CMS Highlights State Policies to Improve Access to Long-Acting Reversible Contraceptive Methods

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Over 13 million women of reproductive age rely on Medicaid for their health care coverage.[1] In addition, many women who are not eligible for full Medicaid coverage receive family planning services and supplies through Medicaid.[2] Medicaid enrollees should have timely access to the contraceptive method of their choice. However, state Medicaid payment policies may prevent providers from offering long-acting reversible contraceptive (LARC) methods, creating barriers for women seeking to access intrauterine devices or contraceptive implants.

Last Friday, as part of the Maternal and Infant Health Initiative, the Centers for Medicare & Medicaid Services (CMS) released an Informational Bulletin highlighting state payment policies aimed at making LARC methods more available.[3] CMS gathered information about challenges related to payment for LARC methods, as well as promising payment policies, from several sources, including a September 2014 Technical Review Panel on Contraceptive Services in Medicaid and the Children's Health Insurance Program (CHIP). The National Health Law Program was among the

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[1] USHA RANJI, YALI BAIR, AND ALINA SALGANICOFF, KAISER FAMILY FOUND., MEDICAID AND FAMILY PLANNING: BACKGROUND AND IMPLICATIONS OF THE ACA 2 (2016), http://kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/.

[2] *Id*. at 6. Twenty-eight states have implemented family planning expansion programs. *Id*. at 7.

[3] CTRS. FOR MEDICARE & MEDICAID SERVS., INFORMATIONAL BULLETIN: STATE MEDICAID PAYMENT APPROACHES TO IMPROVE ACCESS TO LONG-ACTING REVERSIBLE CONTRACEPTION (2016). For background information about the Maternal and Infant Health Initiative *see* CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET: OVERVIEW OF THE CMCS MATERNAL AND INFANT HEALTH INITIATIVE (2014), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/mih-initiative-fact-sheet.pdf.

experts participating in the Technical Review Panel and has been promoting many of the payment policies described in the Informational Bulletin.[4]

Barriers to LARC Access

In the Informational Bulletin, CMS identified a number of challenges related to reimbursement for LARC methods, including the following:

- State Medicaid agencies typically pay hospitals a single predetermined fee for all labor and delivery services (generally structured as global billing or bundled payment), and the fee does not account for the costs associated with providing LARC methods immediately postpartum.
- In outpatient settings, payment rates may be insufficient for LARC devices and/or insertion procedures.
- Providers may face significant upfront costs to obtain LARC devices. In addition, if a provider orders a device for a particular patient, and the patient doesn't ultimately use the device, the provider may have to discard it at a financial loss.
- Some states do not reimburse providers for replacement and reinsertion of LARC devices, or for removal under all circumstances.
- Some states and Medicaid managed care organizations (MCOs) have adopted prior authorization and step therapy requirements for LARC methods.[5] These requirements can delay or prevent women from accessing LARC methods.

Promising State Policies and Practices

To assist states in increasing access to LARC methods and thereby reducing the rate of unintended pregnancy, CMS identified state payment policies that address one or more of these barriers. The majority of the payment policies address the problems associated with providing LARC methods immediately postpartum. CMS pointed to 14 states that have unbundled payment for LARC devices and/or insertion procedures from other labor and delivery services.[6] In addition, CMS referred to payment policies designed to

[4] *See, e.g.,* Memo from Nat'l Health Law Program to Interested Parties, Postpartum LARC Resources for Advocates (2014); ERIN ARMSTRONG, NAT'L HEALTH LAW PROGRAM, MARA GANDAL-POWERS AND SHARON LEVIN, NAT'L WOMEN'S LAW CTR., AMANDA KIMBER KELINSON, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASS'N, ALICIA LUCHOWSKI, AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS, AND KIRSTEN THOMPSON, UNIV. OF CAL., SAN FRANCISCO, BIXBY CTR., INTRAUTERINE DEVICES AND IMPLANTS: A GUIDE TO REIMBURSEMENT (2nd ed. 2015).

[5] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 3, at 2-3. Step therapy means that enrollees must try a less expensive drug or device and experience failure or contraindications before a more expensive drug or device will be covered.

[6] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 3, at 4-16. Additional states have adopted similar payment policies for providing LARCs postpartum. For a complete list of

make LARC methods more available to women who seek them in outpatient settings, such as:

- Increasing reimbursement rates for insertion, removal, and reinsertion procedures;
- Allowing providers to bill Medicaid for insertion or removal procedures in addition to an office visit (evaluation/management visit);
- Permitting Federally Qualified Health Centers and/or Rural Health Centers to receive reimbursement for LARC devices in addition to their normal encounter rates;
- Contracting with a specialty pharmacy to deliver LARC devices to providers and allowing providers to return unused and unopened devices to the specialty pharmacy; and
- Prohibiting MCOs from adopting prior authorization and step therapy requirements for LARC methods.

What Else is Needed?

The Informational Bulletin represents an important step in improving access to LARC methods by explicitly allowing states to adopt these payment policies. However, further action is needed to ensure that Medicaid enrollees have timely access to LARC methods. CMS should require all states to adopt some of these payment policies.

In particular, CMS noted that states and MCOs have adopted prior authorization and step therapy requirements for LARC methods. Under prevailing medical standards of care, women should have access to the contraceptive method of their choice.[7] Step therapy requirements prevent some women from using their preferred method of family

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these states, *see Medicaid Reimbursement for Postpartum LARC By State*, AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Coding-and-Reimbursement-for-LARC/Reimbursement-Resources-for-Postpartum-LARC-Initiation/Medicaid-Reimbursement-for-Postpartum-LARC-By-State (updated April 8, 2016).

[7] AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR WOMEN'S HEALTH CARE: A RESOURCE MANUAL 183 (3rd ed. 2007) (noting "in the absence of contraindications, patient choice should be the principal factor in prescribing one method of contraception over another."); Ctrs. for Disease Control and Prevention & U.S. Office of Population Affairs, *Providing Qualify Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, MORBIDITY & MORTALITY WEEKLY REP., April 25, 2014, at 37, http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf (noting that contraceptive choice is an important aspect of quality care).

planning. In fact, the use of step therapy for LARC methods may violate the federal regulation requiring enrollees to be "free from coercion or mental pressure and free to choose the method of family planning to be used."[8] CMS should make clear that states and MCOs may not implement prior authorization or step therapy requirements for family planning services and supplies, including LARC methods.[9]

In addition, some states do not cover all removal procedures.[10] CMS should make clear that such payment policies may be coercive. States must cover LARC removal whenever a woman decides that she wishes to discontinue use.

Finally, CMS should remind states that Medicaid funding is available for LARC services provided immediately post-abortion, regardless of whether or not federal funding is available for the abortion.[11]

[8] 42 C.F.R. § 441.20.
[9] *See* Letter from Elizabeth G. Taylor, Executive Dir., Nat'l Health Law Program, to Victoria Wachino, Dir. Ctr. For Medicaid & CHIP Servs., Ctrs. For Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs. 132, 143 (July 27, 2015), http://www.healthlaw.org/publications/comments-managed-care#.Vwz4BPkrKM9.
[10] *See, e.g.,* S.D. DEP'T OF SOCIAL SERVS., SOUTH DAKOTA MEDICAID PROFESSIONAL SERVICES BILLING MANUAL 98 (2016), https://dss.sd.gov/formsandpubs/docs/MEDSRVCS/professional.pdf ("The removal of an implant is only reimbursable by South Dakota Medicaid when due to infection, rejection or when determined medically necessary. South Dakota Medicaid will not reimburse for the removal of the implant if the intent is for the recipient to become pregnant.")
[11] CMS, State Medicaid Manual § 4432.