Indiana Perinatal Quality Improvement Collaborative

Finance Task Force Potential Payment Innovation /Reimbursement Strategies
Long-Acting Reversible Contraception (LARC)

Approved by IPQIC Governing Council – September 2014

Reimbursement for LARC devices update August 2020:

When this original reimbursement strategies document was developed a significant barrier to providing immediate post-partum LARC was related to the lack of a separate facility reimbursement for the LARC device. As supported by the IPQIC Governing Council, since June 1, 2015, the IHCP has allowed separate reimbursement (outside the global fee for delivery) for LARC devices implanted during an inpatient hospital or birthing center stay for a delivery. This reimbursement change applied to fee-for-service and OMPP contracted Managed Care Entity (MCE) claims for dates of service on or after June 1, 2015. The cost for the LARC is billed on a professional claim by the hospital. LARC devices are also covered in an outpatient setting and do not require prior authorization.

To evaluate the utilization of immediate post-partum LARC insertion OMPP compiled claims data for dates of service in 2017, 2018 and 2019 calendar years. This was shared with the IPQIC Finance Task Force on May 7, 2020.

Data on recipient counts of LARC device insertions was provided for inpatient claims that matched to a delivery claim and for outpatient claims within 7 days of a delivery. The assumption for inpatient identified claims was that it was an immediate postpartum insertion.

The claims data presented showed evidence that **less than 1%** of the Medicaid population who delivered are receiving LARC immediate post-partum or as outpatient with 7 days of delivery, with a drop in rates in 2019 from 2018. Available Medicaid claims data indicates that the LARC usage immediate post-partum is largely concentrated in Marion County hospitals and surrounding counties. About 61% of total LARCs inserted are in the 20-30-year-old Medicaid age group.

Given the low utilization of LARCs, the IPQIC Finance Task Force recommends that further data collection is needed to identify possible reasons for the low utilization rates and for consideration of interventions for improvement, including provider and patient education.

Current initiatives within OMPP:

- LARC Cost and Stocking:

The access and cost to the LARC device continues to be voiced as a significant barrier to LARC insertion. OMPP is working on the issue related to reducing the cost of stocking devices to facilitate LARC insertions post-delivery and same day insertion at clinic site appointments. Proposed actions based on a program in Tennessee and the use of a specialty pharmacy were under evaluation by the Indiana State Board of Pharmacy. The specialty pharmacy, in its stocking, delivery and charging policies for example would facilitate same day insertion that could avoid another scheduled office visit, provide the facility or clinic site a lower cost policy for stocking LARC devices, and to charge out stocked LARC devices per prescription rather than pre-stocked and labeled for an individual patient. Unfortunately, the Finance Task Force was by notified that the company involved in the Tennessee project pulled out of its expansion proposal to do business in Indiana due to reorganization. OMPP is currently evaluating other options, but those may require an amendment to the state plan.

- Package B-Emergency Services Only Coverage with Pregnancy Coverage

  While the Healthy Indiana Plan, Hoosier Healthwise and Hoosier Care Connect packages provide reimbursement coverage benefits for LARC, Package E (Emergency Services Only) does not reimburse for the LARC device/insertion. Package E covers emergency services only for certain non-US citizens.

  However, effective November 30 2019, *Package B-Emergency Services Only Coverage with Pregnancy Coverage*, expands IHCP benefits for certain qualified immigrants identified as permanent residents. This package covers prenatal and postpartum services in addition to Package E – Emergency Services only. Pregnancy coverage is up to the 60-day postpartum period. Under the new Package B, OMPP did clarify that Package B members are eligible for routine prenatal, delivery including immediate post-delivery LARC insertion and for postpartum care which would include LARC at the follow up visit.

The original IPQIC Finance Committee Potential Payment Innovation /Reimbursement Strategies LARC document submission begins below.

Summary of Issue:

Long-acting reversible contraception, intrauterine device (IUD) or implant is a reliable form of contraception that is clinically appropriate for placement in the immediate postpartum period. Providing women with easy access to LARC methods greatly reduces the risk of unplanned pregnancies, and improves the health of newborns by facilitating healthy spacing between pregnancies. This is particularly important for adolescents where rapid repeat pregnancies occur too often. The adolescent birth rate for the state of Indiana is estimated to be 37.3 births per 1,000. For all 15-19 year-old women who have had an adolescent pregnancy, 17.1% have a second pregnancy within 12 months and 22.5% percent have another pregnancy within 18 months.

Currently, a significant barrier to providing post-partum LARC is related to facility reimbursement. In the Diagnosis Related Group (DRG) reimbursement system, which is widely used for inpatient payments, it is believed there is no additional reimbursement for the LARC as

it is bundled into the facility payment for the admission in certain cases, and in other cases the reimbursement may be insufficient to cover the cost of the device. Given the cost of a device, it is seldom, if ever, used in the immediate postpartum period and the patient often leaves the hospital unprotected. This is a missed opportunity to provide reliable family planning while extending the interpregnancy interval, decreasing the risk of subsequent preterm birth. Although insertion may occur at a later post-partum visit, the likelihood of a new mother receiving this service falls dramatically if she leaves the hospital without it.

Background & Analysis:

- LARC is widely acknowledged as safe and highly effective. ACOG strongly supports the use of LARCs. ACOG has created and promotes their LARC Program which includes Practice Bulletins, clinical guidelines, educational materials and training opportunities, which can be accessed through their website. http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception
  The guidelines state "LARC methods should be offered as first-line contraceptive methods and encouraged as options for most women."

- An increasing number of state Medicaid programs (e.g. South Carolina, Iowa, New York, Colorado, New Mexico, Louisiana, Georgia), are addressing the reimbursement barriers associated with the use of LARCs in the immediate postpartum period. They have implemented or are in the process of implementing policies allowing for separate reimbursement for the LARC device when provided in the inpatient setting in the immediate postpartum period. In July, in an attempt to prevent unplanned pregnancy and unplanned short interpregnancy intervals, New York health officials went public encouraging health providers to ensure women have access to LARC devices immediately after delivery, calling on private insurers to follow their lead.

  States that have recently implemented coverage policies allow for the LARC to be reimbursed separately on an outpatient claim and are reimbursed either by submission of a cost invoice or an established fee. Current IHCP fee schedule amounts for LARCs are as follows:

HCPCS Code	Description	Fee
J7300	Intrauterine copper contraceptive	$627.90
J7301	Levonorgestrel-Releasing intrauterine contraceptive system (SKYLA)	$682.84
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 m	$811.28
J7306	Levonorgestrel Implant system, including implants and supplies	$426.30
J7307	Etonogestrel implant system, including implant and supplies	$692.39

- The Centers for Medicare and Medicaid Services (CMS) also recently addressed the importance of increasing the use of effective contraceptive methods. Excerpts from a CMS Informational Bulletin dated July 17, 2014 include:

- In recognizing the urgency presented by our nation's poor birth outcomes, CMCS is experiencing a unique time in this nation's history in which the federal and state governments, maternal and infant health advocacy groups and provider groups are working in tandem to improve perinatal outcomes and reduce disparities.
- After considering the advice of the Expert Panel and partnership opportunities, CMCS has identified two distinct yet interrelated goals for its Maternal and Infant Health Initiative. The initiative leverages existing partnerships and activities to:
  - Increase by 10 percentage points the rate of postpartum visits among pregnant women in Medicaid and CHIP in at least twenty states over a 3-year period; and
  - Increase by 15 percentage points the use of effective methods of contraception in Medicaid and CHIP in at least twenty states over a 3-year period.
- Reproductive planning which includes access to contraception, either during the immediate postpartum period or during any other time in the reproductive continuum, allows for appropriate birth spacing and improved access to services that can, in turn, improve perinatal outcomes. One of the key themes that emerged from the Expert Panel is that current public and private reimbursement mechanisms do not align well with achieving good perinatal outcomes. Through the Maternal and Infant Health Initiative, CMCS will promote payment, program and coverage policies that enhance provider service delivery for use of effective contraception and timely postpartum care and enhance the accessibility of these services to women.

- Traditionally, LARC has been provided at the postpartum visit, 4-6 weeks after the delivery. Unfortunately, show rates for postpartum visits tend to be particularly low for adolescents where rapid repeat pregnancy and short interpregnancy intervals are particularly prevalent. Moreover, women who are bottle-feeding or supplementing breastfeeding with formula may resume ovulation as early as 3 weeks postpartum and thus are at-risk for unintended pregnancy if not using reliable contraception.

- There is growing published evidence of the effectiveness of immediate postpartum implant contraceptive devices and that patient's continuation timeframe is longer when compared to control groups. For example, Tocce, et al found that at 6 months, 9.9% of the control participants were pregnant (21/213); there were no immediate postpartum implant (IPI) pregnancies. By 12 months, 18.6% of control participants (38/204) experienced pregnancy vs 2.6% of IPI recipients (4/153; relative risk, 5.0; 95% confidence interval, 1.9–12.7). Implant continuation at 6 months was 96.9% (156/161 participants); at 12 months, the continuation rate was 86.3% (132/153 participants). Consistent contraception use was 99.4% in the IPI group at 6 months after delivery vs 54.9% among control subjects. At 12 months, consistent contraception was 94.3% in the IPI group and 52.3% in the control group. (1)

  Cost effectiveness has also been demonstrated. Han, et al, found for every dollar spent on IPIs, $0.79, $3.54, and $6.50 would be saved at 12, 24, and 36 months. Savings in this study were based on participants in an adolescent prenatal-postnatal program that were enrolled in a prospective observational study of IPI insertion (N=171) vs standard contraceptive initiation (N= 225).

- IU School of Medicine conducted a research project to evaluate the impact of immediate postpartum contraception on rapid repeat pregnancies (RRP) in their urban hospital

system. The 2013 study focused on adolescents, given the need for specific and effective interventions for this age group.

Results and findings of the IU School of Medicine Research Project included the following:

- Immediate postpartum contraception was used in 28.9% of the adolescents who delivered from January 1, 2010 to July 1, 2012. Of the patients who received immediate postpartum contraception, 16.3% had a RRP, compared to 33.5% of those who did not receive any type immediate postpartum contraception (p-value = 0.005). The RRP rate was lowest for patients who received an immediate postpartum estonorgestrel (ETN) implant (3.7%, 1/27) compared to those that received immediate postpartum depot medroxyprogesterone acetate injection - DMPA (22.6%, 12/53) and those who received no immediate postpartum contraception (33.5%, 66/197; p-value 0.001). Twenty-six of 27 adolescents who had an ETN implant placed in the hospital continued that method during the 18-month study period.
- Missing a postpartum visit was associated with a high rate of RRP. Of note, 48.1% of those RRP missed their postpartum visit; the overall show rate for the postpartum visit in this study patient population was approximately 67%.
- Perhaps the most important aspect of the study highlights that the type of contraception utilized significantly impacts the reduction of RRP rates. ETN implants had the highest benefit in the reduction of RRPs. This correlates to the Tolle noted above (1) as well as the findings of Simon et. al. that showed that the failure to use the ETN implant during the postpartum period was the strongest predictor of repeat pregnancy during the first 2 postpartum years (3). Furthermore, the use of the ETN implant had a 4 times stronger effect on reduction of RRP than did DMPA (4)

The IU study further demonstrated that immediate postpartum contraception has a significant impact on the reduction of RRP rates and is consistent with the evidence that providing immediate postpartum contraception is essential in decreasing RRP especially in a high-risk population such as adolescent patients.

Recommendation:

- Provide sufficient reimbursement to the professional for LARC (IUD or implant) insertion that encourages providers to perform the procedure in the hospital setting immediately post-delivery.
- Allow adequate reimbursement to facilities for the implant device when provided in the inpatient setting in the immediate postpartum period.
- Encourage educational efforts directed toward providers regarding the provision, coverage, and reimbursement of LARC in the immediate postpartum period.
- Emphasize that LARC insertion is a decision between patient and physician.
- Offer Provider and Consumer Education on clinical guidelines and options.

Key Participants

- Any hospital providing maternity services
- Obstetric providers (Ob/Gyns, FPs, nurse practitioners)
- OMPP, commercial payers
- Consumers

Expected Outcomes & Feasibility:

Expected outcome is increased utilization of LARC which will decrease unplanned pregnancy and increase the interpregnancy interval, leading to decreased preterm birth risk. Cost savings should also be demonstrated. The feasibility of implementation is high.

Outcome measures*:*

- Track utilization of LARC by Medicaid beneficiaries in the postpartum IP setting
- Track discontinuation rates and time to discontinuation
- Track birth rates pre and post implementation including pregnancy rates by 12 and 18 month intervals after delivery

Notes:

1) Tocce KM, Sheeder JL, Teal SB. Rapid repeat pregnancy in adolescents: do immediate postpartum contraceptive implants make a difference? Am J Obstet Gynecol 2012;206:481.e1-7.
2) Han L, Teal SB, Sheeder J, et al. Preventing repeat pregnancy in adolescents: is immediate postpartum insertion of the contraceptive implant cost effective? Am J Obstet Gynecol 2014;211:24.e1-7.
3) Neena T. Qasba, M.D., Impact of immediate postpartum contraception on the rate of rapid repeat pregnancy in adolescents in an urban hospital system. Indiana University, Department of OB/GYN, 2014.
4) Kelly LS, Sheeder J, Stevens-Simon C. Why lightning strikes twice: Postpartum resumption of sexual activity during adolescence. J Pediatr Adolesc Gynecol 2005;18:327e35.
5) Tocce K, Sheeder J, Python J, Teal SB. Long acting reversible contraception in postpartum adolescents: Early initiation of etonogestrel implant is superior to IUDs in the outpatient setting. J Pediatr Adolesc Gynecol. 2012;25:59-63.