

Enhancing Long-Acting Reversible Contraception (LARC) Uptake and Reimbursement at Federally Qualified Health Centers: A Toolkit for States¹

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Introduction

Long-acting reversible contraception (LARC)—including the intrauterine device (IUD) and the birth control implant^{1,2}—are highly effective methods of contraception that are increasingly being used to prevent unintended pregnancies and enable planning of birth spacing. However, for many women who seek family planning services from Federally Qualified Health Centers (FQHCs), access to LARC may be hindered by Medicaid coverage provisions that do not support comprehensive outpatient reimbursement for all of the costs associated with LARC, including insertion, removal, education and counseling, and the device itself. Indeed, recent guidance from the Center for Medicaid & CHIP Services (CMCS) emphasizes the importance of eliminating “(1) administrative and reimbursement barriers that result in high upfront costs for devices and (2) payment policies that reduce (or do not provide) reimbursement for devices or placement”³ in order to enhance access.

Supported by a growing body of research demonstrating the effectiveness and cost-effectiveness of LARC, there is momentum among states and providers, and at the federal level to remove impediments and to reform LARC payment policies. The potential health and financial benefits are significant, considering that 45% of U.S. pregnancies in 2011⁴ were unintended⁵ and that public insurance programs paid for most (68%) of the 1.5 million unplanned births in 2010.⁶ Addressing the challenges that federally qualified health centers (FQHCs) face in providing LARC is of particular importance because of the large number of low-income women of childbearing age (15-44) who seek care from them (estimated at about 5.8 million women—or 27% of all FQHC patients—in 2013⁷) as well as the higher rates of unintended pregnancy among women below the federal poverty level.⁸

State Medicaid programs are the primary financier of FQHC services and have a number of policy and payment levers at their disposal to promote LARC use in these settings. The goal of this toolkit is to be a resource for states seeking to enhance LARC access in FQHC settings by highlighting some of the reimbursement and policy options they can leverage. We also discuss advantages, disadvantages, and implementation considerations. Specifically, this toolkit explores:

- LARC access barriers and relevant federal guidance
- Medicaid reimbursement options for LARC devices provided in an FQHC setting
- Key considerations and/or decisions for states to make regarding LARC coverage and policy changes
- Operational and implementation issues for LARC, with a focus on FQHCs

This toolkit also points states and FQHCs toward additional information and resources. Relevant supplemental resources are included in the appendix as well as in the references listed at the end of the toolkit.

¹ This report was prepared for The National Institute for Reproductive Health by Health Management Associates.

This toolkit was developed with the support and guidance of the Community Health Care Association of New York State (CHCANYS), and was heavily informed by their successful advocacy to reform state policy allowing FQHCs to bill for LARC devices outside of their threshold PPS rate. Their experience, including the issues and questions they faced, the solution they adopted, and lessons learned, forms the foundation of this toolkit.

It should be noted while this toolkit is intended to be a practical resource and support for decision making, it is not exhaustive and does not capture all of the nuanced LARC policy and reimbursement issues that may exist at the state level. Nor does it describe all possible decision points or courses of action. We also do not attempt to quantify the results of specific policy and reimbursement options, as the impact will vary from state to state. In many cases where changes have only recently been implemented, it is too soon to be able to assess the impact. Instead, this toolkit is intended to be used by states as the start of a thorough process that involves an analysis of the state's current landscape, an assessment of potential solutions, and engagement of local stakeholders. This is an issue with some obvious barriers, as well as more nuanced challenges that require sustained partnership and dedicated focus to overcome. In general, the toolkit is designed to support the larger public health goals of removing all barriers to contraception, and of ensuring that every woman has ready access to the contraception method of her choice.

1. LARC Access Barriers

LARC utilization is still relatively low in the United States⁹ despite their safety, effectiveness, and high rates of patient satisfaction, and despite an increase in their use in recent years.¹⁰ Studies show that the overall percentage of U.S. female contraception users of childbearing age (age 15-44) who use LARC has grown, increasing from 2.4% in 2002¹¹ to 8.5% in 2009 to 11.6% in 2012.¹² However, women with Medicaid coverage were one of the few groups that did not see an increase in utilization during the most recent study period. Between 2009 and 2012, use of LARC among Medicaid-covered women remained fairly flat at 11.0% (compared with 11.5% in 2009), whereas prevalence of LARC use among women with private insurance and "other" coverage¹³ increased to 11.1% (up from 7.1%) and 14.0% (up from 8.0%), respectively.^{14,15} Compared with other countries, the prevalence of IUD use among married or in-union women in the United States is far below the global average (5.1% in the United States compared with 13.7% worldwide).¹⁶ Given that LARC (implants and IUDs) are considered by the CDC to be the most effective family planning method,¹⁷ more can and should be done to ensure that women are informed about and have access to LARC options.

Broad underlying Medicaid coverage issues exist in many states that limit access to and utilization of LARC. Medicaid family planning coverage varies from state to state, although most states cover LARC in some way.¹⁸ Depending on the state, patients and providers may face challenges such as restrictive utilization management requirements or lack of same-day access. The Centers for Medicare and Medicaid Services (CMS) has made an effort to clarify these points and make recommendations to address some of the access barriers. In a June 2016 letter to State Health Officials, CMS encouraged states to cover all FDA-identified contraceptives (including LARC) under their state plan and indicated that one pathway to do this is to align their state plan with their Alternative Benefit Plan (ABP) coverage for these services.¹⁹ Since there is a 90% federal match for family planning services and supplies, the cost to states of covering LARC can be relatively low.²⁰

The State Health Official letter also clarifies several key Medicaid coverage issues that are often cited as barriers to accessing LARC, stating that:

- States and managed care plans **cannot require step therapy** for family planning (i.e., cannot require that a particular contraception method be used first) or impose policies that restrict a change in method;
- States and managed care plans should not adopt practices or policies that delay provision of a preferred contraception method or impose medically inappropriate **quantity limits** (such as allowing only one LARC insertion every five years, even in cases where an earlier LARC was expelled or removed);
- The only allowable **prior authorization** criteria is the determination that the contraception method is medically necessary and appropriate for the individual;
- LARC reimbursement to providers **must include insertion, removal, and the device itself** (although these may be billed and paid separately); and
- Family planning services and supplies, including contraceptives and pharmaceuticals, must be provided to the patient **without cost sharing**.²¹

Links to the State Health Official letter and other CMS guidance can be found in Section 6.

The financial burden of purchasing and maintaining a stock of LARC devices for same-day insertion is also commonly cited as a barrier for providers. A state's decision about whether to cover LARC under the Medicaid pharmacy benefit or under the medical benefit plays a key role in this issue, as this determines how the devices are obtained and who pays for them.

In states that cover LARC through their pharmacy benefit, the process typically involves the dispensing pharmacy billing the state for the LARC and dispensing fees and delivering the LARC to the provider; then the provider bills for insertion or implantation. In this scenario, the woman must see the provider twice, first to get the LARC prescription and then to get it inserted or implanted. If the woman does not return for insertion, providers generally are not permitted to return unused LARCs to the pharmacy, which results in an unnecessary financial loss for the state and ultimately means that the woman is not using the most effective contraception.

In states that cover LARC through their Medicaid medical benefit, providers are able to stock the devices in-house, eliminating the need for the patient to come back for a second visit and reducing potential waste from unused LARCs. However, there is a high upfront cost to stocking LARCs,²² which contributes to FQHCs and other providers being unable or unwilling to stock an adequate number of devices for same-day insertions.²³ The following section further explores device reimbursement options.

2. LARC Coverage and Reimbursement for FQHCs

FQHCs, depending on their state's LARC coverage and reimbursement policies under Medicaid, may face specific incentives or disincentives to providing LARC because of their unique payment structure, which can preferentially drive them toward other, less effective forms of contraception. Pursuant to federal law, FQHCs are paid for Medicaid services via a Prospective Payment System (PPS) rate or an approved Alternative Payment Methodology (APM). The PPS rate is an all-inclusive, cost-based encounter rate, which includes a face-to-face visit with a provider and any services provided incident to that visit (e.g., lab services).²⁴ The PPS per-visit rate is calculated based on reasonable and allowable costs for FQHC services, as documented during a baseline period. The rate is inflated annually by the Medicare

Economic Index (MEI) and when an FQHC experiences a change in the type or intensity of services that results in a meaningful change in cost per visit.

If a state elects to utilize an Alternative Payment Methodology (APM), the APM must pay providers at least what they would have been paid under the PPS and providers must voluntarily elect to be reimbursed under the APM rather than the PPS. The PPS per-visit rate is calculated based on what is considered a reasonable cost for such services, as documented during a baseline period, with adjustments.

For FQHCs, the PPS rate is an important factor for states to consider in seeking to improve LARC uptake. How the PPS rate is structured, what costs are carved out of the rate, and whether the rate is enough to cover LARC costs, can impact the ability and willingness of FQHCs to offer LARC. To briefly define the terminology used in this toolkit, LARC “costs” may refer to: (1) the cost of providing LARC-related **services** and/or (2) **device** costs. Providing LARC-related **services** under the PPS visit rate may pose challenges for some FQHCs if their rate does not account for a longer or more complex visit that may be necessary for LARC procedures, however it is cost of the **device**—which typically ranges from \$50 to \$500 under 340B²⁵—that often represents the most significant financial barrier. For this reason, the options presented below primarily focus on device reimbursement and only lightly touch upon issues related to reimbursement of LARC services for FQHCs.

Following is a description of options states currently have to reimburse FQHCs for LARC device costs, both included in and separate from PPS rates.

LARC Device Reimbursement Under the PPS Rate

States may include Medicaid-covered LARC devices as part of the PPS encounter rate, meaning that FQHCs cannot bill separately for them. For example, in Colorado, FQHCs do not receive an additional payment for LARCs since the FQHC encounter payment rates are based on “full-cost” reimbursement calculations.²⁶ And in New York State, the policy as of spring 2016 was that FQHCs may not bill for LARC devices outside of their PPS rate, although this policy was recently changed via a State Plan Amendment to allow FQHCs to bill separately for the device.^{27, 28}

Including LARC devices as part of the PPS encounter rate can present an obstacle for providers in FQHC settings since the encounter rates, depending on how they are structured, may not be sufficient to cover the high cost of the device. Although PPS rates are based on FQHCs’ reasonable and allowable costs, rates in many states are based on FQHC costs from the baseline period of FY 1999 - FY 2000²⁹ when LARC methods were much less prevalent. States do not typically do a statewide “re-base” of PPS rates unless it is as part of an APM (such as Arizona, which re-bases its PPS every three years as part of its APM).

States are, however, required to have processes in place to adjust individual FQHCs’ PPS rates based on an increase (or decrease) in the scope of services provided by the FQHC, such as adding a new service or a change in the intensity of services. In states with LARC covered under the PPS rate, FQHCs would typically need to appeal to the state for a rate adjustment to account for any addition or increase in LARC device costs or if they are beginning to offer LARC for the first time. The FQHC would go through a state-defined change in scope process, which varies from state to state in terms of the definition of what constitutes a scope change, the threshold for what would justify a rate adjustment, the timeframe within which the rate adjustment must take effect, and the overall complexity or transparency of the process. In order to enhance access under this methodology, states would need to provide a clear and

simple pathway to allow FQHCs to request and obtain a higher encounter rate for providing LARC and to ensure that the rate covers the device and other LARC-associated costs.

When deciding whether to include LARC devices as part of the PPS rate, states should consider how they would capture these device costs as part of an all-inclusive encounter rate, the potential administrative burden imposed on FQHCs to submit a rate adjustment request, and the burden on the state itself to process these requests. In aggregate, unless the increase in LARC provision is large and represents a significant cost relative to other services the FQHC provides, the change may not ultimately result in a meaningful increase in the FQHC’s overall cost per visit and may not justify the FQHC going through the process.

As described in Section 1, there are also significant acquisition, stocking, and disposal costs associated with LARC devices that contribute to same-day access issues. Because upfront stocking of LARC devices is expensive and because it can be challenging for states to adjust the PPS rates to fully account for increases in LARC provision, bundling LARC device costs into the PPS rate is generally viewed as less likely to incentivize LARC uptake than carving it out of the PPS rate or other innovative approaches.

Carving LARC Devices Out of the PPS Rate

There is considerable variability across states in the extent to which certain services are “carved out” of the PPS rate and billed independently. Several states have carved payment for LARC devices out of the PPS per-visit rate using a State Plan Amendment (SPA). Reimbursement for LARC in these states typically is set at the 340B acquisition cost or for devices purchased outside that program, the lower of the provider’s charges, or the rate on the Medicaid provider fee schedule.

Carving out LARC devices is generally the recommended option to ensure adequate reimbursement, particularly in states where an FQHC is unlikely to meet the threshold for a change in scope PPS rate adjustment, or in states where there are caps or other limitations on rates. Table 1 illustrates recent examples of state carve-out language.

State	SPA/Policy Language
<p>New York: New York carved out LARCs from the PPS rate for FQHCs and RHCs in 2016. As of publication, the change is still being implemented, but payments will be available retroactively.</p>	<p>SPA language: “For services provided on and after April 1, 2016, the cost of long acting reversible contraceptives (LARC) will be separated from the PPS reimbursement. Reimbursement for LARC will be based on actual acquisition cost. The facility must submit a separate claim to be reimbursed for the actual acquisition cost of the LARC device.”³⁰</p>
<p>Georgia: Georgia carved out LARCs from the PPS rate for FQHCs and RHCs in 2015</p>	<p>Georgia used the following SPA language for both FQHCs and RHCs. “Effective for dates of services on or after May 15, 2015, FQHCs may elect to receive reimbursement for Long Acting Reversible Contraceptives (LARCs) (specifically intrauterine devices and single rod implantable devices) for contraceptive purposes. Reimbursement for the LARCs shall be made in accordance with the following:</p> <ol style="list-style-type: none"> I. To the extent that the LARCs were purchased under the

State	SPA/Policy Language
	<p>340B Drug Pricing Program, the FQHC must bill the actual acquisition cost for the device.</p> <p>II. Reimbursement shall be made at the FQHC’s actual 340B acquisition cost for LARCs purchased through the 340B program. For LARCs not purchased through the 340B program, reimbursement shall be made at the lower of the provider’s charges or the rate on the Department’s practitioner fee schedule, whichever is applicable.</p> <p>III. Reimbursement is separate from any encounter payment the FQHC may receive for LARCs.”³¹</p>
<p>Illinois: As highlighted in a recent CMS bulletin³² on state efforts to expand access to LARCs, Illinois has taken a number of steps including a PPS carve-out for FQHCs and RHCs, and an additional \$35 incentive payment for 340B providers that use LARCs.</p>	<p>SPA language: “FQHC/RHC Implantable Contraceptive Devices. Effective for dates of service on or after October 13, 2012, FQHCs and RHCs, as described in subsection (2)(a), may elect to receive reimbursement for intrauterine devices (IUDs) and other implantable devices emitting hormones or drugs for contraceptive purposes. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:</p> <p>I. To the extent that the implantable contraceptive device was purchased under the 340B Drug Pricing Program, the FQHC or RHC must bill the actual acquisition cost for the device.</p> <p>II. Reimbursement shall be made at the FQHC or RHC’s actual 340B acquisition cost for implantable contraceptive devices purchased through the 340B program. For implantable contraceptive devices not purchased through the 340B program, reimbursement shall be made at the lower of the provider’s charges or the rate on the Department’s practitioner fee schedule, whichever is applicable.</p> <p>III. Reimbursement is separate from any encounter payment the FQHC or RHC may receive for implanting the device. Additional Dispensing Fees to Providers: Effective July 2014, HFS increased the dispensing fee add-on payment to \$35 for providers who dispense highly-effective contraceptives through the 340B federal drug pricing program. In order to receive the additional fee, providers must identify 340B purchased drugs by reporting modifier “UD” in conjunction with the appropriate procedure code and actual acquisition cost for the birth control method on the claim form.”³³</p>
<p>Maryland: Maryland began reimbursing FQHCs for a visit and the acquisition costs of LARCs in 2013, detailing payment rates for copper and hormonal IUDs and the</p>	<p>CMS summarized the state’s policy as follows: ³⁴</p> <ul style="list-style-type: none"> • “FQHCs are reimbursed for an office visit and the acquisition cost for one (1) of the three (3) covered LARC devices. Practitioners receive reimbursement for one of the three devices, as indicated by their respective J code:

State	SPA/Policy Language
contraceptive implant.	<ul style="list-style-type: none"> ○ J7300 ○ J7302 ○ J7307”³⁵ <p>The policy memo listing 2013 payment rates is available at https://mmcp.dhmh.maryland.gov/Documents/PT%2022-13%20FQHC%20Transmittal%20No.%201.pdf</p>

States interested in learning more about state plan possibilities or the family planning state plan option can contact their CMS Regional Office.³⁶

Additionally, certain services can be “carved out” of the PPS and paid for separately. For example, Ohio established separate PPS rates for each FQHC for Medical, Dental, Speech Pathology and Audiology, Mental Health/Behavioral Health, Physical Therapy, Optometry, Podiatry, Chiropractic and Transportation services.³⁷ The idea of carving out a separate PPS encounter rate for an FQHC family planning encounter has been proposed³⁸ by some researchers and advocates. This payment methodology does not appear to have been applied to family planning services as of the writing of this toolkit, however it is an idea that would likely be in line with CMS’s focus on improving LARC access.

Other Innovative Approaches

CMS also encourages states to consider and/or develop innovative solutions to alleviate LARC reimbursement and inventory challenges for FQHCs and other providers. These could include:

- **Alternative Payment Methodologies:** State Medicaid programs can use Alternative Payment Methodologies (APMs) either in place of or alongside the PPS rate, as long as they ensure that FQHCs are still paid at least the amount they would have received under PPS and as long as the FQHC receiving the APM agrees to it. There are many examples of APMs, which generally apply to the full range of FQHC services. For example, Arizona’s APM allows FQHCs to re-base their rates every three years. Oregon operates a pilot APM program that seeks to encourage practice transformation by allowing participating FQHCs to retain their full PPS-equivalent payments even as they transition some face-to-face encounters to virtual encounters. In 2014, 30% of states used an APM model to pay FQHCs, and 19% used both APM and PPS. Additionally, states are including FQHCs in broader value-based payment initiatives such as pay for performance (P4P), shared savings, supplemental care management payments, and capitation.³⁹ A state looking to enhance LARC access at FQHCs could design an APM that incorporates family planning incentives and/or performance metrics⁴⁰ as part of a broader payment methodology. This would be a new approach that would align with CMS’s increasing emphasis on supporting access to LARC for women in Medicaid.
- **1115(a) demonstration waivers:**⁴¹ CMS in its recent State Health Official Letter expressed interest in exploring section 1115(a) demonstration authorities to ensure that providers who furnish covered medical assistance for eligible individuals have access to an inventory of LARC devices. One idea offered is that states could purchase a batch of LARC devices (e.g., a month’s worth of devices, leveraging the 90% federal match) and furnish them to Medicaid providers who offer LARC, without cost to the provider. The provider would then have the LARC readily

available to implant/administer. The provider would not bill the state for the devices used, just services such as insertion and removal, and the state would replenish the provider's LARC supply once it is depleted. CMS stated that it will consider "other state ideas like this, related to all types of family planning services, subject to the regular process for review, approval, and evaluation of section 1115(a) demonstrations."⁴²

- **Medicaid Managed Care Organization contract requirements:** CMS noted in its recent bulletin that the states taking the most proactive approaches to increasing LARC access through Medicaid policy have MCO contract requirements intended to promote access and reinforce the 2014 Centers for Disease Control and Prevention (CDC) recommendations on family planning. For example, Illinois' external quality review organization (EQRO) "developed a family planning readiness review tool and reviews the plans' family planning policies and procedures. Additionally, the MCO contract was revised to include language that provider policies/protocols shall not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements; and that clients should receive education and counseling on all FDA-approved birth control methods from most effective to least effective, and have the option to choose the preferred birth control method that is most appropriate for them."⁴³ MCO contract requirements are another policy lever to influence LARC access that more states may want to consider. For reference, see Section 1 above for a description of utilization management provisions that CMS has indicated are not permissible.
- **Manufacturer arrangements:** Establish arrangements with LARC manufacturers to stock providers with the devices and also allow them to be returned if unused.⁴⁴ One example of this is a pilot program in Illinois with Bayer HealthCare (Mirena and Skyla) and Teva Pharmaceuticals (Paragard) to stock physician offices with these devices without charging an upfront cost to the providers. This allows providers to have a stock of LARC devices on-hand so that if the patient decides she wants to use this type of contraception, it can be inserted immediately and she does not need to return for a second visit.⁴⁵ Another manufacturer—Medicines 360—offers a low-cost device when FQHCs purchase through the 340B program (LILETTA).

3. Key State Decisions

States looking to adopt an FQHC payment methodology and policy reforms that will incentivize appropriate, informed, and choice-driven use of LARCs should consider the following issues and questions.

1. Assess the Landscape

- What is our state's current LARC reimbursement structure for FQHCs?
- Does our state Medicaid program cover the full range of LARC devices and services?
- How does our reimbursement for LARC discourage (or encourage) use of LARC?
- What are the current LARC utilization rates in the state?
- What do stakeholders (FQHC providers and patients, particularly women using contraception) see as the barriers to utilization?
- Does our state have an APM for FQHCs? Were the PPS rates recently rebased?
- Is there a clear pathway for FQHCs to request/receive higher payments for any increase in LARC provision? Is this change in scope process utilized by FQHCs in our state?
- Are there caps or limits on PPS rates that might prevent FQHCs from being adequately reimbursed for the cost of LARC devices and/or services?
- Does our state use Medicaid managed care?
 - If yes, do the MCOs currently require step therapy or prior authorization, or have restrictive quantity limits on LARC?
- Do FQHCs have challenges with maintaining an inventory of LARC for same-day administration? If so, what are the specific challenges?
- Are there any state-specific administrative or political considerations to take into account? Or other initiatives going on in the state that may impact these efforts?

2. Analyze Potential Solutions to Enhance LARC Uptake

- Could LARC devices be carved out of the PPS rate? What would the billing and coding requirements be for carve-outs?
- Is the state interested in developing a new methodology to carve family planning/LARC services out of the PPS rate, and seeking federal approval for it?
- Would it be feasible make changes to the state plan to provide more comprehensive coverage of LARC services/devices?
- Is our state willing to submit a SPA to carve out LARC from the PPS?
- Is our state willing to submit an 1115(a) demonstration waiver proposing an innovative approach to increasing LARC access, such as the state purchasing an inventory of devices for FQHCs?
- Is our state (and are the FQHCs) willing to implement an APM?
- If LARC devices in our state will remain "carved in" to the PPS, are there ways we can change, clarify, or streamline our state's process for FQHCs to request a PPS rate adjustment, to ensure that the PPS encounter rate fully reimburses them for any increase in LARC utilization and costs?
- How could the Medicaid MCOs in our state be involved in removing LARC access barriers? Will we change our MCO contracts to ensure that MCOs are not imposing unnecessary barriers to LARC?
- Is our state willing to facilitate agreements with manufacturers to ensure that Medicaid providers of LARC have an inventory of devices?
- Should our state directly stock Medicaid providers with needed LARC devices?
- What are the state and federal costs associated with the approach(es) under consideration?
- What feedback and reactions do stakeholders and advocates have about the potential approach(es)?
- What options are there to address any state-specific administrative or political considerations?

3. Decide on and Implement an Approach

- Based a thorough analysis of the options, determine which solution, or combination of solutions, is most likely to enhance access to LARC while satisfying any state-specified requirements and criteria (such as cost neutrality).

Regardless of the payment model and reforms adopted, the reimbursement strategy should be coupled with efforts to address the operational and implementation challenges that FQHCs face in providing LARC, as described in the next section.

4. Operational and Implementation Challenges

In addition to considering the reimbursement methodology for FQHCs, there are other significant barriers that clinics and providers can experience when attempting to increase LARC provision at their sites. This section offers a high-level overview of commonly cited challenges that many FQHCs face with regards to providing LARC to their patients as well as the state's role in addressing those challenges.

Billing / Coding

Accurate billing and coding for LARC counseling visits and insertions is essential to ensure rapid and accurate reimbursement for the visit. Incorrect coding of a visit can lead to denied claims, which further limits the financial capabilities of a clinic to invest in keeping more LARC devices in stock. A quick reference guide for codes for LARC devices and procedures is available in the Appendix of this toolkit and includes new ICD-10 codes.

Proper and adequate documentation in a patient's medical record is also essential to support each billing code in order to receive reimbursement from a payer (public or private). Medicaid beneficiaries should not be billed cost-sharing for family planning services and supplies.

Provider Education

One common challenge to providing LARC is maintaining an adequate network of available providers who are trained and comfortable with providing IUDs, which includes counseling about the available options, benefits and risks, as well as the actual insertion of the device. LARC have only recently become the recommended first-line option for nulliparous women (women who have not given birth), including adolescents.⁴⁶ Given the recent shift, some providers still are not trained on LARC insertion and/or do not offer LARC as a method for their patients, even if the woman would be an eligible candidate for a LARC device. Increasing the number and types of providers trained on LARC⁴⁷ can contribute to the uptake of the devices not only by leading more providers to offer the devices to more women, but also by making more providers available to do insertions.

Stocking / Same-Day Availability

As mentioned throughout this toolkit, LARC devices have a high up-front cost. As such, clinic sites like FQHCs that see a predominantly lower-income population, including a substantial number of Medicaid enrollees and uninsured, are reluctant to bear the cost of ordering a supply of LARC devices to keep on-site for same-day insertions. More often, a clinic will order the LARC device specifically for the patient, or have it ordered through the pharmacy benefit, and the patient will return to the clinic for the insertion at a later date. This allows a site to bill the patient's insurance (either public or private), or assist the patient with paying for it individually. However, the patient may not return for the insertion visit (one study found that 45.6%—nearly half—of women did not return for the second visit⁴⁸), leaving the woman at higher risk for an unintended pregnancy without the LARC. For this reason, having same-day availability of devices is crucial. Additionally, states should ensure that clinics are allowed to bill for an office visit and LARC procedure (device insertion) that occur on the same day, if necessary. In some states, FQHCs are not permitted to bill Medicaid for more than one encounter on the same day.⁴⁹

340B Program

The 340B drug pricing program is a federal program administered by the Health Resources and Services Administration (HRSA), which mandates that pharmaceutical manufacturers provide discounted rates

for their products to qualified entities such as FQHCs. For a patient to receive a 340B price on a drug or device such as LARC, they must meet eligibility requirements.⁵⁰ 340B-eligible sites can order LARC devices at the discounted rate and provide them to eligible patients. However, program rules can be complicated depending on the patient visit and how the patient chooses to pay (e.g., public or private insurance, or self-pay). FQHCs eligible for 340B pricing must be clear on state and program rules for using 340B-priced drugs or devices for patients. For example, while an FQHC may provide a 340B-priced device to a patient who is covered by Medicaid, the FQHC may not wish to do so, because it could lead to an improper “duplicate discount,” which occurs when the pharmaceutical manufacturer pays a rebate to the state Medicaid agency⁵¹ on a drug already purchased at the discounted 340B price. 340B-covered entities that chose to use 340B drugs or devices for Medicaid patients are required to inform the state Medicaid agency that they are doing so and comply with other guidance to prevent duplicate discounts. An FQHC seeking to use 340B pricing for LARC should have policies and procedures in place to avoid duplicate discounting as well as diversion of 340B drugs or devices to ineligible patients.⁵² Failure to adhere to program rules can result in an FQHC needing to repay the price difference to the pharmaceutical manufacturer.

State Supports for Operational Challenges

States can support FQHCs in navigating LARC-related operational challenges in a number of ways. At minimum, states can provide clear and straightforward guidance to providers on Medicaid cost reporting, billing and coding guidance, and policy clarifications related to LARC, as necessary, to ensure that FQHCs understand the state’s coverage provisions and know how to get reimbursed for LARC.⁵³ States may also consider convening provider learning collaboratives, offering technical assistance on LARC provision and reimbursement, and encouraging and disseminating information about LARC clinical training opportunities.⁵⁴ As described above, states also have various options available to help with the up-front device costs (e.g., by directly supplying or working with manufacturers to supply an inventory of LARCs to providers).

5. Conclusions

Despite the challenges, there is substantial momentum at the federal, state and provider level to increase the uptake of LARC and significant potential for improved health outcomes and financial benefits. Recent success in Colorado shows that when LARC devices were made more readily available the teen pregnancy rate in the state decreased by 40%, and the abortion rate also decreased (42% for ages 15-19, and 22% for ages 20-24).⁵⁵ And nationally, data show that the increase in LARC utilization (as described in Section 1 above) has been accompanied by declines in the U.S. abortion rate, which dropped 13% between 2008 and 2011. Births also declined during that period, indicating that births were not replacing abortions. Although there are multiple possible explanations and factors that may be influencing this trend, the data suggest that the unintended pregnancy rate is declining at the same time that use of highly effective contraception is increasing.⁵⁶ The financial benefits of reducing unintended pregnancies are apparent, since for every public dollar spent on contraception services, Medicaid saves an estimated \$5.68 on costs associated with unintended pregnancy and infant care.⁵⁷

The Centers for Medicare and Medicaid Services (CMS) has been actively promoting the use of safe, effective and appropriate contraception, via the CMCS Maternal and Child Health Initiative and guidance issued to states. An informational bulletin⁵⁸ in April 2016 described how different states have approached confronting some of the barriers highlighted above, including policy changes to pay for

immediate post-partum LARC outside of the global delivery rate, and to reimburse FQHCs and rural health centers (RHCs) for the cost of the LARC device in addition to their normal encounter rate reimbursement. A subsequent State Health Official and State Medicaid Director letter issued in June 2016 reinforced these points and provided additional guidance on provision of Medicaid family planning services and supplies. This recent guidance and widespread interest in promoting access to LARC and other forms of effective contraception and family planning services create an ideal opportunity for states to re-examine and reform their current LARC-related policies and payment structures.

6. Additional Resources

In addition to the resources in the footnotes throughout this toolkit, the following are excellent sources of information related to LARC.

General LARC

American College of Obstetricians and Gynecologists, “Long-Acting Reversible Contraception Program,” <https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception>

ACOG provides a wealth of information about the clinical and administrative sides of LARC, including resources for provider education, billing and coding, and policy guidance for states who may be seeking to change Medicaid policy surrounding LARC.

Gavin, Loretta, et al. “Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs.” April 25, 2014.

<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>

This report established LARC among the first-line recommended options for family planning, including for nulliparous women. The report provides recommendations developed collaboratively by CDC and the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS). The recommendations outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services.

Coding Guidance

“Coding Guidelines for Contraceptives,” UpstreamUSA, October 1, 2015.

http://www.upstream.org/wp-content/uploads/2015/11/Upstream-Contraceptive-Coding-Guide_111215_1115A.pdf

This guide focuses on the specific codes that should be used for different contraceptive methods, not specific to LARC. It does provide guidelines for contraceptive coding in general, and explains the different types of codes, when/how the codes should be used, and provides some sample scenarios to give examples of how certain encounters should be coded and documented.

“Intrauterine Devices & Implants: A Guide to Reimbursement,” University of California San Francisco, Last updated April 2016. <http://larcprogram.ucsf.edu/>

The UCSF LARC Reimbursement Guide, which is regularly updated on the website, provides clinicians and administrators with tools and guidance for billing and getting reimbursed for LARC. It also provides

assistance to assist clinics with addressing challenges around stocking, provider education, and other barriers.

LARC and Medicaid

Vikki Wachino, “Medicaid Family Planning Services and Supplies.” SHO #16-008, Center for Medicare and Medicaid Services, June 14, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>

This CMS letter to State Health Officials clarifies previous guidance on the delivery of family planning services and supplies to all Medicaid beneficiaries.

Vikki Wachino, “State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception,” CMCS Informational Bulletin, Center for Medicare and Medicaid Services, April 8, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf>

This CMS Informational Bulletin describes various states’ approaches for increasing access and uptake of LARC under the Medicaid program.

Other Federal Programs

Multiple federal agencies work on contraception issues and other issues related to improving maternal and child health and wellbeing. In 2014, CMS launched a Maternal and Infant Health Initiative. In addition to CMS, there is the Title X program overseen by the Office of Population Affairs and the Centers for Disease Control and Prevention’s (CDC) Winnable Battles, which include a focus on teen pregnancy. Information about maternal and infant health and contraception is available from the CDC’s Division of Reproductive Health as well as from the Health Resources and Services Administration’s (HRSA’s) Maternal and Child Health Bureau (MCHB). Links and further information are available here: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/contraception.html>

Appendix

Coding for LARC Methods and Procedures⁵⁹

4.5: Coding for LARC methods and procedures

Providers should be aware that payers may have specific requirements for coding preventive services covered by the ACA. Providers should check with their payers for guidance regarding appropriate coding because patients' cost-sharing requirements may be affected.

Correct coding can result in more appropriate compensation for services. To help practices receive appropriate payment for providing LARC methods, the following information can be helpful. Updates to this [Quick Coding Guide](#)⁶⁸ are available at the ACOG website, as is a [Billing Quiz](#)⁶⁹ that delves into further detail.

Basic contraceptive implant coding

The insertion and/or removal of the implant are reported using one of the following CPT** codes:

- 11981 Insertion, non-biodegradable drug delivery implant
- 11982 Removal, non-biodegradable drug delivery implant
- 11983 Removal with reinsertion, non-biodegradable drug delivery implant

The diagnostic coding will vary, but usually will be selected from the Encounter for Contraceptive Management code series - V25 in ICD-9-CM or Z30 in ICD-10-CM. These codes are:

- V25.5 Encounter for contraceptive management, insertion of implantable subdermal contraceptive or
- Z30.018 Encounter for initial prescription of other contraceptives in ICD-10-CM.
- V25.43 Surveillance of previously prescribed contraceptive method; implantable subdermal contraceptive or
- Z30.49 For checking, reinsertion, or removal of the implant in ICD-10-CM.

Note: ICD-10 codes are scheduled to go into effect October 1, 2015. They may not be reported prior to effective date.

The CPT procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS (Healthcare Procedural Coding System) code:

- J7307 Etonogestrel [contraceptive] implant system, including implant and supplies

Basic IUD coding

The insertion and/or removal of IUDs are reported using one of the following CPT codes:

- 58300 Insertion of IUD
- 58301 Removal of IUD

Most IUD services will be linked to a diagnosis code from the V25 series (Encounter for Contraceptive Management) or the Z30 series in ICD-10-CM:

- V25.11 Insertion of intrauterine contraceptive device or
- Z30.430 Encounter for insertion of intrauterine contraceptive device in ICD-10-CM.
- V25.12 Removal of intrauterine contraceptive device or
- Z30.432 Encounter for removal of intrauterine contraceptive device in ICD-10-CM.
- V25.13 Removal and reinsertion of intrauterine contraceptive device or
- Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device in ICD-10-CM.
- V25.42 Surveillance of previously prescribed contraceptive method, intrauterine device or
- Z30.431 Encounter for routine checking of intrauterine contraceptive device in ICD-10-CM.

The CPT procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS code:

- J7300 Intrauterine copper contraceptive
- J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
- J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg

Reporting contraceptive services with other services

Under some circumstances, an Evaluation and Management (E/M) services code, a procedure code, and a HCPCS code, may all be reported. Documentation must support each billing code.

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E/M Services Code

If a patient comes in to discuss contraception options but no procedure is provided at that visit:

- If the discussion takes place during a preventive visit (99381–99387 or 99391–99397), it is included in the Preventive Medicine code. The discussion is not reported separately.
- If the discussion takes place during an E/M office or outpatient visit (99201–99215), an E/M services code may be reported if an E/M service (including history, physical examination, or medical decision making or time spent counseling) is documented. Link the E/M code to ICD-9-CM diagnosis code V25.09 (General family planning counseling and advice) or ICD-10-CM diagnosis code Z30.09 (Encounter for other general counseling and advice on contraception).

E/M Services Code and Procedure Code

If discussion of contraceptive options takes place during the same encounter as a procedure, such as insertion of a contraceptive implant or IUD, it may or may not be appropriate to report both an E/M services code and the procedure code:

- If the clinician and patient discuss a number of contraceptive options, decide on a method, and then an implant or IUD is inserted during the visit, an E/M service may be reported, depending on the documentation.
- If the patient comes into the office and states, “I want an IUD,” followed by a brief discussion of the benefits and risks and the insertion, an E/M service is not reported since the E/M services are not significant and separate.
- If the patient comes in for another reason, such as an annual exam, and during the same visit a procedure is performed, then both the E/M services code and procedure may be reported.

If reporting both an E/M service and a procedure, the documentation must indicate a significant, separately identifiable E/M service. The documentation must indicate either the key components (history, physical examination, and medical decision making) or time spent counseling. In order to report an evaluation and management visit based on time, more than 50% of the visit must be spent counseling the patient. When time is the determining factor for the selection of the level of service, documentation should include the following:

- The total length of time spent by the physician with the patient,
- The time spent in counseling and/or coordination of care activities, and
- A description of the content of the counseling and/or coordination of care activities.

Note the “typical times” listed in outpatient E/M services codes 99201–99215. For example, if an established patient is seen for 25 minutes, including 15 minutes spent counseling, report code 99214—this code lists a “typical time” of 25 minutes. The level

of history, physical examination, and medical decision making do not matter in selecting this code. Not all payers recognize time spent counseling. Providers should consult third-party payers before instituting this coding practice to ensure compliance with specific plan guidelines.

A modifier 25 (significant, separately identifiable E/M service on the same day as a procedure or other service) is added to the E/M code to indicate that this service was significant and separately identifiable from the insertion. This indicates that two distinct services were provided: an E/M service and a procedure.

Coding guidance for specific LARC clinical scenarios can also be found on the [ACOG LARC Program](#)⁷⁰ website and the [ACOG Department of Coding and Nomenclature](#)⁷¹ website.

ACOG Fellows and their staff can submit specific coding questions to the ACOG Department of Health Economics and Coding at the coding ticket database: [acogcoding.freshdesk.com](#). Questions are answered in the order received, usually within 3–5 weeks. There is no charge for this service.

4.6: Concerns about inadequate reimbursements

The [CAI LARC Modeling Tool](#)⁷² may be helpful to providers who do not currently offer LARC methods out of a concern that available reimbursements would result in a financial loss to a practice. This tool uses information about a practice’s estimated LARC demand, payer mix, and reimbursement rates to explore the costs associated with provision of each LARC method. It may also help identify payers with anomalously low reimbursement rates and provide information useful in future contract negotiations. Efficacy and patient satisfaction rates for LARC methods can also be useful during discussions with third-party payers to negotiate increases in reimbursement rates.

Providers that experience decreased reimbursement rates for Mirena LNG-IUS devices due to reimbursement adjustments in the market may be eligible for loss-offsetting rebates from the manufacturer. To be eligible for a rebate:

- The device was purchased sometime between April 1, 2015 and June 30, 2015.
- The device was used on a date of service between July 1, 2015 and December 31, 2015.
- The payer responsible for reimbursement of the device has reduced its reimbursement rate for HCPCS code J7302, which resulted in a payment at less than the provider’s net acquisition cost.

Providers should refer to the [Mirena Rebate Program policy](#)⁷³ for more information on submitting a rebate request.

¹ The American Congress of Obstetricians and Gynecologists, FAQ184, May 2016.

<http://www.acog.org/Patients/FAQs/Long-Acting-Reversible-Contraception-LARC-IUD-and-Implant>

² LARC devices include a contraceptive implant (brand name Nexplanon), and intrauterine devices (IUDs), for which there are several options. Mirena, Skyla, and Liletta contain low doses of levonorgestrel, while ParaGard is a copper IUD. They are commonly referred to as hormonal versus copper/non-hormonal IUDs.

³ Wachino, Vikki. "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," CMCS Informational Bulletin, Center for Medicare and Medicaid Services, April 8, 2016.

<https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf>

⁴ Finer, Lawrence B. and Zolna, Mia R., "Declines in Unintended Pregnancy in the United States, 2008-2011," The New England Journal of Medicine, March 2016: 843-852. <http://www.nejm.org/doi/full/10.1056/NEJMsa1506575>

⁵ Unintended pregnancies refers to pregnancies that were either mistimed (the woman did not wish to become pregnant at that time) or unwanted (the woman did not want to become pregnant at that time or in the future). Intended pregnancies refer to when a woman becomes pregnant at the time or sooner than the pregnancy occurred. (Source: Guttmacher Institute, "Unintended Pregnancy in the United States." March 2016 Fact Sheet. <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states#15>)

⁶ Furthermore, the cost burden of unplanned births is significant, as the average cost of a publically funded birth in 2010 was \$12,770 per birth in prenatal care, labor and delivery, postpartum care and 12 months of infant care. (Source: Sonfield, Adam and Kost, Kathryn, "Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care National and State Estimates for 2010," Guttmacher Institute, February 2015: 8.)

⁷ Rosenbaum, Sara, et al. "Using Payment Reform Strategies to Strengthen Family Planning Services at Community Health Centers." Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Research Brief #38. January 7, 2015.

⁸ Finer, et al.

⁹ Daniels, Kimberly et al. "Current Contraceptive Use and Variation by Selected Characteristics Among Women Aged 15–44: United States, 2011–2013." CDC National Health Statistics Reports, Number 86, November 10, 2015.

<http://www.cdc.gov/nchs/data/nhsr/nhsr086.pdf>

¹⁰ Guttmacher Institute news release. "Use of Long-Acting Reversible Contraceptive Methods Continues to Increase in the United States." October 8, 2015. <https://www.guttmacher.org/news-release/2015/use-long-acting-reversible-contraceptive-methods-continues-increase-united-states>

¹¹ Daniels, et al.

¹² Kavanaugh, Megan, et al. "Changes in Use of Long-Acting Reversible Contraceptive Methods Among U.S. Women, 2009–2012." *Obstetrics & Gynecology*, VOL. 126, NO. 5, NOVEMBER 2015.

https://medweb.nch.org/INTERMED/Data/ComponentFiles/1362/11_ABOG_January%202016.pdf

¹³ Other coverage in the study refers to Medicare, military health care, or other forms of government health care (not including Indian Health Service).

¹⁴ Kavanaugh, et al.

¹⁵ The CDC National Health Statistics Report show slightly different percentages for LARC use among the different insurance coverage groups for 2011-2013. That data can be found in Daniels, et al:

<http://www.cdc.gov/nchs/data/nhsr/nhsr086.pdf>

¹⁶ United Nations 2015 estimates show that contraceptive prevalence among married or in-union women (age 15-49) globally was 13.7% for use of IUDs (compared with 5.1% in the U.S.), and 0.7% for use of implants (1.0% in the U.S.). (Source: United Nations Department of Economic and Social Affairs, Population Division, "Trends in Contraceptive Use Worldwide, 2015."

<http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf>)

¹⁷ Implants and IUDs are considered most effective by the CDC, with an effectiveness of less than 1 pregnancy per 100 women in a year; injectables, birth control pills, patches, rings, and diaphragms have 6-12 pregnancies per 100 women in a year; condoms, withdrawal, sponge, spermicide and fertility awareness based methods are considered least effective with 18 or more pregnancies per 100 women in a year. (Source: CDC "Effectiveness of Family Planning Methods, Adapted from World Health Organization (WHO) Department of Reproductive Health and

Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. *Contraception* 2011;83:397–404. <http://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/family-planning-methods-2014.pdf>)

¹⁸ Intrauterine Devices & Implants: A Guide to Reimbursement. University of California, San Francisco. <http://larcprogram.ucsf.edu/medicaid>

¹⁹ Alternative Benefit Plans (ABP), which cover states' optional Affordable Care Act Medicaid expansion population as well as other groups in certain states, must cover at least one form of contraception within each method approved by the U.S. Food and Drug Administration (FDA)—including LARC. Traditional Medicaid state plan benefits packages are not required to cover all FDA-identified contraceptive methods for beneficiaries, although CMS recommends that they do. (Source: Wachino, Vikki. "Medicaid Family Planning Services and Supplies." SHO #16-008, Center for Medicare and Medicaid Services, June 14, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>)

²⁰ Ranji, Usha et al. "Medicaid and Family Planning: Background and Implications of the ACA." Kaiser Family Foundation, February 3, 2016. <http://kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy/>

²¹ Wachino, SHO #16-008, 2016.

²² FQHCs qualify for 340B pricing, a federal drug pricing program that establishes a price ceiling for pharmaceutical companies to charge qualified entities. As such, the 340B costs for LARC devices range from \$250 to \$500 for the implant and the Mirena, Skyla, and Paragard IUDs; the Liletta IUD has a 340B price of \$50. (CHCANYS, "Medicaid Fee for Service Reimbursement for Long-Acting Reversible Contraceptives (LARC) at Federally Qualified Health Centers," Memo, December 2015.)

²³ Wachino, SHO #16-008, 2016.

²⁴ Certain services can be "carved out" of the PPS and paid for separately. Additionally, a state may use a single rate for all FQHC services (e.g., medical, dental, behavioral) or multiple rates based on the costs of each specific service type.

²⁵ The \$50 IUD, Liletta, is much less expensive than other LARC devices on the market (which range from \$250-\$500) but is not appropriate for all women. (CHCANYS, "Medicaid Fee for Service Reimbursement for Long-Acting Reversible Contraceptives (LARC) at Federally Qualified Health Centers," Memo, December 2015.)

²⁶ Wachino, CMCS Informational Bulletin, 2016.

²⁷ NYC LARC Access Taskforce, "IUD and Implant Reimbursement under Medicaid in New York State: A Primer." Spring 2016.

http://larctaskforce.org/sites/default/files//sites/all/themes/pika/IUD_TaskForce_Docs/LARC%20Coverage%20Under%20Medicaid%20in%20NYS-%20A%20Primer.pdf

²⁸ New York SPA: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NY/NY-16-0028.pdf>

²⁹ Under the Medicare and Medicaid Benefits Improvement and Protection Act (BIPA) of 2000, the initial Medicaid PPS base rate for an FQHC in 2001 was set based on its costs for the prior two fiscal years. States were required to pay FQHCs 100% of their average reasonable and allowable costs during FY1999 and FY2000, adjusted to account for any increase (or decrease) in the scope of services furnished in FY2001 by the FQHC. These costs were then divided by the average number of encounters to derive a per encounter payment for the FQHC.

³⁰ New York SPA: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NY/NY-16-0028.pdf>

³¹ Georgia SPA: https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/15-001%20FQHC_RHC%20%20Reimbursement%20for%20purchase%20of%20LARCs.pdf

³² Wachino, CMCS Informational Bulletin, 2016.

³³ Illinois SPA: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IL/IL-12-026-Att.pdf>

³⁴ Maryland indicated that it did not use a SPA to carve LARC out from the PPS, however no further information was available. CMS indicated that SPAs are currently the expected approach for states seeking to carve LARCs out of the PPS.

³⁵ Wachino, CMCS Informational Bulletin, 2016.

³⁶ Contraception in Medicaid: Improving Maternal and Infant Health. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/contraception.html>

³⁷ State of Ohio Medicaid State Plan.

http://medicaid.ohio.gov/Portals/0/Medicaid%20101/Medicaid%20State%20Plan/Section%204/4_19B-Methods.pdf

³⁸ Rosenbaum, et al.

³⁹ Waldman, Beth et al. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)." Robert Wood Johnson Foundation, December 2015. <http://www.bailit-health.com/articles/2015-1215-bhp-rwjf-implementing-state-payment-reform-strategies.pdf>

⁴⁰ See Rosenbaum, et al.

⁴¹ States that are interested in section 1115 family planning demonstrations can contact the Family Planning Demonstration team at Family_Planning_Demos@cms.hhs.gov to learn more.

⁴² Wachino, SHO #16-008, 2016.

⁴³ Wachino, CMCS Informational Bulletin, 2016.

⁴⁴ Wachino, SHO #16-008, 2016.

⁴⁵ Wachino, CMCS Informational Bulletin, 2016.

⁴⁶ In Fall 2014, the American Academy of Pediatricians recommended LARC as the "first-line contraceptive choice" for adolescents. (Source: American Academy of Pediatrics, "Contraception for Adolescents," October 2014 <http://pediatrics.aappublications.org/content/134/4/e1244>). (See also Gavin, Loretta, et al. "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs." April 25, 2014. <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>)

⁴⁷ Numerous types of licensed health care professionals can be trained to insert LARC, including MDs, PAs, NPs, and CNMs.

⁴⁸ Bergin, A., Tristan, S., Terplan, M., Gilliam, M. L., & Whitaker, A. K. (2012). A missed opportunity for care: Two-visit IUD insertion protocols inhibit placement. *Contraception*, 86(6), 694-697. DOI: 10.1016/j.contraception.2012.05.011. <https://uic.pure.elsevier.com/en/publications/a-missed-opportunity-for-care-two-visit-iud-insertion-protocols-i>

⁴⁹ National Association of Community Health Centers, "Medicaid Reimbursement for Multiple Same-Day Encounters: Florida's Experience." Issue Brief #7, October 2012. <http://nachc.org/wp-content/uploads/2015/11/Medicaid-Same-Day-Visits-FINAL.pdf>

⁵⁰ Eligible patients must: receive services from a health care professional who is employed by (or under contract with) the 340B entity; have an established relationship with the entity; and receive a service that is consistent with the grant that qualified the entity for 340B. (Source: National Family Planning and Reproductive Health Association, "340B and Medicaid: An Explanation For Family Planning Providers," April 2016: 2. http://www.nationalfamilyplanning.org/file/documents---fact-sheets/340B_Guide_FINAL.pdf)

⁵¹ Medicaid law requires pharmaceutical manufacturers to provide state Medicaid agencies with rebates on the purchase price of pharmaceuticals for Medicaid patients. Pharmaceutical companies do not have to provide such rebates on drugs/devices at the 340B price.

⁵² National Family Planning and Reproductive Health Association, "340B and Medicaid: An Explanation For Family Planning Providers," April 2016: 2.

⁵³ For instance, see The Texas LARC Toolkit: <https://www.hhsc.state.tx.us/WomensHealth/Documents/texas-larc-toolkit.pdf>

⁵⁴ Examples of LARC clinical training resources and opportunities can be found here: <https://www.acog.org/-/media/Departments/LARC/20160219TrainingResource.pdf?la=en>

⁵⁵ Colorado Department of Public Health and Environment, "Reducing Unintended Pregnancies in Colorado." <https://www.colorado.gov/pacific/cdphe/reducing-unintended-pregnancy>

⁵⁶ Guttmacher Institute, "Use of Highly Effective Contraceptives in the U.S. Continues to Rise, with Likely Implications for Declines in Unintended Pregnancy and Abortion." December 2014.
<https://www.guttmacher.org/article/2014/12/use-highly-effective-contraceptives-us-continues-rise-likely-implications-declines>

⁵⁷ Guttmacher Institute Analysis, "Contraception Needs and Services, 2010." <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/contraception.html>

⁵⁸ Wachino, CMCS Informational Bulletin, 2016.

⁵⁹ Extract from "Intrauterine Devices & Implants: A Guide to Reimbursement," UCSF, Last updated April 2016: 24-25.