

Strategies to Increase Access to Long-Acting Reversible Contraception (LARC) in Medicaid



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Long-acting reversible contraception (LARC) options, intrauterine devices (IUD) and contraceptive implants represent an opportunity for women of all ages to prevent unintended pregnancies. LARC is easy to use, highly effective and lasts for a number of years. Over the past half decade, there has been a movement to increase access to this birth control method based on its safety and efficacy; however, barriers related to patient and provider education, stocking and reimbursement remain. This brief, which is based on a review of publically available materials, provides an overview of the history of LARC use, reviews LARC products and safety, addresses the various barriers to wider LARC adoption, and highlights the opportunities states have to improve LARC access through Medicaid policy and reimbursement strategies.

Background

Unplanned pregnancies can be a tremendous challenge for many women, healthcare payers and the community, and are associated with a number of negative health outcomes, including delayed prenatal care, premature birth, low-birth weight and other health complications.ⁱ

Medicaid bears a significant burden for the complications accompanying unplanned births. State programs cover nearly two out of three unplanned pregnancies (approximately 1.7 million births a year), spending over \$10 billion dollars on these births annually.ⁱⁱ

LARC implants and devices are a safe and effective option for reducing unplanned pregnancies. Studies show IUDs, the most common form of LARC, to be among the most effective methods of birth control, with a failure rate of less than 1 percent with one year of typical use.ⁱⁱⁱ Failure rates for typical condoms are around 20 percent, and the pill, patch and ring birth control methods all have a typical use failure rate of 9 percent.^{iv} A Centers for Disease Control and Prevention (CDC) study found that an increase in postpartum LARC utilization by teens in

TYPES OF LARC

LARC includes the IUD and the birth control implant. The following are the four Food and Drug Administration (FDA)-approved IUDs currently on the market:

- **Liletta** is a new hormone levonorgestrel IUD that was approved in 2015 for three years of continuous use. Liletta was specifically designed to be affordable and available to clinics enrolled in the national 340B Drug Pricing Program, which gives access to reduced cost pharmaceuticals for providers that serve low-income populations.
- **Mirena** is a soft, flexible plastic IUD that releases small amounts of the hormone levonorgestrel and is approved for 5 years of continuous use.
- **ParaGard** is a copper IUD that is FDA approved for 10 years of continuous use. ParaGard is the only copper-containing approved device in the United States.
- **Skyla** is a hormone levonorgestrel-releasing IUD that is approved for up to three years of use, and can be utilized by women who have not previously been pregnant. This product made LARC available to teens and other nulliparous (never previously pregnant) women.

Colorado, as a result of a targeted LARC program, resulted in a 45 percent decrease in repeat births over four years in the state.^y

Despite its effectiveness, LARC remains highly underutilized by women across the country. Only 10 percent of women who report using contraception use LARC^{vi}. This can be partially attributed to a lack of available patient education from providers on LARC options, as women have been shown to prefer a LARC method once it has been introduced as an option. A recent survey of women ages 14 through 45 found that 75 percent of those who were educated on all contraception options ended up selecting a form of LARC. That same study also found that the women who end up choosing LARC have significantly lower pregnancy rates, 20 times less than women who use other forms of birth control (i.e., the pill, the patch, the ring).^{vii}

Safety of LARC Use

LARC methods have been found to be safe for all women, including postpartum women and teens. National organizations, including the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), have issued national policy statements that indicate that are LARC devices safe and are the preferable method of birth control for women.

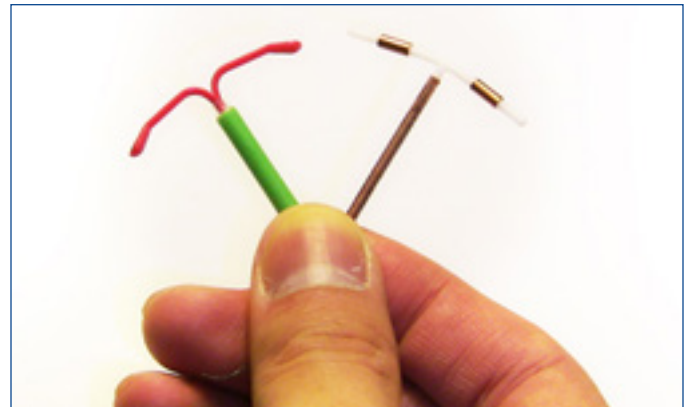
Teens and Nulliparous Women

In 2012, ACOG released an opinion saying for the first time that IUDs and implants should be among the first contraceptives suggested to **all** women of reproductive age, including adolescents and nulliparous women^{viii}. In an updated policy statement released in 2014, the AAP similarly recommended that LARC be the first-line contraceptive choice for sexually active adolescents. New research, generated in the past decade, demonstrates the safety of LARC for pre-pregnancy young adults, going beyond previous research suggesting that use should be limited to women who had undergone childbirth.

Pediatricians are encouraged to be familiar with counseling, insertion and/or referrals for LARCs.^{ix}

Postpartum Mothers

ACOG has acknowledged that there are theoretical concerns related to breastfeeding duration and infant growth regarding the use of a hormone-based implants in women less than four weeks after childbirth. However, both observational and randomized controlled studies have found little evidence to support these concerns, and in a recent trial there were no differences in breastfeeding duration or infant growth between women who received hormonal and copper IUDs.^x



Barriers to LARC Access and Utilization

There are a number of barriers that can prevent women from accessing their preferred LARC device. These barriers include a lack of provider education and training, low patient knowledge, and high costs for stocking the device.

Provider education and comfort with prescribing LARC devices are major factors related to LARC access. One study found that providers who had recently finished training or saw a higher number of patients using contraceptives were more likely to insert an IUD than their counterparts.^{xi} Provider misconceptions about IUD usage and risk, including



a false belief in an association between IUDs and an elevated likelihood of pelvic inflammatory disease, were found in a number of studies.^{xii xiii}

Patient education is also a major barrier, with the majority of women reporting unfamiliarity with LARC and an additional percentage having misinformation regarding device safety.^{xiv} One recent study found that 55 percent of women interviewed between the ages of 14 and 27 were unaware of the availability of IUDs.^{xv}

Once the patient and provider have identified an interest in utilizing LARC, the cost for the devices can be a major barrier to insertion.^{xvi} The price of an IUD can range from \$400 to \$1,000 per device. However, Liletta, an affordable, alternative IUD that was introduced in 2015 for low-income women, has the potential to change the ability of clinics to purchase devices. Medicines360, the non-profit pharmaceutical company that produces Liletta, currently charges public health clinics \$50 per device.^{xvii} It is too soon to know if other LARC manufacturers will follow suit and reduce their costs as a result of this new product.

As a result of high device costs, many providers and hospitals do not stock LARC. Without available inventory, women interested in LARC are required to make multiple visits to a provider and the likelihood

of the device being inserted decreases with each visit. A 2012 study found that between 40 percent and 60 percent of mothers who expressed interest in LARC at the time of birth never returned for a follow-up gynecological visit for device insertion.^{xviii}

IUDs are highly cost effective despite the significant upfront expense. The low-failure rate of IUDs allows for savings through the avoidance of unplanned pregnancy, which are estimated to average \$10,000 per birth for Medicaid programs^{xix}. Additionally, copper and hormonal IUDs are the most cost-effective reversible methods of birth control over time, with an estimated 5-year cost of \$647 and \$930, respectively.^{xx} To compare, oral contraceptives (i.e., the birth control pill) had an estimated total cost of \$3,381 over the same time period.^{xxi}

State Strategies to Increase LARC Access for Medicaid Beneficiaries

The following section highlights strategies and policy levers that states can use to promote use of LARC among women, particularly those in low-income households. States seeking to significantly increase LARC utilization may wish to consider all the barriers to access and potential remedies, including those policy options listed below.

Monitoring and Tracking Use of LARC in Medicaid and CHIP Programs

In recent years the Centers on Medicare and Medicaid Services (CMS), which administers the Medicaid program, has increased its focus on women’s reproductive health. To encourage states to invest resources in women’s health and contraceptive care, CMS has identified a developmental performance sub-measure^{xxii} related to the percentage of women “ages 15–44 years of age who are at risk of unintended pregnancy that adopt or continue use ... LARC.” The measure’s goal is to “encourage providers/service sites that are performing well below [average] to focus on removing unnecessary barriers to LARC access.”^{xxiii}

States seeking to meet this performance measure and improve LARC access for their Medicaid populations may wish to focus on two issues: (1) updating payment models to allow for greater flexibility for how LARC products are billed for and reimbursed and (2) improving education and outreach to providers and patients to ensure that both groups are aware of the efficacy and safety of LARC.

In April 2016, the CMS released supportive guidance highlighting efforts undertaken by states to use existing Medicaid payment and reimbursement

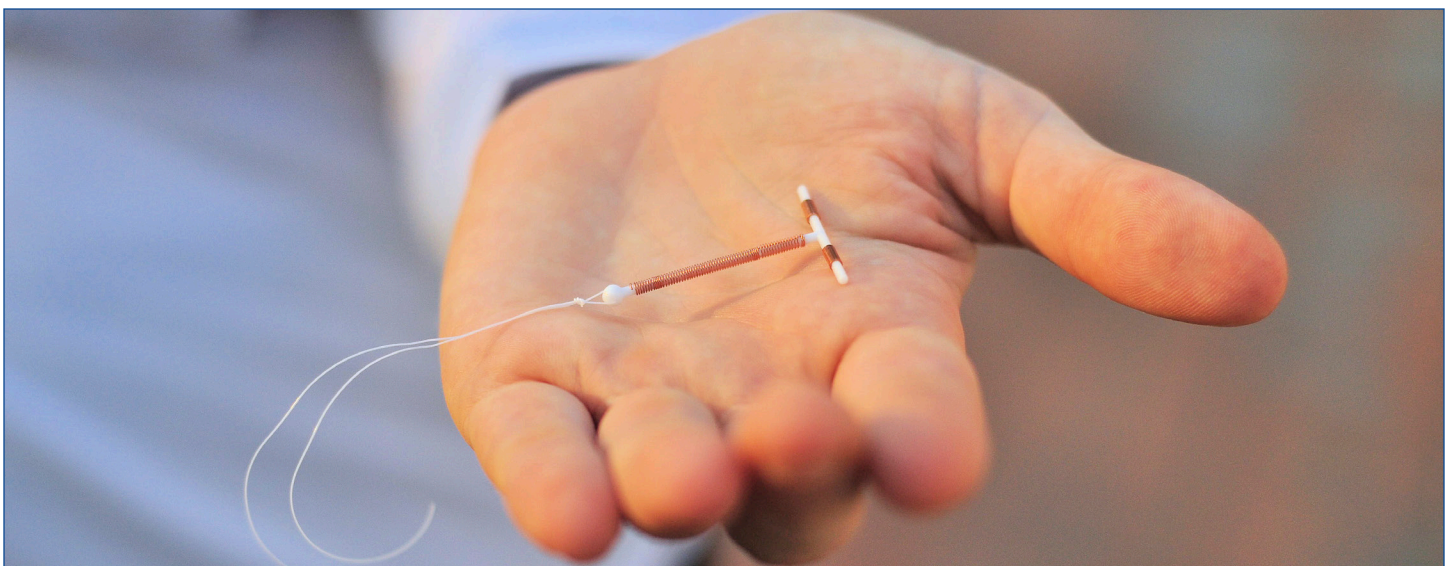
levers to increase access to LARC. This new guidance, which can [be found here](#), features examples of LARC Medicaid policies and in-depth reviews of work being done by several leader states (Illinois, Louisiana and South Carolina) that have partnered with Medicaid payers and providers to promote greater access to LARC.

Updating Payment Models to Allow Greater Flexibility

Addressing LARC’s Upfront Costs

There are two approaches that state Medicaid agencies are able to use to bill for LARC in outpatient settings: (1) “buy and bill” and (2) reimbursing the device as a pharmacy benefit (sometimes referred to as “white bagging”). “Buy and bill” involves providers stocking the devices and receiving payment upon insertion. With the “buy and bill” approach, providers have the product on hand to insert when a woman enters their office. The drawback to this, however, is a provider needs to pay for the product upfront and risks absorbing the cost for unused devices. When devices are treated as a pharmacy benefit, providers are able to avoid stocking costs, but a follow-up appointment is needed for insertion. Both methods of billing have significant barriers to cost-effective and streamlined device insertion.

Recognizing the tremendous efficacy of LARC



devices, a number of state Medicaid agencies are either implementing or considering payment models designed to remove barriers to IUD utilization that result from current billing methods. In a review of publically available information, it was unclear whether any states currently have a Medicaid reimbursement model that allows clinics to be reimbursed for proactively stocking devices, which would further reduce barriers to LARC availability.

- The **South Carolina** Department of Health and Human Services (SCDHHS) began reimbursing outpatient utilization of LARC through its pharmacy program in early 2014. Any LARC billed to a pharmacy will be shipped directly to the provider’s office for insertion, reducing the time between billing and device insertion. While promising, this model still requires multiple visits.
- In **Texas**, providers working with Medicaid or the state’s women’s health program are able to order LARC devices from select pharmacies at no upfront cost (in Texas, devices cost between \$600 and \$800 per unit). Providers who obtain LARC through specialty pharmacies will be able to return unused and unopened devices to the manufacturer’s third-party processor. This model still includes lag time, however, between prescription and device insertion for the patient.

Allowing For Postpartum Insertion

Medically, an IUD can be successfully inserted within minutes of childbirth.^{xxiv} Insertion at this time also makes sense logistically, as women are known not to be pregnant and should already be having conversations about birth spacing with their provider. However until recently, Medicaid reimbursement for medical procedures provided during postpartum care was not permitted and the costs related to the LARC device was unaffordable under the labor and delivery payment model. Recognizing an opportunity to remove an unnecessary barrier to preventing unwanted pregnancy, 19 states have recently adapted their labor and delivery reimbursement policies to allow for separate reimbursement

DELAWARE CONTRACEPTIVE ACCESS NOW (CAN)

In February, Delaware’s governor announced Delaware CAN, a new LARC access program, which uses a combination of funding from the state’s Department of Public Health and private foundation contributions to stock provider offices with LARC devices. This new program includes support for an evaluation and may provide states with important information about whether same day device availability leads to a decrease in unwanted pregnancies. Read more about Delaware’s new program, which includes a significant focus on provider education and training, [here](#).

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of the IUD insertion and contraceptive implants.^{xxv} This number is up from zero states just 3 years ago. ACOG is tracking the status of postpartum LARC policies across states, and has a comprehensive and periodically updated list of state postpartum LARC insertion policies [here](#).

- Many Medicaid programs have made this change under state authority to define scope of coverage for family planning services. For example, **South Carolina** was able to implement a new postpartum LARC reimbursement policy that treated the cost of a LARC device as an add-on to its Medicaid labor and delivery payment with only a written request to the CMS, in lieu of the more time-intensive process of submitting a Medicaid State Plan Amendment.^{xxvi}
- In addition to the 19 states that have adopted

SUPPORTING STATE EFFORTS TO IMPLEMENT POSTPARTUM LARC INSERTION POLICIES

The Association of State and Territorial Health Offices (ASTHO), with support from CDC and CMS, has convened an Immediate Postpartum LARC Community, designed to support a group of 13 states that are working to increase access to highly effective birth control options through the implementation of postpartum LARC initiatives. The learning community will take place over the next two years and provide technical assistance and promising practices to assist states in increasing immediate postpartum LARC insertion. More information about the Learning Community, the participating states, and resources for states related to postpartum LARC insertion policies can [be found here](#).

a postpartum insertion policy, another eight states have begun taking steps towards instituting postpartum insertion reimbursement.^{xxvii}

This second group includes **Colorado**, where the Medicaid agency currently does not allow for billing services outside of a bundled labor and delivery payment, but there has been a pilot program developed involving two urban health-care providers offering immediate postpartum LARC at no cost to the patient.

- In interviews with states that have adopted a postpartum LARC reimbursement policy, researchers found that the most frequently cited reasons for implementing the policy was net savings and improved maternal and child health outcomes.^{xxviii}

Incentivizing the Use of Highly Effective Birth Control Methods

As described above, a major barrier to LARC utilization is limited provider knowledge about the device and lack of education for patients. **Illinois**, as part of a larger Medicaid Family Planning Action Plan, changed its payment model in 2014 to provide additional reimbursement for birth control methods that demonstrate higher efficacy. The new provider policy requires that Medicaid patients receive education and counseling on all FDA-approved birth control methods, from most effective to least effective, with the most effective options presented first. To supplement this education policy, the Medicaid agency doubled the provider reimbursement rate for IUD insertion from \$44 to \$88 and has increased the medical providers' dispensing fee for LARC methods from \$20 to \$35. In increasing reimbursement, the state is structuring incentives to encourage providers to learn more about LARC.

Addressing Education Barriers for Providers and Women

The LARC Program at ACOG connects providers and patients with up-to-date information on LARC and works to increase overall access. In **Georgia**, **New York** and **Washington, D.C.**, ACOG has invested resources into the development of training and educational materials targeted at providers, including the inclusion of Medicaid practitioners. ACOG's resources related to LARC clinical resources, webinars, clinical education and training,



coding and reimbursement, among others, can [be found here](#).

Continued support for these types of efforts will be critical in achieving widespread LARC usage. Education is particularly important for LARC, as studies show that providers often hold misconceptions that can be easily addressed and that patients are highly likely to prefer LARC when they learn about its availability.

Challenges to be Addressed

Coercion

In recent years, and with the growing interest in increasing access and utilization to LARC, advocates and scholars have raised serious questions about the right of a woman to reproduce as it relates to IUDs and LARC. These advocates highlight the troubled history of Medicaid and forced steriliza-

tion, and the importance of valuing reproductive choice. Experts on this topic have indicated that some women prefer birth control methods with low failure rates, while others may value the ability to end their birth control use without visiting a doctor’s office. The literature related to LARC and reproductive autonomy emphasizes that women should be informed about the efficacy and reliability of LARC, but states working with providers should be aware that there are a number of personal, social, cultural and religious factors that can inform a decision and patients should not be pressured to select one particular method.

Policies Related to LARC Expulsion and Removal

Although expulsion of LARC devices is uncommon, occurring in just 3 percent to 5 percent of users,^{xx-ix} there are instances where the device becomes dislodged and needs to be reinserted. To better incentivize LARC usage, state policies may need to be adapted to allow for appropriate and timely provider reimbursement for this service. In one state’s Medicaid program, providers must obtain “medical necessity” declarations for re-insertion reimbursements, creating unnecessary delays and reducing the likelihood that patients will have the device reinserted. Additionally, current LARC reimbursement rates do not cover service cost, provider training or health education related to reinsertion.

Similar issues are faced by states related to removal. While removal is generally considered to be a covered Medicaid service, new state payment models (including bundled payments or global payments) often fall short in providing enough funding to cover all LARC-related costs. The Affordable Care Act has addressed this issue by requiring reimbursement for all necessary LARC follow-up and side effect management, including removal, for the new Medicaid expansion population. States looking to encourage expanded LARC access may consider adopting this reimbursement model for all Medicaid populations. State officials interested in working with Medicaid to enact these changes can use long-term cost and efficacy data to demonstrate the

LARC AND COERCION

With a rise in LARC use, concerns have been raised about whether efforts to expand access to long-term birth control methods limit the ability of low-income women to exercise their right to reproduce. The following resources provide additional context on this important issue:

- [Guarding Against Coercion While Ensuring Access: A Delicate Balance. Guttmacher Institute.](#)
- [Celebration Meets Caution: LARC’s Boons, Potential Busts, and the Benefits of a Reproductive Justice Approach. Contraception.](#)
- [Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. Perspect Sex Reprod Health.](#)

importance of LARC. Covering all costs related to LARC insertion supports the ability of providers to offer LARC as an option.

Conclusion

The research is clear, LARC is the most effective and, over time, the least expensive reversible contraceptive method. Unplanned pregnancies are both medically difficult, with higher rates of pre-term birth and low-birth weight babies, and incredibly costly. Wider adoption of LARC is a significant opportunity for states to reduce unnecessary expenditures in Medicaid programs, as Medicaid and other public payers are responsible for paying for a large percentage of unplanned births. However, misperceptions about LARC safety, low provider knowledge and barriers within current reimbursement systems make it difficult to increase access to LARC in a number of states. Medicaid programs that want to increase access can look at examples in peer states, where recent changes have allowed for reimbursement of immediate postpartum LARC insertion, provided more flexibility around stocking and inserting the devices, and where non-profit groups have funded additional education. Moving forward, states will need to continue to review LARC policies to ensure that reimbursement is fully inclusive of all related costs and that incentives and policies are sensitive to concerns about the reproductive rights of low-income women.



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