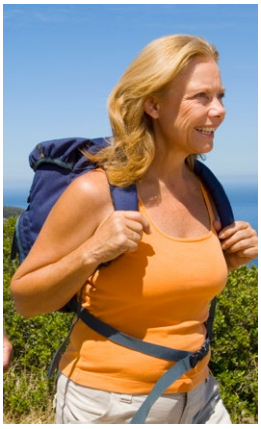
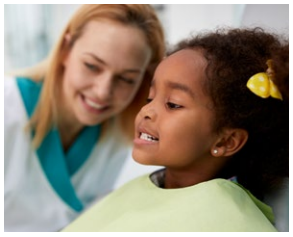
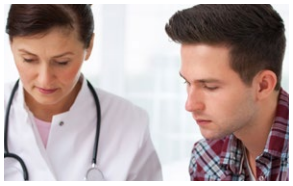
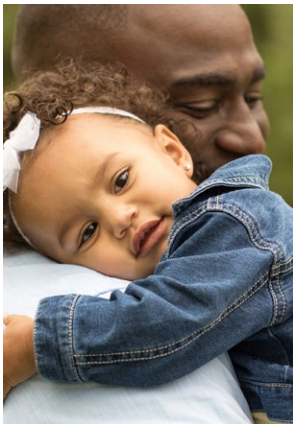
2018

Preventive and Reproductive Health Services

A Report to the Legislature



Oregon Health Authority
PUBLIC HEALTH DIVISION

Acknowledgments

Health Evidence Review Commission
Catherine Livingston, MD, MPH
Jason Gingerich

Contact

Jason Gingerich at jason.d.gingerich@dhsoha.state.or.us or 503-385-3594

Citation

Health Evidence Review Commission. Preventive and reproductive health services: A report to the Legislature. Oregon Health Authority. Portland, OR. 2018 December.

Contents

Executive summary

The Oregon Legislature passed the Reproductive Health Equity Act (House Bill 3391) in 2017. The act includes a list of reproductive and other preventive health services provided without cost sharing to people insured under state-regulated health benefit plans (see Oregon Revised Statute (ORS) 743A.067(2)). In addition, the bill created a program that covers these services for individuals who could become pregnant and who would be eligible for Medicaid if not for their immigration status. The bill also required the Health Evidence Review Commission (HERC) to regularly report to the Legislature on recommended changes to coverage required through the act.

In response to this requirement, HERC recommends the following changes to the list of required reproductive services and other preventive health services:

- Update the cutoff for U.S. Preventive Services Task Force (USPSTF) and Health Resources & Services Administration (HRSA) recommendations to Jan. 1, 2018.
- Add risk-based aneuploidy screening for pregnant women (i.e., testing for chromosomal defects).
- Clarify the requirement to cover postpartum long-acting reversible contraception (LARC) as a separate reimbursable service.
- Clarify that detailed policies regarding coverage of listed preventive services must align with national evidence-based standards (i.e., USPSTF), when applicable.

A bill that enacts these recommendations would:

- Align coverage required in statute with current recommended federal standards for commercial coverage
- Add additional evidence-based services important for reproductive health, and
- Reduce administrative barriers in delivering contraceptive services.

HERC recommendations to the Legislature

As required by ORS 414.694, HERC reviewed coverage requirements listed in (ORS) 743A.067(2) during its May 17, 2018 and Aug. 9, 2018 public meetings. HERC staff and commission members identified four potential changes:

- Update the cutoff for U.S. Preventive Services Task Force (USPSTF) and Health Resources & Services Administration (HRSA) recommendations to Jan. 1, 2018.
- Add risk-based aneuploidy screening for pregnant women (i.e., testing for chromosomal defects).
- Clarify the requirement to cover postpartum long-acting reversible contraception (LARC) as a separate reimbursable service.
- Clarify that detailed policies regarding coverage of listed preventive services must align with national evidence-based standards (i.e., USPSTF), when applicable.

Update the cutoff for U.S. Preventive Services Task Force (USPSTF) and Health Resources & Services Administration (HRSA) recommendations to Jan. 1, 2018

Rationale

Currently, the law refers to USPSTF and HRSA recommendations identified as of Jan. 1, 2017. USPSTF and HRSA have approved additional recommendations since that date. Extending that date to Jan. 1, 2018 would ensure coverage of more recently identified evidence-based services. These additional services are unlikely to have a significant cost. Enacting this change would align state requirements with the Affordable Care Act (ACA). This preserves the status quo in the event ACA preventive services provisions are overturned, amended or repealed.

Impact

Updating the date cutoff for USPSTF and HRSA recommendations would result in coverage of additional evidence-based preventive and reproductive services. Specifically, it would align with current federal requirements around coverage of:

- Preeclampsia (hypertension during pregnancy) screening (USPSTF)
- Screening for obesity in children and adolescents (USPSTF)

- Vision screening in 3- to 5-year-olds (USPSTF)
- Skin cancer prevention counseling (USPSTF)
- Fall prevention for community-dwelling older adults, i.e., adults not living in institutional settings (USPSTF)
- Screening for diabetes mellitus after pregnancy (HRSA)
- Screening for urinary incontinence (HRSA)

Add risk-based aneuploidy screening for pregnant women women (i.e., testing for chromosomal defects)

Rationale

Information about significant genetic abnormalities in the fetus such as Down's Syndrome can inform a patient's choices about pregnancy care. These options may include:

- Further diagnostic testing
- Pregnancy management, and
- Decisions around appropriate delivery setting.

Some tests are quite expensive. Coverage may also vary significantly, which can deter women from having this screening.

HERC previously reviewed the evidence for prenatal genetic testing. Based on that review, the commission made the following evidence-based recommendations on risk-based aneuploidy screening coverage:

- Screening for aneuploidy with any of five screening strategies:
    1. First trimester (nuchal translucency, beta-HCG and PAPP-A)
    2. Integrated
    3. Serum integrated
    4. Stepwise sequential, and
    5. Contingency

- Cell-free fetal DNA testing for evaluation of aneuploidy in women who have an elevated risk of a fetus with aneuploidy:
  - Maternal age >34
  - Family history, or
  - Elevated risk based on screening

Impact

Including coverage of risk-based aneuploidy screening may significantly increase the number of women choosing to have this screening due to reduced financial barriers. This will allow them to make more informed decisions in their pregnancy care. Women requiring follow-up tests, e.g., amniocentesis, may be responsible for cost sharing. This can include deductibles and co-insurance, as coverage of services may vary by plan type.

Clarify the requirement to cover postpartum long-acting reversible contraception (LARC) as a separate reimbursable service

Rationale

Significant reimbursement barriers exist to providing postpartum LARC. LARC provides effective contraception for an extended period without requiring user action. It includes injections, intrauterine devices (IUDs) and subdermal contraceptive implants. Postpartum LARC occurs when a contraceptive implant or intrauterine device is provided immediately after delivery in the hospital. Plans should be required to develop and make available an implementation pathway for postpartum LARC payment that includes device reimbursement. HERC completed a review of this topic on Nov. 10, 2016* and came to the following conclusion:

- HERC recommends coverage of immediate postpartum LARC (implant or intrauterine device) placement (*strong recommendation*).

Current federal and state law, in addition to coverage requirements under HB 3391, contain extensive provisions related to contraception. However, they may not be sufficient to address hospital billing and claims reimbursement practices. These practices may prevent LARCs from being paid for when provided immediately after delivery.

* See https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/LARC-CG.pdf

A HERC letter to coordinated care organization (CCO) medical directors in 2016 summarized several barriers to appropriate reimbursement of LARC devices, specifically:

- Lack of specific reimbursement for these devices when provided after an in-hospital birth due to global diagnosis-related group (DRG)-based payment for delivery services
- Lack of reimbursement to professionals and facilities for placement in the inpatient setting
- Inadequate inventory of these devices to allow for their placement on a timely basis in all care settings
- Lack of health system support to implement policies and procedures that support immediate access
- Provider reimbursement rates lower than the provider's cost for the devices
- Lack of providers able to perform postpartum placement of IUDs.

To address these barriers, the Centers for Medicare & Medicaid Services has created a bulletin and identified many viable options for payment. This includes the following:

- Provide timely, patient-centered comprehensive coverage for contraceptive services (e.g., contraception counseling; insertion, removal, replacement or reinsertion of LARC or other contraceptive devices) for women of child-bearing age.
- Raise payment rates to providers for LARC or other contraceptive devices to ensure providers offer the full range of contraceptive methods.
- Reimburse immediate postpartum LARC insertion by unbundling payment for LARC from other labor and delivery services.
- Remove logistical barriers for supply management of LARC devices (e.g., addressing supply chain, acquisition, stocking cost and disposal cost issues).
- Remove administrative barriers to provide LARC (e.g., allow billing office visits and LARC procedures on the same day; remove preauthorization requirements).

Many of these barriers require more than a simple coverage change. However, the Legislature could require payers to either make a separate payment for a LARC device when provided after delivery or increase their bundled rate to account for the cost of the device. Either solution would eliminate a barrier to effective contraception.

Impact

Requiring insurers to develop a payment strategy for providing postpartum LARC will increase the number of women receiving effective contraception following pregnancy. It may also decrease future unintended pregnancies.

Clarify that detailed policies regarding coverage of listed preventive services must align with national evidence-based standards (i.e., USPSTF), when applicable

Rationale

Most of the recommended services or procedures in the statute are clinical preventive services, which should be provided at specific intervals or to specific groups of patients. HERC recommends clarifying that listed preventive services coverage policies align with evidence-based guidelines (i.e., U.S. Preventive Services Task Force (USPSTF), when applicable.

Impact

The act is currently unclear whether clinical preventive services need to align with evidence-based guidelines (i.e., USPSTF). This could be misinterpreted to say insurers would be required to cover preventive services not recommended for a particular patient at a specific time. This change would clarify the intent to cover these services in alignment with high-quality evidence.

Conclusion

Implementing these recommendations would increase access to important preventive and reproductive health services. In addition, it would align Oregon's coverage requirements with national standards. These services would be available without cost sharing to Oregonians with commercial insurance, and to low-income Oregonians who could become pregnant and are not eligible for Medicaid due to their immigration status.

HERC appreciates your consideration of these recommendations. We look forward to continuing to assist you, so the list of services established by the Reproductive Health Equity Act reflects the most current information on evidence-based health care.

Oregon Health Authority
HEALTH POLICY & ANALYTICS
Health Evidence Review Commission
Phone: 503-373-1985
Fax: 503-378-5511
Email: HERC.Info@state.or.us

You can get this document in other languages, large print, braille or a format you prefer. Contact HERC at 503-373-1985 or email HERC.Info@state.or.us. We accept all relay calls, or you can dial 711.

OHA 8298 (12/2018)