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CMCS Informational Bulletin

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

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

Background

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

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

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

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

LARC Utilization and Medicaid Reimbursement

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

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

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

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

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

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

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

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

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

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

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

State Medicaid Payment Strategies to Optimize LARC Utilization

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

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

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

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
Alabama April 2014	Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting or outpatient practice setting.	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. 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.	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. 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): • 58300 Insertion of IUD • 11981-FP Insertion, non-biodegradable drug delivery implant • 11983-FP Removal with reinsertion ICD-9 diagnosis codes: • V255 Encounter for contraceptive management, insertion of implantable

State Effective Date	Payment Strategy	Policy Description	Implementation
			subdermal contraceptive • V2511 Insertion of intrauterine contraceptive device • V2502 Initiate contraceptive NEC • V251 Insertion of IUD Physician bill on CMS 1500 form using the same coding as above and also indicate Place of Service: • 21 Inpatient hospital setting • 22 Outpatient hospital setting
California July 1, 2015	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: • J7300 • J7301 • J7302 • J7307
Colorado October 2013	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[1], in January 2014 to automatically report if a claim includes LARC insertion. For a temporary system work around: • The insertion will be reimbursed and paid separately from the global	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:

[1] 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
		obstetric fee code. • State will cover two LARC devices every five years.	• V25.11 – encounter for insertion of intrauterine contraceptive device; and/or • V25.13 – encounter for removal and reinsertion of intrauterine contraceptive device.
	Reimbursements for LARCs outside of the normal encounter (per visit) rate for Rural Health Centers (RHCs)	RHCs may receive reimbursement for IUDs and implants used for contraceptive purposes in addition to their normal encounter rate reimbursements. 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.	1. For devices purchased under the 340B Program, individual providers and RHCs must bill the actual acquisition cost for the device. 2. 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. 3. Reimbursement is separate from any encounter payment the RHC may receive for implanting the device. 4. 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.

State Effective Date	Payment Strategy	Policy Description	Implementation
Georgia **April 2014 for practitioner reimbursement;** **Hospital reimbursement to begin in 2016**	Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.	1. Reimburses hospitals and practitioners the cost of the LARC device outside of the global obstetric fee for delivery. 2. Georgia policy, regardless of delivery system (FFS or Managed Care Organization (MCO)) defines "immediate postpartum" as within ten minutes of birth. 3. Devices should be available in the birthing suite to ensure timely insertion.	1. LARC insertion is considered an add-on benefit and is not included in the DRG reimbursement process. 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: • J7300 • J7301 • J7302 • J7307
Illinois **October 2012** **July 2014**	Contraceptive Devices in FQHCs and RHCs Dispensing Fee Incentive	FQHCs and RHCs may receive reimbursement for LARC devices (IUDs and single rod implantable devices) for contraceptive purposes. 340B providers may receive a dispensing fee add-on when dispensing highly-effective contraceptives	1. For devices purchased under the 340B Program, the FQHC or RHC must bill the actual acquisition cost for the device. 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.

State Effective Date	Payment Strategy	Policy Description	Implementation
			3. Reimbursement is separate from any encounter payment the FQHC or RHC may receive for implanting the device.
October 2014	Increased reimbursement for insertion and removal of LARC in the outpatient setting. Allowed reimbursement for office visit along with LARC insertion/removal procedure on the same day. Outpatient provider office stocking.	1. Increased reimbursement rate for insertion/removal procedures of LARC. 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. 3. Pilot program to ensure practitioners have sufficient devices stocked, with automatic re-supply as needed.	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: • Postpartum visit (CPT 59430) • Initial or annual preventive visit (CPT 99381-99397) 2. A practitioner must order the device and document the insertion procedure in both the hospital's and the practitioner's medical record:
July 1, 2015	Reimbursement of LARC insertion immediately postpartum in the inpatient setting.	Medicaid allows hospitals separate reimbursement for the LARC device provided immediately postpartum in the inpatient hospital setting.	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. The hospital must use the appropriate family planning ICD-9-CM diagnosis code (or upon implementation, ICD-10-CM) on the claim.
Iowa **March 2014**	Reimbursement of LARC insertion immediately	1. Medicaid allows the insertion of IUDs and other LARC devices	1. Practitioners may bill for the professional service associated with insertion of the

State Effective Date	Payment Strategy	Policy Description	Implementation
	postpartum in the hospital setting.	before the beneficiary leaves the hospital following delivery. 2. Payment for these services is allowed for both practitioners and hospitals.	LARC with the appropriate CPT code. 2. If a practitioner supplies the LARC, the practitioner may also bill for the device(s). 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.
Louisiana **June 2014**	Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.	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. 2. Reimbursement amount is determined by: • LARC service provided (insertion or reinsertion) • IUD or non-biodegradable drug delivery implant • The beneficiary's age (0 – 15 years or 16+ years) 3. Medical management, including prior authorization and step	1. In FFS: Hospitals use the appropriate LARC J-code on their hospital stay claim. • On a paper claim (CMS 1500) "DME" must be written in bold, black print on the top of the form. • If the hospital bills electronically, the 837P must be used with the Durable Medical Equipment (DME) file extension. 2. Payment for the LARC is equal to the DME fee schedule, and added to the amount of the hospital's per diem payment. 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. 4. MCO contracts with the state prohibit

State Effective Date	Payment Strategy	Policy Description	Implementation
		therapy, are prohibited for LARC devices and procedures.	prior authorization for LARC devices or procedures. Further, 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.
Maryland **July 2013** **September 2014**	Contraceptive Devices in FQHCs Reimbursement of LARC insertion immediately postpartum in the inpatient setting	FQHCs are reimbursed for an office visit and the acquisition cost for one (1) of the three (3) covered LARC ~~procedures~~ devices. LARC devices and insertion procedures are reimbursable and are separate from the delivery fee (Maryland Medicaid does not reimburse physicians for "global" maternity care services; deliveries are billed separately from prenatal care).	Practitioners receive reimbursement for one of the three devices, as indicated by their respective J code: • J7300 • J7302 • J7307 1. Maryland Medicaid reimburses for all LARCs, including those placed immediately postpartum without preauthorization. 2. Hospitals include the LARC invoice separately from the inpatient labor and delivery claim using the appropriate claims using the appropriate codes and modifiers.
Massachusetts **October 2014**	Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting. Comprehensive LARC coverage for outpatient practice settings such as hospital outpatient	1. Hospitals are reimbursed for the provision of the LARC device. The insertion procedure is reimbursed directly through the claim payment, while the device is reimbursed indirectly as part of the hospital's base rate. The device is reported on the annual cost report as a supply, and those costs are incorporated	1. MassHealth payment methodology recently adopted the APR DRG model by 3M Health Information Systems, which weights every service that is entered on the claim. The device is accounted for on the annual hospital cost report, and these costs are incorporated into the hospital's overall provider base rate.

State Effective Date	Payment Strategy	Policy Description	Implementation
	departments or family planning agencies.	into the hospital's provider base rate calculation. 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. 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.	2. Family planning agencies that participate in MassHealth are reimbursed for the LARC device and insertion when billed with the appropriate code: 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 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. 4. Regular HCPCS updates to capture new device availability
Montana January 2015	Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.	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.	These services can now be billed as an outpatient service on a 13X type of bill, and will be paid at the OPPS rates. The following HCPCS/CPT codes are allowed: • J7300 • J7301 • J7302

State Effective Date	Payment Strategy	Policy Description	Implementation
			• J7307 • 11981 • 58300
New Mexico 2014	Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.	1. Practitioners receive reimbursement for insertion in the hospital and for the device if the practitioner supplied it. 2. Hospitals are reimbursed for the device as a medical supply company. 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.	1. Hospitals are reimbursed for the device if: • The facility is enrolled in the New Mexico Medicaid program as a medical supplier (provider type 414); a separate NPI is not required. • Date of service is the same as the DRG date of service. • Hospital's professional claim (837P electronic claim or CMS-1500 form) is submitted as a medical supply company. • Claim includes the appropriate HCPCS procedure code and NDC number for the device. • Place of service (POS) code is 21 (inpatient hospital). • The billing taxonomy number for a medical supplier appears on the claim (typically 332BOOOOOX). 2. Practitioners are reimbursed for the device and insertion if: • Billed on the same professional claim (837P electronic or CMS-1500 paper) as the delivery procedure. • Claim indicates the device HCPCS code and NDC number.

State Effective Date	Payment Strategy	Policy Description	Implementation
			• Claim indicates procedure CPT codes (most likely 58300 or 11981). • Claim indicates the POS as 21 (inpatient hospital).
New York April 2014	Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting.	1. Reimbursement provided for the LARC device and insertion during postpartum inpatient hospital stay. 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.	1. Hospitals include the LARC invoice separately from the inpatient labor and delivery claim. 2. Physicians, midwives, and nurse practitioners may submit a separate claim to FFS Medicaid for their professional services.

State Effective Date	Payment Strategy	Policy Description	Implementation
South Carolina **March 2012**	Reimbursement of LARC insertion immediately postpartum in the inpatient hospital setting. Outpatient procedure using specialty pharmacy.	1. Allows reimbursement to the practitioner and hospital for delivery and all costs associated with LARC. 2. In the outpatient setting, practitioners may order a LARC device for delivery to the practitioner's office by a specialty pharmacy. 3. Increased LARC reimbursement rate to cover slightly more than the practitioner's cost to purchase LARC devices to stock in their office.	1. Inpatient reimbursement guidelines for the cost of the LARC in addition to the DRG for labor and delivery: • Using the HCPCS code. • Using device J-codes. • Using a family planning modifier on the physician claim when billing for insertion 2. Hospitals are reimbursed for the device by submitting: • The ICD-9 Surgical Code • The ICD-9 Diagnosis Codes • A UB-04 or Institutional Claim so that a gross-level credit adjustment can be generated. 3. Payments to hospitals through FFS: • DRG portion of the claim will be paid in the regular weekly claims payment cycle. • The LARC reimbursement will process as a gross level credit adjustment and will appear on a future remittance advice on a monthly quarterly basis. 4. Outpatient reimbursement guidelines for the cost of the device: • Device can be shipped for a specific patient overnight from specialty

State Effective Date	Payment Strategy	Policy Description	Implementation
			pharmacy. • Device billed directly to Medicaid FFS or the MCO. • 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. 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.
Texas	Pharmacy reimbursement	1. Texas Health and Human	1. State currently contracts with two

State Effective Date	Payment Strategy	Policy Description	Implementation
August 2014	for LARC devices.	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. 2. Practitioners may continue to obtain LARC products, then bill for them when they are used under the medical benefit.	specialty pharmacies to deliver Mirena and Skyla to practitioners (Walgreens Specialty Pharmacy, LLC and CVS Caremark Specialty Pharmacy). 2. Practitioners continue to bill for the insertion of the LARC product. 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.

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.[1]

- In 2010, 52 percent of all pregnancies (128,000) in Illinois were unintended.[2]
- 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.[3]
- 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

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[1] 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.
[2] Guttmacher Institute (2014). State facts about unintended pregnancy: Illinois. Retrieved from http://www.guttmacher.org/statecenter/unintended-pregnancy/pdf/IL.pdf .
[3] 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.[4]

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.[5] 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.

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[4] 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 .

[5] 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.[6]

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.[7]

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.

[6] Wheal, L. (2015). Interview with Illinois Medicaid.
[7] 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.[8] 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.[9]

- 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.[10]

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.[11] Manufacturer wholesale prices are re-evaluated and re-adjusted annually.

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[8] Gee, R. (2014). Interview with Louisiana Medicaid Medical Director.
[9] Gee, R. (2015). Interview with Louisiana Medicaid Medical Director.
[10] Guttmacher Institute (2014). State facts about unintended pregnancy: Louisiana. Retrieved from http://www.guttmacher.org/statecenter/unintended-pregnancy/pdf/LA.pdf.
[11] Louisiana Medicaid Management Information System (2015). Louisiana Medicaid professional services fee schedule. Retrieved from 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.[12]

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.[13,14] 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).[15]

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.[16]

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.[17] 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.[18]

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

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[12] Gee, R. (2015). Interview with Louisiana Medicaid Medical Director.
[13] 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.
[14] 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.
[15] 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.
[16] Gee, R. (2014). Interview with Louisiana Medicaid Medical Director.
[17] 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).
[18] 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.[19]

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.

[19] 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.[30]

- In 2010, public expenditures for family planning services in South Carolina totaled $33.7 million, including $25 million paid by Medicaid.[31]
- In 2011, South Carolina ranked as the 12th highest state in teen pregnancy.[32]
- 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).

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

[31] 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>,

[32] 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.[33] 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.[34]

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

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[33] Health Management Associates (2013). Medicaid reimbursement for immediate post-partum LARC. Retrieved from https://www.acog.org/~/media/Departments/LARC/HMAPostpartumReimbursmentResource.pdf.
[34] 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.