

MEDICAID PRESCRIPTION DRUG POLICIES AND PSYCHOPHARMACOLOGIC TREATMENT ACCESS AND CONTINUITY:

Findings from Ten States

Medicaid provides the largest source of funding for mental illness treatment in the US, with \$26.4 billion in expenditures in 2003. Medicaid is also a major purchaser of prescription drugs (PD), with antipsychotics, anticonvulsants, and antidepressants accounting for three of the top five therapeutic classes for total Medicaid pharmacy payments. Consequently, Medicaid programs are increasingly utilizing PD prior authorization and other utilization management (UM) strategies to contain Medicaid costs. However, studies have reported that Medicaid PD UM strategies constraining access to essential drug classes, including psychopharmacologic medications, can reduce appropriate care, adversely affect patient health, and increase costs of care (Soumerai, *Health Affairs*, April 2008).

Study Aims and Methods

The American Psychiatric Institute for Research and Education investigated the clinical impact of commonly used PD UM policies in ten state Medicaid programs of policy interest using data from a large, national study conducted in 2006. The primary aims of this study were to:

- 1) Compare physician-reported rates of psychopharmacologic medication access and continuity problems;
- 2) Assess whether significant adverse clinical events are associated with medication access problems; and
- 3) Identify whether specific PD policies or management features are associated with medication access problems and adverse events.

Five hundred psychiatrists were randomly sampled from the AMA's Physician Masterfile in ten states: California, Florida, Georgia, Massachusetts, Michigan, New York, Ohio, Pennsylvania, Tennessee (only 366 psychiatrists available), and Texas for a total of 4,866 psychiatrists. Psychiatry residents, those with undeliverable addresses and without direct patient care as their practice were excluded. Each psychiatrist was asked to report on two patients whose only insurance was Medicaid. Responses were obtained from 61% of the sample (N=2,599); 34% (N=870) met study eligibility criteria of treating Medicaid only patients their last typical workweek, reporting clinically detailed data on 1,625 Medicaid patients.

Data were collected from September-December 2006, using through-the-mail, practice-based research methods. Each psychiatrist was randomly assigned one of 21 start days and times to report on their next two Medicaid patients. Data were collected on patient characteristics, PD UM practices, medication access problems, and adverse events experienced since January 1, 2006.

Findings

Medication Access Problems

- Overall, 48% of Medicaid patients were reported to have experienced a medication access problem in 2006.
- Rates of medication access problems varied considerably across the states, ranging from 27% to 65% of patients affected.
- States with the lowest rates of reported medication access problems were New York (27%), Texas (31%), and California (32%), while Tennessee (63%), Georgia (64%), and Michigan (65%) had the highest rates.

Findings

Medication Access Problems (cont.)

- The most common medication access problems included:
 - Patients' inability to obtain medication refills or new prescriptions because they were not covered or approved (34% of patients overall).
 - Clinically indicated medications clinicians preferred to use were not able to be prescribed because of PD coverage/approval issues or patient copays (29%).
 - Discontinuing or temporarily stopping medications as a result of PD coverage or administrative or management issues (26%).
 - Patients having problems obtaining medications because of patient copayments (14%).

Adverse Events

- All the medication access problems studied were strongly associated with increased adverse events, including ER visits, hospitalizations, incarceration, or homelessness. 72% of patients with medication access problems had an adverse event compared to 49% of patients without access problems.
- 42% of patients with medication access problems had an emergency room visit reported compared to 28% among patients with no access problems reported.
- Patients with problems accessing medications because of copayments had 6 times increased likelihood of an adverse event. Patients who discontinued/temporarily stopped medications as a result of PD coverage or management had 4 times increased likelihood of an adverse event.

PD Utilization Management (UM) Policies Associated with Access Problems and Adverse Events

- All the PD UM policies studied were highly associated with increased rates of medication access problems. 57% of patients reported to have a UM policy apply to their PDs had a medication access problem compared to 14% among patients without PD UM.
- Prior authorization was associated with 6 times increased likelihood of experiencing a medication access problem; use of preferred drug or formulary lists were associated with 5 times increased likelihood; and "step therapy" or "fail first" protocols were associated with 4 times increased likelihood.
- Each of the PD UM policies studied was highly associated with increased rates of adverse events.
- Patients in states with more PD utilization management features reported had more access problems reported. After adjusting for patient severity, patients in states with the highest rates of medication access problems had 2 times increased likelihood of experiencing adverse events.

Summary and Medicaid Policy Implications

Medications are the first-line, evidence-based treatments for most mental illnesses. While PDs are an increasingly costly component of state Medicaid budgets, current state PD UM strategies are associated with significant adverse clinical consequences for this population. Medication disruptions or switches that are not clinically indicated have been shown in this and other studies to be associated with significant adverse effects for psychiatric patients. It is therefore of concern that reported rates of these problems varied widely across the states, even after adjusting for patient case mix.

This study suggests state PD policies have a major impact on treatment outcomes for mentally ill beneficiaries and highlights the need for more evidence-based PD management strategies and policies to promote medication continuity and more cost-effective treatment. These data are consistent with our previous study of the Medicare Prescription Drug Program (West et al, *American Journal of Psychiatry*, May 2006) and other research indicating PD UM strategies may be associated with greater health care services utilization and costs, as well as costs to the social services and criminal justices sectors. Medicaid and PD UM policies based primarily on cost rather than clinical considerations will likely ultimately result in significant human, economic, and social costs.