Commentary

Government Perspective

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Government programs must run with 3 constraints: what statute requires, what politics allows, and what funding will support. A Medicaid program can be run with no pharmacy benefit according to federal law. But that option is not politically viable. The Missouri Department of Mental Health (MDMH) is statutorily required to provide only 2 services: to accept patients who are involuntarily committed if no other facility does and to provide planning for after-care. We, in fact, provide a great deal more, including pharmacy benefits.

The MDMH obtains medications for the people it serves in 3 ways. First, half the people we serve in the psychiatric division are Medicaid-eligible or Medicaid-enrolled, so they receive the Medicaid pharmacy benefit. If people are ineligible for Medicaid, we suggest they contact the individual drug companies' indigent programs, which establish their own rules for dispensing free medications to those who cannot afford them. Some drug company formularies are open and include their entire product line in their indigent program, and others have only their newest products. The companies are very generous; about half their promotional budget is used to provide samples to physicians, which helps many people. Our community mental health centers receive free samples worth several hundred thousand dollars annually. In Missouri, we have facilitated access to free samples by providing funds in our budget for the administrative costs of receiving the samples. For people who cannot access Medicaid or drug company indigent samples, the MDMH provides funds to each community mental health center to buy medications for the treatment of mental illness. Any money not used on medication can be used to buy more psychiatrist time.

The MDMH believes that persons with severe mental illness should receive the medications that their treating psychiatrist judges best for them. MDMH has no formulary restrictions and no prior authorization requirements. When clozapine was introduced in 1988, we pulled $1 million out of our community-supported living funds to keep our agencies blind to the unit cost of clozapine. We did not want them to have a financial disincentive. That said, these are difficult decisions. We have a set amount of money, we make it go as far as we can, and it covers about a third of the people with severe illness in Missouri. A constant struggle is breadth of service versus depth.

In 1994, the MDMH distributed $4.7 million for medication (data on file, Jefferson City, Mo.). In 2001, the Department spent $14.7 million for medication, an increase of about $9.9 million. Over that period, the Department received about $9.6 million in new funding for medications—a regularly recurring budget request for the last 10 years—and reduced other services by about $300,000. We decided to prioritize funding in what we think is the most cost-effective way: by maximizing case management and psychiatric medication services. Case management is in part a medication delivery system: checking on the person's well-being and housing and reminding the person to take medications. We provide very little psychotherapy or counseling and as little hospitalization as we can given our statutory mandate. Counseling is a wonderful treatment, especially for getting people into recovery. Medications can be a little too easy to use, particularly with the greatly increased utilization among children. Still, medication is cheaper than professional psychotherapy, and I think that it is more cost-effective in the short term in preventing hospitalization.

In the MDMH, only a few new budget requests are approved. What we ask for must be clinically sound and also able to succeed politically. The recent successful requests have been medication access and child services. Those not approved were provider rate increases, rehabilitation programs, psychotherapy, and dental services. We will need to change our major thrust in budget requests from medications to hospitalization or hospital alternatives. We have the statutory mandate to provide hospitalization for people who are committed, and our occupancy is running at 100%. The number of psychiatric private sector beds in Missouri has dropped by 50% in the last 10 years. The private sector has decided that it cannot make money in this

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This commentary was presented at the symposium "The Case for Physician Choice: Implications for Restricted Formularies," which was held November 4–5, 2002, in Washington, D.C., and supported by an unrestricted educational grant from Eli Lilly and Company.

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area and is leaving the field. General hospitals' psychiatric inpatient rates have gotten so low that the best decision for them also is to leave the business.

There is a steady rise in prescription drug costs as a total percentage of health care. Recently a national survey[1] asked all the state Medicaid program directors what the cost increase drivers of health care are, and they ranked pharmacy as the top-ranking cost driver, then enrollment, service costs, and long-term costs. What are the components of that pharmacy cost increase? Switching from an old to a new drug accounts for only 28%.[2] The manufacturer raising the pricing of existing drugs is another 24% of the increase, but 48% is utilization—people are taking many more pills. There are many more indications and drugs to treat them.

In January 2000, the top Missouri Medicaid drug class by payment was antipsychotics at $5.7 million, although this class of drugs had fewer prescriptions than some other classes. Antiulcer drugs were the second most costly class at $3.9 million. Antidepressants were fourth at $2.7 million, and antianxiety drugs were ninth at $1 million. Olanzapine constituted 6.4% of the total Medicaid pharmacy budget, and risperidone was another 3.4%, so those 2 antipsychotics alone were about 10% of the pharmacy program. The price paid per prescription for olanzapine was about twice that of risperidone.

Missouri has decreased early refills, instituted dose optimization, begun more assertive maximum allowable costs to pay pharmacists, and started providing Medicaid coverage for over-the-counter drugs because doctors were prescribing prescription versions that were more expensive than the over-the-counter formulas.

Since Medicaid is the major funder of treatment for persons with severe mental illness, and persons disabled by mental illness are a major cost driver of Medicaid, state Department of Mental Health and Medicaid agencies must work closely to assist each other's missions. A partnership between the MDMH and our Medicaid agency has been created to expand drug utilization review and disease management. We will minimize prior authorization by educating physicians about the choices they make.

The Kaiser Commission survey[1] of Medicaid program directors asked what they planned to do for cost containment. Twenty-six states planned to increase the discounts they demand from pharmaceutical companies, 23 states planned more prior authorization, 22 were considering preferred drug lists, 6 were considering prescription limits, 20 said they may cut or freeze hospital rates, which would get more hospitals out of the business. Seventeen planned to cut or freeze physician payments. Fifteen states were reducing benefits such as home health care, optical care, or dental care. Eighteen states were planning eligibility cuts. Fifteen planned to increase the nonpharmacy copayments. So, if formularies remain completely open, which of these cuts do we make? Do we give optimal treatment to a few, or do we give minimally adequate treatment to many? Who will make those choices? Physicians want to prescribe the medications that they feel will work best for the patient, but government agencies, private sector contractors, legislators, and voters end up making funding choices that affect physicians' ability to prescribe.

Physicians need to take some responsibility for the cost of their drug choices, especially in the area of polypharmacy. The National Association of State Mental Health Program Directors (NASMHPD), a medical council to which I belong, completed a report on polypharmacy.[3] We cited a study by Clark et al.[4] who reported on 5 years of pharmacy claims in the New Hampshire Medicaid records. Of 800 people with schizophrenia or schizoaffective disorder who had 5 years of claim history, 5.7% were taking more than 1 antipsychotic in 1995. In 1999, 24.3% were taking more than 1 antipsychotic. In Missouri records, we found about 100 patients who are taking 3 antipsychotics. Perhaps the state should begin to require prior authorization for 3 concurrent antipsychotics. The NASMHPD report found that patients are staying on polypharmacy for a long duration; it is not just a case of switching from one to another and tapering off the old one. The number of people who remained on more than 1 atypical antipsychotic for more than 9 months increased from 22% in 1995 to 44% in 1999. Our limited literature review found the least evidence supporting the use of multiple antipsychotics, some evidence for use of multiple antidepressants, and the best evidence for use of multiple mood stabilizers. Our consensus was that there is a marked increase in polypharmacy despite limited evidence.

The history of medicine has many examples in which limited knowledge led to widespread acceptance of practices that later were found to be inappropriate. In medicine, hope is important for both the patients and the providers; sometimes physicians' hopes of helping patients extend beyond clinical science. Polypharmacy is an area where some select prior authorization might be justified.

Drug names: clozapine (Clozaril and others), olanzapine (Zyprexa), risperidone (Risperdal).

REFERENCES

1. Kaiser Family Foundation. The Kaiser Commission on Medicaid and the Uninsured: Survey of Medicaid Officials in 50 States and DC, July 2002 and December 2002. Available at: www.kff.org/content/2003/20030113/4082.pdf. Accessed: May 14, 2003
2. Kaiser Family Foundation. Prescription Drug Trends: A Chartbook Update, November 2001. Available at: www.kff.org/content/2001/3112/RxChartbook.pdf. Accessed: May 15, 2003
3. National Association of State Mental Health Program Directors. Technical Report on Psychiatric Polypharmacy, September 2001. Available at: www.nasmhpd.org/polypharmacy.pdf. Accessed: May 14, 2003
4. Clark RE, Bartels SJ, Mellman TA, et al. Recent trends in antipsychotic combination therapy of schizophrenia and schizoaffective disorder: implications for state mental health policy. Schizophr Bull 2002;28:75–84