TSG Task Force Update

To: Arkansas Health Reform Task Force

Re: Pharmacy Savings/Quality Recommendations and Vaccination Findings and Recommendations

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UPDATE

Pharmacy Savings and Quality Recommendations

In the interest of moving the pharmacy recommendations in The Stephen Group report to implementation we suggest the Task Force consider recommending that DHS begin moving the following initiatives to full implementation. The pharmacy network should be re-contracted and the PDL expanded. These activities can bring significant savings to the State.

To ensure all beneficiaries maintain access to participating retail pharmacy providers, we suggest creating two tiers of pharmacies for contacting purposes. One tier should contain retail pharmacies in medically underserved areas of the State. Overly deep discounts demanded from providers in underserved areas could potentially drive retail pharmacies out of the current network. In this tier access needs to be balanced with savings. However, in urban and suburban areas of the State, there tends to be an oversupply of retail pharmacies. In this tier, more emphasis can be placed on discounts as convenient access will likely be maintained.

Each pharmacy in the State can be assigned to one of the two tiers prior to the re-contracting effort. Once the effort is complete it is expected that the retail pharmacies in underserved areas will have higher reimbursements than retail pharmacies in the urban and suburban areas.

The two components of pharmacy reimbursement to be addressed are the ingredient cost and the dispensing fee. It is recommended that the State seek lower brand drug ingredient cost and lower brand and generic drug dispensing fees. Depending on the depth of discounts on both ingredient cost and dispensing fees and the distribution of retail pharmacies in to the two contracting tiers, the annual savings could be as much as $18.3 million.

The current PDL is narrow compared to other state Medicaid PDLs. We recommend joining a multi-state rebate pool to increase leverage and therefore supplemental rebates from pharmaceutical manufacturers. There are several multistate pools from which to choose. Any rule or regulation that would limit which drugs or therapeutic classes can be included in the PDL should be overturned. The annual savings here could be as much as $22.75 million.

There are also recommendations which can improve the quality of pharmacy care in the DHS program. Several recommendations center on improving opioid drug use and management. The current pharmacy lock-in program which limits a beneficiary to filling all opioid prescriptions at one pharmacy is effective but could be expanded. Secondly, the State should implement a prescriber lock-in program in which a beneficiary can only get opioid prescriptions from one prescriber. The last recommendation to improve opioid use and management is to allow DHS clinicians access to The State Opiate Prescription Drug Monitoring Program.

We also recommend restructuring the monthly prescription limits for maintenance medications. Implementation would include creating the maintenance drug list and possibly restructuring the prescription limit for all non-maintenance drugs.

Vaccinations

Findings

For generations Americans have lived in a sick care culture, once we feel ill we seek care. However, many do not avail themselves of preventative care even where certain preventative care services are free to insured patients. Insurance coverage does not mean access to preventative care is always easy. So some disease prevention services like vaccinations are still underutilized. Fewer than half of adults ages 65 or older are up to date with core preventive services, despite regular checkups and coverage by nearly all insurance plans, according to a 2010 report by the Department of Health and Human Services. In addition, fewer than 30% of adults ages 50 to 64 are up to date with core clinical preventive services, according to a 2011 Centers for Disease Control and Prevention (CDC) report.

According to weekly vaccination rate data from the CDC, Arkansas's young children rank behind all but two states, Kentucky and West Virginia. For teens Arkansas ranked a bit better but still in the lowest decile of all states. For adults again, Arkansas ranked very low for vaccination rates. One bright spot was influenza vaccinations where Arkansas ranks in the middle of all states. Research going back about a decade suggests that ethnic and racial minorities, the socioeconomically disadvantaged and rural populations are less likely to receive preventive services, such as vaccinations according to the same 2011 CDC report.

The Vaccine For Children (VFC) program is a great way to provide vaccinations to children covered by Arkansas Medicaid. A modest administration fee of $9.56 is paid to providers for administering each of these otherwise free vaccines. For adults covered by Arkansas Medicaid providers are reimbursed a combined amount to cover both the cost of the vaccine and the professional administration fee.

For eligible Medicaid beneficiaries In CY 2014 11,010 vaccines were reimbursed for adults while 186,475 vaccines were administered to children under 19 years old.

Other state Medicaid programs were reviewed to determine whether or not reimbursement for vaccinations and professional administration charges were combined or separate.

Reimbursement Practices for Vaccinations and Administration Fees

Adults and Children

State Medicaid	Adult vaccine	Adult admin fee	VFC vaccine	VFC admin fee
Arkansas	Combined	Combined	Free	$9.65
New York	Yes	First inj $13.23 Next inj $2.00 First non-inj $8.57	Free	$17.85
Mississippi	Yes	Yes	Free	Yes
Alabama	Yes	Yes	Free	Yes
Tennessee	Yes	Unclear	Free	Yes

None of the states reviewed reimbursed providers with the combined vaccination and administration charges. In New York, it was noteworthy that the administration fee is reduced if more than one vaccination is administered during the same provider visit. All other states, including Arkansas, reimburse a full non discounted administration fee for each vaccination given to a beneficiary, regardless of how many may be given during one provider visit.

Reimbursement Practices for Vaccinations and Administration Fees--Adults

PO Carrier	Adult Vaccine	Adult Admin fee	Adult Vaccine Pharmacy	Adult Admin fee Pharmacy
BCBSAR	Yes	Yes	Yes	Yes (Flu is combined)
NovaSys	Yes	Yes	Don't Know	Don't Know

The private option plans reimburse providers separately for vaccine and administrations fees. One exception is for influenza vaccine given in a retail pharmacy the flu vaccine and administration charges are combined.

Rates for vaccinations and the assumed inclusion of professional administration fees are not updated frequently. It has also been over 10 years since the VFC administration fee has been evaluated or updated. There is anecdotal evidence that providers are dropping out of the vaccination programs for adults and children or routinely referring patients to the Department of Health. The best way to ensure vaccination gaps are filled for patients is to evaluate needs and administer vaccinations in the primary care environment.

Recommendations

The public and individual health benefits of high vaccination rates are well understood. To improve the low vaccination rates in Arkansas it is recommended that the provider reimbursement for adult vaccines and administration fees be separated. Separating the two reimbursement types will allow providers to more easily evaluate their ROI and program participation. Further it is recommended that the VFC administration fee be evaluated.

Evaluating and restructuring these fees is expected to increase vaccination rates in Arkansas. The impact of the changes should be measured periodically and if the progress is not satisfactory, the State could consider implementing secondary measures like improving health literacy of the patient (or parent in the case of children) access to vaccination sites, availability of transportation, decreasing fear of adverse effects, provider motivation, school admission criteria, public service announcements and others.

National, State, and Selected Local Area Vaccination Coverage Among Children Aged 19–35 Months — United States, 2014 *Weekly* August 28, 2015 / 64(33);889-896

National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13–17 Years — United States, 2014*Weekly* July 31, 2015 / 64(29);784-792

Vaccination Coverage Among Adults, Excluding Influenza Vaccination — United States, 2013*Weekly* February 6, 2015 / 64(04);95-102

http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/preventive-services-underutilized-resource