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Rapid Growth Of Antipsychotic Prescriptions For Children Who Are Publicly Insured Has Ceased, But Concerns Remain

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ABSTRACT The rapid growth of antipsychotic medication use among publicly insured children in the early and mid-2000s spurred new state efforts to monitor and improve prescription behavior. A starting point for many oversight initiatives was the foster care system, where most of the children are insured publicly through Medicaid. To understand the context and the effects of these initiatives, we analyzed patterns and trends in antipsychotic treatment of Medicaid-insured children in foster care and those in Medicaid but not in foster care. We found that the trend of rapidly increasing use of antipsychotics appears to have ceased since 2008. Children in foster care treated with antipsychotic medications are now more likely than other Medicaid-insured children to receive psychosocial interventions and metabolic monitoring for the side effects of the medications. However, challenges persist in increasing safety monitoring and access to psychosocial treatment. Development of specialized managed care plans for children in foster care represents a promising policy opportunity. New national quality measures for safe and judicious antipsychotic medication use are also now available to guide improvement. Oversight policies developed for foster care appear to have potential for adaptation to the broader population of Medicaid-covered children.

Antipsychotic medication use among publicly insured US children increased sharply during the early and mid-2000s, as documented by several studies. One study found that this medication use increased by 51 percent among Medicaid-insured youth (ages 6–17) between 2001 and 2004.¹ Use among children and youth in foster care also increased in this decade—from 8.9 percent in 2002 to 11.8 percent in 2007 (ages 3–18), according to one estimate.²

State and federal agencies responded to these trends by implementing multiple initiatives to strengthen the oversight of antipsychotic pre-

scribing to Medicaid-insured youth. Initiatives include increased use of Medicaid prior authorization processes based on preestablished criteria for prescribing antipsychotic medications.³ A 2015 study found that thirty-one states have implemented a prior authorization program for this medication use among Medicaid-insured children, with varying age thresholds.⁴ Other initiatives include telephone access lines enabling primary care physicians who might be considering these medications to consult with child psychiatrists.⁵ As oversight initiatives have increased for both foster children and other Medicaid-insured children, it is important to examine concomitant changes in prescribing pat-

terns for the two populations.

Oversight initiatives for foster children frequently include a clinical review of the medications prescribed to them by mental health specialists other than the prescriber (a practice known as collegial secondary review).³ For example, Texas has promulgated prescribing guidelines that, when not followed, can trigger a collegial secondary review of the treatment being received by that child.⁶ Prescribers for other Medicaid-insured children in Texas are also encouraged to voluntarily use the guidelines. California has also recently issued guidelines for the use of psychotropic medications, of which antipsychotics represent one class, for foster children.⁷ Several states require judges to review and approve initial or ongoing use of antipsychotic medications for foster children (known as judicial review).³ In 2015 new legislation was enacted in California to strengthen judicial review, and stricter Rules of Court (guidelines for judges for review and approval of proposed medication prescriptions) have been proposed to govern the process.⁸ For foster children, forty-four states and the District of Columbia had implemented at least one program to monitor psychotropic medications by 2013.³

Background On Children In Foster Care

TREATMENT CHALLENGES Foster children, for whom the state serves *in loco parentis* (“in place of the parent”), have been a central focus of the increased public attention and oversight initiatives that have taken place since the mid-2000s. These children often experience trauma associated with abuse, neglect, and family separation. In one study, mental health expenditures for foster children averaged 11.5 times those of income-eligible Medicaid-insured children.⁹ Foster children account for approximately 3 percent of all Medicaid-insured children but 29 percent of behavioral health expenditures.¹⁰ Among foster children, impulsive and aggressive behaviors have been associated with increased placement disruptions, longer stays in care,¹¹ and reduced likelihood of family reunification or adoption.¹²

Concerns about the adequacy of behavioral health care for foster children have grown at the state and federal levels. For example, Government Accountability Office (GAO) studies have raised concerns regarding quality of mental health assessment, documentation and monitoring of psychotropic treatment for foster children, and underuse of evidence-based psychosocial interventions.¹³ Generally, foster children receive more oversight of their mental health care than other Medicaid-insured children; with-

in the larger mental health environment, there remains a need for investigation of differences between the antipsychotic medication–associated treatment patterns of foster children and those of other children and the gaps in quality between the groups.

DEFINING AND MEASURING BEST PRACTICES

First, to improve treatment patterns, it is important to define best practices and measure the extent to which treatment is consistent with them. Metrics designed to measure various dimensions of quality in antipsychotic treatment were initially developed through a sixteen-state public and academic partnership.¹⁴ These metrics were subsequently refined into national quality measures through the National Collaborative for Innovation in Quality Measurement as part of the federally sponsored Pediatric Quality Measures Program.

The provision of psychosocial mental health treatment before, or at least concurrent with, antipsychotic treatment has increasingly been identified as a best practice, and states have paid increasing attention to measuring and improving this care process.¹⁵ Second, as evidence has accrued on the adverse metabolic effects of antipsychotics in children, including increased risk of type II diabetes,¹⁶ there has been increased focus on ensuring regular monitoring of blood glucose and lipids for children treated with antipsychotic medication.^{17,18} A third increasingly accepted best practice is avoidance of multiple concurrent prescriptions for antipsychotic medications.¹³ These three aspects of care quality, used in our analysis, were incorporated into the National Committee for Quality Assurance’s Healthcare Effectiveness Data and Information Set (HEDIS) measures beginning in 2015.

MATCHING TREATMENT AND DIAGNOSIS A final important aspect of treatment differences concerns the consistency between antipsychotic treatment and children’s mental health diagnoses. Food and Drug Administration–approved clinical indications for antipsychotic medication use in children are limited to schizophrenia, irritability associated with autism, Tourette’s disorder, and bipolar disorder.¹⁹ However, antipsychotic medications are also often used in children for other purposes, such as treatment for aggressive symptoms associated with attention deficit hyperactivity disorder (ADHD).²⁰

To examine changes in prescribing patterns that occurred during the period of rapid policy and programmatic change since the mid-2000s, we used administrative claims data to study whether the previously reported trend of increasing and broadening use of antipsychotic medications has continued among foster children and other Medicaid-insured children. We also exam-

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ined quality measures in several states to explore gaps in guideline-recommended practices and the extent to which the greater degree of state oversight for foster children translates into improved performance on quality measures.

Study Data And Methods

DATA SOURCES Our claims-based analyses used 2005–10 Medicaid Analytic eXtract (MAX)²¹ data for twenty states identified in prior analyses to have the most complete encounter data for treatments, services, and diagnoses for children in managed care (or minimal managed care enrollment).^{22,23} We also used 2009–11 Medicaid data provided directly by three states and data for privately insured children from 2005–13 Truven Health Analytics MarketScan Commercial Claims Databases.²⁴

STUDY POPULATION We examined trends in multiple measures related to antipsychotic medication use for individuals ages 0–17 enrolled in Medicaid. We excluded the small number of children dually eligible for Medicaid and Medicare, since Medicare is the first payer for this population. Children in foster care were identified through Medicaid eligibility codes. The foster care group was defined as children with one or more months in foster care; as shown in sensitivity analyses presented in the online Appendix,²⁵ restricting analyses to children with longer periods (for example, three or more months and six or more months) in foster care produced similar results.

Because children often receive different diagnoses in multiple health care encounters, we classified each child into one of ten hierarchical mutually exclusive diagnostic categories in descending level of clinical rationale for antipsychotic medication use. Each child was assigned to the highest-listed diagnostic group for which he or she received a first-listed diagnostic code at a health care encounter during the calendar year. For example, a child who received diagnoses of bipolar disorder at some health care encounters and ADHD at other encounters would be classified into the bipolar disorder category.¹ The diagnostic hierarchy is discussed in more detail in the study results section below.

Enrollees were identified as recipients of an antipsychotic medication if they filled one or more such prescriptions in the calendar year; utilization was examined by age, sex, race/ethnicity, and diagnostic group. For three states for which recent data were available, we also examined three quality measures for safe and judicious use of antipsychotics: antipsychotic medication polypharmacy, psychosocial care, and metabolic monitoring. The measure of anti-

psychotic polypharmacy requires concurrent receipt of multiple antipsychotic medications for ninety days or more during the calendar year of measurement. The psychosocial care measure reflects receipt of psychosocial mental health services during the period from ninety days before to thirty days after the date of the first dispensing of an antipsychotic drug after a medication-free lookback period (known as the index prescription start date). For metabolic monitoring, we examined receipt of glucose and cholesterol testing during the measurement year. Specifications for the measures and additional information on methods are provided in the Appendix.²⁵

LIMITATIONS Our results were subject to several limitations inherent in the use of administrative data. Analyses of administrative data offered little insight into clinical decision making processes at the individual patient level or clinical outcomes of treatment choices. Diagnostic coding might not have reflected clinical reasons for prescribing antipsychotics. Although states have strong financial incentives to bill Medicaid for services covered by that program,²⁶ some medications or psychosocial mental health services might not have been captured in the claims data. Finally, defining antipsychotic use in terms of only a single antipsychotic medication prescription fill in a year represents a low threshold that included in the same subpopulation full-year users and those who received an antipsychotic infrequently.

There were also some limitations in the ability to generalize from our specific evaluation studies of state monitoring mechanisms because each operates in a very distinct health systems and organizational context and these policy environments vary widely across states. Some additional information on state antipsychotic monitoring programs for Medicaid-insured children, generally reported directly by the states, is now available in a 2016 Centers for Medicare and Medicaid Services (CMS) report.²⁷

Study Results

PRESCRIBING TRENDS Use of antipsychotics among all Medicaid-insured children peaked in 2008 at 1.86 percent and declined slightly to 1.73 percent by 2010 (Exhibit 1). The state-specific range was 1.02–2.19 percent in 2010 (data not shown). Within the Medicaid-insured population, use remained much higher among foster children (Exhibit 1). In this group, prescription rates for antipsychotics increased from 8.73 percent in 2005 to 9.26 percent in 2008 and then declined to 8.92 percent in 2010 (state-specific range, 4.90–16.49 percent in 2010; data

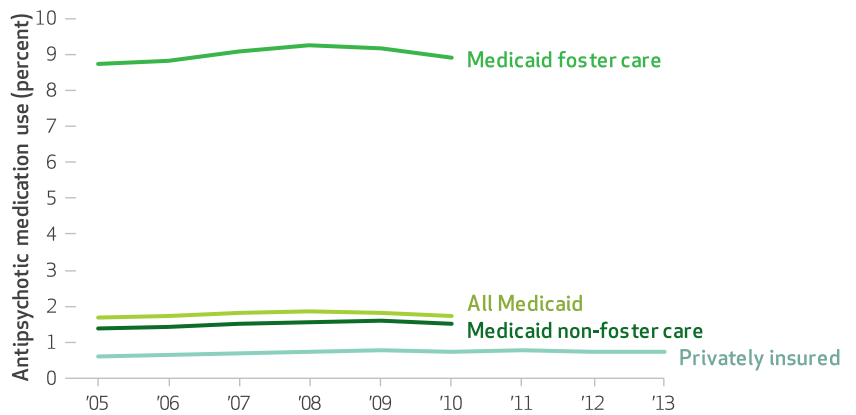
not shown).

Use of antipsychotics remained much higher among Medicaid-insured children than among privately insured children (Exhibit 1). For privately insured children, use rose from 0.62 percent in 2005 to 0.77 percent in 2009 and remained at a relatively steady level through 2013, when the rate was 0.75 percent.

The 3.0 percent of Medicaid-insured children who were in foster care accounted for 15.3 percent of Medicaid-insured children treated with antipsychotics in 2010 (data not shown). In 2010 antipsychotic use was higher among non-Hispanic white than African American or Hispanic children, both children in foster care and other Medicaid-insured children (Exhibit 2). The use of antipsychotics within diagnostic categories did not demonstrate a pattern of diagnostic broadening (increased use for diagnoses with weaker indications) over the 2005–10 period. For example, while antipsychotic use increased for foster and non-foster children diag-

EXHIBIT 1

Antipsychotic medication use among children ages 0–17, by insurance and foster care status



SOURCE Authors' analysis of Thompson MarketScan data (privately insured) and Medicaid Analytic eXtract data.

EXHIBIT 2

Trends in annual antipsychotic medication use among Medicaid-insured children ages 0–17, by foster care status, total, and stratified by demographic and diagnostic characteristics, 2005 and 2010

Characteristic	Percent receiving antipsychotic prescriptions					
	Foster care			Non-foster care		
	2005	2010	p value	2005	2010	p value
All	8.73	8.92	0.01	1.38	1.51	<0.001
Age (years)						
0–5	1.28	0.94	<0.001	0.18	0.15	<0.001
6–12	8.76	8.90	0.23	1.74	1.88	<0.001
13–17	12.56	13.90	<0.001	2.63	3.10	<0.001
Sex						
Male	10.96	11.06	0.39	1.94	2.07	<0.001
Female	6.39	6.66	0.98	0.80	0.92	<0.001
Race/ethnicity						
White	11.06	10.61	<0.001	2.38	2.49	<0.001
African American	7.21	8.54	<0.001	1.06	1.28	<0.001
Hispanic	5.19	5.45	0.10	0.41	0.44	<0.001
Other	6.57	8.38	<0.001	0.60	0.65	<0.001
Diagnosis group						
Schizophrenia	82.61	77.89	0.03	73.32	56.43	<0.001
Autism or mental retardation	29.07	31.12	0.006	20.48	21.56	<0.001
Bipolar disorder	72.61	76.98	<0.001	65.04	67.33	<0.001
Conduct disorder or disruptive behavior diagnosis, no ADHD	19.40	19.24	0.74	10.28	9.28	<0.001
Conduct disorder or disruptive behavior diagnosis, and ADHD	39.52	38.46	0.22	26.26	24.18	<0.001
ADHD	20.35	19.93	0.20	11.18	10.29	<0.001
Anxiety or depression	15.15	13.84	0.001	8.30	7.33	<0.001
Adjustment-related disorders	3.09	2.66	0.05	2.30	1.69	<0.001
Other mental health disorders	5.53	6.42	<0.001	1.81	2.00	<0.001
None of the above	1.86	1.39	<0.001	0.20	0.14	<0.001

SOURCE Authors' analysis of Medicaid Analytic eXtract data. **NOTES** Sample sizes are as follows. Foster care: 2005, n = 295,053; 2010, n = 279,489. Non-foster care: 2005, n = 7,228,666; 2010, n = 9,142,407. ADHD is attention deficit hyperactivity disorder. p values are for chi-square tests. *Diagnoses are hierarchical.

nosed with bipolar disorder (where the indication for use is stronger), there was no increase in antipsychotic use among children diagnosed with ADHD, anxiety or depression, or adjustment-related disorders.

QUALITY OF ANTIPSYCHOTIC TREATMENT MANAGEMENT The proportion of children treated with antipsychotics who received multiple concurrent antipsychotics declined from 3.76 percent in 2009 to 3.02 percent in 2011 (Exhibit 3). Reductions were particularly marked in foster care, declining from 3.98 percent to 2.76 percent. While polypharmacy rates were higher for foster children than for other Medicaid-insured children in 2009, by 2011 the rate for foster children had fallen below the rate for other Medicaid-insured children. Use declined in each racial/ethnic group, with no evidence that guideline-nonconcordant practices were more prevalent among minorities (data not shown).

Almost two-thirds (65.47 percent) of foster children treated with antipsychotics also received psychosocial mental health interventions between ninety days before the start of the medication treatment and thirty days after the start in 2011 (Exhibit 3). By comparison, fewer than one-third (29.01 percent) of other Medicaid-insured children treated with antipsychotics received

psychosocial interventions that same year. The provision of psychosocial services in foster care increased from 58.22 percent to 65.47 percent from 2009 to 2011, while little change was observed in the non-foster care population.

Only 18.01 percent of other Medicaid-insured children, and 28.09 percent of foster children, received metabolic monitoring for both blood glucose and serum cholesterol in 2011 (Exhibit 3).

Discussion

Antipsychotic medication use peaked in 2008 among Medicaid-insured children and in 2009 among privately insured children, with trends toward more judicious use among children with weaker indications for use (for example, those with ADHD) in more recent years. The “new normal” levels of prescribing represent a much higher rate than prevailed before the sharp expansion of the early 2000s. Given safety concerns and uncertainties about long-term effects on brain development, encouraging judicious prescribing of antipsychotic medications for children remains a policy challenge.

Despite the apparent stabilization of prescribing rates, the policy challenges of persistently

EXHIBIT 3

Quality measures for antipsychotic medication use among Medicaid-insured children ages 0-17 in three states, by foster care status, 2009-11

Rates of multiple concurrent antipsychotics (polypharmacy)

	2009		2010		2011	
	Number of antipsychotic medication users (90+ days)	Two or more antipsychotics	Number of antipsychotic medication users (90+ days)	Two or more antipsychotics	Number of antipsychotic medication users (90+ days)	Two or more antipsychotics
All	23,893	3.76%	25,641	3.44%	27,792	3.02%
Foster care	5,358	3.98 ^a	5,229	3.73	5,002	2.76 ^a
Non-foster care	18,535	3.70	20,412	3.36	22,790	3.08

Rates of psychosocial care ninety days prior to or thirty days after new start of antipsychotic Rx

	Number of antipsychotic Rx new starts	Psychosocial care -90/+30 days	Number of antipsychotic Rx new starts	Psychosocial care -90/+30 days	Number of antipsychotic Rx new starts	Psychosocial care -90/+30 days
All	14,471	31.92%	17,676	33.87%	19,900	32.78%
Foster care	1,843	58.22 ^a	1,971	65.55	2,059	65.47 ^a
Non-foster care	12,628	28.08	15,705	29.89	17,841	29.01

Rates of metabolic monitoring (blood glucose and cholesterol) among ongoing antipsychotic medication users (two or more antipsychotic Rx in year)

	Number of ongoing antipsychotic medication users	Any blood glucose and cholesterol test in year	Number of ongoing antipsychotic medication users	Any blood glucose and cholesterol test in year	Number of ongoing antipsychotic medication users	Any blood glucose and cholesterol test in year
All	47,339	20.39%	50,729	20.66%	54,377	19.55%
Foster care	8,751	25.08 ^a	8,520	26.88	8,270	28.09 ^a
Non-foster care	38,588	19.32	42,209	19.41	46,107	18.01

SOURCE Authors' analyses of data provided by states. ^aChi-square tested for 2009 versus 2011; p < 0.001.

high antipsychotic use in foster children remain, as do the difficulties with timely access to psychosocial interventions as the first line of treatment.¹³ We found that children in foster care who were treated with antipsychotic medications received psychosocial mental health services at rates higher than children in the general Medicaid-insured population. However, more than one-third of children in foster care treated with antipsychotic medications continue not to receive these services, which suggests considerable room for improvement. Since the number of child and adolescent psychiatrists as well as other mental health professionals for children in the United States is very limited,²⁸ real progress in this area might require substantial new public investment in evidence-based psychosocial interventions. Such interventions for children with disruptive behaviors include parent-child interaction therapy for young children; anger management skills training for preadolescent children; and intensive family- and community-focused interventions for adolescents, such as multisystemic therapy, an intensive home-based intervention that teaches caregivers how to monitor and discipline children and adolescents, how to disengage them from deviant peers, and how to engage them in prosocial activities.^{29,30}

Broad opportunities also exist to improve the pharmacological management of underlying psychiatric disorders commonly associated with disruptive behavior, including ADHD, anxiety, and depression. Methods for reducing inappropriate use of antipsychotics in this population could include improving clinical recognition and pharmacological management of these underlying disorders.²⁷ Clinical investments in these methods, however, face strong fiscal obstacles in the current political climate, such as state-level pressures to limit the growing costs of their Medicaid programs.

Children in foster care were somewhat more likely than other Medicaid-insured children to receive glucose and lipid monitoring. However, 72 percent of foster and 82 percent of other children failed to receive both glucose and lipid monitoring, which highlights the considerable need for improvement in both populations.

Despite significant shortfalls in receipt of quality antipsychotic treatment among foster children, these children were more likely than other Medicaid-insured children to receive psychosocial mental health interventions, and to some extent metabolic monitoring. This suggests that the increased level of state oversight of foster care might provide a structure with potential for improving use of recommended care processes, which could be adapted to other pop-

ulations. For example, foster care treatment guidelines can also provide direction for other children with behavioral challenges, and variations on the special-needs managed care program model developed in Texas have potential for application for non-foster care children with severe behavioral health challenges.^{31,32}

States have begun to focus increasing attention on these care processes for children in foster care. For example, in 2013 the Texas Department of Family and Protective Services added provisions to its Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care, identifying as a criterion the need for further review in cases in which available records indicate “antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every six months.”³¹ In 2015 California issued guidelines for the use of psychotropic medications for foster children, which emphasized the need for an adequate trial of nonpharmacological interventions.⁷

An important emerging issue is the role of Medicaid managed care organizations for children in foster care. A 2014 GAO report¹³ called attention to the increasing role of managed care for youth in foster care and other Medicaid youth, creating the “risk that controls instituted in recent years under fee-for-service may not remain once states move to managed care” and calling for additional guidance from CMS that helps states prepare and implement monitoring efforts within the context of a managed care environment.

Two state models that arose from the peer-reviewed literature and an academic-public partnership organized through the Rutgers Center for Education and Research on Therapeutics are noteworthy. First, a Mid-Atlantic state employed a prior authorization program with a relatively modest burden that required physicians to submit a form indicating their specialty, the child’s diagnoses, symptoms and history with medication trials, and explanation of why prior medication trials were not effective; physicians were then given the opportunity to appeal if authorization was denied.³³ This prior authorization applied initially for children younger than age 6 and was then expanded to children ages 6–12. Results suggest modest but statistically significant differences in antipsychotic medication use in children ages 6–12 but no impact on younger children.³³

A second significant example has been the 2008 implementation and subsequent evolution in Texas of a statewide specialized managed care plan for children in foster care, called STAR

Health. This managed care plan is tasked with providing clinical services, consultation, care coordination, and monitoring needed by foster children, including peer review of prescribing not aligned with the aforementioned prescribing guidelines. The plan receives enhanced capitation rates adjusted for these responsibilities. The state has reported a significant reduction in overall psychotropic use, psychotropic treatment among very young children, and psychotropic treatment in the absence of a mental health diagnosis.⁶ State analyses indicate that the proportion of foster children receiving antipsychotic medications for more than sixty days decreased from 12.4 percent in 2008 to 10.3 percent in 2013,³⁴ a relative decrease of 17.0 percent. Analyses by the authors of the Texas data indicate that the rate of antipsychotic polypharmacy declined by 45 percent between 2008 and 2012.

This model of specialty managed care plans for foster children—an important structural alternative for meeting the complex behavioral health as well as medical care needs of the foster care population—was adopted by Florida and Georgia in 2014 and is currently being implemented in Washington State.³⁵ Other jurisdictions, such as Milwaukee, Wisconsin, have applied this promising specialty managed care program approach more broadly to children with severe emotional disturbance, including non-foster care children.³⁶

In a larger group of states, foster children—who historically received services mainly on a fee-for-service basis—have been moved into more general forms of managed care. By 2014 an estimated 221,042 foster children nationally (54 percent of the total) were estimated to be enrolled in managed care plans.³⁵ Whether through specialized or more generic managed care plans for foster children, the structural shifts brought about by transition to managed care create both opportunities and challenges for efforts to better address their often-complex behavioral health needs. As highlighted in the 2014 GAO report,¹³ states will benefit from strengthening contractual arrangements with managed care organizations to assure that they include in their provider networks adequate supply of well-qualified providers of behavioral health services for children and assure adequate monitoring and treatment quality for the heightened mental health needs of foster children. As the GAO report highlighted, strong state oversight of managed care plans serving foster children is needed to ensure the appropriate provision of evidence-based psychosocial therapy and optimal pharmacological management.

While rates of antipsychotic use have stabilized in both foster care and other Medicaid-

insured children, further improvement is necessary in care processes. Even in foster care, slightly more than one-third of children treated with antipsychotics do not receive psychosocial mental health services, and the majority of other Medicaid-insured children treated with antipsychotics do not receive these services. Significant improvement will likely require substantial effort and investment, given prevailing limitations in the supply of these services. Improving metabolic monitoring also represents a significant challenge.

Concerted efforts by Medicaid, mental health and child welfare agencies, and managed care plans will likely be needed to achieve sustained improvements in these important dimensions of treatment. The availability of standard, nationally endorsed quality measures can serve as an important tool for measurement-based quality improvement initiatives in coming years. Such an example exists in a different clinical context: antipsychotic use to manage dementia-related behavioral symptoms among nursing home residents. Substantial reductions in the use of antipsychotics among this nursing home population have been achieved through public reporting of quality measures combined with multistakeholder national and state campaigns focusing on more judicious prescribing and alternative psychosocial management strategies. These initiatives led to a more than 25 percent reduction in the use of antipsychotics to manage dementia-related behavioral symptoms among nursing home residents between 2011 and 2015.³⁷ State and federal health policy makers could see opportunities to adapt the successful general strategies in nursing home psychotropic medication oversight to the foster care population.

Additional policy challenges concern the appropriate role of prior authorization requirements for prescribing antipsychotic medications, now implemented for children in a majority of states. Some states, including California, have extended such requirements up to age seventeen.⁴ Few studies of the impacts, intended and unintended, of these policies have been undertaken. There is considerable need to better understand how these policies are variously implemented across states and to evaluate their impact on patient outcomes and health care systems.

The issue of appropriate antipsychotic use continues to pose dilemmas for payers, who must balance concerns about maintaining clinical flexibility, respecting clinicians' autonomy, and ensuring access to needed treatments with concerns about safety and quality. The issue also raises concerns for clinicians, who are confronted with the challenge of trying, within time

constraints, to manage the sometimes dangerous behavior of children and, in many cases, limited access to alternative treatments.³⁰

Conclusion

Concurrent with increased implementation of oversight, monitoring, and quality improvement initiatives, particularly for children in foster care, the pattern of rising and broadening antipsychotic prescribing to children appears to have generally ceased. However, current prescribing patterns at the “new normal” rates of use remain of great concern to many stakeholders.¹³ The 3 percent of Medicaid-insured children in foster care, who account for 15 percent of all Medicaid-insured children treated with antipsychotics, have been a particular focus of public attention.

This population has served as an incubator for policy initiatives to improve oversight and improve access to psychosocial interventions. Specialized managed care plans for foster care children represent one promising strategy to improve oversight for antipsychotics and access to alternative interventions. Promulgation of na-

tional consensus HEDIS measures for safe and judicious antipsychotic treatment provides new tools for quality improvement.

Persistently high rates of treatment with antipsychotics, particularly among foster children, alongside gaps in metabolic monitoring, overreliance on the use of multiple concurrent antipsychotic medications, and underuse of psychosocial interventions, underscore enduring behavioral health care challenges. Emerging managed care models, such as special-needs plans for foster children; recently endorsed treatment guidelines; and new HEDIS quality metrics all provide opportunities to hold Medicaid managed care plans accountable for progress in these key service areas. By seizing these opportunities, state and federal health care policy makers can promote meaningful improvements that bear directly on the symptoms, social function, and quality of life of children with mental health problems who are in foster care. Important opportunities also exist to adapt mechanisms developed for oversight of prescribing among children in foster care to quality improvement for the broader population of Medicaid-insured children with behavioral challenges. ■

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