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Rethinking Medicaid Coverage and Payment Policy to Promote High Value Care: The Case of Long-Acting Reversible Contraception

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A B S T R A C T

Context: Long-acting reversible contraception (LARC) is the most effective reversible method to prevent unplanned pregnancies. Variability in state-level policies and the high cost of LARC could create substantial inconsistencies in Medicaid coverage, despite federal guidance aimed at enhancing broad access. This study surveyed state Medicaid payment policies and outreach activities related to LARC to explore the scope of services covered.
Methods: Using publicly available information, we performed a content analysis of state Medicaid family planning and LARC payment policies. Purposeful sampling led to a selection of nine states with diverse geographic locations, political climates, Medicaid expansion status, and the number of women covered by Medicaid.
Results: All nine states' Medicaid programs covered some aspects of LARC. However, only a single state's payment structure incorporated all core aspects of high-quality LARC service delivery, including counseling, device, insertion, removal, and follow-up care. Most states did not explicitly address counseling, device removal, or follow-up care. Some states had strategies to enhance access, including policies to increase device reimbursement, stocking and delivery programs to remove cost barriers, and covering devices and insertion after an abortion.
Conclusions: Although Medicaid policy encourages LARC methods, state payment policies frequently fail to address key aspects of care, including counseling, follow-up care, and removal, resulting in highly variable state-level practices. Although some states include payment policy innovations to support LARC access, significant opportunities remain.
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Reducing Unintended Pregnancies

In the United States, nearly one-half of all pregnancies are unintended, significantly more than in other wealthy nations, and one out of five unintended pregnancies result in abortion (Finer & Zolna, 2016). Unintended pregnancies are also more common for women with low incomes, and are associated with negative infant, maternal, and family outcomes, including low birth weight and prematurity, maternal depression, and lifelong health, economic, and social difficulties for families. All of these outcomes contribute to increased health care costs (Department

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of Health and Human Services, 2016: CMCS informational bulletin: State Medicaid payment approaches to improve access to long-acting reversible contraception; unpublished manuscript; Mercier, Garrett, Thorp, & Siega-Riz, 2013; Mohllajee, Curtis, & Marchbanks, 2004; Sawhill, 2014; Sonfield & Gold, 2012).

Data strongly demonstrate that unintended pregnancies can be avoided by offering all women, including low-income women, full access to the most effective forms of family planning (Gavin et al., 2014). The most effective method of reversible contraception to reduce unintended pregnancies is long-acting reversible contraception (LARC), which includes intrauterine devices and subdermal implants (Gavin et al., 2014). Despite LARC's effectiveness and the benefits of preventing unintended pregnancy, there is wide variation of LARC usage among young women at the state level, ranging from 0.7% to 25.8% (Romero et al., 2015). This variation is explained in part by provider behavior and the costly insertion of LARCs, because LARCs are relatively expensive; the use of newer, costlier health care technologies is sensitive to patient cost at the point of care and dependent on provider knowledge and training (Boulet, 2016; Romero et al., 2015). Thus, the appropriate use of LARC can be affected by the extent of insurance coverage, a delivery system capable of providing covered services, and adequate payment to support provision of covered services (Carlin, Fertig, & Dowd, 2016). To illustrate, in a recent study where women were given the choice of contraceptive methods in a high-performing delivery system context without financial obstacles, the majority of women chose LARCs (Cleland, Peipert, Westhoff, Spear, & Trussell, 2011).

Medicaid Coverage of Family Planning Services and LARC

Approximately 19.4 million low-income women of childbearing age (WCBA) are insured through Medicaid, which entitles them to coverage for family planning services (Moniz et al., 2015). The precise scope of Medicaid's family planning coverage requirements varies, however, depending on how women's eligibility is derived. For the purposes of this analysis, we focus on the two main broad categories of Medicaid-enrolled women. The first is the woman whose eligibility is tied to what commonly is termed a "traditional" category: pregnant women, WCBA who are also poverty level, children up to age 18, and women with disabilities. The second is the woman whose eligibility is derived from the Affordable Care Act Medicaid expansion, that is, women who are working age (18–64), low income (up to 138% of the federal poverty level), and not traditionally eligible. Beyond these main categories, states also can extend family planning benefits only to women under a special Medicaid eligibility category; however, women whose eligibility entitles them only to these limited benefits would be considered a traditional eligibility group. Traditionally eligible women are entitled to family planning services and supplies, subject to what federal law calls "reasonable" limits. Women eligible under the Patient Protection and Affordable Care Act (ACA), by contrast, are entitled to the same level of family planning benefits covered under the ACA's essential health benefit standard, which also applies to the individual and small group health insurance markets. Under implementing regulations, the extended health benefit coverage standard requires coverage of all contraceptive methods approved by the U.S. Food and Drug Administration (Garfield, Damico, Stephens, & Rouhani, 2016; Patient Protection Affordable Care Act, 2010; Walls, Gifford, Ranji, Salganicoff, & Gomez, 2016). Thus, the legal requirements for covered services are different based on the broad definition of reasonableness for traditionally eligible women and the specific requirements established for ACA-eligible women (Sonfield, 2016).

The Centers for Medicare and Medicaid Services (CMS), which administers the federal Medicaid program, encourages states to follow comprehensive family planning coverage standards for all Medicaid-enrolled women; however, CMS has never explicitly stated that coverage of fewer than all FDA-approved methods would be an unreasonable limit on coverage for traditionally eligible women (Sonfield, 2016). The question, thus, becomes whether, in administering their traditional Medicaid programs, states apply coverage rules that encompass all FDA-approved methods generally, and in particular, LARC. This question, along with the question of whether states that do cover LARC also cover and pay for all necessary services and procedures in connection with LARC, took on particular importance in the wake of comprehensive guidelines issued in 2013 by the Centers for Disease Control and Prevention (CDC) and the Department of Health and Human Services Office of Population Affairs (OPA). These guidelines outline the key elements of quality contraceptive care, including coverage of a full range of contraceptive services and supplies (including LARCs), counseling on methods, and removal of devices, and follow-up care as needed (Gavin et al., 2014).

Barriers to the Provision of LARCs among Medicaid Programs

A recent survey of state Medicaid programs found that 100% of the states that responded reported coverage of fee-for-service (FFS) LARCs (Walls et al., 2016). However, even when states report that they cover LARC methods, barriers to accessing these highly effective contraceptives remain. Medicaid providers, often working with limited resources, may struggle to deliver covered LARC services owing to operational and financial challenges (Beeson et al., 2014; Mestad et al., 2011; Wood et al., 2013). These barriers include the cost of stocking LARC intrauterine devices, implants, and any related products, so that supplies are readily available for use when requested, and the cost of insertion, removal, and follow-up care (Beeson et al., 2014; Potter et al., 2014). Other barriers are inadequate professional training, and insufficient resources to support the counseling necessary to effectively help women select the method best for them (Beeson et al., 2014; Greenberg, Makino, & Coles, 2013; Harper et al., 2008; Mestad et al., 2011; Wood et al., 2013).

Given the absence of detailed CMS guidelines regarding family planning coverage under traditional state programs, we sought to understand how well state Medicaid payment policies cover and facilitate delivery of LARC for women seeking these methods of contraception from their Medicaid providers. We focused specifically on LARC because of its effectiveness and because the higher initial costs associated with LARC elevate the importance of insurance coverage policy, especially for low-income patients and health care safety net providers serving low-income communities on limited budgets.

The specific research questions we sought to answer were (1) to what degree does state Medicaid coverage and payment policy reimburse the following: comprehensive counseling, LARC devices and drugs, LARC insertion, removal, and follow-up; (2) are there any unique policy innovations that address financial and operational challenges to enhance LARC service delivery; and (3)