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CMCS Informational Bulletin

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SUBJECT: **State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception**

In July 2014, the Center for Medicaid and CHIP Services (CMCS) launched the Maternal and Infant Health Initiative to improve maternal and infant health outcomes. The initiative has two primary goals: 1) increasing the rate and improving the content of postpartum visits; and 2) increasing access and use of effective methods of contraception. Medicaid provides coverage for more than 70 percent of family planning services for low-income Americans. Given this important role, CMCS sought to identify approaches to Medicaid reimbursement that promote the availability of effective contraception.[1] This Informational Bulletin describes emerging payment approaches several state Medicaid agencies have used to optimize access and use of long-acting reversible contraception (LARC).

Background

Beyond preventing unplanned pregnancies, research indicates that effective contraception helps prevent poor birth spacing, thereby reducing the risk of low-weight and/or premature birth.[2] It can also be essential to a woman's long-term physical and emotional well-being. LARCs—intrauterine devices (IUDs) and contraceptive implants—are highly effective methods of birth control that last between 3 and 10 years (depending on the method) without requiring daily, weekly, or monthly user effort.[3] The Centers for Disease Control and Prevention has identified LARCs as among the most effective family planning methods with a pregnancy rate of less than 1 pregnancy per 100 women in the first year. For comparison, the contraceptive pill has a rate of 9 pregnancies per 100 women in the first year, while the male condom has rate of 18 pregnancies per 100 women in the first year.[4] While Medicaid agencies typically reimburse for multiple types of contraception, LARCs possess a number of advantages: they are cost-effective, have

[1] Sonfield A and Gold RB. (2012). Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2010, New York: Guttmacher Institute, <http://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf>.
[2] Agustin Conde-Agudelo, MD, MPH; Anyeli Rosas-Bermúdez, MPH; Ana Cecilia Kafury-Goeta, MD (2006). Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis. *JAMA* 295 (15): 1809-1823.
[3] Trussell J. Contraceptive efficacy. In: Hatcher R, Trussell J, Nelson A, Cates W, Kowal D, Policar M, eds. Contraceptive Technology. 20th ed. New York, NY: Ardent Media; 2011:779–863.
[4] U.S. Centers for Disease Control. Effectiveness of Family Planning Methods. http://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf. Accessed March 28, 2016.

high efficacy and continuation rates, require minimal maintenance, and are rated highest in patient satisfaction.[5]

Despite these known advantages, LARC utilization in the U.S. remains relatively low when compared to rates in other countries. As of 2009, LARC utilization rates among contraception users in the U.S. are higher for women covered by Medicaid (11.5 percent) than the national rate (8.5 percent).[6] But more can be done to increase the use of this form of contraception. Two reasons cited for the low utilization of LARCs in the U.S. are (1) administrative and reimbursement barriers that result in high upfront costs for devices and (2) payment policies that reduce (or do not provide) reimbursement for devices or placement.[7,8] States have flexibility in how they reimburse for LARC, and by promoting access to contraceptive methods of choice—and the support necessary to use chosen methods effectively—states can support not only the health of women and their children, but also reduce the number of unintended pregnancies.

LARC Utilization and Medicaid Reimbursement

Payment challenges related to LARC utilization exist in both fee-for-service (FFS) and managed care environments, as well as in inpatient and outpatient settings (primary, specialty, or other ambulatory care).

In the inpatient setting, for example, the use of a single prospective payment for labor and delivery services may not sufficiently address the additional costs associated with the provision of LARC. There are significant advantages to providing LARC immediately after delivery while the woman is still under hospital care.[9] But many states do not provide additional payment for the cost of LARC, and do not provide additional payment to either the hospital or the practitioner for placement or insertion services.

In outpatient settings, payment rates may be insufficient for LARC devices and/or for placement services. LARC placement may require significant up-front costs to providers, primarily costs to obtain devices prior to placement. For devices covered through a patient's pharmacy benefit, and in the absence of prior arrangements (or state policy), providers may not be able to return a dispensed device if it is not used for the specific patient for whom it was dispensed; these devices must then be discarded at a financial loss to the provider.

If states limit provider payment to an initial LARC placement, but do not provide payment for replacement or reinsertion when necessary, providers may face further disincentives.

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[5] Peipert JF, Zhao Q, Allsworth JE, Petrosky E, Madden T, Eisenberg D, Secura G.(2011) Continuation and satisfaction of reversible contraception. *Obstet Gynecol*. 117(5):1105-13.

[6] Finer LB, Jerman J, Kavanaugh ML. (2012). Changes in use of long-acting contraceptive methods in the United States, 2007-2009. Fertility and Sterility 98(4), 893-89

[7] Committee Opinion No. 615. American College of Obstetricians and Gynecologists. 2015. Access to contraception. Obstet Gynecol: 125: 250-5.

[8] Rodriguez, MI, Evans, M, Espey, E. (2014). Advocating for immediate postpartum LARC: increasing access, improving outcomes, and decreasing cost. *Contraception*. 90, 468-471.

[9] Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 121. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2011; 118:184–96.

Additionally, providers may be hesitant to insert LARC devices for women when continued coverage for individuals is uncertain in the event there is later need for removal of the LARC.

Finally, some states or Managed Care Organizations (MCOs) require prior authorization and, as part of the prior authorization, may question medical necessity absent failure using another birth control method (sometimes called step therapy).

State Medicaid Payment Strategies to Optimize LARC Utilization

To assist states in optimizing the existing statutory flexibilities in this area, this Informational Bulletin identifies LARC reimbursement strategies implemented by states. Information on challenges and opportunities were obtained through several sources, including a September 2014 Technical Review Panel on Contraceptive Services in Medicaid and the Children's Health Insurance Program (CHIP) and a scan of state policies and interviews with several state Medicaid officials. Emerging approaches to mitigate challenges in fourteen states, identified as of March 2015, involve a combination of contractual, payment strategies, and policy guidance. Additional states may also use similar strategies which fall into five broad categories:

1. Provide timely, patient centered comprehensive coverage for the provision of contraceptive services (e.g., contraception counseling; insertion, removal, replacement, or reinsertion of LARC or other contraceptive devices) for women of child-bearing age.
2. Raising payment rates to providers for LARC or other contraceptive devices in order to ensure that providers offer the full range of contraceptive methods.
3. Reimbursing for immediate postpartum insertion of LARC by unbundling payment for LARC from other labor and delivery services.
4. Removing logistical barriers for supply management of LARC devices (e.g., addressing supply chain, acquisition, stocking cost and disposal cost issues).
5. Removing administrative barriers for provision of LARC (e.g., allowing for billing office visits and LARC procedures on the same day; removing preauthorization requirements).

The following table summarizes state efforts to optimize LARC utilization, followed by a detailed summary of the approaches three states use. CMS is available to provide technical assistance to states who are interested in reviewing options for modifying LARC policies. For additional information on this Informational Bulletin, please contact Karen Matsuoka at karen.matsuoka@cms.hhs.gov or 410-786-9726.