Position Statement 32: Access to Medications

Policy

Mental Health America (MHA) envisions a society in which all people in need have access to the full array of high quality, community-based, culturally and linguistically competent, integrated mental health and substance abuse services, regardless of ability to pay. For many mental health consumers, access to the full range of the most effective medications is a crucial component of successful treatment and recovery. Such medically necessary psychotropic medications, and their combination with other services and supports, are often essential to permit people with mental health and substance use conditions to recover and to lead healthy and productive lives in their communities.

MHA opposes policies that restrict access to medically necessary medications. Such policies, which include preferred drug lists with prior authorization requirements, restrictive formularies, fail-first requirements, monthly prescription limits, and tiered co-payment structures, not only fail to achieve their intended purpose of reducing overall healthcare costs but prolong human suffering, and reduce the potential for an individual with a mental health or substance use condition to achieve full recovery. Moreover, restrictive policies fail to acknowledge that physicians and consumers should make individualized treatment decisions, recognizing the unique and non-interchangeable nature of human beings and psychotropic medications, and acknowledging that lack of access to medications has both human and fiscal consequences.

Background

MHA recognizes that health care administrators are faced with the challenge of containing costs while maintaining or improving the quality of the care provided to consumers. MHA supports state efforts to implement utilization management strategies that promote and improve the quality of care for individuals with mental health and substance use conditions while seeking containment and reduction of pharmaceutical costs to state Medicaid and other public health programs. Such strategies –which are premised on open access to all medications approved for the treatment of mental health conditions – include closer scrutiny of utilization data to manage cases of polypharmacy, fraud and abuse; provider education initiatives targeted at high volume prescribers; disease management programs; best practice prescribing edits; and algorithms and other practice standards that promote appropriate prescribing based on clinical data and evidence-based practice. Additionally, MHA supports the use of tools to enhance appropriate prescribing and other treatment practices in light of best practice models. Sophisticated modeling and the appropriate use of consumer and professional boards can assure credibility in the prescription of medicine as well as assuring consideration of the full range of treatment options and the active involvement of consumers in treatment decisions.[1]

MHA believes that decisions should always be clinically based and that best practice prescribing will provide long-term cost containment. If implemented based upon the evidence, the practices and tools identified above can be useful for policy makers, practitioners, and consumers to

ensure appropriate access to and prescribing of medications leading to quality improvement and cost containment.

- *Best practice prescribing edits* are intended to promote adherence to accepted mental health medication regimens and well as ensure safe and effective use. Edits are not formulary restrictions, but rather utilize clinical evidence to encourage quality and effective prescribing by preventing therapeutic duplication, overdosing, subtherapeutic dosing, and adverse medication related reactions. Claims data can be reviewed to identify any providers who appear to have unsafe or inappropriate prescribing practices. This practice of processing edits should identify problems or inconsistencies with the clinical evidence around drug interactions, frequency of refills, dose optimization, days supply, and quantities dispensed. Once identified, those providers with prescribing practices that are not clinically based can be targeted for training on best practices and monitored for fraud and abuse.
- *Algorithms* are treatment protocols for medication prescribing, guiding a practitioner with regard to what drug to try first, and in turn, if it is not effective, which medications can subsequently be prescribed. Algorithms that are clinically based are especially helpful for those providers with less expertise with treating mental illnesses, like primary care providers. If used appropriately, algorithms may help in providing a more thorough and informed clinical response, potentially leading to greater long-term use of outpatient services instead of hospital and institutional care. Algorithms can also define where a new medication fits in the sequence of steps for optimal clinical outcomes. It is important to remember that while algorithms can help assist the clinician in clinical decision-making, they must be voluntary, and they are not a substitute for clinical judgment and common sense. A well-constructed medication algorithm is not a cookbook for care, but can guide the clinician through multiple treatment options. By including prior history, consumer preference, and past responses in each step of the algorithm, a clinician can tailor the treatment to an individual consumer's needs with the goal of achieving full remission, community integration, and recovery. Like other clinical tools, algorithms should not be based on a fail first mentality, use cost rather than clinical evidence as a determiner, or specify which brand of drug is preferable.
- *Consumer and professional boards* are yet another venue for monitoring the appropriate prescribing of mental health medications. A consumer and professional board can be established by statute to review and implement the coverage practices of state Medicaid plans and the prescribing practices of providers to ensure safety and improve adherence, quality and outcomes. The board may make recommendations based on peer reviewed medical literature, observational studies, health economic studies, and input from physicians and patients. An effective board also recommends prescribing edits that are consistent with best practice and clinical evidence.

Recognizing that many states have already implemented a preferred drug list, MHA supports the exemption of all medications used to treat mental health and substance use conditions from prior authorization requirements. Such an exemption should address all classes and not include limits based on diagnosis. Moreover, states that have implemented preferred drug lists and other restrictive policies should ensure that the following consumer protection policies exist and are enforced:

- No "fail-first" requirements;
- Prescribers should have the option to designate “Dispense As Written” to prevent automatic switching at the pharmacy point-of-sale;
- A “grandfathering” policy should exist to ensure that consumers who are successfully being treated on a non-preferred medication are not forced to switch.
- Preferred drug lists should be developed and revised based on clinical evidence and scientific consensus taking into account efficacy, safety, and cost;
- Utilization management strategies should be developed by a Pharmacy & Therapeutics Committee that includes practicing physicians in the field of mental health and substance abuse treatment;
- The process for developing state utilization management strategies should include meaningful involvement from consumers and adequate opportunity for public input;
- Prior authorization should be timely and efficient so as not to delay access to medication, nor to deter the prescriber from ordering medications that will have optimal benefits;
- Appeals and grievance procedures must be clearly disseminated to beneficiaries subject to restrictions and must be both accessible and timely;
- Management of consumer information during the prior authorization process should be consistent with Mental Health America’s Standards for Responsible Management of Consumer Information.[2]

For further background information and detailed examples of alternative utilization management strategies, refer to Mental Health America’s *Issue Brief Series: Access to Medications for Public Health Programs*, which includes the following components:

1. The Case for Open Access to Medications
2. State Policies that Restrict Access to Medications
3. Essential Consumer Protections for Medication Policy
4. Promoting Appropriate Use of Medications

Call to Action

Advocates and MHA affiliates should be vigilant to determine whether the shifting limits on access to medications are both reasonable and flexible and comport with this position statement.

Effective Period

The Mental Health America Board of Directors approved this policy on September 18, 2010. It is reviewed as required by the Mental Health America Public Policy Committee.

Expiration: December 31, 2015

1. See, e.g., The Indiana legislation that creates the Indiana Drug Utilization Review Board, IC 12-15-35.5 and IC 12-15-35-51, http://www.in.gov/legislative/ic/code/title12/ar15/ch35.5.html , The Wisconsin Mental Health Drug Advisors Group, https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/pac/mhda/index.htm.spage and complex algorithms like California’s CalMEND program, http://www.calmend.org/. The CalMEND “Decision Aid for Antipsychotic Use,” [link needs to be repaired] is a good example. See also, Parks, J., Radke A., Parker G.,, Foti, M-E. Eilers, R., Diamond, M., Svendsen, D., and Tandon1, R., “Principles of Antipsychotic Prescribing for Policy Makers, Circa 2008. Translating Knowledge to Promote Individualized Treatment,” NASMHPD (2008). http://nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Principles%20of%20Antipsychotics%20final.pdf
2. MHA Position Statement 27. http://www.nmha.org/go/position-statements/27