

Managed Care Cost-Containment Strategies and Their Impact on Physician Prescribing and Treatment of Depression

Based on a presentation by Robert K. Schreter, MD

Presentation Summary

Pharmacy costs are outpacing other healthcare expenditures, with psychotropic medications accounting for 16% to 25% of the total pharmacy costs. Managed care organizations (MCOs) can be expected to exert considerable pressure to control such costs. Avenues for cost containment include changing the management and spending decisions of MCOs, influencing physician prescribing patterns, encouraging economi-

cally efficient pharmacy policies and procedures, and controlling patient access to prescription drugs. From the cost standpoint of an MCO, briefer approaches to treating depressed patients are desirable. The MCOs prefer a limited number of psychotherapeutic sessions, rapid titration and prescription of higher dosage levels of appropriate drugs, and a longer continuation phase of pharmacological treatment to avert a relapse.

Because the public perceives saving money as the driving force behind all managed care organization (MCO) procedures, this presentation examines various avenues of cost containment and the effect of those strategies on the delivery of treatment for depression, such as limiting physician practices, inviting uniformity, and imposing greater accountability on healthcare.

Business Practices

The US Health Care Financing Administration has predicted that for the first time in a decade healthcare premiums will increase 10% in the year 2000.¹ Thus, MCOs will probably exert further pressure on physicians to contain costs, and pharmacy costs are often targeted first for review. In fact, pharmacy costs are surpassing other healthcare expendi-

tures, with psychotropic medications accounting for 16% to 25% of the total pharmacy costs.²

Pharmacy policies and procedures are often intended to affect utilization and cost of practice. Under this umbrella, an area in which MCOs can reduce expenses is formularies, of which there are several types, such as open, closed, and preferred. The variations among the formularies are extensive, and no one type is most beneficial in all treatment programs. Some drugs may be locked out by the National Drug Code restrictions on formularies. That often means the clinician can prescribe drugs that are locked out but he or she will not be reimbursed. More study into the intricacies of the formulary process is necessary for this aspect of managed care to be fully understood by the healthcare community.

Another area in which costs can be controlled is the local pharmacy. In many pharmacies, each time patients submit a new prescription, their files are processed through a database. At that time, a search is undertaken to learn whether a patient is at risk for drug interactions with another medication that he or she is taking, and another search is processed through a pharmacy benefits manager who discovers whether a generic substitution or a completely different drug is an option. The changes save money for the MCO and often mean that the pharmacist and the prescribing clinician receive an incentive for having made cost-effective changes.

The Effects of Managed Care on Physician Prescribing Practices

The effect of managed care on pharmacotherapy has far-reaching consequences. Instituting physician incentives is a powerful strategy used by MCOs to contain costs. Incentives can affect what physicians prescribe; for example, the use of less expensive drugs, such as tricyclics over selective serotonin reuptake inhibitors (SSRIs), could be encouraged. Incentives may also lead to complications, such as on what basis should physicians make their prescribing decisions and that physicians must bear the consequences of those decisions. Also, large physician group practices have been known to discontinue capitated psychopharmacology agreements not only because they perceived that the ethical issues were in conflict with the mandates of the capitated program but also because the physicians couldn't adjust to the financial consequences of such prescribing as they thought best.³

Mental health carve-ins and carve-outs can influence referral to specialists. If a provider or system is at risk for the cost of referral of mental health patients, those patients are more likely to be treated in-house. In those situations, the patient might receive inappropriate or inadequate

treatment, depending on the expertise of the practitioner who provides the care.

Pharmacy benefits managers use a series of strategies to influence physicians' prescribing patterns. They conduct drug utilization reviews to identify trends in the types of medications being prescribed and patient compliance. Physicians are sent "Dear Doctor" letters about these factors in an attempt to influence subsequent prescribing behavior. More study is needed to discover the effect pharmacy benefits managers, who are employed at approximately 90% of MCOs in the United States, have on the treatment of depression.

Preauthorization requirements, medication sequence protocols, and treatment guidelines also influence physician prescribing behavior.

Current managed care treatment guidelines for depression encourage brief and intensive treatment. Brief treatment encourages getting appropriate patients on antidepressants as soon as possible, initiating rapid titration, and prescribing a higher drug dosage. Managed care also encourages a longer continuation phase of treatment to prevent relapse. A goal of those strategies is to achieve hospital diversion because hospitalization significantly increases the cost of treatment.

Compliance is also an important issue for clinicians and MCOs, because patients who continue to take their medication have fewer relapses, which translate into fewer presentations and fewer hospitalizations.

The Effect of Managed Care on the Patient

Managed care also influences drug use at the patient level. It imposes limits on benefits for conditions that can be treated with pharmacologic agents and sometimes reduces the patient's access to newer agents for covered conditions. Limits are frequently set on the number of prescription refills allowed without

physician approval and on the time interval between refills.

Other plans have tiered copayment systems or require a patient to fail treatment with one agent before another can be prescribed, often requiring patients to endure an ineffective therapy or drug-related side effects. Such methods increase the cost to the patient, discourage the use of medications, and reduce the use of medications that are both essential and cost effective as well as of those that are not cost effective.

The Positive Effects on Healthcare Delivery

In spite of its negative effects, managed care has exerted a positive influence on healthcare delivery. It has played a significant role in fostering the development of clinical support services. Case managers spend a great deal of time tracking patients, finding out whether they are taking their medications, and whether those patients are taking the correct doses. Such tracking could have clinical value by encouraging patients to focus attention on treatment compliance.

Managed care also encourages the development of disease management programs that focus on wellness and reward case managers for their attention to treatment plans. Currently, there are great differences in physician behavior that have no bearing on quality or outcomes. If treatment guidelines can be developed and followed and their outcomes compared, there is a better chance of achieving evidence-based prescribing.

Administratively, managed care creates a demand for a standardization of care, which can only be achieved by instituting policies and procedures. Large systems of care must comply with accreditation standards. They must generate and publish outcome and benchmarking data. The measures for nonbehavioral health developed by the National Committee for Quality Assurance

and used by the larger MCOs have become important both clinically and financially.

... DISCUSSION HIGHLIGHTS ...

Mr. Vodoor: Choosing the least costly drug is not always an option, because with certain drugs there is no choice. A majority of the therapeutic categories have multiple drugs listed. For those categories, if all else is equal, the cost of the medication becomes the deciding factor.

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—Robert K. Schreter, MD

Physicians Need Flexibility in Prescribing

Mr. Vodoor: We want to give physicians flexibility in prescribing and in titrating drugs to the needs of individual patients. If a patient fails to benefit from a particular drug, physicians can try another drug, either the preferred agent or something else. If a patient has been stabilized on a drug, we don't want to change that.

In our plan, after we have reviewed the clinical profile of a drug for its safety and efficacy, we examine our experience with it. If we are comfortable with that, then cost becomes a consideration. We're not talking a penny here or a dollar there. There has to be a significant cost difference in using one drug as opposed to another.

When we sign a contract with a pharmaceutical company, we are looking for about a 3-year commitment. We don't want to be giving the

patient an orange pill today and a blue pill tomorrow.

Dr. Goodman: How compliant will patients be if the color of a pill changes 3 or 4 times during a year?

Dr. DePaulo: They won't be compliant. Most patients think the pharmacist has made a mistake.

Formularies Backed by Sound Clinical Data

Mr. Urick: This isn't entirely a cost issue. Formularies from reputable health plans reach conclusions based on sound clinical data. It would be a conflict as well as a liability issue if a drug were prescribed that was not only less effective but less expensive as well. You try to identify parallels with a commodity market and strike a deal on price that is to your members' advantage.

Of course, you can give everybody what they want, but we've tried fee-for-service, and it did not work. If people were able to pay \$250 a month out of pocket for their pharmacy benefit, cost would be not be an issue, but we're simply trying to provide good clinical care that patients can afford.

The NCQA [National Committee for Quality Assurance] requires managed care companies to have input from physicians when drugs are selected for inclusion on formularies. This is a tremendous way to strike a balance that offers the best clinical advantage to a population.

Dr. Schreter: The way in which formulary decisions are made at the plan level by people who interact with patients is quite different from the way they are made by PBMs [pharmacy benefits managers]. I often get letters from PBMs informing me that I have used a particular medication a certain number of times compared

with other clinicians and suggesting that I use another instead.

Dr. DePaulo: I'd like to raise an issue. It seems to me that MCOs in general have done a good job of looking at the prescribing practices of their clinicians overall, but I don't see that they have done a good job of looking at the practices of their reviewers. We don't know if they are consistent, and we don't know how they impact clinical and economic aspects of care.

Case Managers Assist Pharmacy Benefits Management

Mr. Vodoor: You're talking about medical support services, and you're 100% correct. Pharmacy benefits management companies need case managers who target high-risk patients. When that is addressed, the economics will fall in line. The problems of drug interactions, noncompliance, incorrect prescribing, or a patient's taking too much or too little of a medication have to be linked to the provider. Someone has to spend time dealing with the provider and with the patient if we want to succeed in providing appropriate care.

Dr. Schoenbaum: Why isn't that happening?

Mr. Vodoor: It takes money, time, and resources. These days, private physicians are overwhelmed with paperwork and insurance forms. The insurance companies for which they work all have a ton of paperwork; it's an administrative nightmare and a major problem that somehow must be overcome.

Dr. DePaulo: I'm attending on our inpatient unit this month, and for the first time in a while I have been turned down in the first 3 requests for continued inpatient treatment. The case for 1 patient was debatable, but

the other 2 clearly had to be in the hospital. I have learned over the years not to get upset about questions regarding my judgment, but it is in the obvious cases that we need consistent and sensible reviewer decisions.

Dr. Goodman: How do we stabilize the entire system when it comes to treating patients and standardizing the managed care industry?

Mr. Urick: I don't think the answer lies in legislation. I am very concerned when someone proposes legislative mandates that outpace clinical wisdom. Improvement lies in better partnerships with industry, evidence-based medicine, and providers.

Dr. Goodman: Psychiatry values the fact that it has diverse perspectives. It uses 2 methods of approaching a patient; one is medical, the other psychological. As clinicians, we all value our ability to make choices, but I'm not sure psychiatrists' choices of antidepressants and the ability to predict which patient will respond are as good as we would like.

Evidence-Based Practice Standardizes Clinical Guidelines

Dr. DePaulo: One area in which algorithms seem to work is in oncology. In that speciality, the exact effect of each drug is known. The issue of concern in oncology is not what a drug does but the empirical question about combining one drug with others.

Dr. Schoenbaum: What you have just described is a standard of care, and there isn't one, not even in oncology.

Dr. DePaulo: But oncology does have protocols.

Dr. Schoenbaum: True, but when you look at cancer patients who are not participating in a clinical trial, do you

think they are receiving what the patients in the control arm of the trial are getting? The trial is structured so the control arm is supposed to receive standard therapy, so everyone in the community should be receiving standard therapy, if there were such a thing, and in oncology that is absolutely not the case.

“That’s why I believe algorithms are so problematic in psychiatry today. We don’t have good evidence about how to pick any one antidepressant over another. We don’t know whether they succeed nor why they fail.”

—J. Raymond DePaulo, MD

Dr. DePaulo: I agree but it is reasonable to hope that the protocols will generate the kind of evidence needed to develop standards of care.

Dr. Schoenbaum: I accept your contrast between oncology and mental health, but if oncologists don't follow standard practice guidelines, then we in mental health are even farther behind.

Dr. DePaulo: That's why I believe algorithms are so problematic in psychiatry today. We don't have good evidence about how to pick any one antidepressant over another. We don't know whether they succeed nor why they fail.

Dr. Goodman: If you don't standardize treatment for disease management, then managed care is going to attempt to manage finite resources with a group of physicians who don't want to be managed by algorithms and protocols. I'm not a big fan of algorithms, but I understand the need for standardization. That's why we have the standardization of psychiatric diagnoses. We don't let psychiatrists randomly decide which disorder

a patient has and then institute some idiosyncratic type of treatment.

Complications of Algorithms

Dr. Jefferson: Nobody wants to adhere to an algorithm because they think they know something more specific about their patient that doesn't quite fit the algorithm. Besides, people don't like to be told what to do.

Mr. Vodoor: When you talk about standardizing therapy for depression, there's not much we can do. Some algorithms recommend using an SSRI but not necessarily a specific drug. For that, a formulary document would have to be consulted.

Dr. Schreter: Across the country, there is tremendous variability. Some patients with major depression are not referred for months and months. Others will be treated with medications you've never heard of or benzodiazepines. Variability becomes a major issue, especially with giant managed care systems. Some standardization is very important.

Dr. Schoenbaum: I agree. I think practice guidelines are the way to go. Because I'm not a clinician or a PBM, practice guidelines represent a kind of middle ground. Clinicians as well as MCOs must live with established guidelines. If the guidelines recommend things the plan doesn't cover, then there's room for negotiation. I'm concerned with who develops those guidelines.

Dr. DePaulo: I don't like guidelines, and I don't like to impose them on anyone else. But the key issue is what level of specificity do we want included in them. I think guidelines would be helpful in terms of requiring good clinical assessments of patients prior to treatment decisions.

Mental Healthcare Expenditures

Dr. Schreter: Nonpsychiatrists haven't quite understood that psychiatry has been subjected to much more management over a longer period of time than the rest of medicine. During the past decade, the dollars going into direct healthcare may have decreased 7%, but the dollars for mental healthcare have decreased 54%.⁴

What troubles me is that clinical decisions are being made by the marketplace, and the marketplace is basically concerned with dollars, but we need a marketplace influenced by science. I don't think we are there yet.

Dr. Goodman: Within psychiatry, there are broad ranges of practice skills according to the practitioner's expertise. The same thing could be true in the managed care arena. Some in the healthcare community are extraordinarily conscientious about how they prescribe medications and use their formularies, but the quarterly reports of others continue to convey the attitude that the dollar is the final calling card.

We should work together to try to understand that there are limited resources allocated to an increasing number of patients diagnosed with a psychiatric illness.

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