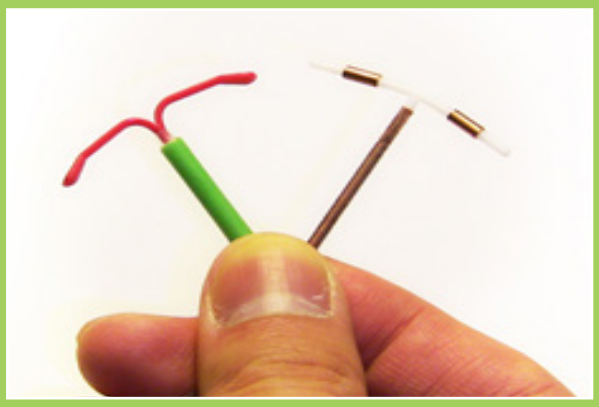
State Strategies to Increase Access to LARC In Medicaid:

"Contracteptive Access Now" and the Expansion of LARC in Delaware



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Introduction

Unplanned pregnancies present a challenge for many women, their families, and communities, and are associated with a number of costly health outcomes, including delayed prenatal care, premature birth and low birth weight. Public insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP), bear a significant financial burden for unplanned pregnancies in the U.S., covering nearly 1 million unplanned births a year at an annual cost of over $21 billion. In an effort to improve health outcomes and cost-savings, many Medicaid agencies are partnering with other state programs and stakeholders to promote well woman care and healthy birth spacing. One promising strategy is to increase access to the most effective contraception, specifically long-acting reversible contraception (LARC). LARC includes the intrauterine device (IUD) and the birth control implant; five types of IUDs (Kyleena, Liletta, Mirena, ParaGard and Skyla) and one type of contraceptive implant (Nexplanon) are currently licensed for use in the U.S. LARC devices and implants, which have historically been financially and logistically difficult to attain, are not only safe but they are the most effective options for women to avoid unplanned pregnancies and prevent pregnancy intervals shorter than the recommended 18 months, thereby reducing the risk of low-weight and/or premature birth.

Delaware is a member of the National Institute for Children's Health Quality's Collaborative Improvement and Innovation Network to Reduce Infant Mortality (IM CoIIN), actively working to reduce infant mortality and improve birth outcomes statewide. The following case study highlights an emerging approach to improve LARC access in Delaware through new Medicaid policy and reimbursement guidance. This case study supplements the issue brief Strategies to Increase Access to Long-Acting Reversible Contraception (LARC) in Medicaid, which provides an overview of the history of LARC use, reviews LARC products and safety, addresses the various barriers to wider LARC adoption, and underscores the opportunities states have to improve LARC access.

> "In 2010, 57 percent of all pregnancies in Delaware were unintended."

Background

In 2010, 57 percent of all pregnancies in Delaware (11,000) were unintended. In the same year, approximately 71 percent of unplanned births in Delaware were publicly funded, compared with 68 percent nationally. Unsatisfied with the negative health, educational and financial outcomes for Delaware women and children associated with these unplanned pregnancies, Governor Jack Markell made access to effective contraception a priority in his 2012–2016 term.

During his State of the State address in January 2016, Governor Markell cited poor insurance coverage for the full range of contraceptive options as a major barrier to women's health. Delaware's Medicaid agency has addressed this barrier by revising its reimbursement policies to clarify that LARC is a fully covered benefit. Markell also announced the Contraceptive Access Now (CAN) initiative, a comprehensive statewide plan that will increase access for all women to the full range of contraceptive methods, including LARC. Key activities under the CAN initiative include customized training and technical assistance to healthcare providers, the elimination of state agency policy barriers, a consumer-facing public awareness campaign, and a rigorous evaluation. As a part of CAN, Delaware has formed a public-private partnership with Upstream USA, a nonprofit group that will provide the initiative's training and technical assistance.

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Contraceptive Access Now (CAN)

In order to reduce Delaware's unplanned pregnancy rate, the Health and Social Services Agency (DHSS) – the state's largest agency responsible for providing services in the areas of public health, social services, substance abuse and mental health, and more – is managing the state's involvement in the CAN initiative. The Division of Public Health (DPH), a section of DHSS, along with Upstream USA lead the Delaware CAN Workgroup, a group of state and community stakeholders monitoring the progress and direction of the CAN initiative. Other members of the workgroup include the Division of Medicaid and Medical Assistance (DMMA), the Delaware Healthy Mother and Infant Consortium (a governor appointed body focused on reducing infant mortality), the Division of Substance Abuse and Mental Health and providers.

Provider education and confidence prescribing LARC devices are major factors related to access. Upstream is providing training, technical assistance, and quality improvement to all publicly funded health centers and nearly 40 of the largest private providers in Delaware to ensure patients are offered same-day access to the full range of contraceptive methods, including low- or no-cost LARC, in a single appointment. Delaware's comprehensive training model provides staff education not only on contraceptive counseling and LARC insertion, but also organizing the logistics of scheduling same-day LARC insertions, and billing for the devices and procedures to achieve maximum reimbursement. As of June 2016, over 50 health centers have received training as part of CAN, including the University of Delaware Nurse Managed Primary Care Center, Christiana Care Health System and Planned Parenthood of Delaware. Upstream anticipates holding 80 trainings with community health centers, hospital systems, and pediatric, primary care and women's health practices.

Inpatient Hospital Reimbursement for Immediate Post-Partum LARC

LARC insertion within minutes of childbirth is both medically and logistically favorable, as women are known not to be pregnant and are often highly motivated to use contraception. However, a major barrier to women receiving their choice of effective contraception immediately after delivery is access and financial reimbursement. Most insurance pays a lump sum for labor and delivery, without reimbursement for provider, hospital and device costs associated with providing LARC during the hospital stay. This approach creates a financial disincentive to offer the full range of contraceptive methods at the time of delivery.

Delaware has long offered contraceptive management, including devices and related surgical procedures, as a covered service under the state's Family Planning and Related Services Benefit Package. However, previously the bundled rate for this service did not account for provider and device costs associated with LARC insertion and removal. In 2015, after reviewing its policies that may present

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barriers to LARC access, DMMA added fee-for-service LARC reimbursement separate from the typical provider bundled payment reimbursement for obstetric care, thereby enabling hospitals providing labor and delivery services to offer LARC placement to interested Medicaid patients immediately after childbirth.

Device Stocking and Reimbursement

High up-front costs related to stocking often result in providers and facilities not having devices on hand to offer women. 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. Delaware Medicaid previously had limits on the dispensing of medications and pharmaceuticals that may have discouraged LARC use; generally, outpatient pharmacies must dispense directly to the client and cannot send medication to another facility. However, as of DMMA's 2015 revisions, outpatient pharmacies can dispense LARC devices and implants to facilities like a hospital or health center.

> "Delaware is fortunate to have a strong public-private partnership supporting the CAN initiative..."

Providers and facilities order LARCs out of pocket through the hospital's inpatient pharmacy, and stock the devices in an automated dispensing cabinet on the labor and delivery floors. This strategy requires providers and practices to closely monitor stock and insertion rates. The hospital's inpatient pharmacy technology team tracks devices removed from the automatic dispensing cabinets, verifies administration, and passes the information to the appropriate outpatient pharmacy. The outpatient pharmacy submits a claim for the device to Medicaid; the cost of the device then gets transferred to the outpatient pharmacy, as it will receive the reimbursement.

Sustainability

Delaware is fortunate to have a strong public-private partnership supporting the CAN initiative; leadership and staff from the Delaware CAN Workgroup are actively involved in troubleshooting system and policy issues. In addition, discussions are taking place to develop a sustainable system for providing comprehensive family planning and reproductive health services to uninsured and underinsured women of reproductive age. A system needs to be in place that ensures low-income women who do not have health insurance have the same access to low- or no-cost contraception that

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women with insurance enjoy. With strong political will and support, Delaware is in a good position to leverage a new funding stream or develop a mechanism that covers the cost of contraceptive care for uninsured women.

Outcomes and Next Steps

Delaware is investing $1.75 million of its Division of Public Health dollars for the multi-year CAN project. Additionally, Upstream USA has raised over $10 million dollars from private sources, including the Robert Wood Johnson Foundation, the William and Flora Hewlett Foundation, and the Silicon Valley Community Foundation. As a comparison, Delaware used $36 million in state funds in 2010 to pay for unintended pregnancies. Delaware CAN investments have the potential for major cost savings; according to projections from the University of Wisconsin, the CAN initiative is estimated to have a net cost annual savings of $16.2 million, and a three-year net cost savings of $48.5 million.

An independent evaluation process will measure progress by tracking pregnancy and birth outcomes, as well as spending in Medicaid and private insurance plans. The University of Delaware will contribute research expertise and data coordination with Delaware state agencies, and the University of Maryland will lead the overall evaluation and coordinate comparisons of Maryland and Delaware Medicaid-eligible women. The evaluation, which was launched in June 2016, will measure the CAN program against its aims of reducing unintended pregnancies, decreasing Medicaid costs for unintended pregnancies, and supporting policy development that enables contraceptive access. Evaluators will be looking at comparison geography, cost-benefit analyses, and changes in attitudes, beliefs, and behaviors. Delaware was also awarded four years of grant funding by the Centers for Medicaid and Medicaid Services to support the collection and reporting of data on women's use of contraceptive methods, which the state can leverage in evaluating CAN's success in improving pregnancy planning and birth spacing.

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Author's Note:

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