Long-Acting Reversible Contraception (LARC):

2016 update from the perspective of the Pregnancy Medical Home program

Community Care of North Carolina

Why LARC

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- Most effective forms of contraception
  - Safe, few contraindications, no risk of user failure
  - Cost effective, high patient satisfaction
  - Effectiveness equivalent to sterilization
  - Completely reversible
- Unintended pregnancies more likely to result in a poor birth outcome (low birth weight, preterm birth)
- Half of all pregnancies are unintended (unwanted or mistimed)
- Closely spaced pregnancies more likely to result in poor outcome

Why LARC

- National and state-level momentum to increase access to LARC
  - ASTHO learning collaborative
  - ACOG and AAP
  - NC DHHS infant mortality reduction
  - NC LARC stakeholders workgroup (SHIFT NC)
  - Pregnancy Medical Home clinical priority
  - Evidence-based strategy for “ICO 4 MCH” counties
    - Improving community outcomes for maternal and child health in 13 NC counties
  - NC COIIN team for interconception care

LARC themes

- Pregnancy Medical Home (PMH) postpartum quality improvement project
- “Same-day access”
- In-patient LARC
- Consumer perspective/reproductive justice

PMH Postpartum Standards

- Comprehensive postpartum visit that includes:
  - Standardized depression screening
  - Transition to ongoing source of care
  - Reproductive life planning/contraception
- Postpartum visit is incentivized for PMH providers
  - $150 payment if completed within 60 days of delivery
- PMH Care Pathway on Postpartum Care and the Transition to Well Woman Care
  - Establishes best practices for postpartum care
  - Sets 14-42 days postpartum as optimal timeframe for comprehensive postpartum visit

Postpartum QI Project 2016: Goals

Increase the number of Medicaid patients who receive a postpartum visit

- Test practice-specific strategies to increase adherence to the postpartum visit

Improve data quality

- Use PMH practice-based data reports combined with record review to determine “true” baseline postpartum visit rate
- Implement changes in coding/billing processes to increase the alignment between completed postpartum visits and paid PMH incentive claims
- “Win-win” – increased revenue to practice and improved accuracy of PMH data

Postpartum Visit Rate Based on PMH Incentive Claims

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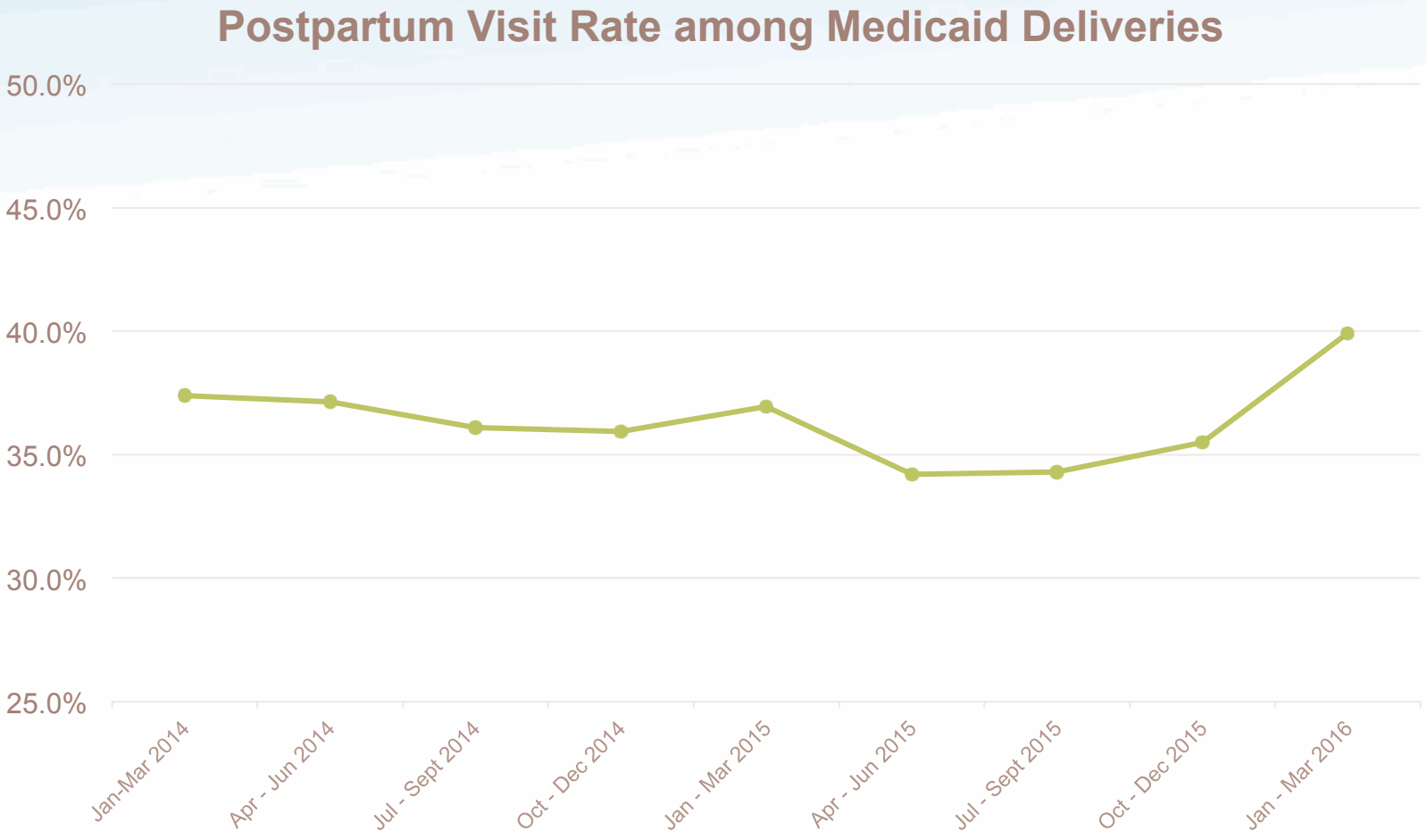

Postpartum LARC: "Same Day Insertion"

- Per ACOG Committee Opinion 666, Optimizing Postpartum Care (June 2016):

Systems should be in place to ensure that women who desire long-acting reversible contraception or any other form of contraception can receive it during the comprehensive postpartum visit, if immediate postpartum placement was not done earlier.

- Access to same day insertion at family planning visits outside of postpartum period

Postpartum LARC: Acquisition and Billing

- LARC placement can be billed at the same time as the postpartum visit
  - Work with local CCNC OB team for technical assistance
- Device acquisition:
  - Physician Drug Program – provider purchases supply in advance and bills at the time of placement ("buy and bill")
  - Specialty Pharmacy – device is ordered by provider and shipped to practice for placement
- "Buy and bill" is the best option to ensure availability of LARC device at the time of the visit and minimize wastage of Medicaid dollars

In-patient LARC

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 670, August 2016

Committee on Obstetric Practice

The American College of Nurse-Midwives and the Society for Maternal-Fetal Medicine endorse this document. The American Academy of Family Physicians and the Association of Women's Health, Obstetric and Neonatal Nurses support this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Ann E. Borders, MD, MSc, MPH and Alison M. Stuebe, MD, MSc, and reviewed by the Long-Acting Reversible Contraception Work Group.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

PDF Format

Immediate Postpartum Long-Acting Reversible Contraception

In-patient LARC

- Increasing evidence supports immediate postpartum LARC placement (within 10 minutes of delivery of placenta for IUD, prior to discharge for implant)
  - CDC Medical Eligibility Criteria rate immediate postpartum LARC as Category 1 or 2
- Important option for patients who may be unlikely to return for postpartum care prior to risk of unintended pregnancy or per patient request
- Comprehensive postpartum care remains important even if LARC was placed at the time of delivery

CDC MEC

- CDC Medical Eligibility Criteria (MEC) for Contraceptive Use, revised July 2016

Category 1 – No restriction for the use of the method

Category 2 – Advantages of using the method generally outweigh the theoretical or proven risks

Category 3 – Theoretical or proven risks usually outweigh the advantages of using the method

Category 4 – Unacceptable health risk if the contraceptive method is used

CDC MEC: Timing of Postpartum LARC

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- Per CDC Medical Eligibility Criteria for Contraception (revised July 2016):
  - All forms of LARC are Category 1 by postpartum day 30
  - All forms of LARC are either Category 1 or 2 throughout the postpartum period
  - Copper IUD is Category 1 for immediate postpartum placement; hormonal IUD is Category 2 for immediate postpartum placement
  - IUD placement is Category 2 for the time period following immediate postpartum placement (>10 minutes after delivery of placenta) until postpartum day 28 due to increased risk of expulsion

In-patient LARC: Acquisition and Billing

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- Hospitals must have “chain of custody” of drugs and devices used while patients are admitted to the facility to be in compliance with Joint Commission regulations
  - Hospitals purchase drugs/devices for use in inpatient setting
  - NC Medicaid reimburses hospitals exclusively through DRG codes, which are “package” codes for an entire admission.
  - No mechanism to reimburse hospitals separately or directly for the LARC device
  - Providers cannot supply devices from their office for patients in the hospital

In-patient LARC

- August 2016 Medicaid Special Bulletin:

"The payment of LARCs is included in the DRG payment of the delivery… the cost of the LARC is an allowable cost on the cost report, which is used in the calculation of the MRI/GAP supplemental payments."

- Hospitals undergo an annual "cost settlement" process with the state for expenses in excess of the DRG reimbursement

In-patient LARC

- DMA October Medicaid Provider Bulletin article:

"The weights for newborn deliveries have increased to encourage the use of long-acting reversible contraceptives (LARC) procedures in the inpatient setting."

- Hospitals are receiving a higher payment for all deliveries as of 10/1/16, with the intention of increasing revenue to hospitals in order to make LARC available in the in-patient setting

LARC Barriers/Solutions

- Outpatient LARC barriers:
  - “Buy and bill” is affected by legislative freeze on Medicaid reimbursement rates to providers
  - As pharmaceutical companies increase price, cost of the device to providers may exceed frozen Medicaid rates
    - Currently, Nexplanon implant and Skyla IUD are “underwater”
  - Provider willingness to purchase up front, ability to negotiate volume discounts
- Solutions:
  - Continue work to address Medicaid reimbursement rates
  - Innovative pilots with pharmaceutical companies, other stakeholders

LARC Barriers/Solutions

- Same-day insertion barriers:
  - Provider misunderstanding about billing
  - Provider concerns about patient counseling
  - Availability of device at time of visit
- Solutions:
  - Ongoing technical assistance from CCNC, DPH and others about correct billing
  - Promotion of best practices for same-day insertion
  - PMH Care Pathway on Reproductive Life Planning and LARC in development

LARC and Consumers

- Understanding the patient perspective about LARC and contraceptive choices
- NC DPH Women's Health Branch administering consumer survey as part of COIIN interconception care activities
- Other options to engage consumer perspective in statewide LARC activities being explored

LARC and Reproductive Justice

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- "The right to have children, the right to not have children, the right to raise children with dignity and in safety"
- Evidence-based contraceptive counseling
  - Free of coercion and bias
- Culturally-sensitive, patient-centered counseling
- Shared decision-making
- Fulfilling sterilization requests
- Offering LARC throughout postpartum period

Postpartum LARC Among PMH Patients

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Postpartum Utilization of Long Acting Reversible Contraception			
	Year Ending March 2014	Year Ending March 2015	Year Ending March 2016
Overall	12.6%	13.9%	12.9%
By Race/Ethnicity			
White	13.4%	14.5%	13.5%
Black	11.0%	12.4%	11.2%
Hispanic	14.6%	17.1%	16.5%

Unintended Pregnancy

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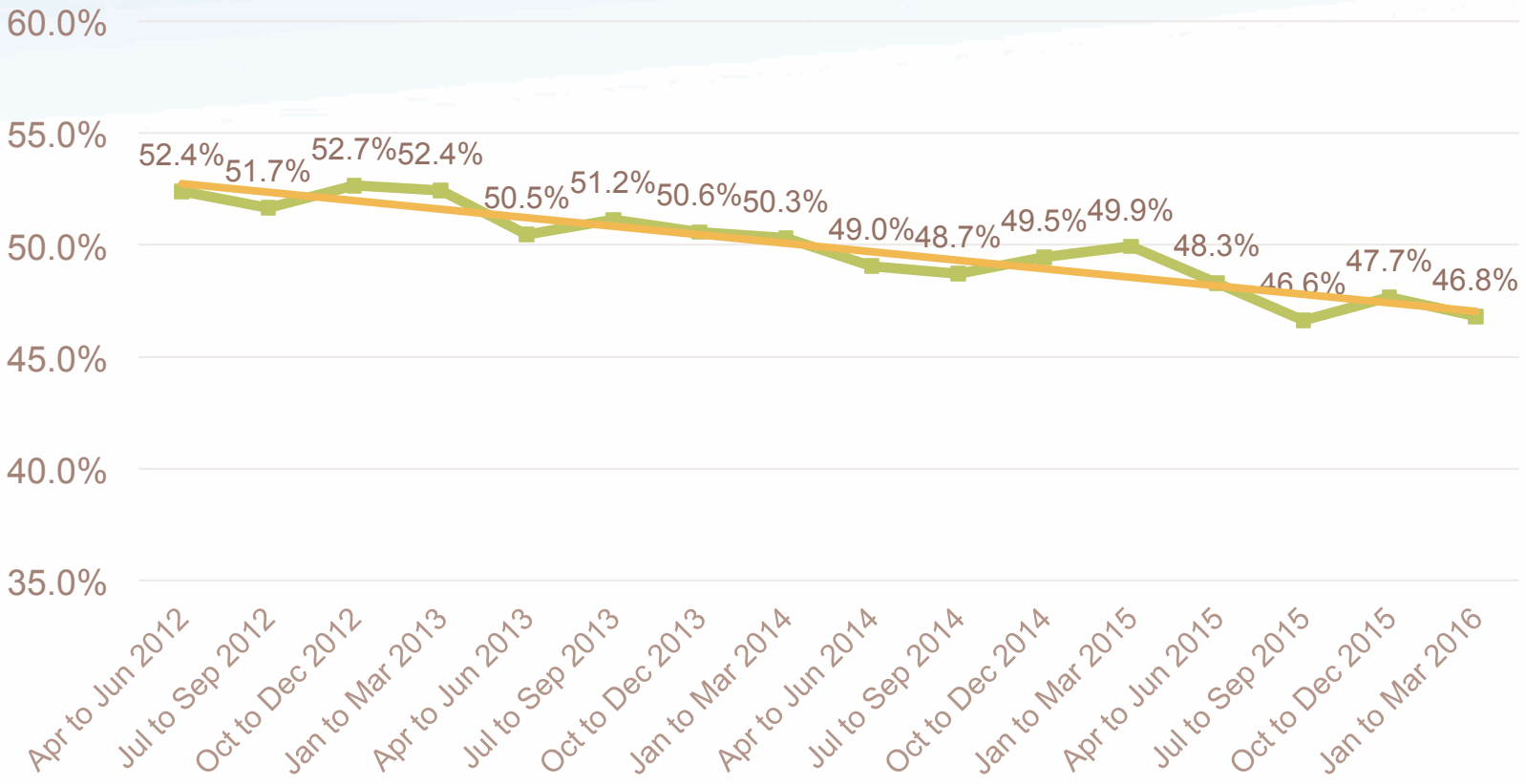
Unintended Pregnancy Among PMH Births



Questions?

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https://www.communitycarenc.org/population-management/pregnancy-home/