

---

# Increasing the Use of Postpartum LARC Placement

Quality Health Outcomes Committee (QHOC)  
February 9, 2017

Cat Livingston, MD, MPH, Associate Medical Director, HERC  
Maria Rodriguez, MD, MPH, Department of Obstetrics and Gynecology, OHSU  
Kim Wentz, MD, MPH, Medicaid Medical Director, OHA



Cat Livingston, MD, MPH  
Associate Medical Director  
Health Evidence Review Commission



**HEALTH EVIDENCE REVIEW COMMISSION (HERC)  
COVERAGE GUIDANCE: TIMING OF LONG-ACTING REVERSIBLE  
CONTRACEPTIVE (LARC) PLACEMENT**

Approved 11/10/2016

**HERC Coverage Guidance**

Immediate postpartum and postabortion placement of a long-acting reversible contraceptive (LARC) (implant or intrauterine device) is recommended for coverage (*strong recommendation*).

**HERC approved guideline note,  
effective 1/1/2017**

**GUIDELINE NOTE 162 LONG-ACTING REVERSIBLE CONTRACEPTIVE (LARC)  
PLACEMENT**

*Line 6*

Long-acting reversible contraceptives (implant or intrauterine device) are included on Line 6 in all settings, including (but not limited to) immediately postpartum and postabortion.

The development of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/Pages/blog-long-acting-reversible-contraceptives.aspx>. HERC leadership added a letter (<http://www.oregon.gov/oha/herc/Documents/LARC-Implementation.pdf>) to Medical Directors regarding implementation issues, which references CMS requirements around contraceptive coverage and guidance on ways to implement effective LARC policy.

# Immediate postpartum long acting reversible contraceptives

An important option for maternal and neonatal health

Maria I. Rodriguez, MD MPH



## Benefits to planned pregnancy



Less preterm delivery



30%



53% costs  
\$4.6 billion



Trussell, et al Contraception, 2013.

Flower, et al BMC Pregnancy Childbirth, 2013. Wendt, et al. Paediatric and Perinatal Epidemiology, 2012.



## Why is immediate postpartum LARC an important option?

- 40-57% of women report unprotected intercourse prior to standard postpartum visit
- Many women simply do not attend a postpartum visit
  - 41% attendance in a California Medicaid population
- Many women who want LARC don't get it
  - 63% attendance in an Oregon Medicaid population

ACOG. Committee Opinion 670. August 2016  
Thiel. Obstet Gynecol. August 2013



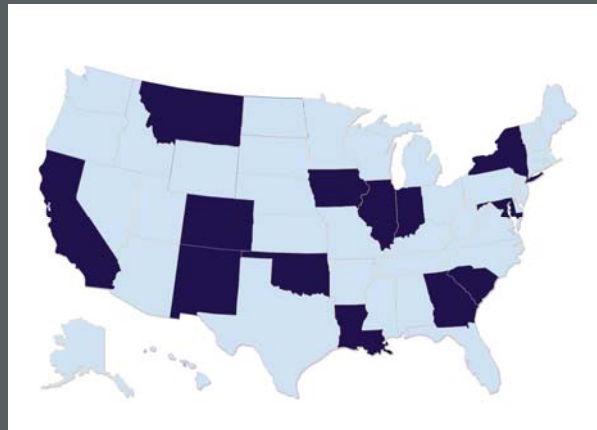
## Postpartum IUD Safety

	LNG-IUS	Copper IUD
< 10 min	2	1
10 min to 4 weeks	2	2
> 4 weeks	1	1
Puerperal sepsis	4	4

World Health Organization. Medical Eligibility Criteria for Contraceptive Use. 2015



## Policy barriers: advocating for access



**ACOG**  
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

the **LARC** program  
Long-Acting Reversible Contraception

States with reimbursement for immediate PP LARC

<http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception>



## Immediate postpartum LARC in Oregon

- OHSU offers postpartum LARC to a limited population (since 2008)
- OHSU Program (2014-2016 data)
- 423 devices placed
  - **Implant 66%**, Copper IUD 5%, LNG IUD 29%
- Payor distribution
  - **Medicaid 65%**, CAWEM 30%, Private 5%



# OHSU Cohort Study

*Postpartum LARC would save Oregon \$2.94  
for every dollar spent*

N=1037	2003	2004	2005	2006
Pregnancies without PP IUD program	27	80	78	81
Costs without PP IUD program	\$213,278	\$637,126	\$631,010	\$636,210
Costs of IUD program	\$106,000	\$14,927	\$16,931	\$15,106
Costs of pregnancies expected with PP IUD program	\$102,310	\$297,970	\$356,180	\$395,320
<b>Net Savings for Oregon</b>	<b>\$4,968</b>	<b>\$324,229</b>	<b>\$257,899</b>	<b>\$225,784</b>

Rodriguez. Contraception. 2010



## Hospital

- Whole site approach for training and implementation
  - Pharmacy
  - Nursing
  - Physicians & Midwives
  - Lactation
- Local champions
  - Didactics
- Evaluation & Monitoring



## Quality and Reimbursement Strategies for Oregon FFS Medicaid

Kim Wentz, MD, MPH  
Medicaid Medical Director  
Oregon Health Authority

### Barriers

- Billing bundled delivery Diagnosis Related Group (DRG) plus LARC insertion and device on the same day = FOF (Fear of Fraud)
- Supply and cost
- Awareness of providers and members
- Guidance: HERC, CMS Bulletins

## Chief barrier: billing bundled inpatient delivery claim and LARC claim on same day

14 states are taking 3 primary approaches:

- Postpartum LARC as an add-on benefit to delivery DRG claim
  - IL, GA, LA, MA, SC
- “Unbundling,” which enables reimbursement of both inpatient and outpatient claims on same day
  - AL, DE, IA, MD, MT, NM, NY, SC
- Enhanced DRG reimbursement
  - CO

## Themes

- Commitment to reimburse full cost of device and insertion
- Mandated elimination of barriers: copays, prior authorization, step-therapy, coverage of removal
- Worked closely with hospital billing staff before, during and after
- Worked closely with internal claims staff
- Maintained federal family planning match
- Everything else was variable!

## FFS approach

### Approach #2: unbundling

- Hospital bills DRG as usual
- Hospital bills LARC device, CPT code for insertion, as separate outpatient claim
- FFS previously “kicks out” second claim if both inpatient and outpatient claims are received for same date
- Now second claim suspends, enters file marked for payment if LARC code “flag” is present on second or first claim
- Use J code for device, CPT code 58300 or 11981, and Family Planning Modifier V25.11

## FFS work plan

### QUALITY

- Collaborate with provider champions
- Work with hospitals
  - Compliance and Clinical Leadership
  - Ongoing technical assistance to Billing staff
- Work with Health Analytics and Public Health

### COMMUNICATIONS

- Alert members and providers
- Present to Oregon Perinatal Collaborative and Oregon Professional Societies

## Quality strategies to consider

- Determine adequacy of fee schedules
- Eliminate any barriers
- Collaborate with local provider champions, professional societies, neighbor CCOs, stakeholders
- Ongoing technical assistance/support to hospitals
- Provider and member education and awareness
- Ensure LARC placement counted in metric
- Provider training
- Labor and Delivery unit tool kits
- Assess baseline utilization and improvement
- Consider a Performance Improvement Project

## Questions?

# HEALTH EVIDENCE REVIEW COMMISSION (HERC) COVERAGE GUIDANCE: TIMING OF LONG-ACTING REVERSIBLE CONTRACEPTIVE (LARC) PLACEMENT

Approved 11/10/2016

## HERC Coverage Guidance

Immediate postpartum and postabortion placement of a long-acting reversible contraceptive (LARC) (implant or intrauterine device) is recommended for coverage (*strong recommendation*).

Note: Definitions for strength of recommendation are provided in Appendix A *GRADE Informed Framework Element Description*.

## RATIONALE FOR DEVELOPMENT OF COVERAGE GUIDANCES AND MULTISECTOR INTERVENTION REPORTS

Coverage guidances are developed to inform coverage recommendations for public and private health plans in Oregon as they seek to improve patient experience of care, population health and the cost-effectiveness of health care. In the era of the Affordable Care Act and health system transformation, reaching these goals may require a focus on population-based health interventions from a variety of sectors as well as individually focused clinical care. Multisector intervention reports will be developed to address these population-based health interventions or other types of interventions that happen outside of the typical clinical setting.

HERC selects topics for its reports to guide public and private payers based on the following principles:

- Represents a significant burden of disease or health problem
- Represents important uncertainty with regard to effectiveness or harms
- Represents important variation or controversy in implementation or practice
- Represents high costs or significant economic impact
- Topic is of high public interest

Our reports are based on a review of the relevant research applicable to the intervention(s) in question. For coverage guidances, which focus on clinical interventions and modes of care, evidence is evaluated using an adaptation of the GRADE methodology. For more information on coverage guidance methodology, see Appendix A.

Multisector interventions can be effective ways to prevent, treat, or manage disease at a population level. For some conditions, the HERC has reviewed evidence and identified effective interventions, but has not made coverage recommendations, as many of these policies are implemented in settings beyond traditional healthcare delivery systems.

## GRADE-INFORMED FRAMEWORK

The HERC develops recommendations by using the concepts of the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system. GRADE is a transparent and structured process for developing and presenting evidence and for carrying out the steps involved in developing recommendations. There are several elements that determine the strength of a recommendation, as listed in the table below. The HERC reviews the evidence and makes an assessment of each element, which in turn is used to develop the recommendations presented in the coverage guidance box. Estimates of effect are derived from the evidence presented in this document. The level of confidence in the estimate is determined by the Commission based on assessment of two independent reviewers from the Center for Evidence-based Policy. Unless otherwise noted, estimated resource allocation, values and preferences, and other considerations are assessments of the Commission.

Outcomes	Estimate of Effect for Outcome/ Confidence in Estimate
<p><b>Unintended Pregnancy</b> (Critical outcome)</p>	<p><u>Postabortion IUD (intention to treat at 6 months):</u> 3/406 (0.74%) for immediate IUD vs. 11/472 (2.3%) for delayed IUD ARD 1.59% RR 0.37 (95% CI 0.12-1.14) ●●●○ (Moderate confidence, based on 3 RCTs, N=878 women)</p> <p><u>Postpartum IUD:</u> 0/85 for immediate IUD vs. 0/85 for delayed IUD The identified systematic review of RCTs did not provide aggregate data on unintended pregnancy. No repeat pregnancies were reported in the 2 included RCTs providing pregnancy outcome data. ●○○○ (Low confidence because no unintended pregnancies were observed, based on 2 RCTs, N=170)</p> <p><u>Implants:</u> No systematic reviews or RCTs were identified addressing immediate postpartum or postabortion implant use and unintended pregnancy.</p>

Outcomes	Estimate of Effect for Outcome/ Confidence in Estimate
<b>Abortion</b> <i>(Critical outcome)</i>	<u>IUDs:</u> None of the identified systematic reviews reported on abortion rates in the follow-up period.  <u>Implants:</u> No systematic reviews or RCTs were identified addressing implants and abortion rates.
<b>Presence of LARC at one year</b> <i>(Important outcome)</i>	None of the identified systematic reviews reported on LARC presence at one year but all reported on presence of an IUD at 6 months based on intention to treat analyses.  <u>Postabortion IUD (Presence at six months, including women who experienced an expulsion followed by reinsertion):</u> 260/406 (64.0%) for immediate IUD vs. 219/472 (46.4%) for delayed IUD ARD=17.6% NNT=6: For 1000 patients treated, 167 more have an IUD in place at 6 months RR 1.4 (95% CI 1.24-1.58) ●●●○ <i>(Moderate confidence, based on 3 RCTs, N=878)</i>  <u>Postpartum IUD (Presence at six months, including women who experienced an expulsion followed by reinsertion):</u> 97/120 (80.8%) for immediate IUD vs. 83/123 (67.4%) for delayed insertion ARD=13.3% NNT=8: For 1000 patients treated, 125 more continue to have an IUD in place at 6 months OR 2.04 (95% CI=1.01-4.09) ●●●○ <i>(Moderate confidence, based on 4 RCTs, N=243)</i>

<p><b>Need for alternate or replacement contraception</b> (e.g., expulsion of IUD, elective, indicated removal of device) <i>(Important outcome)</i></p>	<p><u>Postabortion IUD Expulsion at 6 months:</u> 18/406 (4.4%) for immediate IUD vs. 8/472 (1.7%) for delayed insertion ARD=2.74% NNH=37: For 1000 patients treated, 27 more experience expulsion RR 2.64 (95% CI 1.16-6.0) ●●●○ <i>(Moderate confidence, based on 3 RCTs, N=878)</i></p> <p><u>Postabortion IUD Removal:</u> 20/362 (5.5%) for immediate IUD vs. 12/428 (2.8%) for delayed IUD ARD 2.72% RR 2.01 (95% CI 0.99-4.06) ●●●○ <i>(Moderate confidence, based on 2 RCTs, N=790)</i></p> <p><u>Postpartum IUD Expulsion by 6 months:</u> 19/113 (16.8%) for immediate IUD vs. 3/97 (3.1%) for delayed insertion ARD=13.7% NNH=8: For 1000 patients treated, 125 more experience expulsion OR 4.89 (95% CI 1.47-16.32) ●●●○ <i>(Moderate confidence, based on 4 RCTs, N=210)</i></p> <p><u>Postpartum IUD Replacement:</u> When expulsion occurred after post-cesarean placement, replacement was more common for those undergoing immediate IUD placement (3 out of 4 expulsions in immediate group vs. 0 out of 1 in the delayed group, statistical analysis not reported). No data are available about IUDs placed after vaginal delivery. ●○○○ <i>(Very low confidence, based on one fair quality RCT, N=112)</i></p> <p><u>Implants:</u> No systematic reviews or RCTs were identified addressing implants and need for alternate/replacement contraception.</p>
--	---

Outcomes	Estimate of Effect for Outcome/ Confidence in Estimate
<b>Harms</b> <i>(Important outcome)</i>	<p><i>Important harms specific to IUD insertion include uterine perforations and infections.</i></p> <p><u>Postabortion IUD Perforation:</u>  0/258 for immediate IUD vs.  0/317 for delayed IUD.  No uterine perforations were observed in women randomized to immediate or delayed IUD insertion following first trimester abortion.  ●○○○ <i>(Very low confidence, based on no observed perforations in 1 fair quality RCT, N=575)</i></p> <p><u>Postabortion IUD infection:</u> (Rates of upper genital tract infections).  5/406 (1.2%) for immediate IUD vs.  6/472 (1.3%) for delayed insertion  ARD=0.04%  OR 1.0 (95% CI 0.32-3.14)  ●●●○ <i>(Moderate confidence, based on 3 RCTs, N=878)</i></p> <p><u>Postpartum IUD infections:</u>  2/120 (1.6%) for immediate IUD vs.  2/123 (1.6%) for delayed IUD.  Reports of upper genital tract infections were rare in both groups (no statistical analysis provided).  ●○○○ <i>(Very low confidence, based on 4 cases reported in 4 RCTs, N=243)</i></p> <p><u>Implants:</u>  No systematic reviews or RCTs were identified addressing implants and harms.</p>

**Balance of benefits and harms:**

Although there is insufficient data to show a reduced risk of unintended pregnancy from immediate placement, IUDs are among the most effective forms of contraception. The unintended pregnancies in the included intention-to-treat studies of IUD placement timing occurred almost exclusively in women who failed to return for their follow-up appointments and thus never received an IUD. The lack of statistical significance of the findings on postabortion IUD placement may be a result of differential loss to follow-up among the immediate and delayed study arms and the small study sizes relative to the rare occurrence of selected outcomes. The only “harm” shown by this evidence is an increased risk of IUD expulsion, which is easily remedied and usually without morbidity. Thus, the balance is in favor of immediate placement. Implants are also among the most effective forms of contraception, and there is no evidence of differential harm based on timing of placement.

**Resource Allocation:** The costs of unintended pregnancy are significant. Effective contraception is cost-saving (not just cost-effective). Economic modeling predicts high levels of cost savings from immediate placement of LARC.

**Values and Preferences:** Evidence shows most women of reproductive age desire to control their fertility and time their pregnancies. When women who desire contraception are presented with all contraceptive options, more than 70% select a LARC method, including teens. When women select their preferred contraceptive method, continuation rates across all methods are higher. Evidence about women’s preferences for timing of LARC placement is not available, but low dropout rates in the immediate placement arms of the trials examined here suggest it is an acceptable option for most women choosing an IUD. For IUDs, women would need to balance the higher expulsion rate for immediate insertion against the observed higher perforation rate for actively breastfeeding women with routine (delayed) placement, as well as the convenience and immediate effectiveness of IUDs compared to alternative forms of birth control. For implants, there is no evidence about differential effectiveness or harms based on the timing of placement. Based on these factors, we expect low variability in values and preferences, with most women who have the option choosing immediate placement.

**Other Considerations:**

Missed opportunities for contraception are significant in the postpartum and postabortion periods: 30-40% of insured women do not attend a postpartum visit and 40-75% do not attend a postabortion visit, thus increasing the risk of unplanned pregnancy, abortion, or unmet contraceptive needs. Uninsured women, including those who are no longer covered under the Citizen Alien Waived Emergent Medical (CAWEM) program, may have additional access and financial barriers to obtaining contraception at a future visit. Uninsured women may also struggle to obtain important follow-up care including continued contraceptive management and/or device removal.

Ensuring that women are able to make a free, uncoerced, and informed choice about contraception is important.

**Rationale:** Although there is strong evidence that LARC use reduces unintended pregnancies and abortions, there is not direct randomized evidence comparing the timing of LARC placement (immediate postpartum or postabortion vs. delayed insertion) resulting in lowering rates of subsequent unintended pregnancy or abortion outcomes based on intention-to-treat analyses. However, 13 of the 14 unintended pregnancies in these studies occurred in the delayed placement arm to women without IUDs present.

In addition, there is direct evidence that immediate postpartum and postabortion IUD insertion results in higher LARC use rates at 6 months. Based on evidence of the effectiveness of LARC, this would lead to lower rates of unintended pregnancy and abortion. Although there is an increased rate of IUD expulsion with immediate postpartum insertion, IUD use is still higher at 6 months, and economic analyses show the cost savings from immediate insertion. There is also observational evidence from a study of 61,000 women that a 6-fold risk of uterine perforation exists in actively breastfeeding women with delayed insertion compared to immediate insertion. Immediate postpartum LARC is a highly cost-saving strategy even considering IUD expulsion rates, and with the possibility of avoidance of uterine perforation. For implants, there is no RCT evidence about differences in pregnancy outcomes based on immediate versus delayed implant placement, but the CDC recommends the use of implants immediately postabortion and postpartum, and the disadvantages associated with an increased risk of an IUD expulsion do not exist for implants.

The strong recommendation for coverage for either type of LARC (IUD or implant) is based on existing evidence and guidelines on the benefits of LARC, lack of significant harms for immediate placement, high cost-savings associated with immediate placement, and strong values and preferences.

**Recommendation:** Immediate postpartum and postabortion placement of LARC (implant or intrauterine device) is recommended for coverage (*strong recommendation*).

\*The Quality of Evidence rating was assigned by the primary evidence sources, except where indicated, not the HERC Subcommittee.

Note: GRADE framework elements are described in Appendix A. The GRADE Evidence Profile for these outcomes is provided in Appendix B.

## Prioritized List Guideline Note

*January 1, 2017 Prioritized List*

### **GUIDELINE NOTE 162, LONG-ACTING REVERSIBLE CONTRACEPTIVE (LARC) PLACEMENT**

#### *Line 6*

Long-acting reversible contraceptives (implant or intrauterine device) are included on Line 6 in all settings, including (but not limited to) immediately postpartum and postabortion.

The development of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/Pages/blog-long-acting-reversible-contraceptives.aspx>. HERC leadership added a letter (<http://www.oregon.gov/oha/herc/Documents/LARC-Implementation.pdf>) to Medical Directors regarding implementation issues, which references CMS requirements around contraceptive coverage and guidance on ways to implement effective LARC policy.



November 15, 2016

500 Summer Street NE, E-65  
Salem, OR 97301  
Voice (503) 373-1985  
FAX (503) 378-5511

Dear Medical Directors:

In developing our Coverage Guidance on Timing of Long-Acting Reversible Contraceptive (LARC) Placement, we have become aware that administrative issues, rather than coverage policy per se, are discouraging the use of highly effective LARC devices (intrauterine devices and subdermal implants). While placement of LARC devices is already covered for most plans, administrative issues are preventing patients from receiving these devices at the point when they are most likely to achieve the objective of preventing unintended pregnancy. The LARC devices are safe and effective, and are more cost-effective than any other contraceptive method. For example, one cost-effectiveness analysis found that over 2 years, placement of a postpartum IUD was associated with a savings of \$282,540 per 1,000 women. They cannot be effective or cost-saving, however, unless they are placed.

In order for placement to occur, an appropriate device must be offered and placed at a time convenient to the woman desiring contraception, preferably when she is already receiving care for another condition. Best practices for timing of insertion include placement immediately following birth or abortion, as well as same-day placement in the outpatient setting. Currently, due to administrative barriers, women are often required to return for one or more visits in order to receive a LARC device. Many women do not return for follow up visits, including postpartum visits. Others may become pregnant before such a visit can occur. In order to offer immediate placement, providers must be confident that they and the facilities in which they work will be appropriately compensated for the devices and related care. We have heard reports of major hospital systems halting placement of these devices in the postpartum setting due to reimbursement issues and are aware of others that simply do not offer postpartum LARC placement unless funded through a grant for a very limited population.

As you implement the changes related to this coverage guidance, we urge you to address the following administrative barriers, if they are present in your plans and provider networks.

- Lack of reimbursement for the cost of these devices when provided after an in-hospital birth due to global DRG-based payment for delivery services
- Lack of reimbursement to professionals and facilities for the service of placing these devices in the inpatient setting
- Inadequate inventory of these devices to allow for their placement on a timely basis in all settings of care
- Lack of health system support for the uptake of policies and procedures supporting the immediate placement of LARC.
- Reimbursement rates to providers which are lower than the provider's cost of the devices
- Lack of providers able to perform postpartum placement of IUDs

- For devices provided through a pharmacy benefit, lack of a mechanism for providers to recoup the cost of the device if a device assigned to a particular woman is not placed
- Lack of provider reimbursement when LARC removal, replacement or re-insertion is required
- Any prior authorization requirements, which can delay or block placement of these devices
- Payer refusal to pay for two distinct services on the same day (e.g., a birth or the termination of pregnancy followed by LARC placement)

We have attached two documents to the coverage guidance from the Center for Medicaid and CHIP Services. The first (Appendix F) is an [Informational Bulletin from April, 2016](#) which outlines these issues as well as options other states have implemented to resolve them. Appendix G is a [State Health Official's Letter](#) outlining implementations option for same day LARC placement as well as other coverage requirements for state Medicaid programs, including limitations on prior authorization and applicability to managed care plans.

We hope that this information will help you as you work with your plan and contracted providers to ensure effective access to these important devices.

Sincerely,

Somnath Saha, MD, Chair, Health Evidence Review Commission

Wiley Chan, MD, Chair, Evidence-based Guidelines Subcommittee

Postpartum LARC Update for QHOC 1-9-17, canceled

As presented in previous QHOC meetings, the HERC Coverage Guidance: Timing of Long-Acting Reversible Contraceptive (LARC) Placement, and Guideline Note 162: Long-Acting Reversible Contraceptive (LARC) Placement, were approved 11-10-16 and went into effect 1-1-17. Guideline Note 162 can be found at <http://www.oregon.gov/oha/herc/Pages/Searchable-List.aspx> and the guidance can be found at <http://www.oregon.gov/oha/herc/CoverageGuidances/LARC-CG.pdf>

Postpartum LARC placement is a covered benefit for Medicaid members in CCOs and FFS, both the device and the insertion, effective 1-1-17; however the payment strategies are up to each CCO. As noted in the letter from the HERC to Medical Directors, administrative barriers have been the major reason reimbursement for postpartum LARCs has been lacking; technically they were always covered by Medicaid regardless of setting or timing. <http://www.oregon.gov/oha/herc/Documents/LARC-Implementation.pdf>

Please see the attached directive from CMS April 2016, which includes detailed information on the methods 14 states have used to optimize LARC utilization, in particular postpartum placement, and supply of outpatient clinics. Please see also the directive from CMS June 2016, with additional detail on strategies states can use to reimburse postpartum LARC.

These strategies fall into 3 general categories below with states using each specific strategy:

1. Postpartum LARC as an Add-on Benefit to Delivery Charges: IL, GA, LA, MA, SC
2. “Unbundling” approaches, enabling reimbursement of both an inpatient plus an outpatient claim on the same day: AL, DA, IA, MD, MT, NM, NY, SC
3. Enhanced DRG reimbursement: CO

Oregon FFS has chosen a strategy in the “unbundling” category. Strategies in categories 1 and 3 were not viable given the nature of FFS distribution across the entire state, and the billing and payment methodology available to FFS. However, a small, geographically limited CCO may find it easier to choose a strategy in category #1.

The FFS strategy is based on allowing hospitals to bill a normal delivery DRG claim on the same day as an outpatient claim. The outpatient claim must include the J code (HCPCS) for the device, and the CPT code 58300 for IUD insertion, or 11981 for implant insertion, together with the V25.11 modifier. We have removed an edit from our claims processing, which “kicked-out” the second claim received for the same day, when both an outpatient and an inpatient claim were submitted for the same day for the same member, and a LARC code is present.

FFS is working with hospitals statewide, through the Oregon Association of Hospitals and Health Systems (OAHHS) and their quality organization, Apprise HealthInsights on LARC billing strategy. OHA is also working with compliance specialists and billing staff to provide assurance that this billing methodology for postpartum LARC will not trigger auditing. Additionally, CMS is directing states to consider this strategy to optimize LARC utilization.

OHA is in the process of developing collaborative efforts around the use of LARCs including work with the Oregon Perinatal Collaborative, the Oregon chapter of ACOG, and other professional societies.

In addition to reimbursement of postpartum LARC placement, CCOs are recommended to consider:

1. Review fee schedules for devices and procedure codes to insure adequacy; fee schedules should not dis-incentivize hospitals or providers for either the device or insertion procedure.
2. Insure that no cost-sharing, step-therapy or prior authorization requirements exist for LARCs
3. Collaborate with local hospitals and provider champions
4. Consider provider education for insertion skills and advocacy
5. Alert members and providers to encourage LARC utilization
6. Insure that LARC placement is counted in the effective contraception CCO financial incentive metric
7. Make sure appropriate provider types are able to bill LARC insertion

8. Consider hospital Labor and Delivery toolkits to facilitate postpartum placement
9. Insure that removal of device is covered
10. Consider a performance improvement project

---

**SHO # 16-008**

**Re: Medicaid Family Planning Services  
and Supplies**

June 14, 2016

Dear State Health Official:

The purpose of this letter is to clarify previous guidance on the delivery of family planning services and supplies to all Medicaid beneficiaries, as well as to highlight approaches states may take to ensure timely access to this benefit. Specifically, this letter provides guidance on family planning services provided under both fee-for-service and managed care delivery systems; clarifies the purpose of the family planning visit; offers strategies to reduce barriers to receiving family planning services and supplies; and suggests ways to increase access to contraceptive methods. The guidance in this letter is effective immediately.

**Background**

Under section 1905(a)(4)(C) of the Social Security Act (the Act), family planning services and supplies must be included in the standard Medicaid benefit package and in alternative benefit plans (ABPs). The mandatory family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, a medical visit to change the method of contraception, and (at the state's option) infertility treatment. For expenditures for family planning services and supplies, states receive an enhanced Federal Financial Participation (FFP) of 90 percent.

In addition, section 1902(a)(10)(G) of the Act, as amended by section 2303(a)(3) of the Affordable Care Act, added an optional family planning eligibility group. While full benefit Medicaid eligible individuals receive a wide array of care under other Medicaid coverage categories, individuals in this optional eligibility group are covered only for family planning services and family planning *related* services. Family planning *related* services are medical, diagnostic, and treatment services provided pursuant to a family planning visit that address an individual's medical condition and may be provided for a variety of reasons including, but not limited to: treatment of medical conditions routinely diagnosed during a family planning visit, such as treatment for urinary tract infections or sexually transmitted infection; preventive services routinely provided during a family planning visit, such as the HPV vaccine; or treatment of a major medical complication resulting from a family planning visit. Expenditures for family planning *related* services are matched at the states' regular Federal Medical Assistance Percentage (FMAP). The clarifications in this letter supplement all earlier guidance.

The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Directors letter on July 2, 2010 (SMDL #10-013), which provided guidance on the new optional family planning state plan eligibility group created by section 2303 of the Affordable Care Act. In a subsequent

letter issued on April 16, 2014 (SMDL #14-003), CMS provided additional clarification on coverage of family planning-related services provided to individuals eligible under the new optional family planning state plan group.

### **Applying Family Planning Policy to Fee-for-Service and Managed Care**

In accordance with section 1902(a)(23)(B) of the Act, an individual has free choice of a family planning provider regardless of the state's delivery system (i.e., fee-for-service or managed care) and cannot be required to obtain a referral prior to choosing a provider for family planning services. In managed care, enrollees can select any qualified family planning provider from in-network or out-of-network without referral.

In addition to a beneficiary's free choice of provider, beneficiaries are free to choose the method of family planning as provided for in 42 C.F.R. § 441.20. States must provide that individuals are free from coercion or mental pressure and free to choose the method of family planning to be used. States cannot have requirements that would place an undue burden, coercion, or mental pressure that would impinge on access to family planning services.

While states and managed care plans have the ability to apply medical necessity or utilization control criteria for a beneficiary's request for family planning services, such processes cannot interfere with a beneficiary's freedom to choose the method of family planning or the services or counseling associated with choosing the method. For example, a state or managed care plan cannot require that a particular method be used first (e.g., step therapy) or have in place policies that restrict a change in method (which may involve removal of an implanted or inserted method). The only permissible prior authorization requirement would be the determination that the method is medically necessary and appropriate for the individual, using criteria that may include considerations such as severity of side effects, clinical effectiveness, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service. States and managed care plans should avoid practices that delay the provision of a preferred method or that impose medically inappropriate quantity limits, such as allowing only one long acting reversible contraceptive (LARC) insertion every five years, even when an earlier LARC was expelled or removed. To the extent that states elect to employ utilization practices, they should pursue only those practices that ensure beneficiaries choice in family planning providers and method of contraception.

### **Clarification of the Purpose of the Family Planning Visit**

CMS is clarifying that, when family planning services and supplies are delivered during a medical visit in which family planning and non-family planning services are furnished, expenditures for such family planning services and supplies are eligible for 90 percent FFP. Therefore, if an individual presents at a medical visit for any reason, such as an annual physical exam, and obtains a family planning service or supply for a family planning purpose during that visit, an expenditure for the family planning service or supply, if properly identified on the claim, is eligible for the 90 percent FFP. The family planning purpose must be for the purpose of preventing or delaying pregnancy (or at the state's option, for treating infertility). In order for the state to claim the 90 percent FFP for that family planning service, states must ensure that

provider claims are appropriately documented to reflect the provision of family planning services and supplies.

### **Assuring Access to Family Planning Services and Supplies**

Coverage of specific family planning services and supplies is one key to ensuring access to family planning for Medicaid beneficiaries. However, family planning benefit requirements differ depending on whether a beneficiary has coverage under the traditional state plan benefit package or under an Alternative Benefit Plan (ABP).<sup>1</sup> In general, ABPs allow states flexibility in defining benefit packages that are different from the Medicaid state plan. ABPs must include all Essential Health Benefits (EHBs). Under the Preventive Services EHB category, coverage must include all U.S. Food and Drug Administration (FDA) approved methods of contraception prescribed for women by a health care practitioner. ABPs must cover at least one form of contraception within each method approved by the FDA. For a list of approved methods, see FDA Office of Women’s Health Birth Control Guide available at <http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf>.

For Medicaid beneficiaries whose coverage is governed by the state plan rather than the ABP’s, states may determine the specific services and supplies that will be covered as Medicaid family planning services and supplies so long as those services are sufficient in amount, duration, and scope to reasonably achieve the purpose of preventing or delaying pregnancy and permit beneficiary choice of the method of family planning. Although it is not required, CMS recommends that states cover all FDA-identified contraceptive methods for beneficiaries, including both prescription and non-prescription methods. Because not all forms of contraception are appropriate for all beneficiaries, in the absence of contraindications, patient choice and efficacy should be the principal factors used in choosing one method of contraception over another. One pathway for states to accomplish this would be to align ABP and state plan coverage for these services.

Under both ABP and state plan coverage, whether provided through a fee-for-service or a managed care delivery system, family planning services and supplies, including contraceptives and pharmaceuticals, must be provided without cost sharing pursuant to 42 C.F.R. §447.56(a)(2)(ii) and 42 C.F.R. §438.108. Additionally, existing timely claims payment provisions specified in 42 C.F.R. §447.45 and §447.46 apply to claims for family planning services and supplies. For managed care plans, these provisions apply to claims from in-network and out-of-network providers, unless a mutually agreed to alternative payment schedule is in place.

Other confidentiality requirements protect individuals seeking family planning services. State Medicaid programs and managed care plans are “covered entities” under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Under 45 C.F.R. §164.522(b)(ii), the

---

<sup>1</sup> States are required to provide Medicaid benefits through an ABP for the Medicaid expansion population. The state has the option of providing benefits through an ABP for other populations, otherwise individuals receive traditional state plan benefits.

state Medicaid program and managed care plans must accommodate a beneficiary's reasonable request to receive communications, including explanation of benefits, by alternative means or at an alternative location when the individual clearly states that disclosure could endanger the individual. For example, a beneficiary may request that a plan communicate with her/him via cell phone instead of paper mail. States and managed care plans are responsible for ensuring that beneficiaries are informed of this option. In addition, under 45 C.F.R. §164.522(b)(i), health care providers must accommodate an individual's reasonable request for alternative means of communication in all circumstances. All states and Medicaid managed care plans (and health care providers) should already be ensuring confidentiality as part of their compliance with the HIPAA Privacy Rule.

### **Strategies for Improving Access to Long Acting Reversible Contraceptives (LARCs)**

LARCs, including IUDs and contraceptive implants, are an extremely effective form of contraception. LARCs are administered by physicians and other providers who may administer them within their scope of practice. LARCs may also be cost effective (and when expenditures are federally matched at the 90 percent rate, the costs to states are extremely low). For Medicaid eligible individuals, reimbursement to providers for LARCs should be reasonable and must include not only the insertion and removal of the LARC, but also the LARC itself, even if the service and device are billed and paid separately. CMS issued an informational bulletin on April 8, 2016, highlighting emerging payment approaches that several state Medicaid agencies have used to optimize access to and use of LARCs.<sup>2</sup>

States may cover LARCs through their pharmacy benefit. Covering LARCs through the pharmacy benefit means that dispensing pharmacies bill the state for the LARCs and applicable dispensing fees, then deliver the LARCs to providers for insertion or administration. The provider then bills the state for the furnished insertion or implantation service. These steps may present barriers to access since this process requires the woman to see the provider twice: once to obtain the LARC prescription and then again for insertion or administration. Another challenge is that, absent permissible state policies or prior manufacturer arrangements, providers may not return un-inserted or un-administered LARCs, resulting in waste and financial loss for the state.

Issues have also arisen when states cover LARCs through the medical benefit. In these states, providers can stock the array of LARCs and implant or administer the most appropriate one during the patient's visit, which helps improve access by reducing the need for a second visit. It could also reduce the waste from unused LARCs. High upfront costs required to maintain a stock of LARCs, however, may deter providers from implementing this approach, resulting in barriers to access due to a potential unwillingness of providers to furnish LARCs.

CMS encourages states to explore and pursue the following models, some of which are already being used by states, to overcome administrative and logistical barriers to the provision of LARCs:

---

<sup>2</sup> State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. April 8, 2016. <https://medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf>

First, states are encouraged to implement measures that facilitate immediate postpartum LARC insertion, when a woman chooses this option. As a result of the global or bundled pregnancy and delivery payment arrangements, some states have established policies of not covering additional services provided immediately following delivery. These policies have the effect of deterring providers from inserting LARCs immediately after delivery. In addition, when multiple procedures are performed during a single hospital stay and submitted as a single inpatient claim, if those costs attributable to family planning services are separately identified, the state can receive federal matching funds at the 90 percent rate. To the extent that there are shared costs between family planning services and other services, the state should develop a methodology for allocating these costs. CMS strongly recommends that states establish payment policies that, when a woman chooses, permit and encourage insertion of LARCs immediately following a vaginal delivery or surgical procedure as a separately identified service that is eligible for the 90 percent FFP. CMS also recommends similar policies with respect to coverage of free standing birth center services, which are generally reimbursed at the state's regular FMAP unless the free standing birth center provides family planning services. These services would then be eligible for the 90 percent FFP.

Another approach to ensure same-day access, to the extent permissible, is for publicly funded providers of family planning services who also serve Medicaid patients to pre-purchase and stock their inventories with LARC methods and bill Medicaid or the pertinent third-party payer for the LARC when it is used.

Additionally, states are encouraged to direct pharmacies and providers to utilize programs already established by manufacturers that facilitate stocking providers with LARCs for medical benefit coverage, as well as those that facilitate the return of, and reimbursement by manufacturers to states for unused LARCs dispensed under the pharmacy benefit. Or states can seek to establish new arrangements with LARC manufacturers to increase Medicaid beneficiary access to their LARCs. In one such arrangement piloted in a number of states, the LARC manufacturer proactively furnishes providers with its LARCs without upfront costs. At a reasonable time post-implantation or administration, the manufacturer bills the provider for the cost of the LARC to ensure providers have had the time to be reimbursed by third party payers, including state Medicaid programs. With this approach, providers can be stocked with a supply of LARCs without incurring upfront costs. Providers' funds which would otherwise be invested in inventory could be used in other ways to improve the range and quality of services provided. Beneficiaries would also receive LARCs in a more timely and efficient manner. Lastly, providers may be able to focus more on the provision of healthcare and not the administrative duties related to stocking and being reimbursed for LARCs. This approach is consistent with existing Medicaid policy, including the availability of manufacturer rebates on the drugs.

CMS is also interested in exploring with states the use of section 1115(a) demonstration authority to make available administrative funding at the 90 percent federal matching (authorized by section 1903(a)(5) of the Social Security Act) for states to maintain an inventory of LARCs for providers who furnish covered medical assistance for eligible individuals. The 90 percent federal matching is available for costs related to the state's administration of family planning services and supplies. CMS envisions that, under a section 1115(a) demonstration, the state would incur an administrative expense to purchase a stock for a Medicaid provider for use by

Medicaid beneficiaries. Once the entire stock is used, the state Medicaid agency would re-stock the provider with the same number of LARCs. To be a reasonable administrative cost, the stock would be expected to be used in the course of a period of time, such as a month, and would be replenished as a stock consisting of the same number of items. To account for the costs, states would claim the cost of the stock as a family planning administrative cost, make the stock available without cost to providers, prohibit any further claim by the provider for the cost of LARCs taken from stock for Medicaid use (the provider would bill for insertion or removal of the LARC, but not for the LARC itself), and provide for replenishment of the stock when LARCs are used. CMS will consider other state ideas like this, related to all types of family planning services, subject to the regular process for review, approval, and evaluation of section 1115(a) demonstrations.

### **Clarifying Policies Regarding Sterilization and Delivery**

Federal funds are available for sterilizations as a family planning service, including when the sterilization is provided immediately following delivery with the informed consent of the patient as an add-on procedure. When provided with the informed consent of the patient, postpartum sterilization is an effective form of contraception that provides convenience for the woman, reduces costs, and reduces unplanned pregnancies. All sterilization services require informed consent in accordance with 42 C.F.R., Part 441, Subpart F. The Federally required consent form, without alteration, must be used and consent must be obtained at least 30 days before the sterilization, but not more than 180 days before the date of the sterilization. The only exception is in the case of procedures performed post-premature delivery or following emergency abdominal surgery. Under those exceptions, the informed consent must be given no less than 72 hours prior to the sterilization and, in the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

CMS encourages states to develop appropriate policies and procedures that eliminate barriers to requested postpartum sterilization while ensuring informed consent. Providers should be encouraged to discuss postpartum sterilization with interested patients early in the course of treatment to ensure that the requirements for informed consent and for completion of the consent form are met pursuant to 42 C.F.R., Part 441, Subpart F, to avoid payment disallowances. When a postpartum sterilization is performed that does not comply with the requirements for informed consent described in 42 C.F.R., Part 441, Subpart F, FFP is not available for costs related to the sterilization.

CMS is committed to assuring that all Medicaid beneficiaries have access to and receive vital family planning services and supplies without limitations on their choice of provider or their choice of contraception method. CMS hopes that states find the information and clarifications provided within this letter useful in administering the Medicaid family planning benefit. If you have any questions regarding this information, please contact, Kirsten Jensen, Director, Division of Benefits and Coverage, at 410-786-8146.

Sincerely,  
/s/

Vikki Wachino  
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

AcademyHealth

---

## ***CMCS Informational Bulletin***

**DATE:** April 08, 2016

**FROM:** Vikki Wachino, Director  
Center for Medicaid and CHIP Services

**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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup> While Medicaid agencies typically reimburse for multiple types of contraception, LARCs possess a number of advantages: they are cost-effective, have

---

<sup>1</sup> 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>>.

<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> U.S. Centers for Disease Control. Effectiveness of Family Planning Methods. [http://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive\\_methods\\_508.pdf](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.<sup>5</sup>

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).<sup>6</sup> 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.<sup>7,8</sup> 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.<sup>9</sup> 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.

---

<sup>5</sup> 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.

<sup>6</sup> 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

<sup>7</sup> Committee Opinion No. 615. American College of Obstetricians and Gynecologists. 2015. Access to contraception. *Obstet Gynecol*: 125: 250-5.

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

<sup>9</sup> 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](mailto:karen.matsuoka@cms.hhs.gov) or 410-786-9726.

**Table 1. State Medicaid Payment Strategies to Optimize Long-Acting Reversible Contraception (LARC) Utilization in 14 States**

A scan of state reimbursement policies on LARC was conducted in 2014, resulting in the identification of payment practices in 14 states. This table describes the payment strategies that these 14 states used to optimize LARC utilization. The payment strategy noted for each state is intended to be a short title, while the policy description provides an overview of the key components of the state Medicaid policy that supports the strategy. The implementation considerations are specific details about how the state implements the payment strategy while maintaining compliance with the state policy.

State Effective Date	Payment Strategy	Policy Description	Implementation
<p><b>Alabama</b> <b>April 2014</b></p>	<p>Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting or outpatient practice setting.</p>	<p>1. Covers the cost of the LARC device/drug implant as part of the hospital’s cost, and the insertion of the device/drug implant is billable to Medicaid when the insertion occurs immediately after a delivery before discharge from an inpatient setting.</p> <p>2. Covers the cost of the LARC device/drug implant as part of the hospital’s cost, and insertion is billable to Medicaid when the insertion is provided in an outpatient setting after delivery and immediately after discharge from an inpatient setting.</p>	<p>1. Inpatient: the hospital must use an International Classification of Diseases (ICD-9) delivery diagnosis code within the range 630 – 67914 and must use the ICD-9 surgical code 69.7 (insertion contraceptive device) to document LARC services provided after the Delivery.</p> <p>2. Postpartum LARC in the outpatient hospital setting immediately after discharge from inpatient settings, should be billed on a UB-04 claim form using one code from each of the following with family planning modifier (FP):</p> <ul style="list-style-type: none"> <li>• 58300 Insertion of IUD</li> <li>• 11981-FP Insertion, non-biodegradable drug delivery implant</li> <li>• 11983-FP Removal with reinsertion</li> </ul> <p>ICD-9 diagnosis codes:</p> <ul style="list-style-type: none"> <li>• V255 Encounter for contraceptive management, insertion of implantable</li> </ul>

State Effective Date	Payment Strategy	Policy Description	Implementation
			subdermal contraceptive <ul style="list-style-type: none"> <li>• V2511 Insertion of intrauterine contraceptive device</li> <li>• V2502 Initiate contraceptive NEC</li> <li>• V251 Insertion of IUD</li> </ul> Physician bill on CMS 1500 form using the same coding as above and also indicate Place of Service: <ul style="list-style-type: none"> <li>• 21 Inpatient hospital setting</li> <li>• 22 Outpatient hospital setting</li> </ul>
<b>California July 1, 2015</b>	Reimbursement of LARC	General acute care hospitals may submit claims for the long-acting reversible contraceptive methods on an outpatient claim, even when treatment is provided on an inpatient basis	Hospital LARC claims should be billed using the following Healthcare Common Procedure Coding System (HCPCS) codes: <ul style="list-style-type: none"> <li>• J7300</li> <li>• J7301</li> <li>• J7302</li> <li>• J7307</li> </ul>
<b>Colorado October 2013</b>	Temporary system work-around for reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.	Medicaid Management Information System (MMIS) was scheduled for an update to the APR DRG <sup>1</sup> , in January 2014 to automatically report if a claim includes LARC insertion. For a temporary system work around: <ul style="list-style-type: none"> <li>• The insertion will be reimbursed and paid separately from the global</li> </ul>	1. To receive a LARC payment in addition to the APR DRG, the hospital must include the ICD-9 and Current Procedural Terminology (CPT) codes that are included in the Colorado Medical Assistance Program Revenue Codes UB04/institutional billing form on the same claim as the hospital stay.  2. The “trigger” for LARC payment will be the inclusion of these codes:

<sup>1</sup> 3M™ All Patient Refined Diagnosis-Related Group (APR DRG) Classification System for adjusting data for severity of illness (SOI) and risk of mortality (ROM).

State Effective Date	Payment Strategy	Policy Description	Implementation
	<p>Reimbursements for LARCs outside of the normal encounter (per visit) rate for Rural Health Centers (RHCs)</p>	<p>obstetric fee code.</p> <ul style="list-style-type: none"> <li>State will cover two LARC devices every five years.</li> </ul> <p>RHCs may receive reimbursement for IUDs and implants used for contraceptive purposes in addition to their normal encounter rate reimbursements.</p> <p>Federally Qualified Health Centers (FQHC) do not receive an additional payment for LARCs since the FQHC encounter payment rates are based on “full-cost” reimbursement calculations.</p>	<ul style="list-style-type: none"> <li>V25.11 – encounter for insertion of intrauterine contraceptive device; and/or</li> <li>V25.13 – encounter for removal and reinsertion of intrauterine contraceptive device.</li> </ul> <ol style="list-style-type: none"> <li>For devices purchased under the 340B Program, individual providers and RHCs must bill the actual acquisition cost for the device.</li> <li>Reimbursement will be based on the actual 340B acquisition cost. For devices not purchased through the 340B program, reimbursements are the lower of the provider’s charges or the rate on the Department’s practitioner fee schedule, whichever is applicable.</li> <li>Reimbursement is separate from any encounter payment the RHC may receive for implanting the device.</li> <li>When a LARC is inserted, removed, or reinserted during a visit, the practitioner must use the appropriate diagnostic code, such as, V25.11 or V25.5, and use the family planning modifier (FP) on the claim form.</li> </ol>

State Effective Date	Payment Strategy	Policy Description	Implementation
<p><b>Georgia</b> <b>April 2014</b> <b>for practitioner reimbursement;</b></p> <p><b>Hospital reimbursement to begin in 2016</b></p>	<p>Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.</p>	<ol style="list-style-type: none"> <li>1. Reimburses hospitals and practitioners the cost of the LARC device outside of the global obstetric fee for delivery.</li> <li>2. Georgia policy, regardless of delivery system (FFS or Managed Care Organization (MCO)) defines “immediate postpartum” as within ten minutes of birth.</li> <li>3. Devices should be available in the birthing suite to ensure timely insertion.</li> </ol>	<ol style="list-style-type: none"> <li>1. LARC insertion is considered an add-on benefit and is not included in the DRG reimbursement process.</li> <li>2. Practitioners receive additional reimbursement when one of the following four devices, indicated by their respective J code, is inserted within ten minutes of birth: <ul style="list-style-type: none"> <li>• J7300</li> <li>• J7301</li> <li>• J7302</li> <li>• J7307</li> </ul> </li> </ol>
<p><u><b>Illinois</b></u> <b>October 2012</b></p> <p><b>July 2014</b></p>	<p>Contraceptive Devices in FQHCs and RHCs</p> <p>Dispensing Fee Incentive</p>	<p>FQHCs and RHCs may receive reimbursement for LARC devices (IUDs and single rod implantable devices) for contraceptive purposes.</p> <p>340B providers may receive a dispensing fee add-on when dispensing highly-effective contraceptives</p>	<ol style="list-style-type: none"> <li>1. For devices purchased under the 340B Program, the FQHC or RHC must bill the actual acquisition cost for the device.</li> <li>2. Reimbursement will be based on the actual 340B acquisition costs and must include modifier “UD” in conjunction with the appropriate procedure code. For devices not purchased through the 340B program, reimbursements are the lower of the provider’s charges or the rate on the Department’s practitioner fee schedule, whichever is applicable.</li> </ol>

State Effective Date	Payment Strategy	Policy Description	Implementation
<p><b>October 2014</b></p>	<p>Increased reimbursement for insertion and removal of LARC in the outpatient setting.</p> <p>Allowed reimbursement for office visit along with LARC insertion/removal procedure on the same day.</p> <p>Outpatient provider office stocking.</p>	<p>1. Increased reimbursement rate for insertion/removal procedures of LARC.</p> <p>2. Provide reimbursement for evaluation/management (E/M) visits, where a practitioner and beneficiary discuss contraceptive options, in addition to same day LARC insertion or removal procedures.</p> <p>3. Pilot program to ensure practitioners have sufficient devices stocked, with automatic re-supply as needed.</p>	<p>3. Reimbursement is separate from any encounter payment the FQHC or RHC may receive for implanting the device.</p> <p>1. When a LARC is inserted, removed, or reinserted during a visit, the practitioner uses a modifier V25 on the claim along with the type of visit:</p> <ul style="list-style-type: none"> <li>• Postpartum visit (CPT 59430)</li> <li>• Initial or annual preventive visit (CPT 99381-99397)</li> </ul> <p>2. A practitioner must order the device and document the insertion procedure in both the hospital's and the practitioner's medical record:</p> <p>3. The hospital must use its fee-for-service National Provider Identifier (NPI) to bill the appropriate device or implant (by specific National Drug Code (NDC) on the claim.</p> <p>The hospital must use the appropriate family planning ICD-9-CM diagnosis code (or upon implementation, ICD-10-CM) on the claim.</p>
<p><b>July 1, 2015</b></p>	<p>Reimbursement of LARC insertion immediately postpartum in the inpatient setting.</p>	<p>Medicaid allows hospitals separate reimbursement for the LARC device provided immediately postpartum in the inpatient hospital setting.</p>	
<p><b>Iowa March 2014</b></p>	<p>Reimbursement of LARC insertion immediately</p>	<p>1. Medicaid allows the insertion of IUDs and other LARC devices</p>	<p>1. Practitioners may bill for the professional service associated with insertion of the</p>

State Effective Date	Payment Strategy	Policy Description	Implementation
	postpartum in the hospital setting.	<p>before the beneficiary leaves the hospital following delivery.</p> <p>2. Payment for these services is allowed for both practitioners and hospitals.</p>	<p>LARC with the appropriate CPT code.</p> <p>2. If a practitioner supplies the LARC, the practitioner may also bill for the device(s).</p> <p>3. When hospitals provide the LARC services, the claim must be submitted as an outpatient claim, separate from the inpatient DRG claim for the delivery. The outpatient claim will be based on the fee schedule for the HCPCS Level II procedure code billed.</p>
<p><b>Louisiana</b> <b>June 2014</b></p>	<p>Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.</p>	<p>1. Hospitals and practitioners are reimbursed for LARCs as an add-on service in addition to their daily per diem rate for the inpatient hospital stay (DRG rate) or professional services rate, respectively.</p> <p>2. Reimbursement amount is determined by:</p> <ul style="list-style-type: none"> <li>• LARC service provided (insertion or reinsertion)</li> <li>• IUD or non-biodegradable drug delivery implant</li> <li>• The beneficiary’s age (0 – 15 years or 16+ years)</li> </ul> <p>3. Medical management, including prior authorization and step</p>	<p>1. In FFS: Hospitals use the appropriate LARC J-code on their hospital stay claim.</p> <ul style="list-style-type: none"> <li>• On a paper claim (CMS 1500) “DME” must be written in bold, black print on the top of the form.</li> <li>• If the hospital bills electronically, the 837P must be used with the Durable Medical Equipment (DME) file extension.</li> </ul> <p>2. Payment for the LARC is equal to the DME fee schedule, and added to the amount of the hospital’s per diem payment.</p> <p>3. If a LARC device is expelled after insertion, the state applies a pre-determined cost of reinsertion and replacement device to the standard DRG or professional services rates.</p> <p>4. MCO contracts with the state prohibit</p>



State Effective Date	Payment Strategy	Policy Description	Implementation
	<p>departments or family planning agencies.</p>	<p>into the hospital’s provider base rate calculation.</p> <p>2. Hospital-based practitioners bill the professional claim for surgical procedure through the hospital. The professional claim for hospital-based providers does not include the device.</p> <p>3. Community-based practitioners are reimbursed separately for the professional service of inserting the device as well as the device itself (if supplied by the physician) on the claim.</p>	<p>2. Family planning agencies that participate in MassHealth are reimbursed for the LARC device and insertion when billed with the appropriate code:</p> <p>11981 - Insertion, non-biodegradable drug delivery implant                      11983 - Removal with reinsertion, nonbiodegradable drug delivery implant                      58300 - Insertion of intrauterine device (IUD)                      J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg                      J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg                      S4989 Contraceptive intrauterine device, including implants and supplies</p> <p>3. The community based practitioner is reimbursed separately for the professional service of inserting the device as well as for the device itself if supplied by the physician. Billing is done on a professional claim and paid according to a fee schedule.</p> <p>4. Regular HCPCS updates to capture new device availability</p>
<p><b>Montana</b> <b>January 2015</b></p>	<p>Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.</p>	<p>LARCs inserted at the time of delivery are excluded from the PPS inpatient APR-DRG group. Montana Medicaid is allowing PPS hospitals to unbundle the LARC device and the insertion from the inpatient delivery claim.</p>	<p>These services can now be billed as an outpatient service on a 13X type of bill, and will be paid at the OPSS rates. The following HCPCS/CPT codes are allowed:</p> <ul style="list-style-type: none"> <li>• J7300</li> <li>• J7301</li> <li>• J7302</li> </ul>

State Effective Date	Payment Strategy	Policy Description	Implementation
			<ul style="list-style-type: none"> <li>• J7307</li> <li>• 11981</li> <li>• 58300</li> </ul>
<p><b>New Mexico 2014</b></p>	<p>Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.</p>	<ol style="list-style-type: none"> <li>1. Practitioners receive reimbursement for insertion in the hospital and for the device if the practitioner supplied it.</li> <li>2. Hospitals are reimbursed for the device as a medical supply company.</li> <li>3. Insertion within the same surgery as a Cesarean section is considered incidental to the surgery, and therefore not reimbursed. However, the practitioner will still be reimbursed for the device.</li> </ol>	<ol style="list-style-type: none"> <li>1. Hospitals are reimbursed for the device if:               <ul style="list-style-type: none"> <li>• The facility is enrolled in the New Mexico Medicaid program as a medical supplier (provider type 414); a separate NPI is not required.</li> <li>• Date of service is the same as the DRG date of service.</li> <li>• Hospital’s professional claim (837P electronic claim or CMS-1500 form) is submitted as a medical supply company.</li> <li>• Claim includes the appropriate HCPCS procedure code and NDC number for the device.</li> <li>• Place of service (POS) code is 21 (inpatient hospital).</li> <li>• The billing taxonomy number for a medical supplier appears on the claim (typically 332BOOOOOX).</li> </ul> </li> <li>2. Practitioners are reimbursed for the device and insertion if:               <ul style="list-style-type: none"> <li>• Billed on the same professional claim (837P electronic or CMS-1500 paper) as the delivery procedure.</li> <li>• Claim indicates the device HCPCS code and NDC number.</li> </ul> </li> </ol>

State Effective Date	Payment Strategy	Policy Description	Implementation
			<ul style="list-style-type: none"> <li>• Claim indicates procedure CPT codes (most likely 58300 or 11981).</li> <li>• Claim indicates the POS as 21 (inpatient hospital).</li> </ul>
<p><b>New York April 2014</b></p>	<p>Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.</p>	<ol style="list-style-type: none"> <li>1. Reimbursement provided for the LARC device and insertion during postpartum inpatient hospital stay.</li> <li>2. Medicaid will reimburse for the replacement of IUDs once every five years (Skyla every three years) per manufacturer recommendations. Reimbursement will be provided for an IUD sooner than five years if medically necessary.</li> </ol>	<ol style="list-style-type: none"> <li>1. Hospitals include the LARC invoice separately from the inpatient labor and delivery claim.</li> <li>2. Physicians, midwives, and nurse practitioners may submit a separate claim to FFS Medicaid for their professional services.</li> </ol>

State Effective Date	Payment Strategy	Policy Description	Implementation
<p><u><a href="#">South Carolina</a></u> <b>March 2012</b></p>	<p>Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.</p> <p>Outpatient procedure using specialty pharmacy.</p>	<p>1. Allows reimbursement to the practitioner and hospital for delivery and all costs associated with LARC.</p> <p>2. In the outpatient setting, practitioners may order a LARC device for delivery to the practitioner’s office by a specialty pharmacy.</p> <p>3. Increased LARC reimbursement rate to cover slightly more than the practitioner’s cost to purchase LARC devices to stock in their office.</p>	<p>1. Inpatient reimbursement guidelines for the cost of the LARC in addition to the DRG for labor and delivery:</p> <ul style="list-style-type: none"> <li>• Using the HCPCS code.</li> <li>• Using device J-codes.</li> <li>• Using a family planning modifier on the physician claim when billing for insertion</li> </ul> <p>2. Hospitals are reimbursed for the device by submitting:</p> <ul style="list-style-type: none"> <li>• The ICD-9 Surgical Code</li> <li>• The ICD-9 Diagnosis Codes</li> <li>• A UB-04 or Institutional Claim so that a gross-level credit adjustment can be generated.</li> </ul> <p>3. Payments to hospitals through FFS:</p> <ul style="list-style-type: none"> <li>• DRG portion of the claim will be paid in the regular weekly claims payment cycle.</li> <li>• The LARC reimbursement will process as a gross level credit adjustment and will appear on a future remittance advice on a monthly quarterly basis.</li> </ul> <p>4. Outpatient reimbursement guidelines for the cost of the device:</p> <ul style="list-style-type: none"> <li>• Device can be shipped for a specific patient overnight from specialty</li> </ul>

State Effective Date	Payment Strategy	Policy Description	Implementation
			<p>pharmacy.</p> <ul style="list-style-type: none"> <li>• Device billed directly to Medicaid FFS or the MCO.</li> <li>• The practitioner’s office has 30 days to return the unopened device to the specialty pharmacy if the device is not used for the specific patient for which it was ordered. The cost of the device is then credited back to Medicaid FFS or the MCO.</li> </ul> <p>5. Reimbursement for LARC through MCO’s:                      The LARC policy is a FFS benefit; however, provision of LARC is estimated and included in the MCO’s per member per month (PMPM) rate. Reimbursement methodology may differ between FFS and MCO’s. The state currently includes coverage for the provision of LARCs in both its contractual language and its rate setting methodology with the MCO’s.                      MCOs in the state individually contract with providers and negotiate their rates; claim filing procedures differ based on the MCO.</p>
<b>Texas</b>	Pharmacy reimbursement	1. Texas Health and Human	1. State currently contracts with two

State Effective Date	Payment Strategy	Policy Description	Implementation
<p><b>August 2014</b></p>	<p>for LARC devices.</p>	<p>Services (HHS) allows providers the option to prescribe and obtain a limited number of LARC products from specialty pharmacies and to return unused and unopened LARC products through a “abandoned unit return” program.</p> <p>2. Practitioners may continue to obtain LARC products, then bill for them when they are used under the medical benefit.</p>	<p>specialty pharmacies to deliver Mirena and Skyla to practitioners (Walgreens Specialty Pharmacy, LLC and CVS Caremark Specialty Pharmacy).</p> <p>2. Practitioners continue to bill for the insertion of the LARC product.</p> <p>3. If the patient was eligible for Medicaid on the date of service when the LARC product was prescribed and ordered, but the patient is no longer eligible for Medicaid, when the LARC product is inserted, Medicaid will cover the device but will not reimburse for the insertion procedure claim.</p>

### **Detailed Payment and Policy Approaches of Three Selected States**

Below is a more detailed description of the strategies used by three states (Illinois, Louisiana and South Carolina) to optimize LARC utilization and illustrate the range of approaches they have employed within existing state authorities.

The states were selected based on the range of changes they have implemented and the length of experience they have had implementing these innovative approaches. For example, the state of South Carolina was the first state to implement an immediate postpartum payment for LARC separate from the labor and delivery Diagnosis-Related Group (DRG) payment. Since establishing the policy, the state has addressed implementation challenges and seen improvement in its rates. These more detailed state examples provide greater insight for states considering which options may be most viable to address payment barriers for their Medicaid enrollees.

## Illinois

### **Long-Acting Reversible Contraception (LARC) Optimization Strategies**

#### **SUMMARY**

This document describes payment strategies the Illinois Department of Healthcare and Family Services (HFS) incorporated into its Family Planning Action Plan to increase access to safe and effective LARC.

#### **BACKGROUND**

In 2014, HFS implemented the Family Planning Action Plan to increase access to family planning services for Medicaid beneficiaries by: 1) providing comprehensive and continuous coverage for family planning services; and 2) aligning policies and reimbursement to providers to promote provision of highly effective contraception.<sup>1</sup>

- In 2010, 52 percent of all pregnancies (128,000) in Illinois were unintended.<sup>2</sup>
- Its unintended birth rate was 57 per 1,000 women aged 15-44.
- This same year, the reported public expenditures for family planning client services in Illinois totaled \$57 million, of which \$40.7 million was paid by Medicaid.<sup>3</sup>
- Illinois has the 21st highest pregnancy rate in the nation among adolescents between ages 15 and 19.

To address the rate of unintended pregnancies, the state Medicaid agency implemented several payment strategies to increase access to safe and effective LARC, such as IUDs, in an effort to reduce the number of unintended pregnancies. These strategies are: 1) increased provider reimbursement for insertion and removal of LARC in the outpatient practice setting; 2) provide reimbursement for an evaluation/management (E/M) visit on the same day as LARC insertion or removal procedures; 3) provision for reimbursement of actual LARC acquisition costs under the 340B program to Federally Qualified Health Centers and Rural Health Centers; provision for hospital reimbursement of LARC in addition to the DRG reimbursement for labor and delivery; 5) increased providers' 340B federal drug pricing program dispensing fee to encourage providers to supply LARC and other highly effective methods; and 6) established statewide Medicaid policy for family planning and reproductive health services to improve access to LARC methods.

#### **ILLINOIS MEDICAID REIMBURSEMENT FOR LARC**

Effective July 1, 2015, HFS implemented a policy to allow hospitals to receive separate reimbursement for LARC devices provided immediately postpartum in the inpatient setting, in

---

<sup>1</sup> Illinois Department of Healthcare and Family Services (2014). Important family planning policy change and payment increases. Retrieved from <http://hfs.illinois.gov/assets/101014n1.pdf>.

<sup>2</sup> Guttmacher Institute (2014). State facts about unintended pregnancy: Illinois. Retrieved from <http://www.guttmacher.org/statecenter/unintended-pregnancy/pdf/IL.pdf>.

<sup>3</sup> Sonfield A and Gold RB, Public Funding for Family Planning Sterilization and Abortion Services, FY 1980–2010, New York: Guttmacher Institute, 2012, < <https://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf> >.

addition to the DRG reimbursement for labor and delivery. Providers not employed by the hospital may bill the respective Current Procedural Terminology (CPT) code for LARC insertion in addition to the labor and delivery fee.<sup>4</sup>

Illinois also implemented several other payment strategies that are intended to increase access to LARC placement in the outpatient practice setting.

### ***Reimbursement of LARC Procedures in the Outpatient Practice Setting***

In October 2014, HFS increased the reimbursement rate for the insertion, removal, and reinsertion of IUDs and implants in the outpatient practice setting.<sup>5</sup> HFS increased the reimbursement rate for implant insertions by 20 percent and doubled the reimbursement rate for IUD insertions. LARC insertion and removal procedures may be reimbursed on the same day as evaluation and management visits. Physicians can receive the increased reimbursement for LARC insertion by including the LARC insertion CPT code on their billing form. Physicians can also use the relevant CPT codes to bill for the removal and reinsertion of implants, and removal of IUDS.

### ***Federally Qualified Health Centers (FQHC) and Rural Health Center (RHC)***

Effective October 13, 2012, FQHCs and RHCs may elect to receive reimbursement for implantable contraceptive devices. To the extent that the implantable contraceptive device was purchased under the 340B Drug Pricing Program, the FQHC or RHC must bill the actual acquisition cost for the device. Reimbursement is made at the FQHC or RHC's actual 340B acquisition cost for implantable contraceptive devices purchased through the 340B program. For implantable contraceptive devices not purchased through the 340B program, reimbursement is based on the lower of the provider's charges or the rate on the Department's practitioner fee schedule, whichever is applicable. Reimbursement for the device is separate from encounter payment for related procedures.

### ***Additional Dispensing Fees to Providers***

Effective July 2014, HFS increased the dispensing fee add-on payment to \$35 for providers who dispense highly-effective contraceptives through the 340B federal drug pricing program. In order to receive the additional fee, providers must identify 340B purchased drugs by reporting modifier "UD" in conjunction with the appropriate procedure code and actual acquisition cost for the birth control method on the claim form.

---

<sup>4</sup> Illinois Department of Healthcare and Family Services (2015). Informational Notice: Hospital Billing and Reimbursement for Immediate Postpartum Long-Acting Reversible Contraceptives. Retrieved from <http://www.hfs.illinois.gov/html/063015n.html>.

<sup>5</sup> Illinois Department of Healthcare and Family Services (2014). Important family planning policy change and payment increases. Retrieved from <http://hfs.illinois.gov/assets/101014n1.pdf>.

### ***Approaches for Managed Care Entities***

The state's actuarially sound rates include reimbursement for LARC devices and clinical insertion. The state's external quality review organization (EQRO) has developed a family planning readiness review tool and reviews the plans' family planning policies and procedures. Additionally, the MCO contract was revised to include language that provider policies/protocols shall not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements; and that clients should receive education and counseling on all FDA-approved birth control methods from most effective to least effective, and have the option to choose the preferred birth control method that is most appropriate for them.<sup>6</sup>

### ***Pharmaceutical Pilot Programs in Outpatient Settings***

HFS is piloting a new program with Bayer HealthCare (Mirena and Skyla) and Teva Pharmaceuticals (Paragard) to make these products available in physician offices without upfront physician costs. This will allow for an inventory of these LARC devices so that they are available when a patient returns for a postpartum visit, or at their annual reproductive health visit. If the patient decides she wants to use this type of contraception, it can be inserted immediately and the patient will not have to return for a second visit. This will improve the efficiency of this program and should lead to increased use of these devices. If deemed successful, the pharmaceutical companies plan to scale the program to a national level.<sup>7</sup>

## **OUTCOMES**

While the impact of these payment strategies have not yet been assessed, Illinois expects that improved access to contraceptive care for low-income women will result in savings due to a decrease in unintended pregnancies and the associated costs.

---

<sup>6</sup> Wheal, L. (2015). Interview with Illinois Medicaid.

<sup>7</sup> Illinois Department of Healthcare and Family Services (2014). Family Planning and Reproductive Health Services. Retrieved from <http://www.hfs.illinois.gov/assets/062614n1.pdf>.

## Louisiana

### **Long-Acting Reversible Contraception (LARC) Optimization Strategies**

#### **SUMMARY**

This document describes a payment strategy the Louisiana Medicaid agency implemented to increase access to safe and effective LARC.

#### **BACKGROUND**

Prior to June 2014, Louisiana covered LARC devices under the pharmacy benefit. In the clinical setting, the pharmacy reimbursement rate for LARC devices was approximately \$300 less than what the LARC devices cost; hence, physicians who provided LARC devices in the hospital setting suffered financial loss.<sup>8</sup> Furthermore, physicians were not reimbursed for 30 percent of the LARC devices ordered at the time of consent in the hospital, due to the failure of the patients for whom the device was ordered to return for subsequent insertion in the office practice setting.<sup>9</sup>

- In 2010, 60 percent of all pregnancies (53,000) in Louisiana were unintended.
- That same year, the reported public expenditures for family planning client services in Louisiana totaled \$39.3 million; this includes \$34.5 million through Medicaid.<sup>10</sup>

To address the high rate of unintended pregnancies, Louisiana Medicaid initiated a process to increase LARC utilization that included: 1) LARC reimbursement for insertion immediately after delivery in the inpatient hospital setting; 2) provider education; 3) adjustments in its State Plan Amendment (SPA) to allow more flexibility in inpatient and outpatient LARC reimbursement; and 4) the inclusion of LARC reimbursement requirements in its MCO contracts.

#### **LOUISIANA MEDICAID REIMBURSEMENT FOR LARC**

Effective June 2014, the Louisiana Department of Health and Hospitals implemented a LARC reimbursement policy as a central component to reducing the number of unintended pregnancies among low-income women. This policy increases access to LARC placement in the inpatient hospital setting immediately after delivery and before the patient is discharged from the facility by:

- Allowing hospitals to receive reimbursement for the full cost of five LARC devices (Skyla, ParaGard, Nexplanon, Merina, and Norplant) in addition to the DRG that is normally paid to hospital.<sup>11</sup> Manufacturer wholesale prices are re-evaluated and re-adjusted annually.

---

<sup>8</sup> Gee, R. (2014). Interview with Louisiana Medicaid Medical Director.

<sup>9</sup> Gee, R. (2015). Interview with Louisiana Medicaid Medical Director.

<sup>10</sup> Guttmacher Institute (2014). State facts about unintended pregnancy: Louisiana. Retrieved from <http://www.guttmacher.org/statecenter/unintended-pregnancy/pdf/LA.pdf>.

<sup>11</sup> Louisiana Medicaid Management Information System (2015). Louisiana Medicaid professional services fee schedule. Retrieved from [http://www.lamedicaid.com/provweb1/fee\\_schedules/FEESCHED.pdf](http://www.lamedicaid.com/provweb1/fee_schedules/FEESCHED.pdf).

- Allowing hospitals or physicians receive additional fees for LARC insertion.
- Eliminating the use of medical management activities, such as prior authorization or step therapy, for LARC devices or procedures.<sup>12</sup>

### ***Hospital Reimbursement of LARC Insertion Immediately Postpartum***

The recent changes in Louisiana Medicaid payment policies provide reimbursement to acute care hospitals for LARC devices inserted immediately postpartum and prior to discharge.<sup>13,14</sup> The state is separately reimbursing the hospital both for the cost of the LARC device as well as its insertion procedure in order to clearly demonstrate to hospitals that they are fully reimbursed for LARC costs according to the Louisiana Medicaid fee schedule for durable medical equipment (DME).<sup>15</sup>

Louisiana MCOs have also supported and willingly adopted coverage and the reimbursement policy for postpartum LARC insertion. The hospital and the provider must submit their claims to the MCO for payment. The reimbursement rates are established by the MCO.<sup>16</sup>

### ***Practitioner Reimbursement of LARC Insertion***

Practitioners who insert a LARC device immediately post-delivery receive separate reimbursement for this service as defined in the Professional Services Program.<sup>17</sup> In the event that a LARC device is expelled after insertion, Louisiana factors the cost of the expulsion into the reimbursement and also pays for reinsertion of a new LARC. Adding the LARC devices to the physician schedule rather than just the pharmacy schedule allows the physician to store the device in office and not have to provide it to a specific individual.<sup>18</sup>

### ***Capitated Managed Care Implementation***

Louisiana Medicaid is completing a three year transition from a FFS reimbursement model to mandatory managed care, which will account for 95 percent of all Medicaid enrollees by December 2015. Based on retrospective data, Louisiana Medicaid negotiates blended capitated

---

<sup>12</sup> Gee, R. (2015). Interview with Louisiana Medicaid Medical Director.

<sup>13</sup> Hospitals record the appropriate LARC J-code on the paper CMS1500 claim form with “DME” written in bold, black print on the top of the form when submitting their claim to the Fiscal Intermediary (FI). When the hospital bills electronically, the 837P must be used with the DME file extension. The Louisiana Medicaid DME fee Schedule J codes are only intended for use on Inpatient Claims.

<sup>14</sup> Foubister, V. (2013). Case study: Louisiana’s poor rankings make improving birth outcomes a state imperative. Quality Matters. Retrieved from <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2013/february-march/case-study>.

<sup>15</sup> Louisiana Department of Health and Hospitals (2014). Long acting reversible contraceptives (LARCs) for inpatient hospitals. Retrieved from <http://dhh.louisiana.gov/assets/docs/BayouHealth/HealthPlanAdvisories/2014/HPA14-9.pdf>.

<sup>16</sup> Gee, R. (2014). Interview with Louisiana Medicaid Medical Director.

<sup>17</sup> Practitioners include the LARC insertion code with the family planning modifier on their billing form (CMS 1500 or electronic equivalent). The reimbursement is dependent on the LARC service provided and the patient’s age. The global CPT codes include: 11981 - Insertion, non-biodegradable drug delivery implant; and 58300 - Insertion of intrauterine device (IUD).

<sup>18</sup> Gee, R. (2015). Interview with Louisiana Medicaid Medical Director.

per member per month (PMPM) fees to account for projected LARC insertions. MCO contracts require hospital and practitioner reimbursement for LARC devices and procedures at a minimum of the FFS fee schedules for the same DME or CPT codes, respectively. In addition, the MCOs are not permitted to require prior authorization for LARC devices or procedures.

All five Louisiana Medicaid MCOs voluntarily adopted the LARC reimbursement strategy. The MCO contracts contain a requirement for developing birth outcomes quality improvement programs that align with the state's goals, and a one percent withhold of MCO administrative fees to fund shared savings-based pay for performance (P4P) incentives. These provide clear boundaries and predictable revenues that allow MCOs maximum flexibility in their interactions with their network providers and the incentives they offer providers and/or patients.

The Louisiana Medicaid agency achieved the legal authority to require MCOs to fully participate in LARC quality improvement efforts in four phases:

1. Applied non-payment strategies such as provider and MCO education and outreach to establish expectations for MCO performance;
2. Presented a compelling case for the political support needed to establish birth outcomes as the state's highest health priority;
3. Submitted a SPA to include LARC utilization payment policies as a strategy to improve birth outcomes; and
4. Aligned MCO contractual requirements with state Medicaid FFS payment strategies to increase LARC utilization.<sup>19</sup>

## **ANTICIPATED OUTCOMES**

Changes to reimbursement of LARC devices and procedures in the hospital were initiated in 2014. The Louisiana Medicaid Medical Director reports that due to these payment policy changes, voluntary election of LARC insertions increased from nine percent (7,000) of all child-bearing aged enrollees in 2013 to 11 percent (10,000) in 2014.

---

<sup>19</sup> Gee, R. (2015). Interview with Louisiana Medicaid Medical Director.

## South Carolina

### **Long-Acting Reversible Contraception (LARC) Optimization Strategies**

#### **SUMMARY**

The South Carolina Birth Outcomes Initiative (SCBOI) launched in July 2011 to improve maternal and infant health outcomes and to reduce Medicaid costs. The SCBOI has supported the development and implementation of a LARC payment policy, which is a central component of South Carolina's effort to reduce the number of unintended pregnancies among low-income women and at-risk adolescents.

#### **BACKGROUND**

Low-income women of childbearing age who are sexually active with limited access to effective contraception and family planning services are likely to have unintended pregnancies and increase Medicaid spending.<sup>30</sup>

- In 2010, public expenditures for family planning services in South Carolina totaled \$33.7 million, including \$25 million paid by Medicaid.<sup>31</sup>
- In 2011, South Carolina ranked as the 12th highest state in teen pregnancy.<sup>32</sup>
- Only 50% of Medicaid-covered postpartum women in South Carolina attend the postpartum visit.

To address this problem, South Carolina Department of Health and Human Services (SCDHHS) leveraged their Birth Outcome Initiative (BOI), an active collaborative of hospitals, providers, and policymakers, to increase LARC placements through changes to existing payment policies. Payment policy changes included 1) increased reimbursement for LARC devices; 2) reimbursement of LARC insertion immediately postpartum; and 3) supply management through the pharmacy benefit.

#### **SOUTH CAROLINA MEDICAID REIMBURSEMENT FOR LARC**

The selected payment strategies are intended to increase access to LARC placement in both the inpatient hospital setting as well as the outpatient practice setting. Key elements of the reimbursement strategy include:

- Funding the full costs of four LARC devices (Skyla, ParaGard, Nexplanon, and Mirena).

---

<sup>30</sup> Guttmacher Institute (2014). State facts about unintended pregnancy: South Carolina. Retrieved from <http://www.guttmacher.org/statecenter/unintended-pregnancy/SC.html>.

<sup>31</sup> Sonfield A and Kost K, Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010, New York: Guttmacher Institute, 2015, <<http://www.guttmacher.org/pubs/public-costs-of-UP-2010.pdf>>.

<sup>32</sup> U.S. Department of Health and Human Services Office of Adolescent Health (2014). South Carolina adolescent reproductive health facts. Retrieved from <http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/states/sc.html#>.

- Providing additional fees for insertion, device, and removal (if medically necessary) in addition to the DRG fee that is paid to hospital.
- Eliminating prior-authorization or step therapy requirements for LARC procedures.

### ***Reimbursement of LARC Insertion Immediately Postpartum in the Hospital***

In March 2012, the South Carolina became the first state in the country to change its reimbursement policy in order to increase LARC placement immediately after delivery and prior to hospital discharge.<sup>33</sup> Prior to that time, hospitals were not incentivized to perform this procedure due to the lack of payment for this activity (beyond the existing DRG payment). South Carolina's Medicaid program now reimburses hospitals the cost of the LARC device as well as payment to the physician for its insertion immediately post-delivery. This LARC reimbursement is provided in addition to any other payments for maternity related services.

Hospitals receive this increased payment through a quarterly adjustment for prior month's claims (credit adjustment). To receive reimbursement for the LARC device itself, hospitals must include on each Uniform Billing (UB-04) claim for delivery services the Healthcare Common Procedure Coding System (HCPCS) code that represents the device. As well as the International Classification of Diseases (ICD-9) Surgical and Diagnosis Codes that best describe the service delivered.

Physicians may also receive reimbursement for immediate post-delivery LARC insertion by including on their billing form (CMS 1500 or electronic equivalent) the LARC insertion code with the family planning modifier.

After the first year of implementation, South Carolina Medicaid learned that hospitals were not receiving the additional LARC payments; further implementation guidance and system changes were needed. In the second year of implementation, all Medicaid providers received specific billing instructions identifying how to capture appropriate reimbursement for all fees covered by the payment policy. By the third year of implementation, providers were receiving appropriate reimbursement, including retrospective payments that previously had not been billed or processed accurately.<sup>34</sup>

These new payments reimburse all costs and clinical efforts associated with LARC placement and promote a highly cost-effective, preventive health practice. However, payment alone is not sufficient to ensure LARC placements. This strategy also requires continued collaboration with MCOs, hospitals, and physicians to ensure that all stakeholders understand the purpose of these increased payments and the impact LARC will have on reducing unintended pregnancies and Medicaid costs.

### ***Reimbursement of LARC Insertion in the Outpatient Practice Setting***

---

<sup>33</sup> Health Management Associates (2013). Medicaid reimbursement for immediate post-partum LARC. Retrieved from <https://www.acog.org/~media/Departments/LARC/HMAPostpartumReimbursementResource.pdf>.

<sup>34</sup> Giese, M. (2015). Interview with SCDHHS Director of Birth Outcomes Initiative.

SCDHHS also addressed the initial costs to providers for stocking LARC devices in its SCBOI “specialty benefit” in the spring of 2014. The new payment policy allows a physician to order a LARC device for a specific Medicaid recipient which is shipped to the physician’s office by a specialty pharmacy which is designated by either the state Medicaid agency’s Pharmacy Benefit Manager or by the individual MCO’s. The device can be shipped overnight and is billed directly to Medicaid FFS or the MCO so that the physician does not incur the initial cost of the device. The physician’s office has 30 days to insert the LARC for the specific patient for which it was ordered and bill Medicaid the insertion fee only, or to return the unopened device to the specialty pharmacy if the device is not used. The cost of the device is then credited back to Medicaid or the MCO.

### ***Capitated Managed Care Implementation***

Managed care enrollment is mandatory in South Carolina. As a result, approximately 90 percent of all Medicaid births are covered by the six fully capitated MCOs. Although the Medicaid agency did not require its capitated MCOs to adopt this payment policy, all six of them did so voluntarily.

In the first year of implementation of the policy, South Carolina did not develop a payment mechanism specifically for the MCOs to provide this service. Instead, the additional fees associated with LARC payments were prospectively estimated and included in the actuarially sound MCO per member per month (PMPM) rate. The MCO then provides the additional payments to the clinicians in the MCO’s network through their negotiated contractual rates. It is not possible to compare the differences in LARC utilization between the MCO and FFS populations (90 percent and 10 percent, respectively).

The MCOs use their regular claims processing cycles to pay for these LARC services and don’t have a special process like FFS Medicaid, which was described earlier.

### **OUTCOMES**

As noted above, South Carolina initiated changes to the reimbursement of LARC devices and procedures in the hospital setting in March 2012 and issued a clarification bulletin for billing in 2013 which allowed for appropriate claims payment dating back to the inception of the policy. Although the impact of both of these policy changes has not yet been fully evaluated, South Carolina has documented that their rate of voluntary election of inpatient insertions has gone from approximately 0% to 16%. South Carolina also has seen a 110% increase in inpatient LARC utilization between FY2013 through FY 2015.