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GOVERNOR JEFF COLYER, M.D.
JEFF ANDERSEN, ACTING SECRETARY

Good morning Madame Chair and members of the Senate Public Health and Welfare Committee,

My name is Annette Grant and I am a pharmacist and the Kansas Medicaid Pharmacy Program Manager. I appreciate the opportunity to present information regarding Senate Bill 438 and represent the Kansas Department of Health and Environment. My two main responsibilities are patient safety and being a good steward of the tax payer's money, regarding the Medicaid pharmacy program areas.

**For patient safety issues related to the need to monitor mental health medication use, I have these points to present:**

1. 42 CFR Part 2 - Exemption of SUD information of electronic health records (EHR) for these patients. I believe that KSA 65-5602, KSA 59-2979, and KSA 65-5603, Kansas has added the mental health information exemption to this requirement.

    a. Now all physicians, including mental health providers, cannot go to the Medicaid provider portal and see a full medication history for the very patients that they are trying to provide care for. The mental health medications are missing from the list.
    b. This is not only a safety issue for the patients, given the ((one example: drug interactions with the 2nd generation antipsychotics (CYP-450 enzymes – so interactions with seizure drugs, warfarin, etc.), but is also a waste of the provider's time, by requiring them to manually call pharmacies and other provider's offices to inquire about this patient, so they can be able to provide the correct care for this patient.
    c. Therefore, this is a liability to these providers, as well.

2. 2017 Missouri Medicaid lawsuit regarding foster children and excess prescribing and lack of monitoring of mental health medications.
   *Missouri's lawsuit is support for why Kansas needs to have point of sale monitoring (PAs) in place. Again, attention to patient safety and avoiding the result Missouri Medicaid had.
   *Example: One foster child was on seven mental health meds, 3 of which were antipsychotic meds. Some children had to be treated for excessive medication side effects.

3. Current NH report by CMS regarding Kansas Medicaid antipsychotic use in NH patients that have dementia (black box warning) and no diagnosis warranting antipsychotic use. Kansas was last (worst) than the other states in 4th quarter 2017. Removing PAs would exacerbate this problem.

4. Medicaid and Commercial insurance parity. There needs to be concern about all patient care and safety. We are concerned that only Medicaid is included in this bill and private insurance is not. The mental health providers are required to do PAs for privately insured patients and should have to do PAs for Medicaid too.

5. In response to a previous presenter, I have no knowledge of anything Medicaid has in place, either PAs or the PDL, where a patient is required to "retry" a previous medicine that they failed on. Please provide evidence to support this statement.

6. Kansas Medicaid does not have an all-encompassing mental health PA. Meaning, that we currently have no guidelines on the total number of mental health drugs that a single patient could safely be prescribed, however we will address this in the near future.

7. Years ago, general health care consensus was to "not monitor/have limits, opioids are safe drugs, and patients are in pain."….. Now we have the opioid epidemic and I don't believe that we would make the same choice today.

**For other issues related to the need to monitor mental health drug use, I have these points to present:**

1. MPHEA – This law does not exactly apply, but basically <u>with SB 438, we are giving more favorable benefits to providers and patients with mental health issues</u>.

   > The Paul Wellstone and Pete Domenici **<u>Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)</u>** is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from **imposing less favorable benefit limitations** on those benefits than on medical/surgical benefits.

2. We would like to understand why the same providers/supporters for this patient population wanting to be treated equally as a health concern, yet constantly calling this health population out, as different and needing special exemptions?

   As a parent, if I had children with the health conditions listed below, I am going to be equally concerned regarding their safety and patient care.

   Examples:

   i. Severe peanut allergy
   ii. Diagnosed with seizures disorder
   iii. Type One, insulin dependent diabetes
   iv. Mental health issues

   *All of these conditions and related drugs have either a clinical PA or are on the PDL. Other PCP and specialists of other health conditions follow the Medicaid safety and cost effective measures that Medicaid implements.

3. Other Medicaid states monitor mental health meds for safety and cost reasons.

4. There will be a cost to the State and the MCOs to reverse their systems, should this safety net be removed.

5. Other specialists/disease state areas may also request exemption from any restrictions. Therefore, both safety and cost issues will increase.

6. If any provider would be exempt from safety PAs (a.k.a. Preferred Provider Status), then we recommend first proving that they currently prescribe safely/ according to the guidelines that this committee or national standards are set at.

7. Some considerations as to why the fiscal impact reported could be variable.

   a. It took a time for the committee to draft the PA guidelines for each class.
   b. There was a year of grandfathering for each class PA, as there was a staggered in the implementation of the PAs.
   c. The mental health drugs were just added to the PDL in June 2017.

8. We have worked hard to improve the PA forms making them more simplified. Improvements were made, such as changing **from sending in** the required documents **to attestations** to having done the requirements. We also have been working with the MCOs to improve their systematic implementation of the PAs. There have been many improvements.

   When the child antipsychotic PA was first approved, it deemed to be too much of a demand to follow, so the committee requested we revisit this PA, and therefore, we did. It took 3 meetings to revise this criteria. That is ¾ of a year to revise one document.

   Of course, it is very important to the Medicaid program to continually improve patient safety and care. Also, of concern, is that Medicaid has a responsibility to the tax payers to use the money cost effectively. Both safety and cost need to be addressed for patient care and the ability to afford that patient care.

Thank you for your time and I would be happy to address any of your questions.