MENTAL HEALTH DRUG ADVISORY GROUP
Meeting Summary
January 10, 2007

Members Present: Joyce Allen, Virginia Bryan, Clarence Chou, Ted Collins, Hugh Davis, Kevin Hayden, Richard Kilmer, Catherine Kunze, Allen Liegel, Jenny Lowenberg, Kellianne O'Brien, Molli Rolli, Susanne Seeger, Michelle Thoma, and Michael Witkovsky.

Welcome / Introductions: Secretary Hayden introduced himself as the new Secretary of the Department of Health and Family Services. He also introduced two new members.

- Kellianne O'Brien is currently working with the National Alliance for the Mentally Ill Wisconsin (NAMI) and previously worked as the Consumer Relations representative for the Bureau of Community Mental Health.
- Richard Kilmer has been a pharmacist since 1974 and currently works at Community Pharmacy on State Street and ACCESS Community Mental Health.

Secretary Hayden reviewed today's agenda and the meeting summary from August 30, 2006.

Changes in Mental Health Drug Utilization as a Result of Medicare Part D: Richard Albertoni reviewed the Wisconsin Medicaid Fee-For-Service Pharmacy Cost and Utilization by Therapy Class Pre and Post Medicare Part D. This chart compares drug spend pre and post Part D for Medicaid only. The time frame is July 1 through September 30 for both 2006 and 2007. Drug spend was lost for seniors, while drug spend was retained for children. Overall, 34% of drug spend was retained. Antipsychotics are the number one class for drug spend. Due to the retention of younger recipients due to Medicare Part D, Medicaid spending was retained for antibiotics and increased for stimulants. The gross drug spend is $50-55 million.

The Drug Utilization Review (DUR) Board did an intervention last year for Anticonvulsants. Diagnoses such as seizure disorders and neuropathy were matched with the medications in this class. Most of the drugs did not have an approved diagnosis associated with them, especially gabapentin. Psychiatrists had the highest number of prescriptions, followed by neurologists.

Prescribing Patterns for Selected Mental Health Drugs and Impact on Service Utilization: Dr. Michael Mergener and Dr. Richard Carr presented market share graphs that included Medicaid and SeniorCare data for Antidepressants Other, Antipsychotics, Stimulants, and SSRIs. A longitudinal look was included to observe trends. Dr. Mergener noted that one factor affecting the SSRI graph is that many SSRIs went generic during this time. He noted that Medicare Part D went into affect in January 2006. SeniorCare participants were not lost to Part D. Jim Vavra noted that Mental Health Drugs were all grandfathered. Without grandfathering the PDL significantly changes market share to preferred drugs almost immediately.

Dr. Mergener reviewed the "Do No Harm" spreadsheets and noted that these are for Medicaid only because medical diagnoses are not available for SeniorCare. The procedure codes used for these spreadsheets were included in the packets. To be included in the data extract, the reason for the service had to be associated with a mental health diagnosis. For the "Fluoxetine First" spreadsheet, everyone eligible was counted including new patients. Individuals were not used as

controls. It would be good to track the same people for future data. Dr. Mergener noted that there was a decrease in Emergency Department (ED) visits and an increase in outpatient visits. Dr. Carr noted that statistical significance was an important factor to be determined when reviewing this. Dr. Mergener pointed out that there will always be fluctuations for individuals. The length of admissions would also be interesting to see as well as desegregating the data by medication. Are individual profiles available to look at risk assessment? If so, this may be valuable for prevention of crises.

The dual eligibles were taken out for both sets of data. For the Anti-Depressant Other spreadsheet there do not appear to be any baseline changes. For the Atypicals there are slight decreases. There is a claims lag but it is minimal after three months.

Dr. Mergener reported that they have data for different age cohorts for low-dose mono-therapy for atypical antipsychotics: less than 18, less than 13, and less than 6. The vast majority of kids under 6 with prescriptions for atypicals were for Risperdal. Looking at percentages for each drug, Seroquel had the highest percentage of overall prescriptions for low-dose mono-therapy with Risperdal second.

It was suggested that looking at this data with diagnoses might be useful. The DUR Board reviews patient profiles. A number of interventions are done directed to the physicians. It may be helpful to do some interventions directed to consumers.

Secretary Hayden indicated that the vast majority of providers practice with the best of intentions. Mental health drug prescribing varies due to the different levels of expertise. Secretary Hayden reported that Milwaukee is in the early stages of a pilot that will give the science of understanding in order to change prescribing practices. Medicaid will be trying to put an infrastructure in the hands of prescribers. Psychiatrists will then have tools to use when they talk to other physicians.

It was noted that there is often stigma associated with going to the ER for a psychiatric visit. Sometimes the mental health patients are made to wait for significant periods of time before being seen. There are concerns about confidentiality and not wanting all providers to access mental health records. Secretary Hayden responded about the importance of using clinical information to help treat people more effectively and more quickly. He noted that there are ways to respect privacy and dignity and minimize stigma within this electronic system. Consumers and other mental health experts have been working on the e-health issue to assure confidentiality and dignity. He acknowledged that there are other broader issues of professionalism to be explored.

Medications aren't the only way that patients get better. Community treatment and natural supports are very important. It was noted that integrated models would be great. Secretary Hayden noted that Wisconsin Collaborative for Healthcare Quality can integrate through technology. Poor follow-through with treatment was another issue identified. Due to the complexity of treating individuals, the electronic information should include a complete medical record.

Dr. Mergener reviewed the pie charts on provider specialty. Total prescriptions are matched by prescriber. In practice the initial prescription is usually written by a psychiatrist with follow-up prescriptions by general practitioners. This data can not identify if that is occurring. The provider specialty is self reported.

Direct to consumer (DTC) marketing and culture influencing people's perception of their symptoms was discussed. Clinicians use evidence-based medicine and consultation with colleagues rather than DTC marketing. Seniors appear to be more influenced by DTC marketing. Personal websites trigger advertising based on the person's profile. We have to partner to figure this issue out. We don't want uninformed consumers mimicking what they see in the ad. It was noted that sleep is a big area where people are influenced by DTC marketing. Secretary Hayden indicated that this conversation will help to give future direction.

Managed Care PDL Policies and PA Procedures for Mental Health Drugs:
Managed Care representatives participating: Abri - Sue Lund and Barb Francour; Children's Community Health Plan – Teri Frederickson, Director of Clinical Svcs.; Compcare – Carroll Carlson; Dean – None; Group Health Eau Claire – Carroll Carlson; Group Health South Central – Emily Curtis, student pharmacist, and pharmacist; Health Advantage – Mary Olen; Health Tradition – Laura A Dagendesh, nurse, and pharmacy person; *i*Care – None; Managed Health Care/Network – Dennis Olig and Sandi Tunis; MercyCare – Barbara Johnson and Mark Dinnel – pharmacist; Security – Sylvia Wagner and Jennifer Proudfit; United – Ron Austin; Unity – Kathy Ikeman

Marge Hannon Pifer from the Bureau of Managed Health Care Programs gave an overview of the Managed Care policy. HMOs administer their own drug plans. The Department of Health and Family Services (DHFS) establishes contracts with these organizations. She reviewed the Grievance Procedures and data regarding Mental Health Drug Grievances. She noted that managed care here means Family Medicaid, Badgercare, and SSI Managed Care. It does not include Family Care or PACE Partnership. Ms. Pifer reviewed a general statement about expectations. She reviewed the section of the SSI Managed Care Contract related to Coordination and Continuation of Care. This contract is specific to Wisconsin. She talked about a contract that DHFS has with Disability Rights WI to conduct a survey to see if HMOs are following policy.

How is someone notified when they are switched to Managed Care? Angela Dombrowicki indicated that they have worked with Community Support Programs to help with the process for those receiving CSP services. Others received mailings, contract information, and public notices. It was noted that this difficulty of reaching people with notifications is seen in other areas as well. Ms. Dombrowicki noted that if a provider uses the AVR system to check eligibility it will tell you which HMO the patient is enrolled in. HMOs are supposed to try to locate patients to do a health assessment. HMOs have indicated it is difficult to locate people.

Grievances: To become a formal grievance an enrollee only needs to approach DHFS in writing to say that they aren't happy with what is occurring. The contact numbers are in the books they receive entitled "Choosing Your HMO". They are also in any other communication they receive. The hurdles regarding the grievance process are overwhelming. This was mentioned

more than once. It was noted that all a consumer needs to do is to say they aren't happy and any resource listed in the book can help with writing the complaint. HMOs are also required to keep track of informal grievances. Periodically their call logs are audited. An example of past complaints is difficulty people have finding providers who will take them. There are also formal studies done periodically but they aren't broken down by service. Patient satisfaction surveys usually show 20% to 30 % of people are dissatisfied with their care so the numbers presented here are extremely small.

Secretary Hayden indicated that Wisconsin has some of the best performing HMOs in the country. He indicated that we are trying to determine whether a process is in place that is trusted and monitored in the best way. Today's meeting is to determine what the issues are and how we work through them. He will be working with Health Plans to make sure services are provided. Good dialogue with HMOs and CMS assures this occurs. Wisconsin also has robust advocacy groups.

What is available for encounter data with HMOs? Is it similar to what was done with fee-for-service? Ms. Dombrowicki responded that there is a lot of data available on the website. Plans haven't been compared because Medicaid delegates risk to the HMOs. Secretary Hayden noted that whether we should have one PDL for everyone is another policy issue.

Dr. Carr reported that Elaine Gundlach did a study and found that 86% of people were happy with their mental health provider. Performance measures were followed for about seven years in Mental Health and Substance Abuse. They were at the same level for fee-for-service and HMOs.

Are physicians making the right diagnosis and prescribing the right medication? Another concern identified was that it takes a fair amount of effort on the consumer's part to maintain treatment. It is especially difficult for those who don't have case managers. The question is what we aren't measuring such as who isn't receiving treatment. HMOs are expected to do initial health assessments and capture the needs of their patients. This may lead to referrals but will not ensure that appointments are kept or follow-up occurs. Ms. Dombrowicki noted that the BMHSAS recently had a training with the HMOs to address this issue.

There was a question to the HMOs on what is the Step Therapy Model. Dennis Olig from Managed Health Services (MHS) responded that it looks at appropriate use of medication using the most cost effective medications as the first line. MHS currently does not use step therapy for Mental Health drugs. He indicates that the system looks at a minimum of sixty days using the automated process for approval. An example would be with atypical antipsychotics. Abilify and Zyprexa would be denied as first line because they are triple the cost and there is no evidence that they are more effective. He notes that the more cost effective that they can be with an individual the more individuals the HMO can serve. He reports that grandfathering occurs for any mental health drug. The backup to the automated process is the PA process. When records aren't available they work with members.

Secretary Hayden stated that as Secretary, he wants to make sure that appropriate avenues for advocacy are in place so people have help when they can't advocate for themselves. It was noted that we need to look at the breaks in treatment such as when some one turns eighteen or has

changed Managed Care providers. We need to improve information sharing while respecting confidentiality.

Remaining Issues and Future Meetings: Secretary Hayden suggested that the next agenda include the multi-year policy plan for electronic health.
Suggestions for future topic include:

- The lapse of treatment for those on title 19 with a spenddown
- Distinctions between plans on the Prior Authorization Process.

It was requested that the HMOs provide the science behind how they base their decisions regarding formularies.

The next Mental Health Drug Advisory Meeting will be February 21 to review the following classes: Anticonvulsants, Antidepressants Other, and Sedative Hypnotics, and new drugs in Antiparkinson's and Stimulants.