

**California Department of Health Care Services  
Proposed May Revision Trailer Bill Legislation**

**Medi-Cal Cost Containment Proposal: Cap on Outpatient Prescriptions**

**FACT SHEET**

**Background**

This proposal would impose a six prescription “cap”, that is, a limit beyond which the Medi-Cal program would not pay for a prescription. The Department of Health Care Services (DHCS) would automatically exempt from this limit selected drugs that it deems to be life-saving, such as those used for the treatment of HIV/AIDS, cancer, hemophilia and mental health as well as claims for nursing facility patients, pregnant women and children under the age of 21. The drugs exempted from the cap would still be subject to utilization controls. A few other states have cap limits with significant variation in the amount of leeway allowed to obtain drugs above the cap. This proposal would require approval of a State Plan Amendment by the federal Centers for Medicare and Medicaid Services (CMS), and DHCS would implement this proposal only to the extent permitted by CMS.

Legislation limiting the number of prescription drug claims a Medi-Cal beneficiary may have in a single month was first passed in 1992 and implemented July 1, 1994. Originally, the limit was ten prescriptions. The limit was reduced to six prescriptions effective November 1, 1994. The assumption was that by imposing a limitation, a number of unnecessary prescriptions would be avoided. Currently, any prescriptions beyond the limit must receive prior authorization.

The current definition of the six prescription limit is: a limit of pharmacy drug claim lines submitted for dates of service within a calendar month, beyond which prior authorization is required. The prescription limit is not the number of different drugs dispensed in a month, and is not the number of drugs a recipient is currently taking. If the same drug is dispensed four times in a month, it counts as four of the six prescriptions. The current six prescription limit does not apply to:

- Nursing facility patients
- Family planning drugs (for example, oral contraceptives)
- Claims that must be submitted on paper (claims with required attachments)
- Claims for newborns, where the baby uses the mother’s identification number
- Drugs for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions
- Cancer drugs
- Drugs paid per authorized Treatment Authorization Request (TAR), for the period of time approved in the TAR
- Medical supplies

**Why is this change needed (i.e., what problem is the language trying to address)?**

California is facing a multi-billion dollar shortfall, and Medi-Cal, as the second largest General Fund expenditure after education, must be part of the effort to reduce state costs.

**Potential for opposition, if yes, why.**

There will likely be opposition to this proposal by advocates and welfare rights organizations.

The opposition will indicate that beneficiaries will not have access to care and will end up accessing other services, and will have the biggest impact on beneficiaries who utilize services the most.

**Is there a BCP associated with this language (yes or no)?** There is not a BCP associated with this language; this item has been included in the May Estimate.

**Any other brief information that is relevant/important to highlight so that one can fully understand the issue that is being presented**