H.620 An act relating to health insurance and Medicaid coverage for contraceptives

3/8/2016

TESTIMONY FROM DVHA

H.620 Coverage Provisions

Effective 10/1/2016, H.620 requires health insurance plans, including Medicaid, to cover the following:

- All contraceptive drugs, devices, and other products for women approved by the FDA, including products available over-the-counter or as prescribed by an enrollee's health care provider.
- Voluntary sterilization procedures for men and women.
- Patient education and counseling regarding the appropriate use of contraception.
- Clinical services associated with providing the aforementioned drugs, devices, products, and procedures, as well as related follow-up services, including management of side effects, counseling for continued adherence, and device insertion and removal.

H.620 Coverage Provisions (continued)

Vermont Medicaid already covers the services included under the bill, with the following exceptions:

- All contraceptive drugs, devices, and other products for women approved by the FDA, including products available over-the-counter or as prescribed by an enrollee's health care provider.
  - Per federal law, Medicaid is required to cover an outpatient drug if all of the following are met:
    - Drug is FDA-approved,
    - Drug manufacturer participates in the Federal Drug rebate program, and
    - Drug has a National Drug Code (NDC) identifying label.
  - FFP is not allowed if the above 3 provisions are not met.

H.620 Coverage Provisions (continued)

Vermont Medicaid already covers the services included under the bill, with the following exceptions:

- Voluntary sterilization procedures for men and women.
  - Per federal regulation, sterilization of either a male or female may only be covered when the following conditions are met:
    - The beneficiary has voluntarily given informed consent.
    - The beneficiary is not mentally incompetent.
    - The beneficiary is at least 21 years old at the time consent is obtained.
    - At least 30 days but not more than 180 days have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.
      - In those cases, at least 72 hours must have passed between the informed consent and the operation. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
    - FFP is not available for a hysterectomy if it was performed solely for the purpose of rendering an individual permanently incapable of reproducing.

H.620 Coverage Provisions (continued)

Medicaid does not impose any restrictions or delays on the covered services referenced in H.620.

Medicaid does not impose a deductible, coinsurance, co-payment, or other cost-sharing requirement on the covered services referenced in H.620.

13-Month Supply

H.620 requires that Medicaid provide coverage for a supply of contraceptives intended to last over a 13-month duration, which may be furnished or dispensed all at once or over the course of the 13 months at the discretion of the health care provider.

Suggest changing this language to 12 month supply. Believe that most providers would write initial 1 month script and then subsequent 12 months.

Will require State Plan Amendment and administrative rule change.

LARC Reimbursement

LARC Distribution by Service Location

The location of the LARC insertion can impact the cost to Vermont Medicaid.

Physician's Office	Title X (Planned Parenthood)	FQHC & RHC	Hospital
44.9%	31.0%	6.2%	17.8%

FQHCs and RHC are cost based clinics. Hospitals receive a $200 add-on for LARC insertions performed after delivery in addition to the DRG payment. This means that an increase to LARC payment will not impact either of these provider groups.

Factors that Impact Reimbursement Rate for LARCs:

1. Provider Type
2. 340B Drug Discount Program Participation
3. Drug Rebates
4. Individual Medicaid/Provider contracts

LARC Reimbursement: Programmatic Impact

Changing LARC reimbursement requires the following:

- Will require significant staff resources for the following:
  - State Plan Amendment (SPA) to change:
    - LARC reimbursement methodology
      - 7/1/2016 effective date is extremely challenging given administrative work and time needed for CMS negotiations and approval process.
  - Development of revised LARC reimbursement methodology.
  - Rate changes will subsequently require changes to the MMIS.
    - Any changes to MMIS represent new resources (staff time and funds).

LARC Reimbursement: Fiscal Impact

Fiscal estimate is based on DVHA's current reimbursement methodology (not proposed value-based payment):

	No Change in Utilization		+ 10% Utilization		+ 20% Utilization		+ 40% Utilization	
	Annual LARC Spend (Gross)	Additional $ Needed (Gross)	Annual LARC Spend (Gross)	Additional $ Needed (Gross)	Annual LARC Spend (Gross)	Additional $ Needed (Gross)	Annual LARC Spend (Gross)	Additional $ Needed (Gross)
Current Spend	$1,065,783	$0	$1,172,361	$106,578	$1,278,940	$213,157	$1,492,096	$426,313
5% Rate Increase	$1,119,072	$53,289	$1,230,979	$165,196	$1,342,887	$277,104	$1,566,701	$500,918
10% Rate Increase	$1,172,361	$106,578	$1,289,597	$223,814	$1,406,834	$341,051	$1,641,306	$575,523
20% Rate Increase	$1,278,940	$213,157	$1,406,834	$341,051	$1,534,728	$468,945	$1,790,515	$724,732
40% Rate Increase	$1,492,096	$426,313	$1,641,306	$575,523	$1,790,515	$724,732	$2,088,935	$1,023,152
60% Rate Increase	$1,705,253	$639,470	$1,875,778	$809,995	$2,046,303	$980,520	$2,387,354	$1,321,571
80% Rate Increase	$1,918,409	$852,626	$2,110,250	$1,044,467	$2,302,091	$1,236,308	$2,685,773	$1,619,990
100% Rate Increase	$2,131,566	$1,065,783	$2,344,723	$1,278,940	$2,557,879	$1,492,096	$2,984,192	$1,918,409

LARC Reimbursement: Fiscal Impact (continued)

Fiscal estimates do not take into account:

- Potential cost savings resulting from reducing unintended pregnancies.
- Potential cost shift from oral contraceptives to LARC.

Bill Language Revisions

DVHA recommends the following modifications to this bill:

1. Language must be included that appropriates funding to DVHA for the increased reimbursement of LARC.
2. Language that any changes to LARC reimbursement will be effective 10/1/2016.
3. Language that clarifies that Medicaid can only cover products that have National Drug Code (NDC) identifying labels and are produced by manufacturers participating in the Medicaid rebate program, in order to ensure FFP.
4. Language that clarifies coverage policies must be in compliance with federal regulation.
5. Language to the below provision that clarifies that any Medicaid covered service must be medically necessary.
    1. "Not limitations or restrictions on above covered services based on an individual's sex assigned at birth, gender identity, or recorded sex or gender with the health insurance plan."
6. Language that modifies the requirement of a 13-month drug supply to a 12-month drug supply.