Factsheet

Long-Acting Reversible Contraception Payment and Reimbursement: Device Payment Strategies for Providers

Overview

Covering the cost of long-acting reversible contraception (LARC) is critical to increasing women's access in order to help avoid unwanted or unintended pregnancies. Cost can be a significant barrier for both women and providers, as it can be financially prohibitive for providers to cover the $500-$1,000 up-front, out-of-pocket costs of LARC methods while waiting for reimbursement. Easing up-front LARC costs therefore reduces provider barriers to offering LARC as an effective method of birth control.

Many states are interested in Medicaid or private insurance strategies that allow for payment for LARC devices and insertion immediately postpartum (IPP LARC). Policies regarding Medicaid payment and reimbursement structures for IPP LARC vary from state to state: some pay for IPP LARC as an add-on payment in addition to the "global delivery fee," while others cover IPP LARC outside of a hospital's billing codes, i.e., the diagnosis related group (DRG) billing code. States are also increasingly interested in practices that help make LARC more accessible to women in outpatient settings by facilitating provider reimbursement. This factsheet discusses different strategies and important items to consider when addressing provider payment policies for LARC.

Inpatient: LARC Device and Insertion Covered

Providers are more likely to participate in IPP LARC when both the insertion procedure and the device are covered through a health insurance payment policy. In that instance, the hospital orders the LARC device and is responsible for stocking and supply. When the patient presents for delivery, the physician or nurse orders the device through the hospital's pharmacy system and inserts the LARC device—within 10 minutes of birth for intrauterine devices (IUDs), or before discharge from the hospital for the contraceptive implant. When the insertion is covered outside the DRG, the physician bills at the same time as other procedures related to the birth and is compensated additionally for inserting the LARC. The hospital bills Medicaid or private insurance for the device, to be paid in full outside the DRG, and is reimbursed for the cost of the device. In states like South Carolina, managed care plans are compensated in their capitation rate for coverage of the device and insertion.

Outpatient: Specialty Pharmacy ("White Bagging")

Specialty pharmacy, or "white bagging," refers to a method of stocking LARC devices in an outpatient clinic where the provider is not charged for the device at any point. This strategy allows the provider to charge the LARC device to a specific patient's Medicaid identification number through her Medicaid fee-for-service plan or a managed care plan specialty pharmacy. The device is directly charged to Medicaid, not the provider, and is shipped overnight ("white bagging") to the office, which has 30 days to insert the LARC device. If the patient receives the LARC, the device is already paid for and the provider is compensated for the insertion through his or her usual billing.

If the patient does not return, it offers a good opportunity to provide direct educational outreach as a reminder to the patient about unwanted pregnancies. If the patient does not return to the office within 30 days, the device is shipped back to the pharmacy and credited to the patient's Medicaid account. In a South Carolina review of the first six months of claims, there were no devices returned for credit, indicating that there was sufficient time to get the patient back to the office for insertion.

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Outpatient: Pharmacy Medical Benefit ("Buy and Bill")

Pharmacy medical benefit, or "buy and bill," refers to a method where providers in outpatient clinics stock their own devices at their expense. In this situation, a physician orders a number of devices out of pocket that are shipped directly to his or her practice. Upon insertion, the provider bills Medicaid for the device and insertion. If the patient does not return or the office or does not have a use for the device, the device sits on the shelf unused. In the event that the practice over orders a particular device, it loses the money. This strategy requires physicians and practices to closely monitor stock and insertion rates.

Why Paying for LARC Matters

LARC methods are highly effective forms of contraception and include IUDs and the contraceptive implant, methods that are more than 99 percent effective at preventing pregnancy.[1] Because 50 percent of pregnancies in the United States are unintended or mistimed and approximately the same percentage of women return for their postpartum visit six weeks after birth, it is critical that women who want to delay or prevent pregnancies have access to reliable contraception.[2] IPP LARC offers several benefits, including effective protection from unintended pregnancy immediately after birth and added convenience for patients.[3,4] States are undertaking a systems change approach to more effectively apply policies that support IPP LARC use.

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[1] Guttmacher Institute. "Contraceptive Use in the United States." Available at: http://www.guttmacher.org/media/presskits/contraception-US/statsandfacts.html. Accessed 10-5-2015.

[2] Bennett, WL, et al. "Utilization of Primary and Obstetric Care After Medically Complicated Pregnancies: An Analysis of Medical Claims Data." *Journal of General Internal Medicine*. 2014 29(4):636-45. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24474651. Accessed 10-5-2015.

[3] ASTHO. "Factsheet on Long-Acting Reversible Contraception (LARC)." 2014. Available at: http://www.astho.org/LARC-Fact-Sheet/. Accessed 10-5-2015.

[4] Secura, GM, Madden T, McNicholas C, *et al.* "Provision of No-Cost, Long-Acting Contraception and Teenage Pregnancy." *The New England Journal of Medicine*. 2014. 371:14, 1316–1323. Available at http://doi.org/10.1056/NEJMoa1400506. Accessed 10-5-2015.

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