SB 137: Medicaid Amendments

Maximize Savings & Improve Medicaid Quality of Care

Vote YES w/amendments

A Utah Health Policy Project Fact Sheet

Updated: February 10, 2011

Summary

Like many states across the nation, Utah is working to limit cost growth in Medicaid, starting with the biggest cost driver in Medicaid: prescription drugs. Senate Bill 137 (Senator Allen Christensen) limits cost growth in Utah's Medicaid prescription drug program by giving the state flexibility to include medications for mental health conditions on the state's Preferred Drug List (PDL). Since Utah's PDL was implemented in FY2008, the program has saved the state millions of dollars. However, because Utah does not include mental health medications on its PDL, the *state is leaving nearly half of the potential savings on the table*. The budget recommendations unanimously approved by the Social Services Appropriations Committee on January 31 presuppose passage of SB 137. If SB 137 does not pass, critical Medicaid services will be at risk.

Build on Utah's Success with the PDL

The state's PDL has been managed well and access problems for beneficiaries have been minimized. This gives us confidence in the P & T Committee and its ability to identify the most clinically appropriate, cost-effective mental health medication classes to include on PDL. Where possible the list would start with generic equivalents and alternatives, as well as other low cost alternatives. More expensive mental health medications will be available through prior authorization using criteria developed through rigorous review of the clinical literature. The prior authorization process will also interface with the claims processing system to review patients' history to determine whether the patient meets the established criteria for approval of the request. This and other best practices will minimize the impact on the patient and the prescriber community. *Other changes that will address the concerns of the county mental health community are described on page 2.*

Frequently Asked Questions

How much has the PDL saved in Utah?
In the last complete fiscal year the PDL generated over $4.7 million in general fund savings, more than originally projected (http://health.utah.gov/medicaid/stplan/LegReports/PDL%20Savings_09-08-10.pdf).

How much could we save with SB137?
The fiscal analyst estimates $1 mil+ in FY 2012 and $1.5 million each year thereafter.

What % of Medicaid drug expenditures is for psychotropics?
For FY 08, behavioral health drugs represented 45% of the drug budget.

How have states handled mental health medications on their PDLs?
Several states do not exempt mental health medications from their PDLs, though Michigan and others have provisions to moderate the impact of prior authorization. The Kaiser Foundation identified 10 states that required prior authorization for anti-depressants, and 11 for benzodiazepines/tranquilizers. Sen. Christensen will be releasing a substitute bill that will support "grandfathering" of mentally ill patients who are stable on their current prescription regimen. UHPP supports this modification in SB137.

What's the bottom line?
We *can* include mental health drugs on the PDL while protecting access to medically necessary medication. SB137, 1st substitute (and with attached amendments) is the way forward.

For questions or comments, see Judi Hilman (judi@healthpolicyproject.org) or Shanie Scott (shanie@healthpolicyproject.org) (801) 870-3887

Responses to Recommendations from Utah Associations of Counties + Possible Amendment Language

Safety mechanisms recommended by Association of Counties	**Response by Proponents of SB137**
Grandfather all public behavioral health consumers who are stable on potential PDL medications so that they are able to remain on their current medication regimen. Language needs to be developed that allows grandfathering to be of specific duration (potentially permanent) to protect clients from potential adverse outcomes.	The first point is currently addressed in the new language, the only thing to possibly spell out more is that the grandfather provision is renewable annually if patient remains stable—done (see below)
Eliminate any language limiting the number of medications that a client is allowed to be on at any given time.	There is no limit to the number of medications. Rather, after a patient hits 7 meds, the UT College of Pharmacy reviews interactions between meds to see if there are any issues. This is a safeguard for the patient.
Provide for a "dispense as written" exclusion from the PDL for any psychiatric medications that a community mental health psychiatrist believes is necessary.	No, other changes should make this unnecessary.
Consumers who are utilizers of high cost services such as the jail incarcerations and acute care hospitalizations who have an established history of non-compliance with taking medications need to be eligible for high cost injectible medications. Overall savings can be shown to the system of care.	They already are.
Psychiatrists from the public behavioral health system should have a permanent seat on the Medicaid Pharmacy and Therapeutics committee and the Medicaid Drug Utilization Review board and other committees that have responsibility for prescription medications	**Agreed. At one point there was a Psychiatrist on the P & T committee in the past. This should be a permanent position.**
Explore the possibility of purchasing these medications through the Minnesota Multi-group Purchasing Organization (a pharmacy group purchasing organization) already used by the USH and Weber Human Services at a significant discount.	Yes, we recommended this around the time the PDL was created. Needs to be revisited. IS UT part of any purchasing alliance? But this is a separate issue that does not replace the need for SB137, as amended.