

Item for interim consideration: Expansion of the Medicaid Preferred Drug List

Background:

Having a preferred drug list is one important way in which Health Insurance Plans save money on expensive, but necessary, medications.

The Utah legislature has allowed the Department of Health to negotiate better prices on 2/3 of their medications for Medicaid patients via a preferred drug list now for the past 7 years, but has forbidden the Department of Health from trying to negotiate lower prices on 1/3 of their medications (psychiatric medications), so the state continues to pay a higher price for those medications.

All private health plans and most all other state Medicaid programs already consider psychiatric medications on their preferred drug lists as a way to reduce costs.

What is that the argument against including these agents on the preferred drug list?

Various industry and advocacy groups argue that having a preferred drug list will cause mental health patients to become unstable and require expensive hospitalizations.

So the question that needs to be answered is:

Can the state achieve monetary savings by implementing a preferred drug list for psychiatric medications, while still allowing patients to get timely access to needed treatments to keep them stable and functioning?

Items for interim study to answer this question could include:

1. Request a presentation from one of the pharmacy managers at the Department of Health (or PEHP or the U of U) on how having an evidence-based preferred drug list encourages use of medications which have the best evidence for safety and efficacy, while reducing side effects and adverse outcomes.
2. Possible presentation from the Department of Health on what they have done to reduce turnaround time for prior authorization of agents not on the preferred list.
3. Possible presentation from one of the volunteer doctors or pharmacists who serves on the Pharmacy and Therapeutics Committee (the committee that gives the medical input to the state regarding the preferred drug list) to better understand its process.

4. Review by the committee of the amount of savings achieved by the current Preferred Drug List, and review of the annual savings projected by allowing the remainder of the medications to be considered.

5. Our county mental health system is currently stretched very thin, with new patients often having to wait 6 to 8 weeks to be able to visit with a psychiatrist. Part of the money saved from implementing a preferred drug list could be used in a number of ways to improve services for this vulnerable population and prevent them from getting so sick that they require hospitalization. Hiring additional staff to reduce wait times, and implementing better crisis teams that can intervene quickly with individuals when they are decompensating, are two ideas that have been suggested. The committee could ask the Department of Health to bring back a report on some suggestions on how services for this population could be improved if some of the savings from a preferred drug list were to be made available for the treatment of this same group of patients.

6. Ask the Department of Health to collect information and report to the committee on the experience in other states who already consider psychiatric medications on their preferred drug list, specifically, whether they have seen increased costs from hospitalizations, and whether they have been able to achieve lower costs in purchasing the medications.

7. Review safeguards that could be placed in statute to avoid destabilizing patients. These could include a grandfathering clause for patients who are stable on their psychiatric medications.

8. Currently the Department of Health has a rule that requires that if a medication is safer or more effective than other medications in its class, the Pharmacy and Therapeutics Committee must include it on the preferred drug list. The interim committee could review these rules and could decide whether they would feel more comfortable with the safety if these were in statute instead of rule.

9. There are some classes of medications (such as injectable antipsychotics) that some testimony was given by individuals afraid that these classes of medications would not be excluded if a PDL is implemented. We currently have rules that would require that a member of these classes be included on the list, but the committee could consider whether it would be a stronger safeguard to move this assurance of inclusion to statute.

10. Other items as suggested by the committee.