Managing Pharmacy Costs

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Working Hand-in-Hand to Manage Pharmacy Costs

Utah's innovative use of the Behavioral Pharmacy Management program

Most states' Medicaid programs are under financial pressure as the number of enrollees fluctuates, federal matching funds are threatened perennially, prices of pharmaceuticals steadily rise based on a number of market factors, and ineffective and costly treatments tax limited resources. For help in specifically managing their behavioral pharmacy costs, and to improve quality of care, states such as Alaska, Idaho, Missouri, Oregon, and many others have implemented the Behavioral Pharmacy Management Program (BPMP), which is offered through a three-way agreement among the state Medicaid agency, Comprehensive NeuroScience, Inc. (CNS), and Eli Lilly and Company (whose primary role is to fund the program). State officials in Utah, one of the first states to implement the BPMP, have been particularly innovative in maximizing the BPMP's effectiveness.

Olson

Data Analysis

The BPMP is an educational service that focuses on bringing prescribers' practices more in line with evidence-based treatments to improve care quality and reduce costs, says Julie Olson, director of the Bureau of Managed Health Care in the Utah Department of Health. Each month, CNS analyzes Utah's Medicaid data to identify providers whose prescribing practices (such as polypharmacy) trigger selected indicators, as well as providers who are prescribing (probably unknowingly) behavioral health drugs for patients being treated with similar drugs by other prescribers.

The advent of Medicare Part D shifted the population for which the state has pharmacy data and financial responsibility, explains Olson. So beginning this year, the BPMP is focusing more on behavioral drugs prescribed to children and adolescents as well as adults not dually eligible for Medicare and Medicaid.

Based on these data, reports and educational materials are mailed every month to 200 selected providers whose prescribing patterns may be at variance with best-practice guidelines (reports for children/adolescents and adults alternate monthly), as well as to hundreds of providers prescribing behavioral health medications to the same patients. Providers are encouraged to use the data to reevaluate their prescribing practices in light of evidence-based treatments, which are described in the mailings.

Peer Consultants

The outreach doesn't stop there. Utah has a peer consultant program in which well-respected psychiatrists contact selected prescribers to follow up on the mailings and to discuss prescribing practices. Any provider, in fact, can contact the peer consultants for guidance free-of-charge.

The peer consultants also present data and suggest evidence-based treatments in group settings, which is a very popular form of outreach, according to Kristina Hindert, MD, the medical coordinator of the peer consultant program.

"It's an open forum in which doctors can comfortably talk about these issues," explains Dr. Hindert. "In a group setting, doctors often are less defensive than when getting a phone call." It helps, too, that these group sessions are held

during regularly scheduled medical team meetings, notes Dr. Hindert.

Dr. Hindert considers the BPMP and the peer consultation service as "a wonderful opportunity to extend how we interact with doctors in educating them about evidence-based treatment, as well as obtain data about whether doctors are using evidence-based treatment."

Dr. Hindert notes that some providers are hesitant when they first receive mailings from the program, but after hearing from the consultants, they realize how they can really improve the care of their patients, as well as reduce costs. "These are often their most complex and demanding patients, the ones with whom they have the least effective response to medication, and they have great concerns about how they're prescribing," says Dr. Hindert.

The peer consultants already have had meetings at most of the community mental health centers in the state, and also are meeting with primary care physicians. BPMP administrators are hoping to make continuing medical education credits available for both individual and group peer consultation sessions in the near future.

Outcomes

Figures 1-7 illustrate some of the results of the BPMP in Utah. In general the program is moving in the desired direction. Executive Management Reports indicate significant variance between expected and actual monthly behavioral pharmacy spending, a decrease in monthly behavioral prescriptions per patient for high-risk (targeted) patients, and no increase in monthly behavioral pharmacy claims despite an increase in Medicaid membership. The difference between the expected cost of behavioral health drugs if the BPMP had not been implemented and the actual cost since the program's inception has been particularly noteworthy (figure 5).

Olson says that overall, she sees the BPMP as a quality-improvement endeavor: "Improving the quality of care is the greatest outcome we've had from this program." The federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) has commissioned Mathematica Policy Research, Inc., to conduct an independent evaluation of Utah's BPMP.

■ **The number of patients associated with this indicator decreased from 1215 to 292 (76%).**

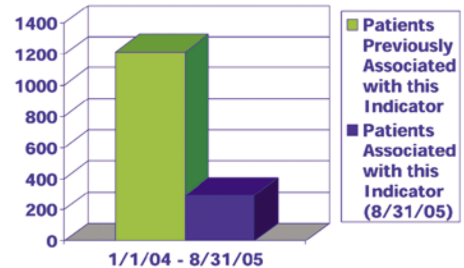

Figure 1. For those prescribers who received educational material from the BPMP, the number of their child and adolescent patients receiving three or more psychotropics decreased from 1,215 to 292 (76%) between January 1, 2004, and August 31, 2005. Note: Changes might have occurred as a result of the BPMP or other outside factors.

■ **The number of patients associated with this indicator decreased from 238 to 75 (68%).**

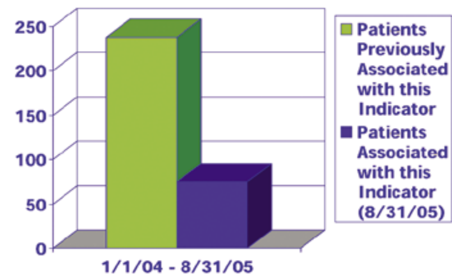

Figure 2. For those prescribers who received educational material from the BPMP, the number of their adult patients receiving five or more psychotropics decreased from 238 to 75 (68%) between January 1, 2004, and August 31, 2005. Note: Changes might have occurred as a result of the BPMP or other outside factors.

Feedback

Olson stresses that the BPMP is an "extremely collaborative project." A group of stakeholders meets at least twice a year to offer their advice, and Olson notes, "They are not quiet people. They do share their feelings with us and have made suggestions that have helped us to improve the project." Providers can offer feedback through a secure Web site or via fax, as well as by sharing their thoughts with peer consultants. Dr. Hindert notes that

- **The number of prescribers associated with this indicator decreased from 1517 to 388 (74%).**

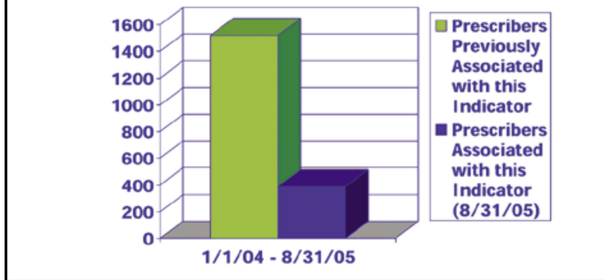

Figure 3. For those prescribers who received notification from the BPMP that their patients were being prescribed behavioral drugs by multiple prescribers, the number who continued this prescribing pattern decreased from 1,517 to 388 (74%) between January 1, 2004, and August 31, 2005. Note: Changes might have occurred as a result of the BPMP or other outside factors.

- **The number of prescribers associated with this indicator decreased from 329 to 87 (74%).**

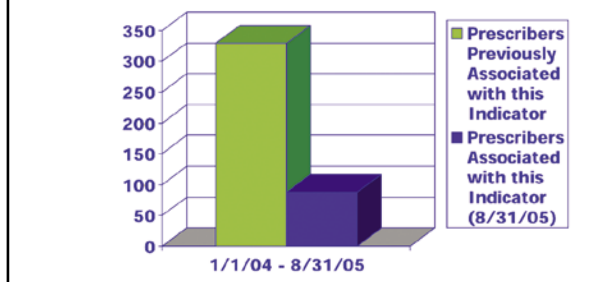

Figure 4. For those prescribers who received educational material from the BPMP, the number prescribing two or more atypicals decreased from 329 to 87 (74%) between January 1, 2004, and August 31, 2005. Note: Changes might have occurred as a result of the BPMP or other outside factors.

Total Behavioral Pharmacy Spending by Quarter

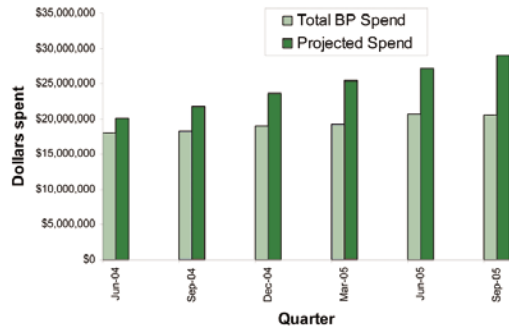

Figure 5. Since the introduction of the BPMP, there has been a significant positive variance between expected and actual monthly behavioral pharmacy costs.

Member count and behavioral claims per quarter

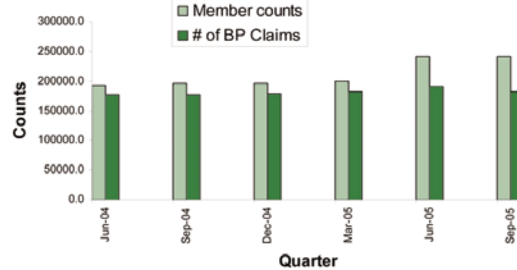

Figure 6. Between June 2004 and September 2005, there was no substantial increase in monthly behavioral pharmacy claims despite an increase in Medicaid enrollment.

Monthly Average Behavioral Pharmacy Prescriptions Per Patient

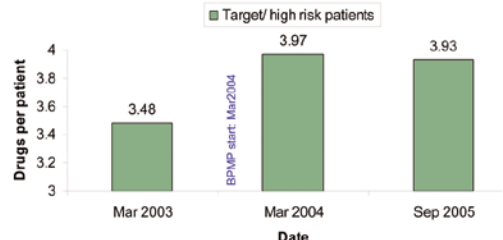

Figure 7. Since the inception of the BPMP, there has been a decrease in monthly behavioral pharmacy prescriptions for "targeted patients" (i.e., those patients whose prescribers received educational material).

peer consultants "often are invited back, and I think that's the best sign that people are finding the service useful."

Additional Reading

To read about the state of Missouri's experience with the Behavioral Pharmacy Management program, see the April 2005 issue of *Behavioral Healthcare Tomorrow*, p. 22, and the February 2006 issue of *Behavioral Healthcare*, p. 12.

Acknowledgment

Figures provided by Comprehensive NeuroScience, Inc.