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MEMORANDUM

To: Senator Claire Ayer, Chair, Senate Committee on Health & Welfare

From: Cory Gustafson, Commissioner, Department of Vermont Health Access;

CC: Al Gobeille, Secretary, Agency of Human Services

Date: January 30, 2017

Re: Medicaid Reimbursement for Long-Acting Reversible Contraceptives

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This memorandum is in response to requests for information on the implementation of an increase to Medicaid reimbursement of long-acting reversible contraceptives (LARCs) as mandated in Act 120 and discussed during testimony and committee discussion on January 25, 2017.

LARC Reimbursement & Utilization Before and After Act 120

DVHA raised LARC reimbursements to implement Act 120. DVHA implemented a 20% rate increase for LARC products on the Medicaid fee schedule effective 10/1/2016. 340B participating providers received a reimbursement increase as well, but the impact of the rate increase depends on Medicaid's fee schedule for a product, acquisition price by the 340B participant, and the provider's agreement with DVHA.

The change is recent and there is a lag between when a service is performed and a claim is paid. Therefore, DVHA has very little data on the impact of this reimbursement change on LARC utilization.

The following tables present information available, to date, for utilization based on provider type and Medicaid expenditures.

Table 1. Number of Medicaid Members Receiving LARCs, by Provider Type

	Before Rate Increase		After Rate Increase
Service Location	**Actuals for Dates of Service SFY 2015**	**Actuals for Dates of Service SFY 2016**	**Actuals for SFY 2017 (July 2016 to November 2016)*** *Rate Increase on 10/1/16*
Federally Qualified Health Center	16	31	18
Nurse Practitioner	6	4	0
Physician	711	1160	692
Rural Health Clinic	5	33	5
Total	**738**	**1228**	**715**

*Utilization for SFY 2017 includes claims submitted to date. Medicaid providers have 6 months from date of service to submit claims to Medicaid. Due to this timely claim filing limit, the actuals for SFY 2017 will increase.

Table 2. Number of Medicaid Members Receiving LARC Over Time (July 2013–Nov. 2016)

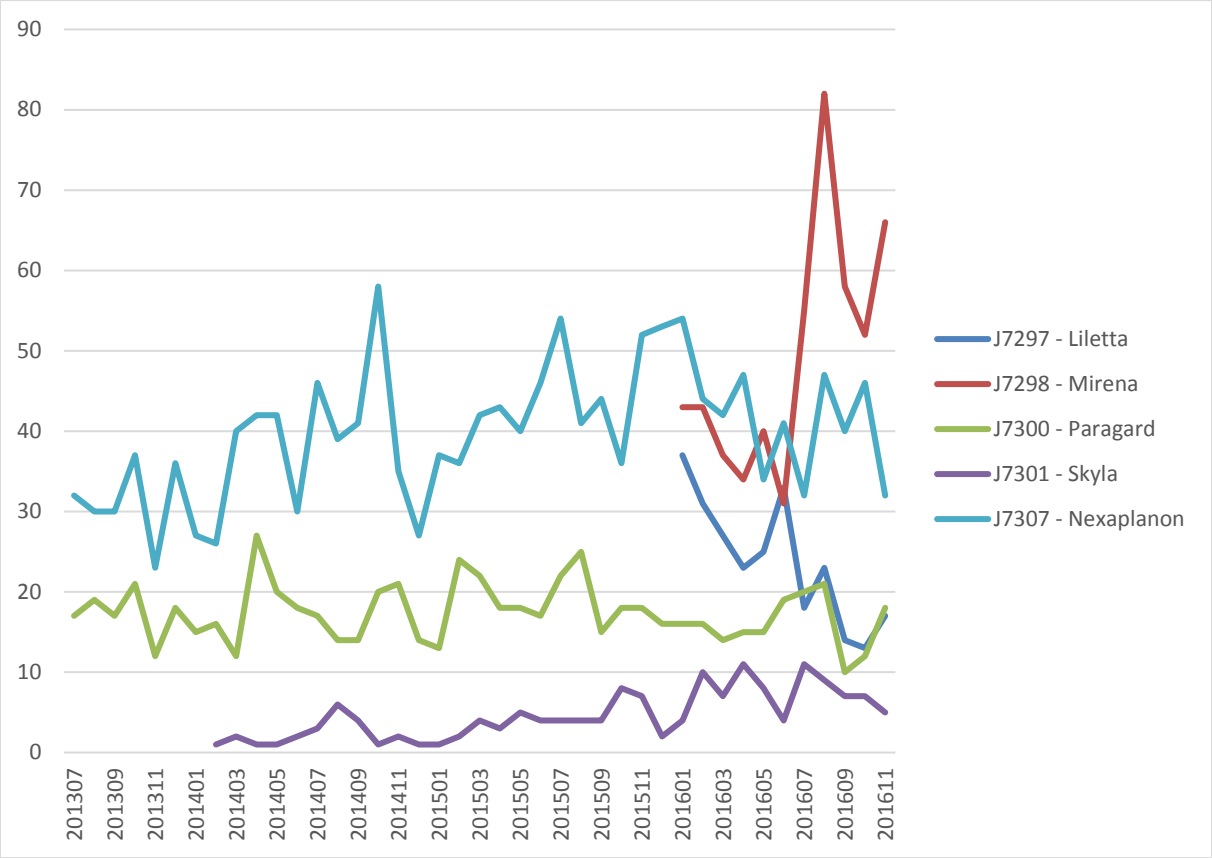

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Table 3. Medicaid Expenditures for LARCs Pre- and Post-Reimbursement Increase

	Before Rate Increase		After Rate Increase	
Product	**Actuals for Dates of Service SFY 2015**	**Actuals for Dates of Service SFY 2016**	**Actuals for SFY 2017 (July '16–January 2017)*** *Rate Increase 10/1/16*	**Actuals for October 2016 to January 2017***
Liletta (J7297)	$ 0	$ 9,370	$ 15,205	$ 11,825
Mirena (J7298)	$ 0	$ 115,978	$ 252,443	$ 139,378
Paragard (J7300)	$104,900	$ 75,257	$ 44,882	$ 25,241
Skyla (J7301)	$ 22,685	$ 38,349	$ 32,875	$ 18,354
Nexaplanon (J7307)	$ 263,650	$ 217,778	$ 110,281	$ 53,458
Total	**$ 391,235**	**$ 456,732**	**$ 455,685**	**$ 248,255**

*Actual spend for SFY 2017 includes claims submitted to date. Medicaid providers have 6 months from date of service to submit claims to Medicaid. Due to this timely claim filing limit, the actuals for SFY 2017 will increase.

Table 4. Utilization of LARCs vs. Other Forms of Birth Control

Paid to Pharmacy Provider		
Percent Changes in Other Contraceptive Methods (CY 2016 over CY 2015)		
-2.56%	32.27%	0.30%
Nuvaring	Depo Provera	Oral Contraceptives*
1,599 services/year	2,499 services/year	6,622 fills/year
Paid to Physician Group		
Percent Changes in Other Contraceptive Methods (CY 2016 over CY 2015)		
-19%	-0.61%	-4.12%
Nuvaring	Depo Provera	Oral Contraceptives*
317 services/year	325 services/year	4,736 fills/year

*Oral contraceptives are typically a 90-day supply.

Cost Avoidance

There are several factors that limit a reliable evaluation of cost avoidance at present, including:

- Increased reimbursement went into effect on 10/1/16,
- Providers have six months from date of service to submit claims, and
- Savings are anticipated from avoided pregnancies so a 12-month period, at least, is needed to determine if there was a change in utilization and Medicaid expenditures for services associated with pregnancy.

DVHA will continue to evaluate the utilization of LARCs and the impact on service utilization and costs associated with pre-natal and post-natal care. This evaluation will help determine potential cost avoidance associated with Medicaid coverage of LARCs and rate of unintended pregnancies.

340B Drug Discount Program Participants

There are 16 distinct 340B entities enrolled in Medicaid's 340B program. 340B providers, including PPNNE, have the opportunity if their business model allows to buy LARCs in bulk in order to stock a sufficient supply of the devices in their offices. Providers can bill Medicaid for the device when the LARC is given to a woman.

Drug Prices & Cost Containment

Prescription drugs are a cost driver in the Medicaid program. Medicaid aims to control expenditures for prescription drugs by negotiating the lowest drug prices possible and driving utilization toward the appropriate drugs with the lowest prices. Medicaid has five main tools to successfully control drug costs:

- Federal rebates
- State rebates
- Supplemental rebates
- Preferred drug list
- Advisement from the Drug Utilization Review Board

Changing LARC Reimbursement Methodology

DVHA is capable, from a technical standpoint, of amending its reimbursement methodology to target specific payments to PPNNE in the amount set forth in the FY 17 BAA. DVHA could potentially add an additional payment for PPNNE only for related services, such as the reimbursement for insertion of a non-biodegradable drug delivery implant and insertion of an intrauterine device. DVHA would increase the amount paid based on projected utilization to attempt to meet a certain financial benchmark.