ADOPTING MEDICAID POLICIES TO ENCOURAGE LONG-ACTING REVERSIBLE CONTRACEPTION

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Tuesday, Oct. 4 | 2 p.m. EDT
FREE CSG eCademy Webcast
Improving Contraceptive Care In Medicaid and CHIP

The Council of State Governments
October 4, 2016

Lekisha Daniel-Robinson, MSPH
Coordinator, CMCS Maternal Infant Health Initiative
In July 2014, CMCS launched a Maternal and Infant Health Initiative in collaboration with states to:

1) Increase the rate and content of postpartum visits; and
2) Increase access to effective methods of contraception in Medicaid and CHIP.

This initiative builds on the work of an Expert Panel that identified strategies CMS and states could undertake to improve maternal and infant outcomes in Medicaid and CHIP.
Exploring Payment Strategies

- Informational Bulletin released on 4/8/16 identified emerging promising payment approaches to increase access to long-acting reversible contraceptives (LARC)

- Key strategies:
  - Timely, patient-centered comprehensive coverage
  - Increasing payment rates for contraceptive devices to ensure access to the range of methods available
  - Reimbursement for Immediate Postpartum LARC by “unbundling” payments for LARC from payment for labor and delivery services
  - Removing logistical barriers for supply management (e.g., addressing supply chain, stocking cost and disposal cost issues).
  - Removing administrative barriers to access for LARC (e.g. minimize preauthorization and “step therapy” requirements)
The Medicaid Managed Care Final Rule (81 FR 27498) promotes access to family planning services and effective contraception methods, including LARC. Specifically, the rule promotes:

- **Choice** – reiterates enrollees’ right to directly access family planning providers without need for referral (42 CFR 438.10(g)(2)(vii))
- **Non-discrimination of providers** – MCOs cannot discriminate in the participation, reimbursement or indemnification of any providers acting within the scope of their licensure or certification (42 CFR 438.12 and 438.214)
- **Utilization management** – clarifies that “step therapy” utilization methods cannot be applied to contraceptive methods (42 CFR 438.210(a)(4)(ii)(C))
- **Cost-sharing** for family planning services and/or items – stipulates that any cost-sharing imposed on Medicaid enrollees must be in accordance with Medicaid’s cost-sharing regulations (42 CFR 438.108 and 447.50 et seq.)
Policy Guidance

• State Health Official Letter, 6/14/16, clarified family planning regulations and offered additional options for increasing accessibility of LARC
  • Application of Family Planning Policy to Fee-for-Service and Managed Care
  • Clarification of the Purpose of the Family Planning Visit
  • Access to Services and Supplies
  • Additional Strategies to improve access to LARC, including an 1115 demonstration project
Measuring Contraception Access

- There are two Contraceptive Care MIHI measures - global and postpartum - that are stratified by age and have multiple rate categories

- The global measure includes a total of 4 rates:
  - Provision of most effective or moderately effective FDA-approved methods of contraception for ages 15–20 and ages 21–44.
  - Provision of long-acting reversible method of contraception (LARC) for ages 15–20 and ages 21–44.

- The postpartum measure includes a total of 8 rates:
  - Provision of most effective or moderately effective FDA-approved methods within 3 days postpartum for ages 15–20 and ages 21–44.
  - Provision of most effective or moderately effective FDA-approved methods within 60 days postpartum for ages 15–20 and ages 21–44.
  - Provision of LARC within 3 days postpartum for ages 15–20 and ages 21–44.
  - Provision of LARC within 60 days postpartum for ages 15–20 and ages 21–44.
Measuring Contraception Access: MIHI Grantees
Next Steps

• Work with states to explore payment that supports high quality prenatal, postpartum, and inter-conception care.
• Continue to explore policy options to address effective contraceptive counseling and removal.
• Identify innovative care delivery models that have demonstrated promising results in improving outcomes, but do not have a sustainable source of funding.
• Consider how contracting, alternative payment bundles and other models may be applied to contraceptive care services.
Long Acting Reversible Contraception: Why Support LARC Policy

Ms. Melanie “BZ” Giese, BSN, RN
Director, South Carolina Birth Outcomes Initiative
SC Department Health & Human Services
October 4, 2016
Questions

• How do you change and implement the state policy for inpatient insertion reimbursement for the LARC device?

• Is supporting coverage of LARCs cost effective to the state and improve health outcomes?

• What other reimbursement methodologies are effective to increase overall LARC utilization and how is the policy implemented?
South Carolina Medicaid Numbers

- FY2017 Total Expenditures $7.1 billion
- Covers 57% of all births in the state
- 90% of teen births
- 60% of all children are on Medicaid
- 90% of all Medicaid births are covered under 5 MCOs in state
United States vs South Carolina

Source: Based on 2010 PRAM data
Percent of Unintended Pregnancies

• 50% of all pregnancies in the U.S. are unintended. However, use of LARCs are low – only 11% of women use LARCs

• Most women (79%) who defined their pregnancy as “unintended” had their births covered by Medicaid

Source: http://www.guttmacher.org/statecenter/unintended-pregnancy/SC
• 78.6% of unplanned births were publicly funded compared with 68% nationally.

• The federal & state government spent $411.2 million on unintended pregnancies.

• The total public costs for unintended pregnancies was $443/woman aged 15-44 vs $201/woman nationally.

Source: PRAMS 2010
• Launched in July 2011
• Housed at the SC Department of Health & Human Services
• 6 Workgroups Meet Monthly
  • Access to Care & Coordination
  • Quality & Safety
  • Health Disparities
  • Baby Friendly & Safe Sleep
  • Behavioral Health
  • Data
South Carolina BOI: A National Leader

Enhanced Medicaid Coverage for Postpartum Birth Control

2012

2015

Source: U-M Health System study

South Carolina Birth Outcomes Initiative
• In most states, the Medicaid Director has the authority
• CMS approval not needed
• Medicaid Bulletin issued & Provider Manual Changed
• Identifying a Clinical Champion for implementation in the hospital is critical
• Educational & strategic component of policy success is described in detail in the SC Postpartum LARC Toolkit on the ChooseWell SC website.
SC MCO LARC Policy Coverage

• Device insertion and removal costs included in the MCO capitation rate

• All five MCOs participate in IPI, White-Bagging/Specialty and Outpatient policy
Sell the Benefits of IPI LARC

• Likely to reduce # of repeat and unintended births due to convenience of inpatient insertion versus outpatient

• Removes barriers to receiving appropriate contraceptive care due to missed post-partum appointments at 6 weeks (55% miss it in SC Medicaid)

• Improve provider relationships and address another identified barrier, i.e. reimbursement amount for the device which was below cost to purchaser (outpatient & inpatient adjusted up)
• Cost for Medicaid is a 90/10 match as Family Planning service

• Offer 3 different ways to get LARCss so women have options
  • IPI
  • OPI
  • White-bagging/Specialty
# LARC Reimbursement Update: Effective July 1, 2016

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Support LARCs Cost-Effectiveness & Improve Outcomes
SC Medicaid MCO and FFS LARCs Claim Volume

84% Outpatient
16% Inpatient

Source: Data through June 2015
Success of SC IPI LARCs

• There was a **96% increase** associated with IPI LARCs for females below the age of 18 from FY2012-FY2015

• There was a **74% increase** associated with IPI LARCs for females above the age of 19 from FY2012-FY2015
• There were **984** patients with a LARC inserted in FY2014

• Over a 21 month period after FY14, those patients had a pregnancy rate **5.65% lower** than the all-state rate.

• This represents **52** subsequent births that were avoided
• Using the LARC insertion cost per payment over the course of the policy/initiative (1/2012-5/2016)

• The total savings to date is $1,742,391

• It's important to note this is just the savings for births after IPI and that LARC expansion outside of IPI could have a much larger impact
Return on Investment (ROI)

- Provide a ROI of LARC cost vs. oral contraceptive (OC)
  - SC’s model shows first year cost (price/women treated w/ OC or LARC), including costs of unintended pregnancy for contraceptive failure (pregnancy)
    - OC: $1,180.56
    - LARC: $596.66
Establish LARC Policy for 3 Options to Meet Needs of Moms and Their Providers
• UB-04 must have following:
  • HCPCS code for device
  • ICD-10 surgical code
  • ICD-10 diagnosis code
  • Physician must bill separately for insertion through CMS 1500 using CPT codes
• Through a gross level adjustment, the hospital provider receives a monthly listing of affected claims with the credit or payment for LARC device appearing on a future remittance

• Payment to hospitals are processed on a quarterly basis for FFS beneficiaries

• MCOs reimbursement are based on each MCO’s contracted policies
LARC White-Bagging/Specialty

- SCDHHS will reimburse for outpatient utilization of LARC’s through the specialty pharmacy program
- LARC will be shipped overnight for specific patient and directly to the provider’s office for insertion
- Provider can only bill SCDHHS for insertion if using specialty pharmacy
- Provider has 30 days after purchase to insert or must return for credit
- Retro review of these claims indicate insertion is taking place within 30 days
• Physician office purchase LARCs upfront

• Physician office bills Medicaid/MCO for the cost of the device and the insertion fee at the same time
Thank you!

“It is amazing what you can accomplish if you do not care who gets the credit.”

– *Harry S. Truman*
Council of State Governments

Adopting Medicaid Policies to Encourage Long-Acting Reversible Contraception

Illinois Family Planning Initiative

Linda Wheal
Maternal Health Program Manager
Illinois Department of Healthcare and Family Services
Bureau of Quality Management
Illinois Family Planning Policy Overview

- Illinois developed Statewide Medicaid policy to support quality family planning and reproductive health services
  - All models of service delivery are aligned
  - Access to full spectrum of family planning options and reproductive health services
    - Follow current nationally recognized evidence-based standards of care and guidelines
    - Provider policies/protocols shall not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements
    - Ensure availability of all FDA-approved contraceptive methods
    - Remove “bundling” payment barriers to LARC – hospitals & encounter rate providers

- Illinois Family Planning Action Plan (IFPAP) Development
  - Goal: Increase access to family planning services for women and men in the Medicaid Program by providing comprehensive and continuous coverage to ensure that every pregnancy is a planned pregnancy.
Multi Pronged Approach: Timeline

Spring 2014:
Stakeholders identify and catalogue problems—what variables can HFS affect?

Fall 2014:
Policy & Payment Reform, Provider Education & website update

Summer 2014:
First notice on FP Contraceptive Equity Summit- IFPAP, Website Update MCO Mgmnt., Review contracts

Winter 2014-Now:
Pilots for Up front LARC distribution with Pharma

Summer 2015:
Immediate PP LARC implementation

IFPAP
Stakeholder/Provider Engagement

- **Internal Engagement**
  - Right people, right place, right time
  - Public Health/Family Planning champion within Medicaid
  - Agency-wide buy-in

- **External Engagement**
  - Identify champions
    - Providers
    - Academic Institutions
    - Advocates
    - Consumers
  - Establish task force

- **Diversity of Engagement**
  - Rural, hospital, consumer
  - Landscape analysis – current LARC utilization, obstacles, access
  - Involvement of national organizations, such as ACOG
IFPAP – Operations

Action #1: Payments and operational policies
- Identified internal team of experts, such as coders, billing, policy, system developers/programmers
  - Opportunity to educate internal staff on importance of family planning, dispel myths, address attitudes
  - Shared other State Medicaid policies
- Recommendations
  - Increase rates
  - Allow payment for two services on same day
  - Unbundle FQHC payment for LARC device (and sterilization device)
  - Increase dispensing fee for effective contraceptives
  - Develop new policy for Postpartum LARC – unbundle payment
- Strategized each action to accomplish goal
  - Cost impact -- ROI
  - Addressing barriers
  - Determine need for SPA
  - Incentives
  - Postpartum LARC – systems experts’ different approaches/lots of opinions
- Met regularly, closely monitored progress, need for Administration’s intervention to finalize
Action #2: Communication and Access

- Conveyed HFS’ commitment to quality, evidence-based family planning and reproductive health services
  - Statewide Medicaid family planning policy
  - Informational Notice on IFPAP, follow-up on status
- Ensured managed care plans had family planning policies, and formularies included all FDA-approved methods
  - EQRO readiness reviews
  - Reviewed family planning policies from each Plan
  - Verified formularies
- Worked with LARC pharmaceutical industry to develop new systems for providers to have LARC inventory on shelf for same day insertion or access at hospital
Obstacles – Immediate Postpartum LARC

- Programming issues with archaic MMIS system
  - FFS billing with DRG bundles, had to submit SPA
  - Entry of NDC in paper or e-form
- Expulsion issue, off label use, breastfeeding concerns, coercion
- MCOs may have different systems
- Inpatient training resources

- HFS supportive and could see the financial return
- Provider could bill separate CPT code for insertion
- IL CHIPRA Quality Demonstration Project $ for Illinois Perinatal Quality Collaborative
  - LARC Quality Improvement Project – hospital preparedness to ensure full implementation and access
Background research on existing Medicaid policies for postpartum LARC

- Reached out to national organizations regarding current policy work, such as American Congress of Obstetricians & Gynecologists (ACOG), National Family Planning & Reproductive Health Association (NFPRHA), Association of State and Territorial Health Organizations (ASTHO)
- Reviewed other States’ policies – many different approaches
- IL systems team identified most workable approach

Monitoring progress

- Constant “check-in” on progress
- Address and resolve concerns ASAP
  - i.e., unbundling DRG for LARC would lead to similar requests for other devices
- After many delays, Medicaid Administrator intervened
• Implementation – Postpartum LARC Policy, July 1, 2015
  ◦ Allows hospitals separate reimbursement for the LARC device
    • Payment made in addition to the Diagnostic Related Group (DRG) reimbursement for labor and delivery
  ◦ Reimbursement is based on the current practitioner fee schedule
  ◦ In order for hospital to receive reimbursement for LARC device:
    • practitioner must order device and document insertion procedure in hospital's medical record as well as the practitioner's medical record
    • hospital must use its fee-for-service NPI to bill appropriate device
    • hospital must identify NDC for specific device
    • hospital must use appropriate family planning ICD-10-CM diagnosis code
    • place of service should be designated as Inpatient
  ◦ Practitioners not salaried by hospital may bill appropriate CPT code for the LARC insertion in addition to their delivery charges
Innovative Approaches

Innovative Approaches with Pharmaceutical Industry
- Goal: Improve access to contraception, specifically LARC
- Objective: Remove financial/inventory barriers identified by providers to increase utilization
- Provide devices at clinic sites without incurring high upfront costs
- LARC inventory ensures same-day insertion

Pilot Testing for Medicaid Providers
- Bayer – consignment program
- TEVA – proprietary technology (Paragard on Demand or POD)
  - Expanded to NC Fall 2015, started slowly expanding nationally in 2016
  - Exploring hospital expansion of POD

Successful Pilots = broader implementation
General Challenges

- Changes in leadership
  - Lack of monitoring and continuous QI
  - Political opposition
- LARC distribution for same-day insertion- still in progress
  - Providers resistant to change
  - State budget impasse
- Patient and consumer education
- Provider training starting with primary care/pediatrics
- MCO move to capitated care with mergers/collaborations
- Birthing hospital mergers/conscience clause
- Data/Evaluation
Summary/Next Steps

- Research/Evaluation
  - UIC School of Public Health (Postpartum Contraception)
  - Northwestern University (Birth Rates/Intervals Among Teen Mothers)
  - HFS Data Analysis

- Postpartum Contraception
  - Revisit PPV Medicaid Policy
  - IL Perinatal Quality Collaborative QI Initiative
  - Internal IPP data analysis

- Broader engagement
- Reduced provider and client issues/complaints
- New Initiatives
Contact Information

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Questions?

Please submit them in the question box of the GoToWebinar taskbar.