



Accelerating Utilization of CE Findings in Medicaid Mental Health: The Medicaid Mental Health Network for Evidence Based Care

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Thanks to AHRQ

**Supporting state policy work at
The Center for Health Services
Research since 2007**

Directed by Stephen Crystal, PhD



Goals for Today: Policy Lessons

- Management and Monitoring of Psychotropic Use in Youth
- Collaborative Efforts to Address Policy and Quality Improvement Challenges
- Context for Challenges in Foster Care Youth
- Using Data to Drive Quality: Lessons from MEDNET



Medication: “The Second Line”

- AACAP guidelines recommend that “Youth in state custody should have access to effective psychosocial, psychotherapeutic, and behavioral treatments, and, when indicated, pharmacotherapy.”



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Increased Antipsychotic Use

- Prescribing trends are increasing at alarming rates, even in very young children
- Continued increase in rates of second generation antipsychotic use in youth
- Often off-label – triggered by aggressive behaviors
- Current diagnostic system is often inadequate for children



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Increased Antipsychotic Use

- Risk of under treatment and/or over treatment
- Lack of safety and efficacy studies for children
- Brains continue to develop through young adulthood
- Metabolic and other adverse effects



High Rates of Use: Sub Populations at Highest Risk

- Psychotropic medications are being prescribed to **very young children**
- Children in **federally funded health care** are at higher risk than children covered with private insurance
- Rate of use for **foster children** is nearly six times that of TANF children in Medicaid



Recent Reports

- **Regulatory Impetus:**
 - Joint *Dear State Official Letter* from key US Dept. of Health and Human Services Agencies: CMS, SAMHSA, Administration for Children and Families (11/23/11)
- **Particular concerns:**
 - Disproportionate prescribing for children in foster care
 - Reliance on medication to address behavioral concerns
 - Polypharmacy
 - Off-label use and limited study in children



Disclaimer: Data Limitations

- **Claims data is not perfect**
 - **Incomplete**
 - **Misclassified diagnoses**
 - **Limited information on symptoms**
- **Patterns of AP medication use are clear**
 - **Increasing, off label, appropriate psychosocial treatments are lacking**

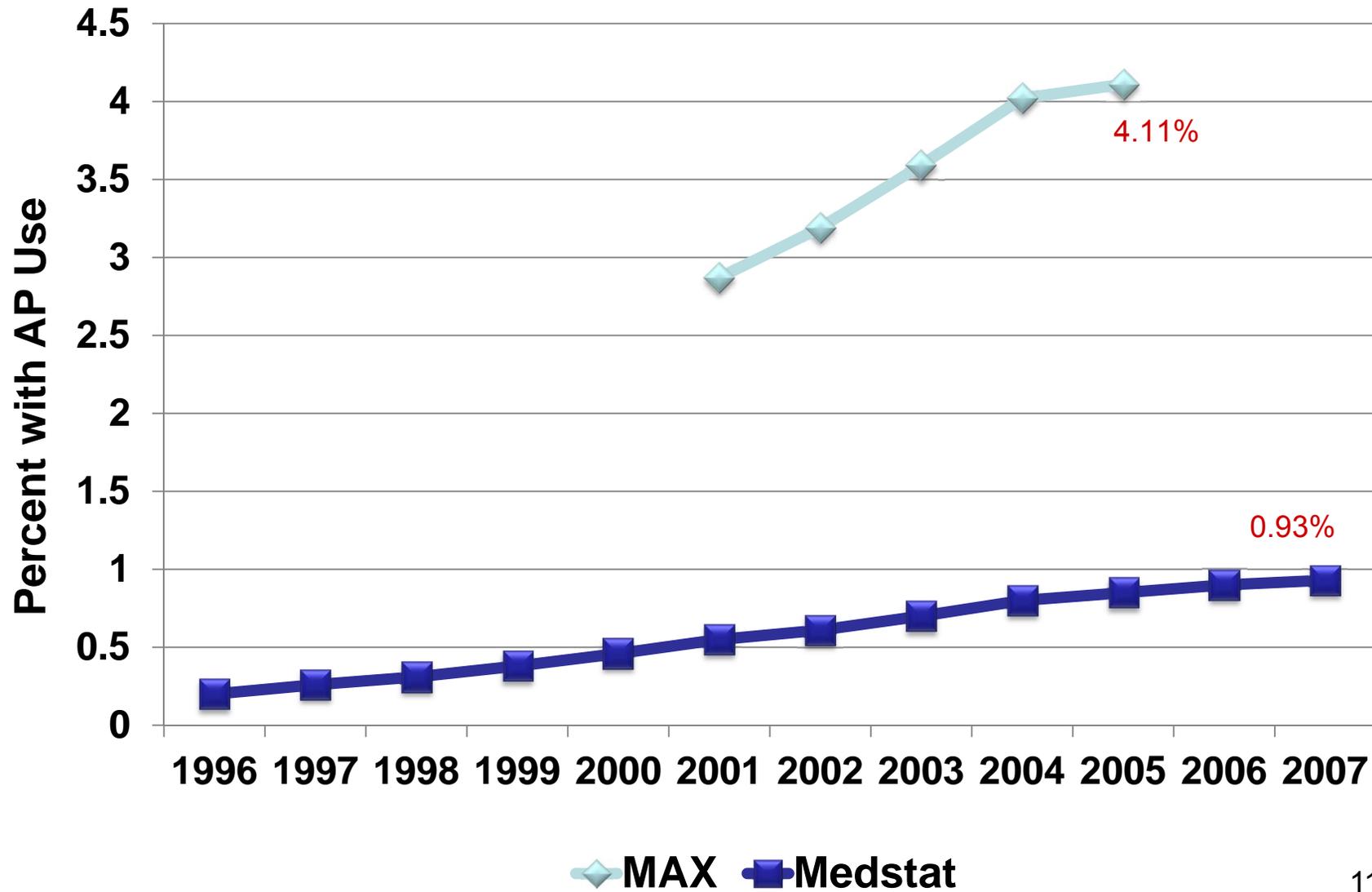


Antipsychotic Use Rates by Gender & Age Medicaid FFS Youth*, Ages 6-17

	Annual rate of use as % of enrollees			Change 2001-2005
	2001	2003	2005	
Total	2.87	3.59	4.11	43% ↑
Sex				
Male	3.99	4.91	5.58	40% ↑
Female	1.68	2.18	2.55	52% ↑
Age Group				
6-12	2.39	2.99	3.37	41% ↑
13-15	3.76	4.63	5.31	41% ↑
16-17	3.58	4.43	5.14	44% ↑

* MAX all states except AZ, DE, DC, OR, NV, RI, NJ, ME

Antipsychotic Use Rates in Youth Ages 6-18





**Annual Antipsychotic Use Rates by Foster Care
Medicaid FFS Youth* Ages 6-17
2001 - 2005**

Annual rate of use as % of perspective enrollees

	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>
Foster Care	9.3	10.5	12.1	13.2	13.6
Non-Foster Care	2.3	2.6	2.94	3.3	3.4

•MAX all states except AZ, DE, DC, OR, NV, RI, NJ, ME



Diagnosis Rates in Medicaid FFS Youth*
Ages 6-17
Mutually Exclusive Hierarchical Groupings

	2001	2005
N	3,879,122	5,065,566
Schizophrenia	0.12	0.11
Autism	0.43	0.56
Bipolar disorder	0.65	1.03
Conduct disorder/DBD <u>and</u> ADHD	1.11	1.18
Conduct disorder/DBD (no ADHD)	2.52	2.29
ADHD	6.67	8.04
Anxiety or depression	2.62	2.60
Substance abuse	0.35	0.34
Adjustment-related disorders	1.85	1.71
Other mental health disorders	4.36	3.97
None of above	79.33	78.19

→ ≈11.5%

* MAX all states except AZ, DE, DC, OR, NV, RI, NJ, ME



National Medicaid Expenditures on Antipsychotic Agents

Highest Cost Drug Groups (in Millions \$) Among Non-dual Eligible Beneficiaries

Rank	1999	2001	2003	2005
1	Antipsychotics (\$700)	Antipsychotics (\$1,174)	Antipsychotics (\$1,898)	Antipsychotics (\$2,466)
2	Antidepressants (\$513)	Antidepressants (\$807)	Antidepressants (\$1,085)	Antiasthmatics (\$1,273)
3	Antivirals (\$452)	Anticonvulsants (\$619)	Antiasthmatics (\$986)	Anticonvulsants (\$1,221)
4	Anticonvulsants (\$388)	Antivirals (\$612)	Anticonvulsants (\$966)	Antivirals (\$1,139)
5	Ulcer Drugs (\$328)	Ulcer Drugs (\$574)	Antivirals (\$950)	Antidepressants (\$1,020)

Esposito, D et al., Trends in Medicaid Prescription Drug Use and Costs: 1999 to 2002. Evidence from Medicaid Analytic eXtract Data. Presented at Academy Health 2007; and CMS, Chartbook: Medicaid Pharmaceutical Benefit Use and Reimbursement in 2003-2005, <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/>



Antipsychotic Use in Medicaid Fee For Service Youth (2005)

- \approx 210,000 (4.1%) received antipsychotics
- Overall use rate increased by 43% (2001-2005)
- Increase consistent across demographic strata
- 75% of use “off label”
- 50% of use “for” CD/DBD, or ADHD
- Triggered by aggressive behaviors?
- Substantial majority also treated with other psychotropic drugs
- Minority received MH assessments or psychotherapy



The “State” Challenge Appropriate Antipsychotic Use

- State Medicaid programs
 - Provide care to youth with SED many of whom are in Foster Care
 - Resources spent are substantial
- Quality varies widely
 - Often sub-optimal
 - EBT practices is uneven
 - Psychotropic medications are a particular challenge
 - Off-label use
- Medicaid Medical Directors identified priority



Background: The MMDLN ACP Project

- MEDNET builds on AHRQ's Medicaid Medical Directors Learning Network (MMDLN) – 2007
 - MMDs prioritized the issue of APs in youth as top priority for a collaborative project, which became the Antipsychotics in Children Project (ACP)
- Originally 16 states – Ohio
- MEDNET 6 of the original 16 states



Background: The ACP Project

- ACP benchmarking of AP prescribing practices across states
- Documentation/sharing of promising practices
- States implemented new and promising practices
- Developed a Report and Resource Guide
- Multi-state learning collaborative



Lessons Learned from ACP Project

- Academic and Public Policy collaboration
- Promise of multi-state QI initiatives in Medicaid mental health
 - Challenges of “siloed” systems
 - Need for a more extensive support
 - Need for more robust implementation of evidence based practices,
 - Need to further engage providers and stakeholders
 - Standardized metrics

MEDNET Mission

- Accelerate adoption in Medicaid mental health of two types of CE findings:
 - Findings on effectiveness and safety of specific clinical practices, in particular patient populations;
 - Findings on effectiveness of organizational practices, strategies and policies related to management of these treatments and of risks associated with treatments across subpopulations.



MEDNET Consortium

- Multi-partner collaboration focused on increasing utilization of evidence-based clinical and service delivery system practices in provision of mental health treatment for Medicaid beneficiaries.
- Partner states California, Washington, Texas, Missouri, Oklahoma, and Maine
- Academic partners: Rutgers, New York State Psychiatric Institute/Columbia University, Translational Partners: AHRQ and AcademyHealth



MEDNET Approach

- Six states collaborated with Rutgers and other partners
- MEDNET Approach
 - Plan for a systematic, collaborative, multistate initiative
 - Accelerate the implementation of CE findings in Medicaid funded mental health care
 - Address treatment challenges for adults and kids
 - Use **common metrics** to support
 - Problem identification
 - Monitoring
 - Provider feedback interventions.



MEDNET Consortium

- State Data
 - Claims and eligibility data for its Medicaid population
 - Rutgers supports development and estimation of quality measures
 - Analyses will provide clearer understanding
 - Core Metrics
 - Treatment patterns
 - Issues and outcomes associated with measures
 - Monitor improvements
 - Provider feedback



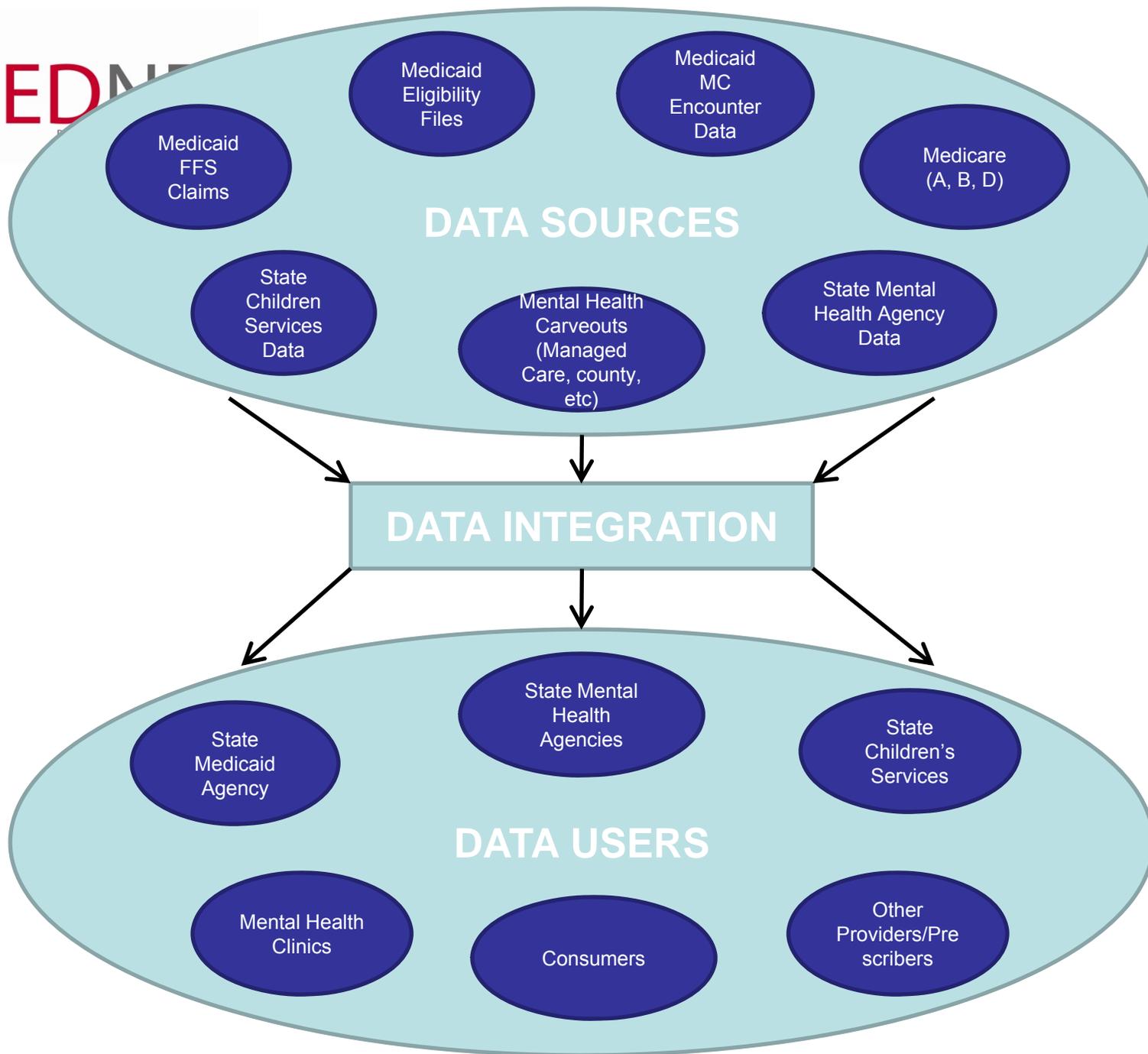
Targeted Clinical Practices

- MEDNET EBP Focus
 - Psychotropic polypharmacy
 - Safe dosing
 - Managing metabolic risks of antipsychotics
 - Improving treatment adherence for adults with SMI
 - Alternatives/complement to medication
 - Special populations
 - Assessing and addressing variations in treatment practices
 - Consistency of treatments and diagnoses



Collaboration: Within - and Across States

- Within states – Key Stakeholders
 - Multiple State agency
 - Clinical providers
 - Clinical settings
 - Consumer and family organizations
- MEDNET Consortium
 - Knowledge sharing and translation of successful practices
 - Common approaches to development and use of metrics
 - “How to” implementation of QI systems





Promising Approaches Include

- Use of BH services and supports before prescribing medication
- Prescriber feedback, education about and adherence to EBP guidelines for children and youth
- Coordinated oversight by public child-serving systems and their partners (CMs, HCHs, MCO/BHOs)
- Red flag systems with peer review/second opinion
- Providing clinical support by specialists to primary care providers
- Provider feedback and monitoring of prescribing patterns
- Patient, family, and provider education about the use of psychotropic medications in children and youth

“Take Aways”

- Cross agency collaboration is essential
- Use extensive data resources to drive quality, improve prescribing
 - Use standardized metrics
- Encourage evidence based practices and policies
- Work at the provider/prescriber level



Questions ??????

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