IUD and Implant Reimbursement under Medicaid in New York State: A Primer

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Prepared by the Reimbursement Workgroup (formerly the Policy and Advocacy Workgroup) of the New York City LARC Access Taskforce

"IUD and Implant Reimbursement under Medicaid in New York State: A Primer" is a white paper developed by the Reimbursement Working Group of the New York City Long-Acting Reversible Contraceptive Access Taskforce. The Taskforce, convened by Public Health Solutions in partnership with the New York City Department of Health and Mental Hygiene, aims to ensure that all New Yorkers have access to the full range of contraceptive methods, including highly effective long-acting reversible contraceptives (LARCs). This white paper has a specific focus on IUDs and implants because of the unique barriers providers and institutions face in stocking and providing IUDs and implants, including high up-front costs and challenges in securing adequate reimbursement for the device and its insertion. However, the recommendations in this paper may prove useful for challenges providers face related to other forms of contraception as well.

Due to their high rate of effectiveness and ease of use, LARCs are important contraceptive options that should be made available to all women. However, it is integral to the mission of the Taskforce that all people have the information and resources they need to make informed decisions about contraception by ensuring that IUDs and implants are offered to women as one of a range of contraceptive options. The Taskforce supports client-centered contraceptive counseling that focuses on the patient's needs and wishes in determining the most effective form of contraception for her. For those women who do not wish to become pregnant, this counseling method supports the selection of the most effective contraceptive option given lifestyle fit, preferences, and priorities. The LARC Access Taskforce also asserts that all advocacy in support of LARCs must include work to make LARC removal as affordable and accessible as LARC insertion for both patients and providers. As with all contraceptive methods, assuring that LARC removal is part of the managed care contract will help providers retain adequate reimbursement and allow women to have LARC methods removed at any time, if desired.

This white paper, therefore, is a tool designed to support the larger work of the reproductive health, rights, and justice movements to remove all barriers to contraception and to ensure that every woman has the ability to determine if, when, and how many children she wants to have. LARCs should be accessible not to reduce spending or childbearing, but because every woman who chooses a LARC as her preferred method of contraception should be able to access it.[1]

NOTE: This white paper is designed to serve as a resource for providers, their staff, healthcare administrators and reproductive health advocates who are seeking a basic understanding of IUD and implant (LARC) reimbursement through public insurance in New York State. Public insurance reimbursement is exceedingly complicated; for every "rule", there are multiple exceptions, and there are many special cases with their own particular procedures and codes. As such, this white paper is not intended to be exhaustive. It should be used as an introductory guide to the most common situations faced by patients and providers. Regulations are subject to ongoing changes. For the most up to date information please refer to NYS Medicaid Provider Manuals and updates.

EXPLANATION OF TERMS

340B
The 340B Drug Pricing Program is a program of the U.S. Health Resources and Services Administration. The program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices in order to enable covered entities to stretch scarce Federal resources as far as possible. Covered entities include most safety net healthcare providers and average savings realized are 25-50%.

Intrauterine Devices
An intrauterine device (IUD)[2] is a small device that is inserted into the uterus by a medical provider (a physician, physician assistant, nurse practitioner, or midwife) to prevent pregnancy. IUDs are 99% effective. Four IUDs are approved for use in the United States:

- Mirena, a progestin (hormonal) IUD that is effective for 5-7 years
- Skyla, a progestin (hormonal) IUD that is effective for 3 years
- Liletta, a progestin (hormonal) IUD effective for 3 years
- Paragard, a copper (non-hormonal) IUD that is effective for 10-12 years[3]

Implants
An implant is a flexible rod about the size of a matchstick that is inserted under the skin of the upper arm by a medical provider (a physician, physician assistant, nurse practitioner, or midwife). It protects against pregnancy by releasing progestin into the body. The only implant currently approved for use in the United States is Nexplanon, previously known as Implanon, which is effective for up to 3 years.

Medicaid
Medicaid is a national public insurance program for low-income individuals and families and for people with disabilities. It is jointly financed by New York State (NYS) and the federal government. Each state administers its own Medicaid program and determines the type and scope of services covered, based on broad federal guidelines.

Medicaid & Family Planning
While the federal government matches the majority of NYS's Medicaid expenditures at a 50% rate, they match family planning expenditures at a 90% rate.[4] Put in place in recognition of the importance and value of family planning, the 90% match is made available to all states that comply with Medicaid rules, helping to ensure that family planning services are accessible to beneficiaries and to increase utilization. The Medicaid beneficiary can obtain family planning services, pharmaceuticals, and devices at no cost to themselves (i.e., without copayments or deductibles).

NYS has two Medicaid programs that cover family planning services for low-income populations who may not be otherwise eligible for Medicaid or who may have confidentiality concerns with using their primary insurance:

- The Family Planning Benefit Program (FPBP), NY's State Plan Amendment (SPA), covers family planning services and related reproductive health care to women, men and adolescents. Eligibility requirements include NYS residency and income of up to 223% FPL. Only citizens, nationals, Native Americans or immigrants with satisfactory immigration status are eligible. FPBP covers individuals who already have health insurance but cannot use that primary plan because they are underinsured for family planning services or due to confidentiality concerns.

- The Family Planning Extension Program (FPEP) extends family planning benefits to NYS women who lose their Medicaid eligibility after the end of their pregnancy. Eligibility requirements include NYS residency and having been pregnant within the past two years. Women and adolescents are eligible regardless of their citizenship or immigration status and regardless of how the pregnancy ended. This

coverage could last up to 24 months and begins when the pregnant woman or teen loses her Medicaid coverage. Enrollment is automatic when a woman does not qualify for Medicaid at the end of the 60-day postpartum continuation. There is no annual recertification.

MEDICAID & LARCS: COST & REIMBURSEMENT

The main costs associated with an IUD or implant include the cost of the device itself, insertion and/or removal. Studies show that requiring a second visit for IUD insertion decreases patient uptake, as many patients do not return for a second visit. For this reason, same-day insertion of an IUD is a recommended best practice.[5] Some reimbursement mechanisms described create barriers to same-day IUD insertion if they do not include the costs of counseling associated with the procedure. Reimbursement for LARC insertion should include options counseling with insertion and also allow insertion to occur and be reimbursed if it takes place at the time of another medical encounter.

Initial Cost of the Device

Because both IUDs and implants are FDA-approved family planning devices, Medicaid beneficiaries are able to obtain them at no cost. However, the cost to the provider varies considerably.

The cost of the LARC device to the provider is dependent on whether or not the organization where the provider practices qualifies for 340B pricing. For providers who are not eligible for 340B pricing, the cost of a LARC can be more than $900[6]. This creates barriers in terms of advance stocking of a range of these devices. The 340B Drug Pricing Program is a federal program that enables eligible health care organizations to access outpatient drugs and devices at significantly reduced prices. Organizations eligible for 340B pricing include Title X Family Planning Clinics,[7] Federally Qualified Health Centers (FQHC),[8] Student Health Services, School Based Health Centers, and Disproportionate Share Hospitals.[9]

Reimbursement

The amount and mechanism of provider reimbursement for the cost of the device and insertion or removal is dependent on whether the Medicaid patient is enrolled in managed care:

Medicaid Managed Care

New York State requires most Medicaid enrollees to be part of a Medicaid managed care plan. If the patient is enrolled in a Medicaid managed care plan and the provider participates in the plan's network, the provider is reimbursed based on the terms of his or her contract with that plan. Providers as well as administrators should review contracts regularly and renegotiate terms if possible. A cost-analysis of procedures and device costs should be taken into account.[10]

For patients enrolled in a Medicaid managed care plan, NY State has a Free Access policy which allows for accessing family planning and reproductive services from any Medicaid participating provider, either in or outside of their plan. The Free Access policy does **not** require anyone with Medicaid to obtain a referral from their primary care provider or to obtain pre-authorization. If a Medicaid patient is receiving care out-of-network under the Free Access policy or if the patient is enrolled in Fidelis Care, the Medicaid NYS Catholic Health Plan that does not provide family planning services, the Medicaid provider bills NYS on a fee-for-service basis.[11]

Fee-for-service (FFS) Medicaid (including FPBP and FPEP)

The total reimbursement amount under fee-for-service is dependent on the type of facility where the provider is practicing. Reimbursement methodology at the most common types of facilities is explored in greater detail below.

Article 28 Licensed Facilities

Article 28 licensed facilities are established, operated and regulated under Public Health Law Article 28. Physician offices are not regulated under Article 28.

Diagnostic and Treatment Centers (DTC) and Free-standing Ambulatory Surgery Centers

Most Article 28 facilities utilize NYS's Medicaid Ambulatory Patient Group (APG) payment methodology[12] to bill for patients enrolled in fee-for-service Medicaid programs. Reimbursement for provider services, including Advanced Practice Clinicians such as Nurse Practitioners, Physician Assistants and Certified Nurse Midwives, is included in the APG payment.[13] The cost of the LARC itself is "carved out" of APG reimbursements and not built into the facility APG payment, so agencies bill and are reimbursed for the device separately, in addition to the service.

Federally Qualified Health Centers (FQHCs)

Under federal law, Federally Qualified Health Centers (FQHCs) are required to be reimbursed at cost for their Medicaid patients, using the Prospective Payment System (PPS). Under this system, FQHCs are reimbursed an all-inclusive PPS rate which covers all allowable services within a threshold visit. States may choose to implement an alternative payment methodology (APM), including continuation of reasonable cost reimbursement, as long as the APM does not pay less than what FQHCs would have received under PPS and the affected FQHCs agree to it. In New York State, the vast majority of FQHCs utilize PPS for billing, although they may choose to be reimbursed under the APG methodology, which is considered an APM. Current New York State policy is that FQHCs may not bill for LARC devices outside of their PPS rate. The high cost of the devices may make purchasing and providing LARCs under this payment mechanism a significant financial burden for FQHCs.

This issue is being explored further by the NYC LARC Access Task Force and other organizations. It warrants addressing in order to ensure that LARC methods are accessible alongside other contraceptives for patients at FQHCs. A memo released on April 8th, 2016 from the Centers for Medicare and Medicaid Services (CMS), states support for reimbursement changes at the state level which may help improve access to effective methods of contraception, including LARC.[14]

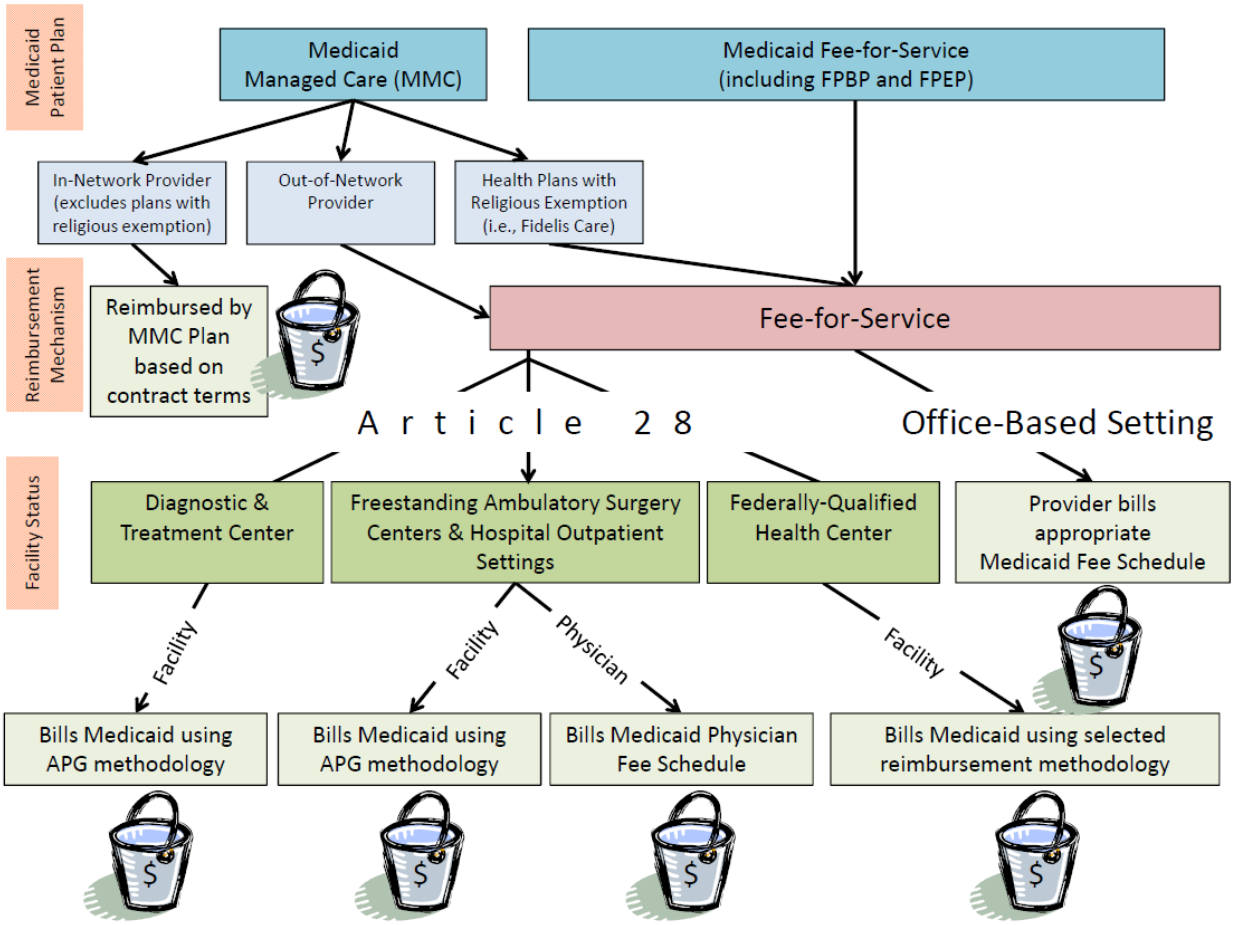
School-Based Health Centers (SBHCs)

Some School-Based Health Centers (SBHCs) can offer LARC insertion and removal. SBHCs are operated by sponsoring Article 28 licensed facilities, most often a hospital, DTC or a non-for-profit agency, and their reimbursement methodology is the same as their parent facility. SBHCs utilize the APG methodology to bill for LARC services unless their sponsoring institution is a FQHC that utilizes the PPS methodology for billing.

Office-Based Setting

In an office-based setting, the provider bills the appropriate Medicaid Fee Schedule for the service.

Figure 1. Pathways to reimbursement for delivery LARC services to Medicaid beneficiaries



RECOMMENDATIONS

Due to the complexity of billing for LARCs, and the challenges that Medicaid providers continue to encounter, the Reimbursement Working Group of the LARC Access Taskforce recommends that:

New York State should take the following steps to ensure appropriate reimbursement rates and procedures for all providers:

- Improve Medicaid reimbursement rates under Medicaid managed care contracts by requiring minimum reimbursement at least cover the cost of IUDs and implants.
- Ensure fee-for-service reimbursement rates for non-Article 28 facilities that are sufficient to cover provider costs.
- Remove access and reimbursement barriers to advance stocking and same-day IUD insertion.
- Ensure FQHCs are reimbursed by Medicaid for the cost of LARC devices, above the standard threshold rate for the visit when billing under PPS.

Providers and Facilities can also take steps to maximize revenue and increase IUD availability.

- Obtain a FPBP Memorandum of Understanding (MOU) with New York State that will allow Medicaid providers to enroll clients onsite for presumptive eligibility, which would enable the current visit to be fully reimbursed.[15] This should be arranged in addition to the capacity to initiate the application procedure for continuing FPBP or full Medicaid coverage.

- Negotiate Medicaid managed care contracts to ensure that reimbursement rates are inclusive of the actual cost of the IUD or implant device, insertion and/or removal.
- Stay updated on the latest policies and best practices on IUDs and implants on a consistent and ongoing basis. The resources listed below are recommended as a place to start; for more specific or detailed information, contact the LARC Access Taskforce at IUDTaskforce@healthsolutions.org.

RESOURCES

The following resources may be helpful for those seeking more information on LARCs and strategies to increase LARC uptake.

- The LARC Access Taskforce Community of Practice: The Community of Practice provides a venue for providers, advocates, researchers, and other stakeholders to collaborate, coordinate efforts, solve problems in real time, and share lessons learned to overcome access barriers to LARCs.
- The ACOG LARC Program: The LARC Program provides information and guidance on LARCs geared towards providers, including resources on counseling and reimbursement.
- Intrauterine Devices and Implants: A Guide to Reimbursement is a resource developed by several national organizations that aims to explain the landscape of LARCs commercial insurance coverage and serve as a resource for providers navigating stocking, reimbursement, and other scenarios that create barriers to the provision of these methods.
- LARC First: LARC First is a project of The Contraceptive CHOICE Project. Their website discusses the three most common barriers to contraception, education, access, and affordability, and provides strategies to overcome them.
- Bedsider and Bedsider Providers: Bedsider is an engaging and user-friendly online birth control support network for women 18-29, with extensive resources on LARCs. Bedsider Provider is geared towards supporting providers who provide birth control by acting as a resource center and supplying free materials and tools to healthcare offices, clinics, classrooms, and health centers.
- New York State Medicaid Provider Manuals and the NYS Medicaid Family Planning Services, Frequently Asked Questions, May 2015. This FAQ developed by NYS Department of Health covers Medicaid family planning programs, confidentiality, billing and claiming, and more.

The LARC Access Taskforce encourages all providers to ensure that their contraceptive counseling offers patients information on the full range of contraceptive options available to them, and all advocates to focus on developing and implementing policies that ensure all people have access to the full-range of contraceptive options. For those interested in working with the IUD Task Force to achieve these goals, please visit www.larctaskforce.org or contact IUDTaskforce@healthsolutions.org.

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[1] For more on this topic, see: Higgins, Jenny. "Celebration meets caution: LARC's boon, potential busts, and the benefits of a reproductive justice approach." Contraception, 89 (4): 237-241.; Gomez, A.M., Liza Fuentes, and Amy Allina. "Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods." Perspectives on Sexual and Reproductive Health, 46(3): 171-175.

[2] IUDs are sometimes referred to as intrauterine contraceptives (IUCs) or intrauterine system (IUS).

[3] Although underutilized for this purpose, the Copper IUD is the most effective form of emergency contraception, and it can be inserted up to five days after unprotected sex. Not all providers who insert IUDs offer them as emergency contraception.

[4] This means that New York State receives $9 from the federal government for every $10 spent on family planning.

[5] Ashlee Bergin, Sigrid Tristan, Mishka Terplan, Melissa L. Gilliam, Amy K. Whitaker, A missed opportunity for care: two-visit IUD insertion protocols inhibit placement, Contraception, Volume 86, Issue 6, December 2012, 694-697.

[6] See Bedsider.org for more information on pricing at http://bedsider.org/methods/iud/dimensions/4.

[7] Title X Family Planning Clinics receive funding from the Title X Family Planning Program to provide contraceptive services, counseling and reproductive health-related preventive services, with priority given to low-income people. Title X Family Planning projects provide family planning services through community-based clinics that include State and local health departments, tribal organizations, hospitals, university health centers, independent clinics, community health centers, faith-based organizations, and other public and private nonprofit agencies.

[8] Federally Qualified Health Centers are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas.

[9] Disproportionate Share Hospitals serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients.
[10] The LARC Modeling Tool developed by Cicatelli Associates Inc. (CAI) can be used by health care providers to examine assumptions about the affordability of long-acting reversible contraception (LARC) method. It can be accessed at http://www.caiglobal.co/larc/.
[11] Federal Law (known in New York as the Free Access policy) allows individuals enrolled in Medicaid managed care plans to obtain family planning and reproductive health services from any Medicaid participating provider, in or out of a managed care plan's network, without referral or prior approval of the plan.
[12] The Ambulatory Patient Group (APG) payment methodology categorizes the amount and type of resources used in visits. Reimbursement is based on the average pattern of resource use of a group of patients in a given APG.
[13] For more information on provider reimbursement, see the Provider Manuals to the New York Medicaid Program at https://www.emedny.org/ProviderManuals/index.aspx.
[14] State Medicaid Payment Approaches to Improve Long-Acting Reversible Contraception. Center for Medicaid and CHIP Services Informational Bulletin. April 8, 2016. Access here: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf.
[15] At some point in 2015, the MA Family Planning Benefit Program (FPBP) will be integrated in to the NY State of Health Marketplace and this will change the ways that providers can conduct direct, onsite enrollment.