Improving the Oversight and Monitoring of Psychotropic Medication Use among Children in Medicaid

September 11, 2015
Presentation Overview

- Why Focus on Psychotropic Medication?
- Behavioral Health Needs among Children and Youth
- Psychotropic Medication Use and Expense in the Medicaid Child Population
- Oversight and Monitoring – Defined
- The Role of the System of Care
- Key Strategies for an Effective Oversight and Monitoring System
- TA Resources
The Issue

- Concern regarding the use of psychotropic medications to address the behavioral health needs of children in Medicaid
- Complexity of reaching consensus about “appropriate” use
- Too many, too much, too young
- Certain populations are of particular concern:
  - Very young children (ages 0-3)
  - Transition age youth
  - Youth with substance use issues or co-occurring mental health and substance use disorders
  - Children in foster care
  - Youth taking antipsychotic medications
  - Youth who experience trauma
“The Department of Health and Human Services has become increasingly concerned about the safe, appropriate, and effective use of psychotropic medications among children in foster care.”

-- November 23, 2011
What do we know about the behavioral health needs of children and youth in Medicaid?
Estimates of Mental Health Needs among Children and Youth

- 1 in 5 children in the general population have a DSM diagnosable mental health disorder or were reported by parents to have an emotional or mental health need
- 11% of youth have been diagnosed with a mental illness
- Two-thirds of youth who have a condition are not identified and do not receive mental health services
- Half of all lifetime cases of mental illness or substance use disorders begin by age 14

Behavioral Health, 2012, United States, Substance Abuse and Mental Health Services Administration.
Mental Health Needs among Children in Medicaid

Estimates of mental health needs among children in Medicaid are higher than for the non-Medicaid population.

| Poverty | Adverse childhood experiences | Lack of access to needed services & supports, including prevention and early intervention services | Inadequate access to mental health & substance use disorder services for parents/caregivers |

What do we know about behavioral health service use among children and youth in Medicaid?
Children in Medicaid Using Behavioral Health Care

- Represented under 10% of children enrolled in Medicaid, but accounted for an estimated 38% of total Medicaid child expenditures
  - 9.6% of Medicaid children used behavioral health care
  - 6.7% used behavioral health services (with or without psychotropic medications)
  - 5.8% used psychotropic medications (with or without behavioral health services)
  - 0.8% of Medicaid children used substance use disorder services
Highest Expenditure Services for Children in Medicaid Using Behavioral Health Services

- Residential treatment and therapeutic group homes:
  - #1 cost driver in 2008 and 2005 – represents about 20% of all BH expenses for under 4% of children using BH care

- Psychotropic medications:
  - 2nd highest cost driver in 2008
  - 3rd highest in 2005

Psychotropic Medications Utilization and Expense Among Children in Medicaid

- 5.8% of children in Medicaid (1.7 million) received psychotropic medications
- Only 51% of children prescribed psychotropic medications received behavioral health services
- Total Medicaid expense for child and adolescent psychotropic medication use in 2005 was $1.6 billion, with 42% of expense represented by antipsychotic use
- Mean expense by aid category, was:
  - $934 per child, in foster care
  - $916 per child, for those with SSI
  - $475 per child, for children covered by TANF
## Distribution of Medication Use by Diagnosis

<table>
<thead>
<tr>
<th>Percent Distribution of Medication Type by Psychiatric Diagnosis</th>
<th>ADHD</th>
<th>Mood</th>
<th>Anxiety</th>
<th>COD</th>
<th>DD</th>
<th>Psychosis</th>
<th>Other DX</th>
<th>No DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotics</td>
<td>24.6%</td>
<td>60.9%</td>
<td>41.0%</td>
<td>51.6%</td>
<td>63.5%</td>
<td>81.1%</td>
<td>53.6%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>6.3%</td>
<td>23.3%</td>
<td>11.1%</td>
<td>15.6%</td>
<td>13.1%</td>
<td>21.7%</td>
<td>12.9%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Lithium</td>
<td>1.4%</td>
<td>8.0%</td>
<td>3.3%</td>
<td>4.1%</td>
<td>3.2%</td>
<td>8.6%</td>
<td>4.9%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>23.0%</td>
<td>62.9%</td>
<td>67.2%</td>
<td>42.1%</td>
<td>40.5%</td>
<td>52.1%</td>
<td>51.5%</td>
<td>49.4%</td>
</tr>
<tr>
<td>ADHD/ stimulants</td>
<td>93.3%</td>
<td>48.0%</td>
<td>47.0%</td>
<td>65.3%</td>
<td>54.9%</td>
<td>42.8%</td>
<td>55.8%</td>
<td>49.4%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.8%</td>
<td>5.1%</td>
<td>9.1%</td>
<td>4.0%</td>
<td>9.4%</td>
<td>7.0%</td>
<td>6.5%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

N = 1,686,387 (Medicaid enrolled children in 2005 with claims for psychotropic medication)

Many Factors Contribute to Reliance on Psychotropic Medication

- Legitimate need among the population
- Inadequate screening and assessment/misdiagnosis including trauma
- Lack of access to non-pharmacologic intervention including EBPs
- Too few child behavioral health specialists
- Lack of coordination across providers and child-serving agencies
- Misaligned financial incentives
- Aggressive/effective pharmaceutical marketing
- Limited clinical knowledge among child welfare case workers*

*Applies to children in foster care
How can we improve the appropriate use of psychotropic medications among children and youth in Medicaid?
### Oversight and Monitoring Defined

<table>
<thead>
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<th>Oversight</th>
<th>Monitoring</th>
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<tbody>
<tr>
<td>- The administrative processes a system has in place to ensure that prescribing is appropriate, and may be either prospective (e.g., prior authorization or second opinion programs) or retrospective.</td>
<td>- The process by which a system ensures the care delivered to individual children and youth is within acceptable limits, and is necessarily retrospective.</td>
</tr>
<tr>
<td>- Oversight is conducted by the system authorizing care and/or payment, and focuses on the prescribing practices of the individual provider or prescriber.</td>
<td>- This can be accomplished through the regular review of utilization reports generated from the Medicaid claims system, or other tracking mechanisms.</td>
</tr>
</tbody>
</table>

Definitions proposed by K. Allen. Input solicited from Psychotropic Medication Quality Improvement Collaborative States.
State Policies: Prior Authorization

• Prior Authorization:
  – The pre-approval process that a prescriber must use in order for a beneficiary’s payer to cover the prescribed drugs.
  – Process varies between payers and even between different prescribed drugs under one payer. Some states limit approval of atypical antipsychotics to children with specific diagnoses.
  – 31 states use prior authorization for at least some children enrolled in Medicaid, the age requirement varies by state.
State Policies: Denial

• Denial:
  – Some states deny the use of atypical antipsychotics for individuals under a certain age. The drug is not covered by the payer, with no exceptions.
  – 3 states that deny antipsychotic coverage for children under a certain age, with no exceptions.

*How Do States Monitor Atypical Antipsychotics Prescribed To Children? OPEN MINDS Market Intelligence Report*
State Policies: Informed Consent

• Informed Consent:
  – The process by which health care providers explain the consequences and benefits of a certain treatment or prescription drug in terms that can be easily understood by the patient.
  – 5 states use written informed consent for the general Medicaid population; at least 9 states require the use of written informed consent for the foster care population specifically.

*How Do States Monitor Atypical Antipsychotics Prescribed To Children? OPEN MINDS Market Intelligence Report*
State Policies: Consultation Hotlines

• Psychiatric Consultation Hotlines:
  – Some states focus on provider education and awareness before a drug is prescribed by offering free psychiatric consultation hotlines.
  – Consultation hotlines allow a physician/prescriber to consult on a child’s behavioral health issue and the best course of treatment.
  – 10 states fund psychiatric consultation hotlines for children.

*How Do States Monitor Atypical Antipsychotics Prescribed To Children? OPEN MINDS Market Intelligence Report*
Opportunities Systems of Care
Create

- Change the culture of the mental health delivery system to support the resilience and recovery of children and youth receiving services
- Change the paradigm from “medicating” children and youth to meeting the needs of individual children and youth
- Supplement the formal treatment regimen with community-based and natural supports and resources
- Ensure that families and youth are engaged in treatment decisions
  - Awareness of alternatives
  - Awareness of possible side effects
  - Ability to engage in discussions about the effectiveness of medications
Key Strategies

- Understand the payment and delivery system
- Aggregate data across systems
- Engage key stakeholders
- Improve access to evidence-based psychosocial interventions and understand trauma
- Ensure informed consent
  - Patient/provider level
  - Agency level in the case of children and youth in foster care
- Invest in training and education for the:
  - Workforce
  - Families
  - Caregivers
  - Youth
- Monitor the impact of changes
Understand the Payment and Delivery System

• It is important to know how – and by whom – psychotropic medications are managed and paid for

• Entities with a role in management or payment should have input into the development of the monitoring system
  • Medicaid
  • Behavioral health, Juvenile Justice, Child Welfare
  • Managed care organizations

• Partners bring important perspectives and tools to the discussion
  • Data capacity
  • Financial incentives/disincentives
  • Provider engagement and network opportunities
  • Clinical and/or administrative expertise
Aggregate Data Across Systems

- Define key indicators
- Use cross systems data to:
  - Determine baseline rates of use and expense
  - Identify outlier prescribing patterns
  - Understand the types, number, and quantity of psychotropic medications prescribed
  - Track quality and cost outcomes
  - Target high-priority providers or children in high-risk populations
<table>
<thead>
<tr>
<th>Measure</th>
<th>Example</th>
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<tbody>
<tr>
<td>On any psychotropic medication</td>
<td></td>
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<tr>
<td>On specific classes of medications (e.g., antidepressants, stimulants, mood stabilizers, antianxietals)</td>
<td></td>
</tr>
<tr>
<td>On more than one medication from the same class (co-pharmacy)</td>
<td></td>
</tr>
<tr>
<td>On two, three, and four or more psychotropic medications</td>
<td></td>
</tr>
<tr>
<td>&lt; 6 years old on any psychotropic medication</td>
<td></td>
</tr>
<tr>
<td>&lt; 6 years old on two, three, and four or more psychotropic medications</td>
<td></td>
</tr>
<tr>
<td>&lt; 6 years old on antipsychotics</td>
<td></td>
</tr>
</tbody>
</table>
State Examples

- **New Jersey**
  - Working to evaluate data from child welfare, Medicaid, and behavioral health agencies to understand psychotropic medication use and psychosocial interventions
  - New data fields have been added to NJ SPIRIT, the State Automated Child Welfare Information System
    - Documentation of psychiatric evaluations
    - Medication screen to capture dates for treatment plans and informed consent
- **Oregon**
  - Integrated data systems
  - Identified metrics for psychotropic medications and diagnoses by using existing Healthcare Effectiveness Data and Information Set (HEDIS) definitions and formats
  - Coordinated Care Organizations have access to a data dashboard to drive clinical improvements of all children, including those in foster care
Engage Key Stakeholders

- Stakeholders are generally those who pay for, provide, regulate, receive, measure, monitor, interact with, or otherwise influence health care
- Critical to achieving systems change and an important component of a psychotropic medication oversight and monitoring program
- Internal stakeholders (agency leaders, managers, and IT departments), and external stakeholders (vendors, providers, and consumers) are essential
- Types of stakeholder involvement
  - Providing individuals with information
  - Seeking public comment
  - Participation in planning, monitoring, or decision-making processes
State Example

• **Texas**
  
  • In 2005, child welfare, Medicaid, and mental health agencies convened the *Department of Family Protective Services Advisory Committee on Psychotropic Medications* and proposed a series of best practices
  
  • Texas Department of Family Protective Services and The University of Texas at Austin College of Pharmacy developed a set of clinical guidelines for the appropriate use of psychotropic medications among children in foster care
    
    • Red flags
    
    • Dosage recommendations
    
    • Black box warnings
    
    • Precautions related to specific psychotropic medications
Improve Access to Evidence-based Psychosocial Practices

- **PRO**: Access to evidence-based practices (EBPs) can reduce reliance on psychotropic medications - “Expand the toolbox!”

- **CON**: Individual EBPs are limited to subsets of the population of children with behavioral health needs - “It doesn’t work for the children in my community”
  - Managing and Adapting Practice ([https://www.practicewise.com](https://www.practicewise.com))
Understand the Role of Trauma

Children exposed to trauma, including maltreatment, family violence, and neglect, exhibit symptoms consistent with individuals diagnosed with post-traumatic stress disorder, attention deficit/hyper-activity disorder, depression, and conduct disorder/oppositional defiant disorder.
Informed Consent

• For a non-custodial population of children, informed consent is meant to ensure that the parent/caregiver/guardian is aware of all potential risks before treatment commences

• State consent policies for psychotropic medications for children and youth in foster care vary in many ways
  • The consenting entity for the child or youth
  • The timeframe of the consent
  • Whether youth assent is required or preferred
  • Whether there are instances when prescribing may occur without consent
Workforce Training and Education

• Changing landscape will increase demand on the workforce
  • By 2020, 12,624 child and adolescent psychiatrists will be needed, but a supply of only 8,312 is anticipated
  • Mental Health Parity and Addiction Equity Act and Affordable Care Act will increase demand for mental health services
  • Integration of behavioral health and primary care, evidence-based practices, and an integrated model of care that is person-centered and utilizes multi-disciplinary teams

An Action Plan for Behavioral Health Workforce Development (SAMHSA, 2007)
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Report to Congress on the Nation’s Substance Abuse and Mental health Workforce Issues (January 24, 2013)
Then What? Monitor the Impact of Changes

- Rely on metrics identified at the outset to track progress – or lack of progress – toward goals
- Share information with key stakeholders
- Identify sustainable funding mechanisms
- Identify areas for continued attention – *Continuous Quality Improvement*
- Access national and statewide resources
  - Stay current with developments in the field and opportunities for technical assistance
  - Join a community of similarly focused colleagues
Select Resources

- Center for Health Care Strategies *Psychotropic Medication Quality Improvement* Online Resource Center
  http://www.chcs.org/resource/psychotropic-medication-quality-improvement-resources-2/
- Managing and Adapting Practices
  https://www.practicewise.com
- National Registry of Evidence-based Programs and Practices
  http://www.nrepp.samhsa.gov
- Network of Child Psychiatry Access Programs
  www.NNCPAP.org
- *Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care*
  http://www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf
- *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*
  http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf