

Mental Health Prescription Drug Advisory Committee Meeting
Meeting Minutes, Open Session
June 24, 2009

<p>MHPDAC Meeting Minutes, Open Session EDS / Forbes Field Capital / Cedar Crest Room Topeka, KS June 24, 2009</p>	<p>Members Present: Kathleen Barrett, A.R.N.P. Michael Burke, M.D, Ph.D., Chair Susan Crain-Lewis, L.M.S.W. Megan Dahman, Pharm.D. Debra Doubek-Phillips, M.D. Eric Harkness, R.Ph. Kristen Page Hellebust Kimberly Harrison, Ph.D. Michael Leeson, M.D. Roy Menninger, M.D. Karen Moeller, Pharm.D. Eve-Lynn Nelson, Ph.D. Russell Scheffer, M.D. Pam Shaw, M.D. KHPA Staff Present: Andy Allison, Ph.D. LeAnn Bell, Pharm.D. Aimee Grubb, Recorder Shelly Liby Margaret Smith, M.D., M.P.H., M.H.S.A.</p>	<p>Representatives: Michael LaFond - Abbott Colin Thomasset - ACMHCK Richard Mesquias - Eli Lilly Ann Gustafson - GSK Gina Robertson - Florence Crittenton Dan Morin - KS Medical Society Amy Campbell - KS MH Coalition Nancy Zogleman - Polsinelli</p>
<p>TOPIC</p>	<p>DISCUSSION</p>	<p>DECISION AND/OR ACTION</p>
<p>I. Welcome by KHPA Staff</p>	<p>Dr. LeAnn Bell called the meeting of the Mental Health Prescription Drug Advisory Committee (MHPDAC) to order at 10:33 am with 14 members present. Dr. Bell introduced herself as the Pharmacy Program Manager at the Kansas Health Policy Authority (KHPA). Dr. Bell introduced Dr. Michael Burke. She noted that Dr. Burke is the chair of both the Drug Utilization Review (DUR) Board and the Preferred Drug List (PDL) Committee and has agreed to chair the MHPDAC as well.</p> <p>Dr. Burke stated that the PDL program was established in 2002. He participated in the establishment and implementation of the program. He said it has been a huge success and Kansas has been recognized nationally as one of the top PDL programs in the country. The attributes cited, with regard to the success of the Kansas PDL program, were the transparency of our group, keeping focus on the needs of the consumer and the provider, and relying on high quality information to</p>	

	<p>make decisions. We've had a successful model of a PDL in Kansas, but the mental health drugs have been carved out of it. In all the reviews that have been done, mental health drugs account for the largest percentage of cost on an annual basis, but that is not something that we've been able to address.</p>	
<p>II. Committee Introductions</p>	<p>Kathleen Barrett teaches nursing at Newman University in Wichita. She also has a private practice and contract with the Mental Health Center of East Central Kansas, Comcare, and Family Consultation Service, Youthville.</p> <p>Russell Scheffer is the chair of psychiatry at the University of Kansas in Wichita and a child psychiatrist. He does a large amount of psychopharmacology research.</p> <p>Roy Menninger is a private practice psychiatrist and chair of the Mental Health Coalition.</p> <p>Susan Crain-Lewis is the President/CEO of Mental Health America of the Heartland, an advocacy organization founded in 1909 by a psychiatric patient.</p> <p>Michael Leeson is Chief Medical Officer with Kansas Health Solutions (KHS). KHS is the pre-paid ambulatory health plan for Kansas. It covers outpatient mental health Medicaid benefits.</p> <p>Pam Shaw is a pediatrician at the University of Kansas and is the president of Kansas Chapter of the American Academy of Pediatrics (KAAP). She also considers herself a consumer because her son is on psychoactive drugs.</p> <p>Eve-Lynn Nelson is a psychologist in the pediatrics department at the University of Kansas Medical Center. She is also the assistant director of the telemedicine department.</p> <p>Megan Dahmen is a pharmacist with post doctoral training in psychiatry and currently works at Via Christi Regional Medical Center in Wichita. She works in collaboration with KU School of Pharmacy and KU School of Medicine to precept students. She is board certified in psychiatric pharmacy.</p> <p>Karen Moeller is board certified in psychiatric pharmacy. She works at the KU School of Pharmacy and also has an appointment in the department of psychiatry. She currently works on the adult inpatient service at KU Medical Center.</p> <p>Kimberly Harrison is an assistant professor of social work at Washburn University. She is also contracted by the Kansas State Department of Education, as a</p>	

consultant, on the Special Education team. Her background is in special education policy and clinical social work in the schools.

Debra Doubek is a family physician from Manhattan. She was appointed to this committee as a representative of the Kansas Academy of Family Physicians (KAFP). The KAFP is composed of 800-900 family physicians across the state of Kansas, many of whom write for mental health prescriptions.

Eric Harkness is a consumer who experiences severe and persistent depression. Prior to the onset of his depression he was able to acquire several degrees from various universities including his pharmacy degree and masters of science in computer science. He practiced as a pharmacist in the psychiatry department at the Topeka VA. He currently serves as the leader of the Topeka affiliate of the National Alliance on Mental Illness (NAMI). He has worked with Depression Bipolar Support Alliance (DBSA) in establishing support groups. He is also on the Board of Directors of the Kansas Mental Health Coalition.

Kristen Hellebust is a consumer whose diagnosis is major depression. She was a 3rd year medical student when her most major episode hit. She expressed concerns about limiting use of medications due to personal experience. She is a participant of the Working Healthy program.

Dr. Bell read a short biography supplied by absent committee member Karen Wakefield. She has a Masters of Nursing and is an Advanced Registered Nurse Practitioner. She is the Director of Clinical Services for Kansas Children's Service League (KCSL). She joined KCSL in June of 2008 to develop a mental health service in the Topeka office and throughout the state. She comes from a long background in working with children and families with mental health issues. Prior to coming to KCSL she was the CEO of Florence Crittenton Services; a residential treatment center for troubled adolescent girls. She was at the Menninger Foundation from 1978-2001 working in the Children's Hospital and directing the outpatient treatment center prior to Menninger moving to Houston, Texas in 2001.

Dr. Burke asked for further comments from the committee members. He stated the goal of this meeting is to educate the group regarding the background leading up to developing a plan or intervention to improve the safe and effective use of mental health drugs in Kansas. Economics factors into this because there is a fixed pool of Medicaid funding resources.

Dr. Roy Menninger asked if there is any assumption that this committee is

	<p>preparing recommendations to deal with the fact that presently the mental health drugs are not on the preferred drug list (PDL). Is this an effort to create a mental health PDL? Dr. Burke said that as an advisory committee the goal is to brainstorm about ways to improve the use of mental health drugs in the state of Kansas. One suggestion may be to create a PDL, formulary, treatment guidelines, or outreach programs. So a PDL would be just one of many things on the table that could be considered or recommended in a final proposal to improve the safe and effective treatment of mental disorders in Kansas. Up front there were a lot of promises about newer psychotropic agents having benefits that were so great that the additional cost was justified. Like any drug class as we gained post marketing exposure and experience we found that the newer agents have their problems too, and some people questioned whether the additional cost is always justified. Nonetheless they are still taking up a large portion of the budget. Dr. Menninger asked if economics is an issue this group will look at. Dr. Burke said it would be great for the committee to look at the economics side at some point. The dollars that go towards Atypical Antipsychotics are dollars that affect the number of clients that the Medicaid program can serve.</p>	
<p>III. Welcome by Acting KHPA Executive Director</p>	<p>Dr. Andy Allison, Acting KHPA Executive Director, welcomed the committee and thanked them for participating in a productive, ongoing conversation and deliberation of the issues at hand.</p> <p>Mr. Harkness offered the hypothesis that if we do an effective job of looking at safety and efficacy the economics will improve. Dr. Allison said we need to find those drug classes or circumstances where there are savings to be had without any impact on care. In the past year our primary purpose has been to improve safety and to make sure our beneficiaries are best served by the medications that are prescribed to them and that they are taking them on a regular basis.</p> <p>The process of reviewing each major component of the Medicaid program began a couple years ago. In January 2008, preliminary work started on the review of the prescription drug component. Claims data was reviewed and compared to spending in the State Employee Health Plan. Data for prescription drugs as a whole showed that a lot of the spending was for mental health purposes. They are also a source of much of the growth in prescription drug spending which exceeds a sustainable rate of growth for the state in revenue, and exceeds growth in spending on other medical care components. The conclusion was then made that something needed to be done, so other questions were asked such as what is going on in mental health drugs and are there other concerns that should be addressed.</p> <p>The KHPA does not have the legal right to impose any edits on the reimbursement</p>	

of mental health drugs. It is a free and unfettered open market as long as the prescription is legal. All drugs that have a rebate agreement in effect with the manufacturer are covered under Medicaid. Federal Medicaid law prohibits the use of a true “formulary.” It is best that we don’t use the term formulary so that it isn’t misleading to the committee members and the audience. We do not have the option to not cover a drug, though we can place certain restrictions on them. All the state has at its disposal in terms of direct edits would be a prior authorization (PA). Beneficiaries have the right to the drug with that process in place. This is true in all states.

The challenge we face is defining the safety concerns of mental health drugs for beneficiaries across the state. In Kansas we have several different markets: rural, urban, areas with specialists and areas that don’t have specialists. There are beneficiaries that have access to those specialists and beneficiaries that do not. There are concerns of polypharmacy and the use of very powerful prescription drugs in circumstances that could be questionable.

Prior authorization is the single most powerful administrative tool to address the use for all our beneficiaries across the state. We’ve reviewed education and other states’ processes. We have yet to find a mix that doesn’t include a direct administrative edit of some kind. Dr. Menninger asked for a definition of an edit. Dr. Allison defined it as an administrative process that is used as a barrier to review a claim before it’s paid. He then explained the PA process.

Dr. Menninger asked how a PDL would change that one way or the other. Dr. Allison said after deeming all drugs in one class clinically equivalent some will be chosen as preferred and the rest are put on non-preferred, PA required. This then gives KHPA leverage to approach the drug manufacturers to provide additional rebates to the state. Dr. Menninger asked if there is any possibility that the drugs on the PDL list would be a function of what kind of deal the state can get. Dr. Allison said there is not. Dr. Scheffer stated in almost every other state that has been the issue and was concerned with how KHPA would guarantee that Kansas would be different. Ms. Hellebust stated she thought the point of a PDL was to save the state money. Dr. Allison agreed that the point of a PDL is to save money, but the question is how to determine that the drugs are equivalent. Dr. Burke said the PDL committee reviews the drugs in each drug class for equivalency. He used the example of statins, cholesterol lowering drugs, and found that many of those are virtually identical in their effect, so they are essentially clinically equivalent. That information is then passed onto the state and they try to get the best deal economically from the drug manufacturers. If a patient has intolerability with the

preferred drug then they can choose another drug in the class, but prior authorization will need to be approved first. In contrast, there were some new interferon products used for treating Hepatitis C and it was determined that two of them were not clinically equivalent. Therefore, both of those drugs are available without prior authorization.

Dr. Menninger asked if this group would determine equivalency. Dr. Allison said there was an effort in the legislature to prevent the application of any edits on mental health drugs. They specifically precluded this committee from taking any action to implement a PDL. Our recommendation in the last legislative cycle was to change the state law and allow for some administration of mental health drugs after having seen no other clear path to protect beneficiaries across the state or to generate any savings from any class of mental health drugs. KHPA worked with stakeholders to ask them what their concerns are and how we can address those concerns. Over the course of six months we arrived at a compromise. In the end that compromise did not pass. That puts us back at square one, knowing that we have real concern about the use and prescribing of mental health drugs; knowing that there are many children in our program who are young, below FDA approved status, who are receiving large amounts of powerful drugs; and knowing that within the agency we don't have the clinical expertise to decide how to address the issues with safety and spending. This committee would be charged with addressing safety concerns and allowing for some savings. But that charge has changed because the original vision is literally precluded in a proviso that was attached to the state budget this year. It said that this group is not to begin the implementation of a PDL which is a moot point since we have no right to add mental health drugs to our PDL.

Dr. Allison talked about the MediKan program. It is a small, state only funded program that is not subject to any of the federal guidelines, requirements, and regulatory processes. There are about 3,000 disabled individuals that are covered. The KHPA provides a limited set of benefits to them including most prescription drugs. There is a fairly heavy use of mental health drugs in the MediKan population. Mental health spending is an issue for this small program. This committee would also have made recommendations for use of mental health drugs in the MediKan population but the proviso in the budget also precludes that process.

Dr. Allison asked if there are concerns about the appropriate use of and prescribing of certain mental health drugs across the state, how can the health policy community in Kansas address that? The list of options is fairly long; how many of

those tools can be effective is an open question and may be one that this group can help to answer. The state, through payment, can drive prescribing which is how all other payers of prescription drugs address mental health drugs and it is how KHPA addresses virtually all of components of medical care. Mental health prescription drugs for the Medicaid program are protected from administrative edits; within the larger health care system they are the exception to the rule. When a drug is put on the PDL it actually changes behavior because the physicians learn what is on the PDL and focus their prescribing in that direction. This is the concern of those who would have much fear about the recommendations and the use of that tool; it's both what makes it effective and what makes it potentially problematic for some providers. Another option is to go to the providers and educate or learn from them appropriate prescribing patterns. One of the limits of education is resources. The most effective education is from peers, which means we have to pay market rates for peers to educate instead of practicing medicine directly. That is an expensive and challenging resource problem. Other options for educating may be associations, continuing education, electronic communication, telephonic communication, letters, etc.

Dr. Scheffer spoke in regard to off-label use. He stated that 2/3 of all prescriptions written in the U.S. are off label. The FDA website will tell you that it is not just acceptable, it is expected that doctors use them off-label. He asked that we get past the issue of off-label use. He also asked that when talking about very powerful drugs that there be mention of the very serious illnesses that are being treated with them. It is true that there is poor prescribing in certain cases throughout the state.

Dr. Allison said there is no line that the FDA will set that will be uniformly applied and best practiced. Dr. Scheffer said the FDA is only supposed to label drugs. Dr. Allison asked without the line, how can the use of those drugs be improved? Ms. Hellebust said she thinks the reason why the mental health drugs were carved out is because there is fear that we would try to draw a line in the sand and you can't do that. She suggested looking at it on a case by case basis. Dr. Allison posed the question of whether there is any useful edit that could be introduced to the payment system. Dr. Scheffer said that if we create an edit based on diagnosis then the doctor will change the diagnosis to get the prescription. The institute of medicine has shown that 80% of doctors say that in order to get the patients the care they need they will exaggerate or extend the diagnosis. You can restrain pharmacy costs but then people wind up in the hospital. Dr. Burke says that it sounds like edits are off the table right now, so we want to open it up broadly to educational programs and communication venues.

Dr. Doubek stated that in her 17 years of private practice as a family physician she has never had to take a stable patient off their medication. She said she has a patient panel of 3,500 patients; 80% have private insurance, 10% have Medicare, and 10% have Medicaid. When prescribing a medication she is trained to know that she has to start with the drug that is on the formularies, but if medication doesn't work she and her nurse will work to get a PA in order to get the patient what they need. Her patients, as a rule, stay out of the hospital by these decisions. She has never had to take a stable patient off a medication. Dr. Scheffer said he has. Dr. Doubek questioned whether or not that happens every day or frequently. Dr. Burke stated that the Medicaid clients have broader access than the board members. Dr. Shaw said her patient panel is made up of 40% Medicaid and 60% of private insurance. The insurance companies aren't doing this to be restrictive they are doing it because there is evidence behind this. We should be evidence based. In 26 years of practice she has seen physicians get caught up in the newest, greatest thing out there and will prescribe it because of that rather than looking at the evidence. We really need to look at evidence. She also stated we need to educate physicians about generic prescribing. One thing that is not done well as primary care providers is take care of mental health patients. There is a large amount of education that can be done. In July, Pediatrics is coming out with its first policy report on what primary care providers should do to take care of children with mental health issues. Medicaid children are a large population but there is a small amount of money spent on children, even children with mental health disorders. If you want to save a large amount of money it would be better to target the adult population. Dr. Burke said what is crystallizing, in terms of the goal, post legislature, is meeting to discuss how to optimize the use of pharmacotherapy in Kansas.

Dr. Burke asked Dr. Allison to broaden it to the whole population of people with mental illness. Dr. Allison stated there are a few reasons why the focus has been on children:

1. public policy trends; most of the attention has been on the children,
2. most tangible and understandable issue to a broader audience,
3. the compromise language focused on the children, and
4. concern about hospitalization.

Ms. Lewis asked for details. How many of those children are there, where are they located, how many are in foster care? She doesn't practice in the foster care docket in Kansas but has in other states and would hypothesize that some of the children that are on multiple meds are the same kids that are in multiple homes with multiple doctors. She thinks educating patients is a novel idea. She has a

patient that will ask her doctor questions about why she is being prescribed that and believes we do a great disservice to folks who are on Medicaid and have been struggling with their illness for years to say that they are not more than capable of communicating with their doctors about their health care.

Dr. Burke said since the DUR Board does not oversee psychotropic pharmacotherapy, but we are federally mandated to do so and we have an outside group, Comprehensive Neuroscience (CNS), who has come in to do some oversight for us. In his opinion, the material hasn't been very effective or meaningful. Often, when analyzing the data, it was found that there were systems errors and children that were on five medicines weren't necessarily on five medicines for one reason or another. Exploring the parallel systems issues that may be driving people's clinical outcomes would be interesting for this committee if we ever get to that point.

Dr. Menninger requested that we hear more about the issues and shortfalls of the beneficiary utilization review concept at a future meeting. Very few can spend time reviewing the literature in any detail to tell if the medication is the best choice.

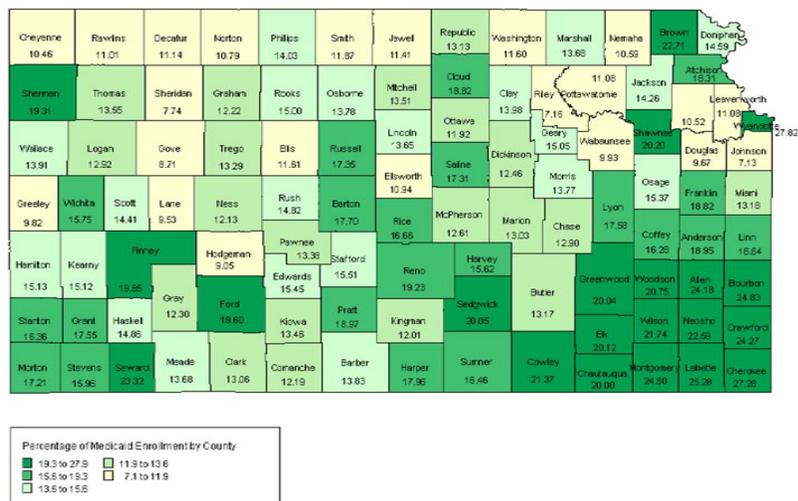
Dr. Burke said that before the PDL, the DUR Board did beneficiary reviews. Specific cases would surface as outliers. The board would take these cases on and complete a clinical review in a non-threatening manner. If you can target those outliers you can really impact the program economically. Dr. Menninger agreed. Ms. Lewis said she would like to see the data to see where specifically the problems are. Dr. Leeson offered KHS to review the outliers. He said if a list of outliers can be pulled in terms of prescription use, KHS can see if they are outliers in terms of heavy or low mental health service utilization and begin to see patterns across more than what the patient's prescriptions are. He also mentioned that he and Dr. Shaw are participating in a focus study group in psychiatric prescribing in the youth population at KU. The results should be out this summer or fall. Dr. Shaw said she's reviewed the data and it isn't as bad as people think. Dr. Scheffer said outcomes should also be considered. Dr. Leeson said prescribing should be compared to community based services to see how they are being used and potentially define the impact. Dr. Allison said we have to be careful with confidentiality; we have not intended and won't plan to review an individual beneficiary's case, nor the peer review of individual physicians. Somehow we have to get to the issue. Mr. Harkness requested education before edits. Dr. Lewis agreed that education is the primary, obvious tool we are left with and we are being told the current education is not effective. It only makes sense to figure out

who we need to educate about what.

Dr. Allison said the broader question is what is the problem and what does it take to address it? Dr. Menninger asked Dr. Allison to define “the problem” in 25 words or less. Dr. Allison stated the problem as: unsustainable increase in cost and very concerning information about inappropriate use in both adults and children from within our program and from the literature. Dr. Burke said his personal thought is that we should not shy away from the unsustainable increase in cost because of the current economic situation and we want to make sure the dollars we are spending are returning value. Dr. Allison reiterated that the committee has expertise to review what the real issues are. Dr. Scheffer said there has never been any study that shows anything where the drugs are being used in more than an expected rate in the population. There probably is some over diagnosis and poor prescribing, but a bigger issue is why so many people, that have these disorders, are not being treated. Dr. Burke pointed out the section of the Pharmacy Program Review, “The National Institutes of Mental Health (NIMH) reports the incidence of schizophrenia in children to be 1 in 40,000 (0.0025%). An NIMH sponsored study reports that the incidence of bi-polar disorder in children is 1%, and the American Academy of Pediatrics reports the incidence of autism spectrum disorders to be 1 in 150 (0.06%) (Nicolson and Rapoport, 1999; Lewinsohn, Klein and Seely, 1995; American Academy of Pediatrics, 2008). It is expected that Medicaid would be the primary insurer of a greater proportion of children with these conditions than is found in the general population because severe mental disability can itself be a qualification for Medicaid services. However, the greater percentage (17% vs. 0.0025-1%) of children receiving atypical antipsychotics cannot be explained by this population characteristic alone.” Dr. Scheffer said that’s assuming they are treating schizophrenia. Dr. Moeller said the review is quoting three different statistics; schizophrenia, bi-polar, and autism, so 17% were being prescribed vs. 0.0025-1%. Ms. Hellebust said just because they are receiving atypical antipsychotics doesn’t mean they are schizophrenic. Dr. Burke said he can see why that would be a provocative number to explore further to see if there is a rational explanation. Dr. Doubek quoted, from the review, “From April to June of 2008, 214 children under 18 years of age were prescribed 5 or more different psychotropic medications within a 90 day period. In the same time period, 201 children under 18 years of age were prescribed two atypical antipsychotics simultaneously.” She confirmed with Dr. Bell that this information came directly from claims data, but we don’t know the stories behind this information. Dr. Burke said he isn’t aware of any published data about the benefit of multiple anti-psychotic drugs used simultaneously. There is data on multiple antidepressants being used simultaneously. This review says psychotropics, so it

	<p>doesn't specify. Dr. Scheffer said the typical bi-polar patient will be on two or more mood stabilizers. Anti-psychotics are now mood stabilizers, so the question is whether or not the patient is on an older more conventional antipsychotic. Dr. Moeller asked Dr. Scheffer about the literature supporting the use of antipsychotics as mood stabilizers. Dr. Scheffer said one of the things people need to be thinking about is why physicians are doing this. It is because they have people in front of them who are doing poorly and they are trying to help. We may be able to help them do this better, but they aren't waking up in the morning thinking they are going to get richer by adding another medicine to somebody. Dr. Menninger said on the contrary he is acutely aware of cost and consciously make a choice on the basis of that.</p>	
<p>IV. Medicaid Overview Presentation</p> <p>a. Introduction to Medicaid</p>	<p><u>Introduction to Medicaid</u></p> <p>Dr. Margaret Smith, Medicaid Medical Director, introduced herself. Her background is family practice. She has limited background in psychiatry, so she welcomes the input from this committee and she thanked the members for their time and willingness to be on the committee.</p> <p><i>Medicaid Overview</i> Dr. Smith gave a basic overview of Kansas Medicaid.</p> <p><i>Statement of Purpose for Medicaid</i></p> <ul style="list-style-type: none"> • Use of state and federal matching funds to provide health care for the most vulnerable in our population. <p>State and federal funds are the monies used to directly reimburse for services to the beneficiaries, administrate the program, billing, and health information technology; anything that is going to improve the health of this population.</p> <p><i>Medicaid as Insurer</i></p> <ul style="list-style-type: none"> • Medicaid is the 3rd largest provider of health benefits coverage in Kansas after Blue Cross/ Blue Shield and Medicare • Single largest insurer of children • Medicaid pays for 40% of births in Kansas <p>Dr. Scheffer asked about Title XIX and Title XXI. Dr. Smith said Title XXI is State Children's Health Insurance Plan (SCHIP).</p>	

Percent of Population Enrolled in Medicaid, by County
2007 - 2008 (2-Year Average)



Medicaid vs. Private Sector

Medicaid

- Low admin. costs
- Discounted rates
- Targets the poor
- Comprehensive: mental health, transportation, senior care, EPSDT for children
- Uses both direct contracting and managed care

Private Sector

- Higher admin. Costs
- Market rates
- Poor cannot afford
- Coverage gaps: mental health, transportation, senior care, EPSDT for children
- Uses both direct contracting and managed care

Medicaid spending in Kansas

- \$2.2 billion in FY 2007 (all funds, all agencies)
- KHPA Medicaid programs accounted for \$1.2 billion

- Historic growth at 9.9% per year over previous decade
- Projected annual growth of 5.5% in FY 2009-2010

What are the Federal Rules?

- Minimum eligibility requirements
 - Recipients of cash assistance (SSI and TAF)
 - Children living in poverty
- Minimum requirements for benefits
 - Comprehensive package
 - All medically necessary care for children
 - Little or no cost to most beneficiaries
- Payor of last resort
- Rules of equity
 - “statewideness”
 - “freedom of choice”

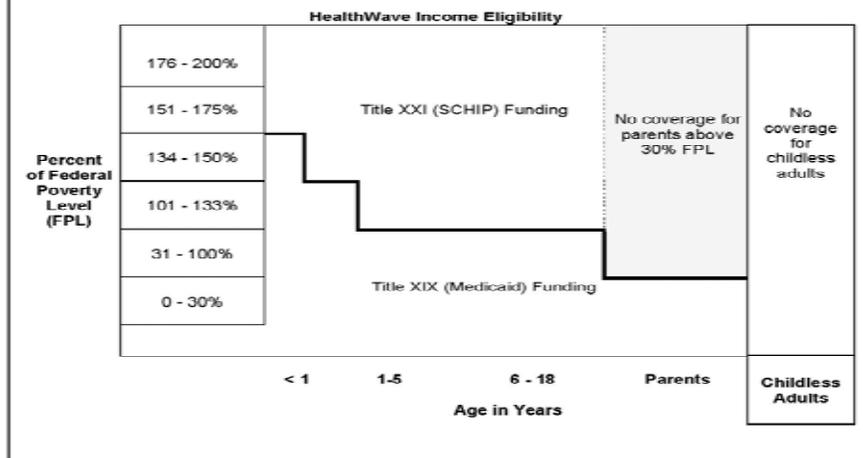
What Flexibility do States Have?

- Optional eligibility requirements
 - Parents above 30% of poverty
 - Children above poverty line (roughly)
 - Individuals with specific health care needs
- Optional benefits
 - Dental services for adults
 - Pharmacy
 - Transportation
- Limited or alternative benefits
 - Deficit Reduction Act of 2005
 - Some freedom to limit benefits or offer cash to consumers to buy health care on their own
- Service delivery mechanisms
 - Managed care
 - Consumer-driven approach (limited)
- Program Administration
 - Health information exchange
 - Pilot programs

Medicaid – Customers

- Eligibility by reason of income and disability or medical condition
- Eligibility by reason of income and age, i.e., children and seniors
- Eligibility by reason of income and family composition, i.e., parents

Income-related eligibility for parents, pregnant women, infants and children



Dr. Menninger asked what HealthWave specifically refers to. Dr. Smith said HealthWave is our brand. The Title XXI and Title XIX are both part of HealthWave. It is our managed care option for children and pregnant women.

Medicaid Services

Mandatory

- Phys. services
- Lab & X-rays
- EPSDT
- Family Planning
- FQHC Services
- RHC Services
- Transportation
- Nursing Facility Care
- Home Health Care
- Inpatient & Outpatient Hospital

Optional Services

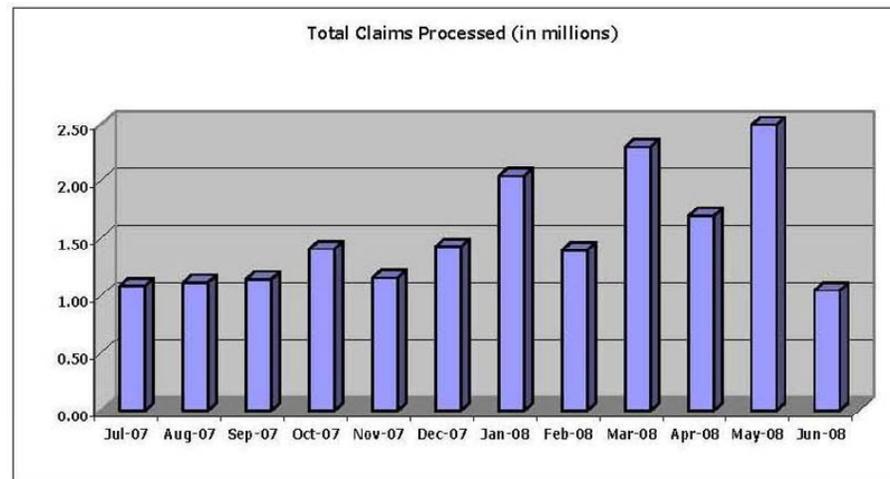
- Prescription Drugs
- Dental Services
- Case Management
- ICF/MR
- Private duty nursing
- Personal Care
- Graduate Medical Education (GME)
- Durable Med. Equip.
- Diagnostic, rehab, preventative services

Dr. Burke asked what Graduate Medical Education (GME) means in this context.

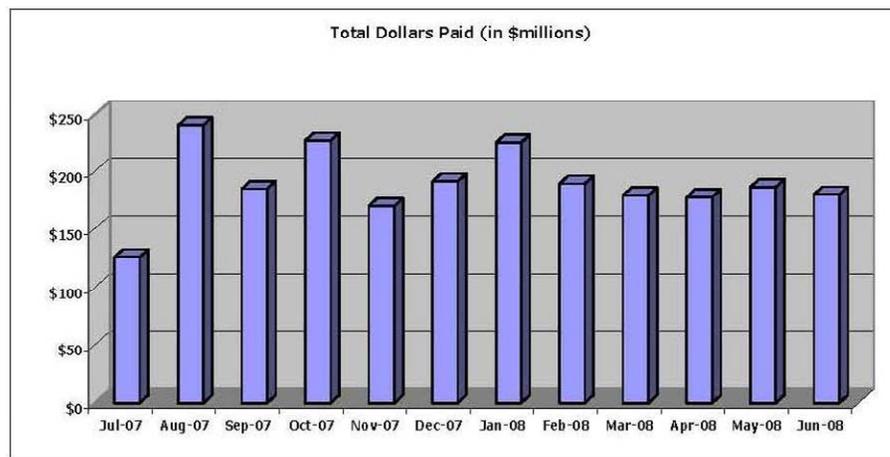
Dr. Allison said the formulas are driven by the Medicare formula. The idea is that educational hospitals bear an additional cost related to medical education that has a public value. In Medicare there are automatic add-ons to the basic payment rate to hospitals that teach. States have the option of doing the same and Kansas does.

Dr. Menninger asked how the money is distributed. Dr. Allison said we map to the Medicare formula. It is paid to the teaching hospitals.

Number of Medicaid claims exceeds 1 million each month



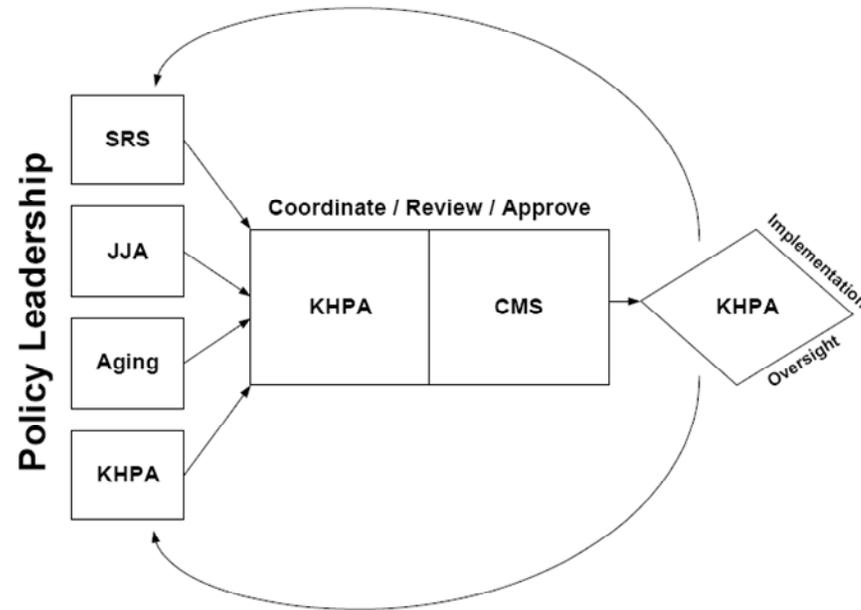
Medicaid claims paid average about \$180 million per month



Comparisons to Other States

- Overall spending per beneficiary is above average
- Coverage of children is typical
- Spending on aged and disabled is above average
- Community-based long-term care ranks in top 10
- Coverage of low-income adults is very low

How is Medicaid Policy Implemented in Kansas?



Agency Roles

KHPA

- Coordinate health policy
- Single state agency, i.e., the Medicaid agency
- Physical health services for Medicaid
- SCHIP (Title XXI)
- MediKan

SRS

- Mental health services
- Disability-related waivers

Aging

- Long-term care services and waiver

Agency Roles – Eligibility

- KHPA determines eligibility policy and rules

- Eligibility determination performed by:
 - SRS
 - 15% of family cases
 - Adult and Elderly cases
 - KHPA Enrollment Clearinghouse
 - All SCHIP eligibility cases
 - Screen and forward Medicaid to KHPA staff for final determination
 - KHPA Staff
 - Screen disability applicants for presumptive enrollment in Medicaid

KHPA - Medicaid Agency Roles

- Ensure compliance with Federal Medicaid rules
- Administer and report all Federally matched payments
- Examine overall Medicaid costs and coordinate policy recommendations where necessary
- Serve as principle conduit for official correspondence and interaction with CMS

Kansas Medicaid: Key Challenges

- Short run challenges
 - Steadily rising costs
 - Immediate need for savings
 - Major gaps in coverage
 - Address questions about program integrity
- Long-run challenges
 - Emphasize prevention and wellness
 - Address health costs
 - Increase quality of care
 - Ensure access
 - Engage stakeholders and expand ownership of the Medicaid program

Transforming Medicaid: KHPA Objectives

- Comprehensive, written, data-driven review of the program to:
 - Improve cost-effectiveness
 - Achieve savings
 - Develop and apply policy goals
 - Increase program integrity
- Disciplined management through the program review process

Dr. Menninger asked for an example of program integrity. Dr. Smith said if you're paying for something that is not happening then it is not program integrity.

Transforming Medicaid: Comprehensive Program Reviews

- Evaluations by program staff, reviewed by senior management, approved by KHPA Board, published on-line
 - Over 40 staff directly involved in review teams
- 14 reviews completed in 2008
 - 8 specific services
 - 2 populations
 - 2 managed care programs
 - 2 over-arching reviews

Transforming Medicaid: 2008 Reviews

- Roadmap for data driven Medicaid reform and cost efficiencies
 - Over 300 pages of description, data, analysis, and recommendations
- Program recommendations and budget savings
 - Initiatives for FY 2009-2010 Budget
 - Administrative initiatives
 - Legislative initiatives
- Areas for further study, management, and policy development

Summary of 2008 Medicaid Transformation Recommendations

- Budget and administrative actions saving \$17 million (SGF) in SFY 2010
 - Outsource transportation services
 - Restructure and limit home health services
 - Scrutinize payments for new medical equipment
 - Improve pharmacy management and pricing
 - Additional long-term program improvements
- Overall savings of \$33 million in SFY 2010

Transforming Medicaid: Observations

- Comprehensive approach is imperative
 - But also difficult, disruptive, and time-consuming
- Creates accountability and improves policy-making
 - Lays bare what we know
 - Presents an alternative to speculative Medicaid reforms based on anecdote
- Grounds KHPA recommendations in data and documented experience
- Defines Transformation as a process

<p>b. Medicaid Pharmacy Program</p>	<p><i>Transforming Medicaid: Next steps</i></p> <ul style="list-style-type: none"> • Program reviews are already well underway for 2009, with several new topics: <ul style="list-style-type: none"> • Physician services • School-based services • Therapies • Family planning services • Services provided by out-of-state providers • KHPA Medicaid operations and program integrity • Medicaid mental health services (SRS) • Medicaid funding of health clinics (with KDHE) <p>Ms. Hellebust asked what home health services we are limiting. Dr. Allison said we have maybe the most liberal use policies in the Medicaid program. We are moving, more or less, from being open ended to a more structured long-term approach to home health.</p> <p><u>Medicaid Fee-For-Service Pharmacy Program Overview</u></p> <p>Dr. Bell gave a brief overview of the Pharmacy Program.</p> <p><i>Federal Guidelines for Medicaid Pharmacy Coverage</i></p> <ul style="list-style-type: none"> • Pharmacy is an optional benefit • All states offer this benefit • States must maintain open formulary <ul style="list-style-type: none"> • Includes all manufacturers with a federal rebate agreement • States may impose conditions on access to drugs, but no rebate-eligible drug is completely unavailable <p>Dr. Menninger asked what a rebate eligible drug is. Dr. Bell explained that the manufacturer of the medication has reached an agreement with the federal government that basically says for every unit of medication that is dispensed the manufacturer will pay a certain amount back.</p> <p><i>Kansas Medicaid Pharmacy Program Overview</i></p> <ul style="list-style-type: none"> • State Fiscal Year 2008 (July 1, 2007 – June 30, 2008) Fee-for-Service pharmacy program: <ul style="list-style-type: none"> • Services provided to 113,446 Kansans • Nearly 2 million prescriptions dispensed • 745 pharmacies • 14,000 prescribers enrolled • Total cost \$159 million 	
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- KHPA contracted Managed Care Organizations (UniCare and Family Health Partners) manage their own prescription benefits, however, are required to abide by the regulations and statutes governing the fee-for-service program

Medicaid Pharmacy Program Management - Tools

- Preferred Drug List (PDL)
- Prospective Drug Utilization Review (ProDUR)
- Retrospective Drug Utilization Review (RetroDUR)
- Prior Authorization (PA)

Medicaid Pharmacy Program Management - PDL

- Implemented in 2002
- 34 drug classes currently on PDL
- Guided by the PDL Advisory Committee
 - Composition: 5 physicians, 4 pharmacists
- Preferred drugs established only within therapeutic classes
 - Example: similar hypertension drug classes ACEs and ARBs – preferred ACEs and preferred ARBs are selected but ACEs and ARBs are not combined into one class
- Non-preferred agents in a therapeutic class generally require PA
- Advisory committee acts independent of cost information
- Not unique to Kansas Medicaid – 45 states have a PDL
- Ubiquitous among commercial health plans

Medicaid Pharmacy Program Management - DUR

- DUR program guided by Drug Utilization Review Board
 - Composition: 4 physicians, 4 pharmacists, 1 physician assistant
- Required by Federal statute: OBRA '90
- Provides guidance for Retrospective DUR (prescriber education efforts)
 - Informational notification letters to prescribers regarding clinical issues involving specific patients (eg: drug-drug interaction, drug-disease interaction, non-compliance based on refill history, multiple prescribers)
 - Academic detailing with one-on-one meetings between KHPA-contract pharmacist and prescriber to provide education on specific clinical issues
- Provides guidance for Prospective DUR (point-of-sale edits)
 - Pharmacy point-of-sale edits on excess dosing, drug-drug interactions, diagnosis restrictions, age restrictions, gender restrictions, etc.
- Approves prior authorization criteria

Mr. Harkness asked if mental health drugs are carved out of the DUR program. Dr. Bell said we can use the retroDUR program on mental health drugs, but the rest of the programs we cannot.

Medicaid Pharmacy Program Management - PA

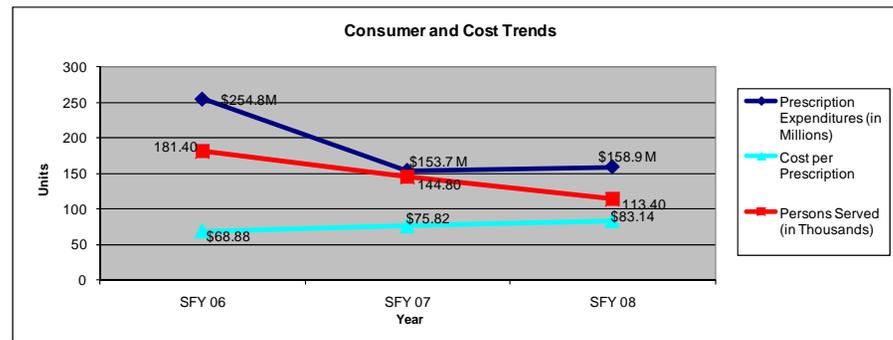
- Common practice for ensuring appropriate drug use
- Used for non-preferred PDL drugs and clinical prior authorizations
- Criteria approved by DUR Board
- Prior Authorization must be obtained before dispensing medication
 - Allowance for dispensation of 72 hour supply of medication if prior authorization department is closed
- 91% of PAs completed on same business day of receipt
 - 100% of PDL requests
 - 88% of clinical PAs on same business day; additional 6% next day

Mr. Harkness asked about the lifespan of a PA. Dr. Bell said that it is variable depending upon the drug. In general it is a year. Dr. Leeson asked what the percent of PDLs are approved. Dr. Bell was unsure and asked Nancy Perry, PA nurse at EDS, and she didn't know for sure either. Dr. Leeson asked if it's closer to 0% or 100%. Ms. Perry said it is closer to 100%.

- Two processes for completion of prior authorization:
 - Manual PA process:
 - Step 1: Pharmacy receives PA required message and contacts prescriber
 - Step 2: Prescriber completes required documentation and faxes to prior authorization unit
 - Step 3: Prior authorization nurses review request and notify prescriber and/or pharmacy of result
 - Automated PA system (DUR+)
 - Implemented March 2, 2009
 - Screens incoming claims against drug and medical claim history
 - Allows instantaneous approval of PA if selected criteria are met
 - Seamless process for beneficiary, prescriber, and pharmacy
 - In April 2009, overall 33% of approved PAs were processed by DUR+; 50% of non-preferred PDL drug approvals were processed by DUR+

Pharmacy Program Trends – General

	FY 2006	FY 2007	FY 2008	% Change 2007-2008
Prescription Expenditures	\$254,789,200	\$153,716,025	\$158,909,440	3%
Prescription Claims	3,698,904	2,027,451	1,911,461	-6%
Cost per Prescription	\$68.88	\$75.82	\$83.14	10%
Persons Served	181,396	144,809	113,446	-22%
Claims per person	20.39	14.00	16.85	20%
Cost per person	\$1,404.60	\$1,061.51	\$1,400.75	32%



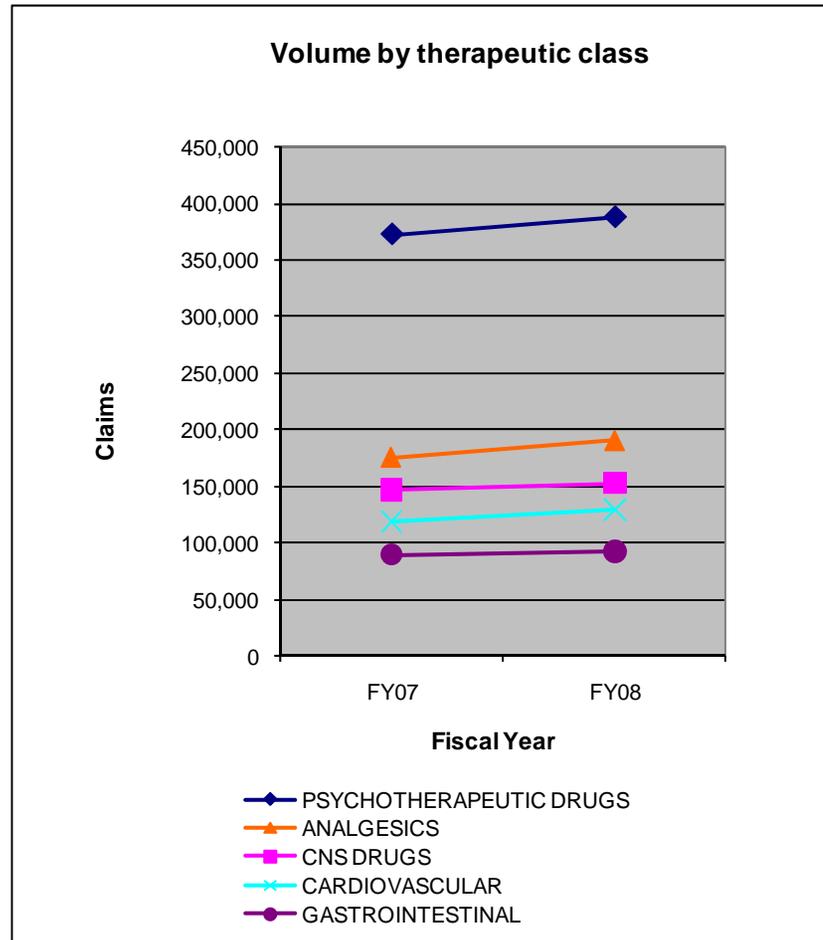
The significant prescription and beneficiary drop between FY06 and FY07 is due to implementation of Medicare Part D. The drop in persons served between FY07 and FY08 is due to two different things. One is the citizenship documentation requirement and the other was changes in eligibility requirements.

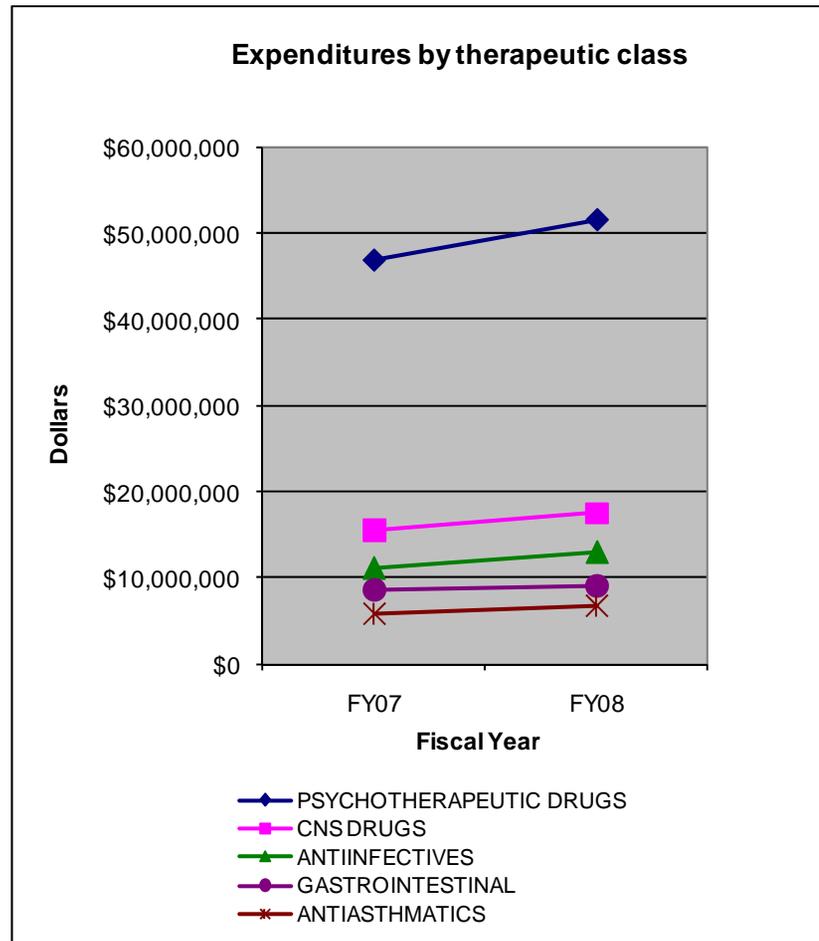
Mr. Harkness pointed out that \$100 million was saved during the implementation of Medicare Part D. Dr. Burke asked if the federal government gives less money to the state for Medicaid because there were less people being covered. Dr. Smith said the federal government doesn't put a cap on Medicaid. As much as we spend they will match. Because we didn't spend that money we didn't have to come up with our part or their part.

Pharmacy Program Trends – 5 Highest Expense Classes in FY08

Therapeutic Drug Class	FY 2006	FY 2007	FY 2008	Drug Class Increase from 2007 to 2008	Increased Spending for Each Drug Class
Psychotherapeutic Drugs	\$69,415,638	\$46,887,670	\$51,572,772	\$4,685,102	29%
CNS Drugs	\$23,425,960	\$15,459,564	\$17,490,353	\$2,030,788	13%
Antiinfectives	\$13,909,624	\$11,139,003	\$12,935,437	\$1,796,434	11%
Gastrointestinal	\$18,834,959	\$8,601,693	\$9,006,524	\$404,831	3%
Antiasthmatics	\$8,290,453	\$5,806,880	\$6,710,627	\$903,747	6%
All other drugs	\$88,254,371	\$43,642,193	\$49,739,674	\$6,097,480	38%
Total	\$222,131,005	\$131,537,003	\$147,455,386	\$15,918,383	100%

Program Trends: Unsustainable Growth





Safety Concerns in Kansas Medicaid – Mental Health

- Nearly 9,000 beneficiaries less than 18 years of age prescribed an atypical antipsychotic in total population (fee for service and Healthwave)
 - 4-5% of total eligible beneficiaries less than 18 years of age
- 350 children in total population less than 4 years of age prescribed an atypical antipsychotic
 - No FDA approved indication for younger than 5 years of age
- 576 FFS children less than 18 years of age prescribed 2 or more atypical antipsychotics simultaneously in fiscal year 2008
 - Written by 424 different prescribers

- 851 FFS children under 18 years of age prescribed 5 or more psychotropic medications within a 90 day period in fiscal year 2008
 - Written by 710 different prescribers

Dr. Menninger asked if we can get the same statistics for adults. Dr. Bell said we can. This information came from the CNS project; they can run similar kind of measures. Dr. Leeson said when he was involved they received data on adults and children. It was reviewed with KHPA. Dr. Menninger asked how this information is used. Dr. Burke said it is to enlighten this group to see if there can be recommendations made. Dr. Menninger would prefer to see the information for adults too.

Children in Foster Care

- 52% of children in state foster care system are on mental health medications
 - 20% of foster children are on an atypical antipsychotic
 - 20% are on an anti-depressant
- Overall use has fallen from 71% in 2004, likely linked to findings of increased risk of suicidality in children
- Payments for antipsychotics has increased from \$2 million in FY 2002 to \$5.5 million in FY 2008

Statute on Medications for Mental Illness

Statue 39-7, 121b

Limitations on restrictions on medications used to treat mental illness; medications available without restrictions.

No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, depression or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available under the state Medicaid plan without restriction for persons with mental illnesses shall include atypical antipsychotic medications, conventional antipsychotic medications and other medications used for the treatment of mental illnesses.

History: L. 2002, ch. 180, § 2; June 6.

Intervention on Mental Health Drugs

- 39-7, 121b essentially allows KHPA to use only one tool - a RetrospectiveDUR-type program - for impacting treatment of mental illness
- Comprehensive Neuroscience (CNS) Behavioral Pharmacy Management project
 - Began in 2006

- RetrospectiveDUR-type program
- Sponsored by Eli Lilly and Company
- Educational mailings sent to the top 100 prescribers outside best practice guidelines established by CNS
- Interventions occur approximately six months after prescription dispensation
- Demonstration of a positive impact is difficult; research indicates modest impact at best from similar educational efforts
- Other states have successfully incorporated provider education projects into a broader pharmacy management programs that include many direct interventions Kansas Medicaid is unable to do - such as prior authorization or mandatory peer review

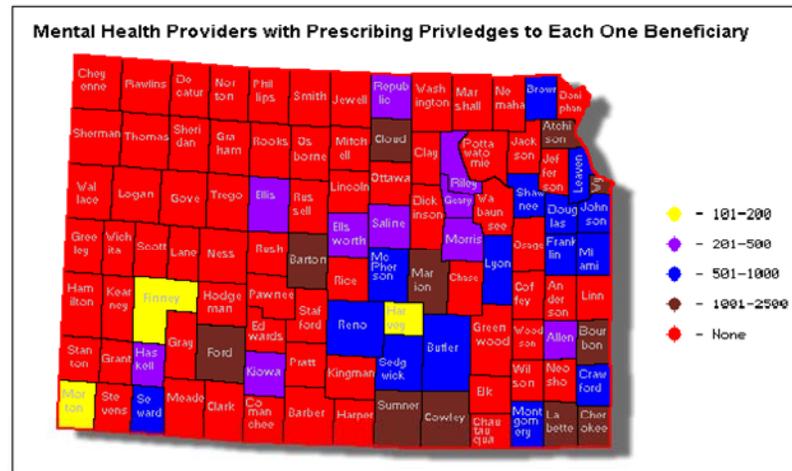
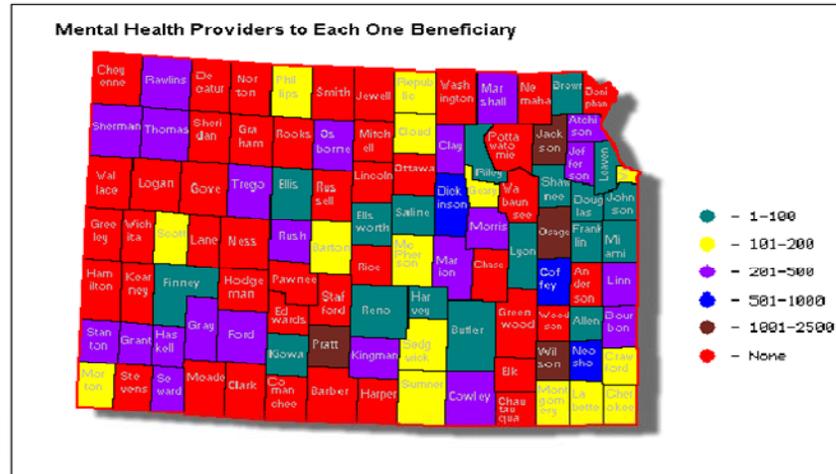
Dr. Burke stated that these letters are pre-prepared versus the other retroDUR subset the DUR board helps to craft those letters so that they are meaningful. Ms. Lewis asked if the vendor is willing to work with us to make changes in the letter. Dr. Bell stated there had been a meeting with the vendor recently and they were very receptive to going in a different direction. Ms. Lewis asked if this is the same system that Missouri is using. Dr. Smith said Missouri is using this program and they have seen better results, but they have other tools they are using along with this program. Dr. Menninger said it would be helpful to know what other states are doing and what their successes have been. Dr. Leeson said Missouri sends mailings to more than the top 100 prescribers. Ms. Lewis said they also make phone calls. Dr. Bell stated it is difficult to compare to Missouri because they are able to do prior authorization and mandatory peer review. Dr. Shaw said that Missouri had a tremendous cut in their Medicaid benefits, so their program looks good but if you look at who they are serving it is not as good as it seems.

Providers of Treatment for Mental Illness

- Community Mental Health Centers (CMHCs), by statute, are required to cover all Kansans but struggle against the rural Kansas landscape like all other medical professionals
- Kansas Health Solutions data shows the ratio of providers and prescribers to Medicaid and HealthWave beneficiaries across the state is as follows:
 - One mental health professional per approximately 175 beneficiaries
 - One mental health professional who prescribes medication per approximately 2000 beneficiaries
- Kansas Board of Healing Arts reports 241 psychiatrists licensed for practice in Kansas; additional 42 psychiatrists with exempt licenses
- More than 60% of all mental health drugs are prescribed by non-psychiatrists

Dr. Menninger said he would like to know out of the top 100 outliers how many of them are psychiatrists. Dr. Bell said we can get that information. Dr. Leeson said one thing to keep in mind is the top100 will shift based on how they are being ranked. Dr. Menninger said the question is there a group of physicians that need the education more.

Provider Distribution



	<p><i>KHPA Policy Initiative</i></p> <ul style="list-style-type: none"> • Right tools... Give prescribers the right tools they need to safely prescribe medications for mental health consumers • Right price... Use taxpayer dollars wisely by providing mental health medications at the right price to meet consumer needs • Right providers... Developed by mental health experts, the right providers to support making decisions for mental health consumers 	
<p>V. Committee discussion a. Program Design and Committee Agenda</p>	<p>Dr. Burke stated that most of the discussion anticipated to occur in this meeting had already occurred during previous portions of the meeting.</p> <p>There was committee discussion about developing a listserv or point of contact so if one of the members thought of a specific topic they wanted data on they could send an email with their idea.</p> <p>Dr. Leeson stated cost and safety are good goals, but they should be targeted differently. Ms. Lewis suggested that we focus on safety at one meeting and economic issues at another. Dr. Burke said we can talk about economics and at some point we need to take it and make very specific.</p> <p>Dr. Menninger asked for a committee roster with institutional identification.</p>	
<p>VI. Future meeting date schedule</p>	<p>Meetings will be held every 3 months on the second Wednesday of the month. The next meeting will be August 12, 2009.</p>	
<p>VII. *Public comment</p>	<p>No public comment.</p>	
<p>VIII. Adjourn</p>	<p>The meeting was adjourned at 2:20 p.m.</p>	<p>Mr. Harkness moved to adjourn the meeting.</p> <p>Ms. Lewis seconded and it carried with a unanimous vote.</p>