who may need assistance and education related to prescribing practices, an overarching theme that could help prescribers may be by the expanded use of electronic health records and e-prescribing. It should be noted that, though existing health information technology investments are still in their infancy, such a model might help inform prescribers.

Using effective e-prescribing can also help avoid potentially dangerous drug interactions.[23]

4. Explore the Potential Use of Safety Edits

The statute as written does not permit the DHHS to implement quantity, dose, or age limits to non-controlled substance psychotropic medications that appear not to align with standards of practice. In future meetings the workgroup would like to have further discussion on whether amending statute to allow for workgroup-recommended safety edits may promote safe prescribing practices and better outcomes for people taking psychotropic medications. There was some concern during ongoing workgroup discussions that this needs to be pursued thoughtfully while weighing the pros and cons of such a change.

5. Explore Future Cost Saving Opportunities

The workgroup discussed its desire to further explore future cost-saving opportunities that could be put into place to help decrease the need for State funds. The workgroup supports exploration of the DHHS' prior budget savings proposal under which psychotropic medications could be labeled as "non-preferred" without the drug being subjected to prior authorization procedures. A manufacturer could gain "preferred" status for its product by paying a supplemental rebate to Michigan. Like other states, the Michigan legislature may wish to consider pharmaceutical cost transparency and pharmaceutical lobbying/marketing laws/regulations, ultimately to help benefit persons served.

6. Continuation of the Workgroup

This psychotropic workgroup supports the continuation of its meetings for purposes of further evaluating best practice models that the State could incorporate in future years

[21] http://wenger-trayner.com/introduction-to-communities-of-practice/
[22] https://aims.uw.edu/collaborative-care
[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3995494/

and leveraging the subject matter expertise from persons served/family representatives, physicians, and pharmacists.