Testimony on:

Senate Bill 123

Medications to Treat Mental Illness

Under the State Medicaid Program

Presented to:

Senate Committee on Public Health

and Welfare

By:

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Good afternoon, Madame Chair and members of the Senate Committee on Public Health and Welfare. I am Denise Cyzman, Executive Director for the Kansas Association for the Medically Underserved, commonly known as KAMU. I appreciate the opportunity to visit with you on opposition to Senate Bill 123, Medications to Treat Mental Illness under the State Medicaid Program.

KAMU has been the Primary Care Association of Kansas for 24 years. We represent 43 safety net clinics that all share the same mission of providing health care services without regard for the patients' ability to pay. Our 43 safety net clinics have 41 satellite sites – 84 sites total - where 252,000 Kansans received health care services through 724,000 visits. Located in medically underserved areas, the safety net clinics serve patient populations that are predominantly low-income, with 2 out of 3 clinic patients in 2013 having an income level at or below 100% of the federal poverty level. Additionally, 48 percent of our patients are uninsured and 29% are KanCare recipients.

The Kansas safety net clinics are committed to leading the effort for integrated, quality care provided through a patient-centered medical home. Safety net clinics meet community needs by providing comprehensive services that go beyond basic medical care. These services include behavioral, dental, and vision services, pharmacy, and "enabling services" that remove barriers to care.

Ensuring access to mental health services is a particularly important role for safety net clinics, since their patients likely have rates of mental illness that are greater than the general population.[1] In 2013, "depression and other mood disorders" was the fifth most common primary diagnosis among Kansas federally qualified health centers (FQHCs).[2,3] In Kansas, seventeen safety net clinics provide mental health services onsite, serving more than 5,500 patients through almost 24,000 visits in 2013.[4] Countless other patients receive mental health treatment through their primary care provider within the health centers. Given that most health center clients are uninsured or Medicaid-insured, many of these patients would have gone unserved if it were not for the safety net clinics.

With growing concern over increasing costs of mental health-related pharmaceuticals in the Medicaid program, we appreciate the efforts of the Kansas Department of Health and

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[1] Burke et al. BMC Health Services Research 2013, 13:245. Accessed at www.biomedcentral.com/1472-6963/13/245 on 2/9/15.
[2] FQHCs make up a portion of the Kansas Safety Net Clinic System, accounting for 16 of the 43 clinics.
[3] National Association of Community Health Centers. *Kansas Health Center Fact Sheet, 2013.* Accessed at www.nachc.com on 2/9/15.
[4] Kansas Association for the Medically Underserved. *Quality Data Reporting System*. 2013 Data.

Environment (KDHE) to explore ways to manage these costs. We support efforts to pursue enhanced safety for KanCare recipients while improving health outcomes for those we serve. And, we recognize that the Kansas Legislature has very difficult decisions to make regarding balancing the 2016-2017 budget, and as part of that, you will need to consider ways to save state dollars.

KAMU's concern with SB123, however, is that it is a full repeal of Kansas law that currently bars KDHE from using regulatory tools — such as prior authorization and preferred drug lists — to manage the use and cost of mental health medications prescribed to Medicaid recipients. The purpose of the initial law was to increase access to mental health medications, ultimately allowing patients to be served in community-based settings, like our safety net clinics. Eliminating barriers to mental health treatment is a high priority for our safety net clinics. As problems with accessing medication increase, so does the probability of adverse events, including emergency room visits, homelessness, and incarceration.[1]

We have heard Secretary Mosier state in other public testimony that patients who are well-controlled through their current treatment regimen will not see changes in their medications, and this is reassuring. Yet, SB123 does not specify the type of prescription drug utilization management features, such as prior authorization, preferred drug lists, step therapy and limits on number and dosing of medication, that could become part of KanCare policy. We ask that state policy makers engage in dialogue with Kansas mental health experts and stakeholders to consider safe and effective alternatives that could become Medicaid policy. Full repeal of the law is a drastic measure, one that goes from full protection to nothing. Limiting access to essential medications to one of Kansas' most vulnerable populations could threaten the safety, health, and ultimately jeopardize the recovery process for Kansans with mental illness. If use of emergency rooms, hospitalizations, homelessness, suicidal behavior, and incarceration rates were to increase as a result, what would be the impact on the State and its ability to balance the budget?

Thank you for your time, your interest and your ongoing support. I am happy to stand for questions.