County Safety-Net **Behavioral Health** Service

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This paper describes a model for clinical pharmacy services for a County Behavioral Health Services (BHS) model. The model is a county safety-net program. Clinical pharmacy support is provided by Craig Stern, PharmD, MBA and Pro Pharma Pharmaceutical Consultants, Inc. for formulary, clinical and utilization screening, as well as financial oversight and management of the drug spend.

How Model Relates to Safety-Net Concept

The County behavioral health program is a safety-net system that is the payer of last resort for uninsured and low-income residents suffering from mental illness. A safety-net based system of care is a program for providing care when no other medical insurance is available, e.g., Medi-Cal, Medicare, third-party insurance, etc. Medications are covered if they are for urgent or emergent mental conditions or for selected ongoing chronic mental conditions. The program has a formulary that is restrictive in that only those medications on the formulary are covered. Further, payments are restricted to generic formulations of medication when they are available. Generics, whether they are available from one or more manufacturers, are covered on the restrictive list.

Exclusions from the formulary include medication not listed in the formulary, over-the- counter medications and specific therapeutic classifications relating to conditions outside the scope of the program. The program in rare cases may cover a non-formulary drug where one of the following conditions is present:

a) All formulary options have been ineffective, or
b) Another non-formulary drug is less expensive, or
c) There is an overwhelming case specified need, and the diagnosis is within the scope of the BHS program and is consistent with the prescription.

Medications paid for by the program are limited to those prescribed by the program physicians and filled in county pharmacies.

The program is the payer of last resort; however, when it is determined that the client being served does not qualify for the many other programs sponsored by the state and federal agencies (i.e., Medi-Cal, Healthy Families, etc.), services provided by the program do not exclude persons with other coverage and the program does bill these funding sources for the services it provides. As a result, program psychiatrists prescribe medications for these persons as well as those for whom the prescription costs are covered. In addition, for Medicare Part D patients the program desires to ensure that its clients with this coverage are not financially deterred from obtaining their medications and decompensating as a result of not maintaining their medication regimens. Therefore, the program covers copays only for clients receiving Medicare benefits as well as deductibles for certain groups.

Medication therapy for the behavioral health model is supported by a managed care pharmacy model that identifies medication therapy issues, addresses them on a patient-specific basis with the medical director who follows up to ensure that applicable interventions were effectuated. The pharmacy model was conceived of, designed, implemented and monitored by a coordinated team composed of a plan administrator, two Medical Directors, and a Clinical Pharmacist consultant. The pharmacy model is anchored in a restricted formulary that contains formulary rules (e.g., substitution bias, prior authorization criteria, etc.), quantity limits, dosing limits, and maximum dollar limits (in some cases) for every drug on the formulary.

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On a bi-monthly basis, pharmacy claims, enrollment, and other relevant data sets are screened for (but not limited to) utilization, benefit

compliance, and cost considerations. Physicians, pharmacies, and patients are profiled monthly. Physicians are contacted with utilization or quality care issues and opportunities for alternative cost-effective treatments. Further, the results of these patient-specific and issue-specific screens are communicated to applicable psychiatrists bi-monthly by the associate medical director. In summary, these screens include:

- Clinical screens which include patient-specific compliance and adherence (overall, by doctor, by therapeutic category, and by patient), doses or quantities greater than prescribed, high severity drug interactions and adverse drug effects, and other issues that are widely divergent or occurring in high severity patients. The following are specific analyses run bimonthly:
  - Dosing outside of established clinical range
  - Drug overlap of 60 days or more
  - High prescription count of psychotropic drugs
  - Therapeutic compliance
- Utilization outliers include coordination of care issues, polypharmacy and duplicate therapy
- The Medical Director also receives spreadsheets that can be filtered for all claims for particular patients or psychiatrists, or the results of any of the above edits.

All screens include notification counters and are tracked monthly by issue, patient, and doctor. The Medical Directors choose which issues to address with applicable psychiatrists. Any doctors who have notifications of greater than three may be contacted by the Medical Director for an explanation of need or of physician awareness including current interventions already taken and not indicated in the encounter data, or a discussion of applicable interventions or alternative options. The screens are designed to cover all issues and usually include thousands of patient issues. The data is also mined for high value patients and issues that are reported as "*call-outs*." These *call outs* are smaller in number, usually thirty or less, and allow for the opportunity to focus priorities on fewer direct interventions by the Medical Director.

On a regular basis all screens are evaluated for effectiveness, currency, and the need for implementing new screens. This process has lead to reports that the Medical Directors can filter and review according to their own criteria.

On a monthly basis the Clinical Pharmacy Consultant and the Medical Directors discuss clinical issues, provider concerns, prior authorization problems, formulary management issues, and other issues of immediate concern. These calls provide benefits beyond problem solving in that they also allow for open and candid discussions. In this environment all options can be aired and discussed with the objective of fairness and parity in clinical judgment.

Resource Requirements

The pharmacy model requires a clinical pharmacist, programmers, data analysts and support staff to analyze, interpret, distribute reports, and arrange calls with the Medical Directors. The Clinical Pharmacist manages the formulary, high severity or outlier issues addressed in utilization screening, support for the Medical Directors, and oversight of screening and reporting.

Successes: Anecdotal and Measurable

The pharmacy program has provided clinical, financial and educational successes. Every intervention is tracked on a patient, issue and physician basis. All results are reported by an aggregated sum, and on a cost per-member-per-month (PMPM) and cost per-patient-per-month (PPPM) basis. Savings in drug spend have accrued through pre-payment screening of invoices, judicious selection of medications for the formulary, and limits on quantities and dosing applied in claim adjudication.

Limitations, Restrictions

The model requires sufficient hardware and software support for screening pharmacy claims, enrollment files, and supporting files. Standard pharmacy-related software is insufficient for population-based screening such that programmatic coding is a necessity. Specialized programs were designed and coded to produce individual queries as well as artificial intelligence datasets to screen across multiple datasets.

What is the Business Case?

The managed care pharmacy model includes clinical, financial oversight, analyses, reporting, and quality oversight.

Separate from the clinical involvement discussed above, the pharmacy claims are screened against the Pharmacy Benefit Manager (PBM) invoice on a monthly basis. These financial reviews include:

- Financials trended month-to-month, and year-to-year
- Invoices screened for conformance with the supporting claims
- Claims screened for eligibility, validity, benefit compliance, contract pricing, AWP and MAC integrity, etc.
- Claims screened for compliance with State and Federal requirements
- Analyses of pricing discounts, payments by network, drug type, etc.

The screening of invoices and financial trending is an enhancement of the Accounts Payable process that allows for recognition of payment variance at the time of pre-payment of each invoice. Further, financial trending allows for identification of cost and utilization drivers such that actions can be formulated and implemented to control and manage the drug spend. While the savings from these processes are

not available for general discussion, the benefit of oversight at pre-payment of an invoice is of notable benefit.

The managed care pharmacy model is based on a consulting fee for services rendered. The fee is fixed and has not varied for several years. Any project work is additional and based on a project fee or time-and-materials basis.

Legal, Regulatory Issues or Restrictions

The only applicable legal issue is HIPAA. The analyses and communications included in this model are covered under the administration component of HIPAA. All communications including patient-specific information must be protected and communicated only to administrative or treating providers. All summary reports must be sterilized for any patient-specific information.

Future program plans

There are several opportunities for cost savings and enhancement of medical oversight. All of these issues are currently being discussed, anticipated, or placed in long-term planning. First, the collection and publication internally for medical encounter data for physician office visits would allow for identification of diagnosis, patient severity, and testing performed. This information can only add to the pharmacy claims detail in defining areas for further oversight or variance from standard guidelines of practice.

Second, the establishment of pre-existing County Psychiatric Clinics as Federally Qualified Health Plans (FQHC), or FQHC-like clinics would allow for patients to receive drugs through Pharmaceutical Assistance Programs (PAP). The PAP programs allow for indigent patients to receive branded medications, particularly atypical antipsychotics in this case, for free from the manufacturers.

Third, the interaction between the therapy of psychiatric patients and the medical treatment of the same patients in the County medical clinics has been discussed. While there are several concerns about arms-length relationships between the psychiatric and medical providers, it is recognized that there is a need for some level of cooperation between the providers for coordination of care, and treatment for drug-induced disease. These discussions continue.

The model discussed above indicates that there are opportunities for pharmaceutical care that bridges the gap between medical and pharmacy practitioners. The use of more population-based models allows for cost-effective involvement to the extent that is clinically relevant to high severity populations. The financial benefits accrue from oversight of drug spend. As psychiatric therapy continues to increase in cost, models such as this provide some opportunities for collegial interactions between pharmacists and physicians.