THE GUIDANCE CENTER
Promoting Healthy Communities

Testimony to the Kansas House Health and Human Services Committee

2/13/2023

Madame Chair and members of the committee, thank you for allowing me to appear before you today. My name is Will Warnes, and I am a child and adolescent psychiatrist and the medical director for the Association of Community Mental Health Centers of Kansas (ACMHCK). I also serve as the medical director for The Guidance Center, the designated community mental health center (CMHC) for Leavenworth, Atchison, and Jefferson counties in northeastern Kansas. I am medical director for Kids TLC, a psychiatric residential treatment facility in Olathe Kansas. In addition, I have practiced as a family practitioner in rural Nebraska prior to my psychiatry training and arrival in Kansas in 2011. I have been a member of the Mental Health Medication Advisory Committee since 7/19/2022. However, it is on behalf of ACMHCK and fellow Kansas mental health prescribers that I am here today to discuss House Bill 2259.

I first started practicing as a child and adolescent psychiatrist in Kansas in 2011. Upon arriving in Kansas, I was pleasantly surprised to find no Medicaid restrictions in prescribing psychotropic medications in Kansas. This allowed me to treat my Medicaid patients (comprising over 80% of my patients) with the exact medication that I felt would be both the safest and most helpful for their mental health symptoms. This freedom was especially helpful as I, like all mental health prescribers, strove to meet the mental health needs of my three-county catchment area despite ever-present stigma against mental health treatment and Kansas's chronic shortage of mental health prescribers.

Practicing medicine in both Nebraska and Iowa had gotten me used to the presence of a mental health medication formulary. I was accustomed to completing prior authorizations (PAs) when I chose medications not on the preferred drug list. I had been told that the primary reason for medication prior authorizations was to optimize the state resources used on this population and therefore to curb the out of control rising health costs. The system functioned because the preferred drug list rarely changed, and responses to PAs were timely.

Therefore, when Medicaid prior authorizations started in Kansas, I felt that I would be prepared. However, as the number of prior authorizations increased, myself and my colleagues noticed significant delays in being notified of a prior authorization. Information given to us was not always clear as to what criteria triggered the prior authorization. Communication was occurring via fax, electronic prescription software, phone calls from the pharmacy, and frequently phone calls from panicked patients or family

members about to run out of medications. Sometimes we were not alerted at all, only to find out from the patient at the next visit that they had not started the new medication because the pharmacy told them they couldn't and so they did not start it. In addition, the prior authorization rules began changing quarterly, making it very difficult for providers to become familiar with the rules for any significant length of time.

The prior authorization system forced our center to monitor all of our communication mediums for possible prior authorizations to ensure that our prescriptions were being filled for our patients. Myself and my fellow prescribers began to spend an increasing amount of time on the phone defending our prescriptions over lunch hours, after hours, and during the small breaks between patients during our clinic days. Our ability to respond to patients needs decreased. Response times for returning phone calls and refilling medications increased. The number of patients we were able to see per day dropped. In response to the increased workload, both The Guidance Center and Kids TLC hired a full-time employee dedicated to the completion of the paperwork, phone calls, and monitoring required to ensure not only that the prior authorization was completed but that our patients were supported while they were without medication (while the prior authorization is being deliberated), and they that they were further supported in selecting an alternative (and usually less appropriate) medication if the prior authorization was not approved.

I began to realize that in addition to the significant time delays in completing prior authorizations, the Kansas prior authorization system was not just targeting cost as I was used to in other states. The prior authorizations were sometimes enforcing clinical treatment parameters. This led to many problems in the prior authorizations for mental health specialty clinics. First, not once has a prior authorization guided me to a more appropriate medication than the one I had originally prescribed. Not once have I heard of it guiding a fellow psychiatrist or psychiatric nurse practitioner to a more appropriate medication. This is because we have been trained to consider all of these clinical parameters before selecting the best psychotropic medication for our patients' diagnoses, symptoms, and individual situations. Board certified psychiatrists and Psychiatric Mental Health Nurse Practitioners are the top trained professionals in mental health prescribing in the country. We are introspective. We collaborate with each other and with other professions consistently. We travel to clinical conferences yearly to learn more about cutting edge mental health prescribing. I am the co-chair of KCOMPS (Kansas Organization of CMHC Psychiatry staff) and head a meeting each month where community mental health prescribers from across the state collaborate on the treatment of difficult clinical cases. When I break a clinical health parameter for one of my patients in my prescribing, I do so purposely but safely

due to the to the unique nature of the clinical case, the severity of the symptoms, or the unique barriers that prevented a more typical prescribing pattern. While I was behavioral health medical director for Sunflower Health Plan – one of the three Medicaid managed care organizations in Kansas – I worked with many excellent physicians who made evaluations on prior authorizations in the MCO system. While many of them were excellent colleagues, they do not possess expertise superior to Kansas's mental health prescribers, especially given that they will have never laid eyes on the patient.

Secondly, prior authorizations that are enforcing clinical guidelines begin to throw whole classes of medications into the prior authorization process. This means that, until recently, if I prescribed an antipsychotic a prior authorization was inevitable unless certain diagnostic conditions were met and bloodwork was obtained. Antipsychotics are one of the top three most important classes of medications for a mental health specialty practice. It is hard for me to imagine in my former family practice clinic a prior authorization that would encompass an entire class of medications as important to a physical health condition such as high blood pressure or high cholesterol as the antipsychotics are to the treatment of mood stability, psychosis, and aggression.

In the past eight years, I have used substantial effort to protect my patients from Medicaid's prior authorizations. Despite my best efforts, I have not always been successful in this. I have had patients not able to get a medication due to it being blocked at the pharmacy harm family members, require psychiatric hospitalization, attempt suicide, disrupt publicly and become incarcerated, and lose their placement in their foster home.

One patient stands out to me. I had been treating a nine-year-old foster child in Kids TLC for six months. While medication is frequently not the most important part of a patient's treatment, in this case, the family and Kids TLC staff felt that the atypical antipsychotic prescribed was integral in calming the child such that he was no longer physically aggressive toward himself and others. After a period of stability, I was able to discharge him back to his foster home. The foster mother, despite not being sure about her ability to continue to parent this child with his challenging symptoms, accepted him back. Upon being discharged from Kids TLC, the family was unable to fill his antipsychotic medication at the local pharmacy. I was alerted to this fact unexpectedly and called the MCO case manager, the MCO pharmacist, the local pharmacist, Kids TLC, and mother multiple times. After hours on the phone giving clinical information to the MCO, I was informed that despite expediting the case it could be multiple days until the case was adjudicated. And it was. The child aggressed against both himself and the foster family multiple times in the 48 hours prior to resuming his medication. Fortunately, the placement

survived this incident, albeit barely. I have many more stories, and if you were to hear from psychiatrists across the CMHC system, you would hear of one heartbreaking story after another.

On January 15th, 2023 myself and the other members of the Mental Health Medication Advisory Committee (MHMAC) eliminated seven prior authorization policy elements. In every case but one the vote to do so was unanimous (the other was passed 7 to 1). In this meeting, it was also discussed that if a future prior authorization was to be considered we should first obtain data indicating that the situation in question is a problem in Kansas as compared to other Midwestern states. It was discussed that instead of statewide prior authorizations perhaps selected involvement with individual providers that are not prescribing correctly should be implemented. It was discussed that the committee should work on being more transparent to the public. I believe the way in which the agenda is set up should be more transparent. All of these would be major advancements in my opinion of the functioning of the committee.

I believe that the rolling back of Kansas's mental health prior authorizations and the above changes to MHMAC, while beneficial, speak to the disastrous effects of the mental health prior authorizations of the past few years. If HB 2259 is not passed and MHMAC continues, I will continue to work hard to effect major improvements in its work following the principles outlined above. However, I believe that even with this four-page testimony I am still understating the harmful effects of the Kansas prior authorization process over the last few years for patients and prescribers alike.

Thank you for your time.