Partnering for Perinatal Health

Christa Christakis, MPP

Executive Director

ACOG District II

DISCLOSURE STATEMENT

I have no financial interest with any commercial or corporate enterprise.

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District II

ACOG District II Overview

- Established in 1985, ACOG District II is the largest and most active single-state district working on behalf of over 4,000 ob-gyns/women's healthcare providers to ensure the highest quality healthcare is readily available and accessible to women of New York State.

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Member Benefit 2016 Highlights

GOVERNANCE + OPERATIONS

- Advisory Council, 9 Committees and Task Forces comprised of practicing ob-gyns from all regions of NYS

MEMBERSHIP ENGAGEMENT

- 328 Leadership opportunities for Fellows and Junior Fellows
- 15 awards
- 44 JF research day participants

MEETINGS

- ADM Premier educational highlight of the year
- 479 providers in attendance
- 21 CMEs offered

MEDICAL EDUCATION

- Cutting edge, innovative clinical education
  - Focus on Female Cancers: Ovarian/ Genetics
  - LARC
  - Opioid Addiction in Pregnancy
  - Maternal Mortality
- In-person meetings, grand rounds, video, web, and printed materials

GOVERNMENT AFFAIRS + ADVOCACY

- Advocacy on behalf of our members and their patients
- 24 Resident Advocacy Program Participants
- Thwarted regressive medical liability legislation

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COMMUNICATION
PLAN


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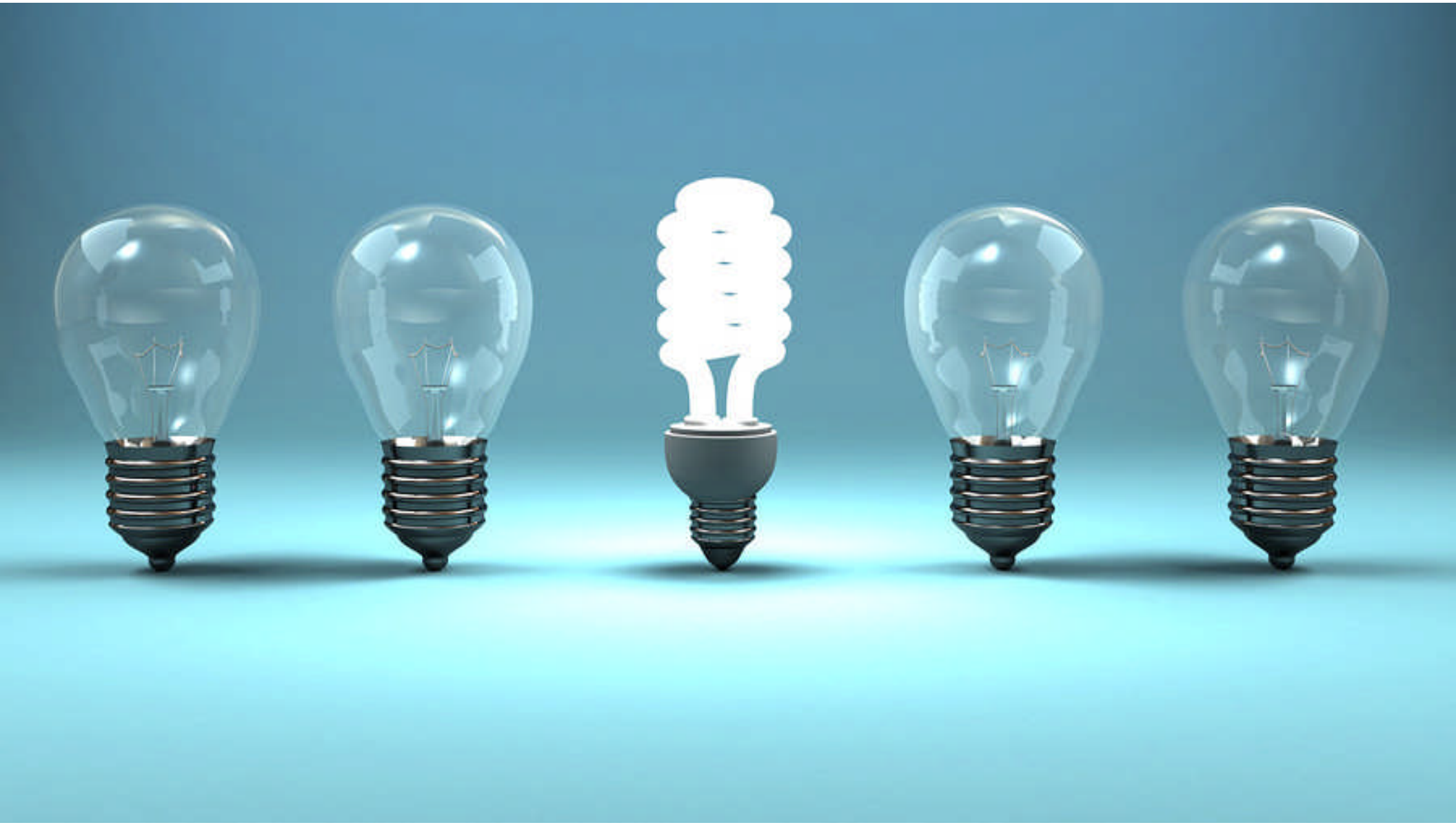
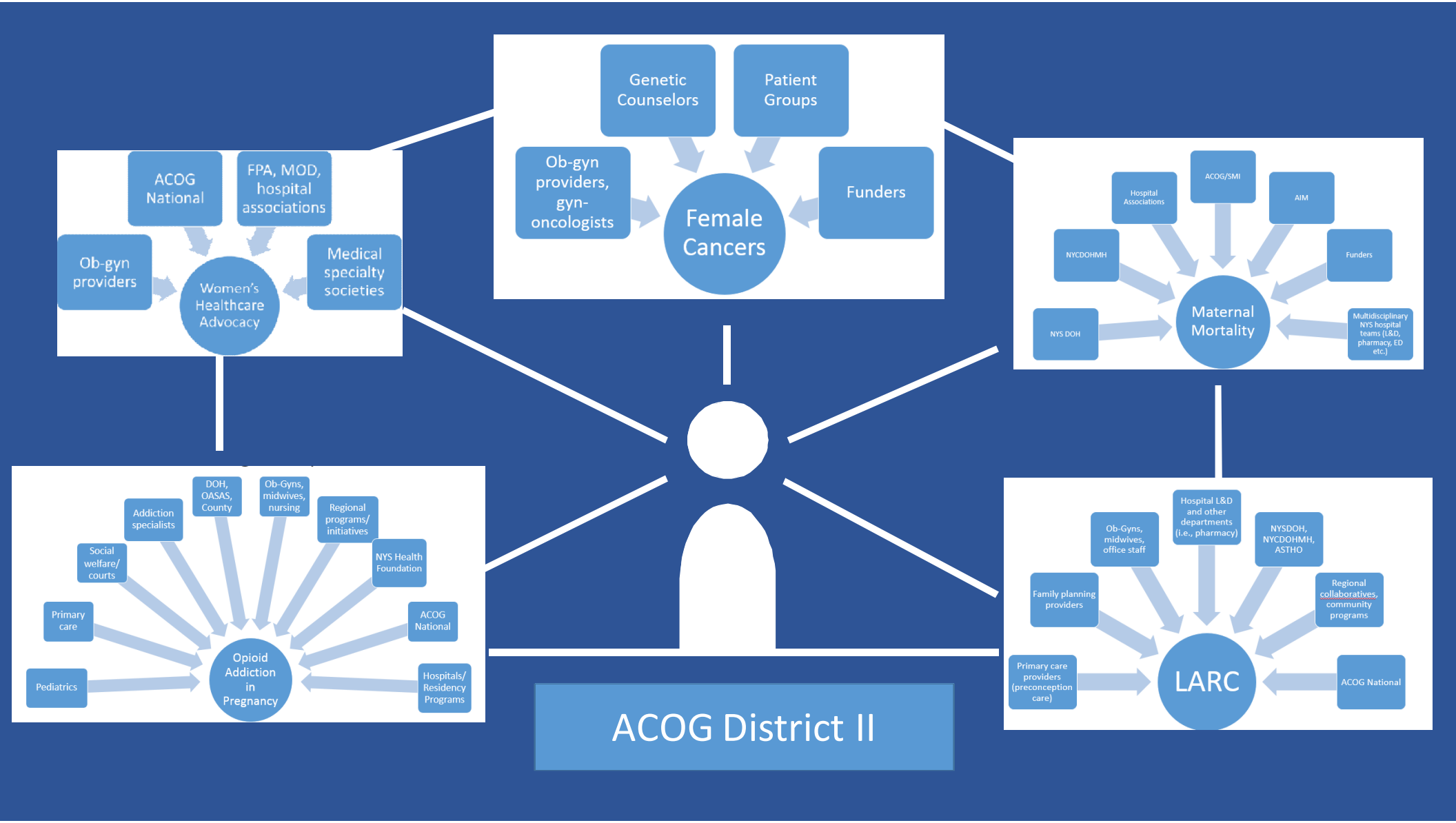



Genetic Counselors
Patient Groups
Ob-gyn providers, gyn-oncologists
Female Cancers
Funders
ACOG National
FPA, MOD, hospital associations
Ob-gyn providers
Women's Healthcare Advocacy
Medical specialty societies
Hospital Associations
ACOG/SMI
AIM
NYCDOHMH
Funders
NYS DOH
Maternal Mortality
Multidisciplinary NYS hospital teams (L&D, pharmacy, ED etc.)
DOH, OASAS, County
Ob-Gyns, midwives, nursing
Addiction specialists
Regional programs/ initiatives
Social welfare/ courts
NYS Health Foundation
Primary care
ACOG National
Pediatrics
Opioid Addiction in Pregnancy
Hospitals/ Residency Programs
Hospital L&D and other departments (i.e., pharmacy)
Ob-Gyns, midwives, office staff
NYSDOH, NYCDOHMH, ASTHO
Family planning providers
Regional collaboratives, community programs
Primary care providers (preconception care)
LARC
ACOG National
ACOG District II

ACOG District II's Advocacy Priorities

S.4080 and A.3339

- Medical liability bills
- If enacted:
  - The statute of limitations on medical malpractice action would change to a date of discovery
  - Ob-gyns' liability exposure would increase on issues like cancer screenings
  - Premiums would rise by as much as 15%
  - We need comprehensive reform , not a piecemeal approach

ACOG DII OPPOSED

S.3668/A.1378

- Comprehensive Contraception Coverage Act (CCCA)
- If enacted, it would provide:
  - Insurance coverage for ALL forms of contraception, no cost sharing
  - Access to 12 months of contraception
  - Emergency Contraception (EC), no cost sharing

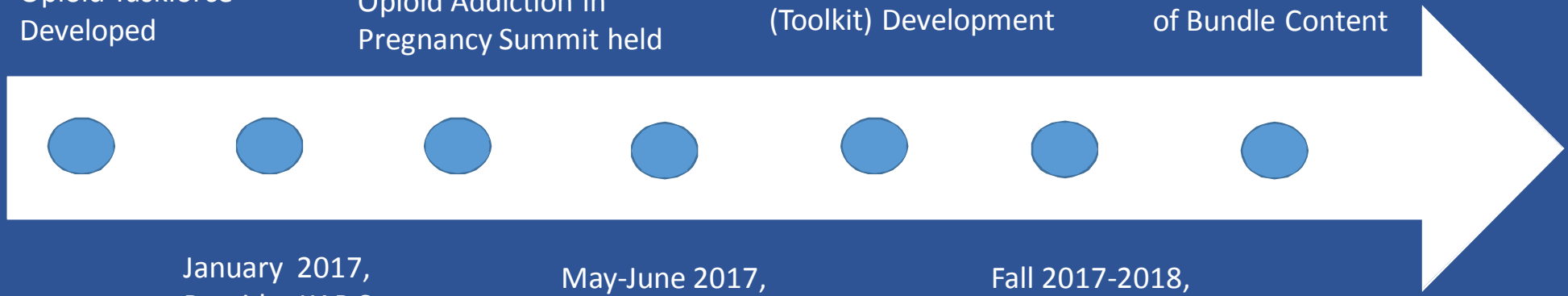
ACOG DII SUPPORTS

S.2796/A. 1748

- Reproductive Health Act (RHA)
- If enacted, it would:
  - Move abortion from criminal code into public health law
  - Allow abortions up to 24 weeks and in cases to protect a women's health and life and in the absence of fetal viability
  - Clarifies APCs can provide abortion services within their scope of practice

ACOG DII SUPPORTS

Opioid Addiction in Pregnancy



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Opioid Addiction in Pregnancy Summit

Left to Right: Leah Kaufman, MD, Opioid TF Co-Chair, Lieutenant Governor Kathy Hochul, David Garry, DO, Opioid TF Co-Chair, Christa Christakis, ACOG DII Executive Director

- 100% of post-summit survey respondents indicated the summit was beneficial to their daily work
- 100% of respondents stated the summit enabled them to create new working relationships with colleagues from other discipline and regions in the state
- 95% of respondents agreed that they learned something new as a result of the summit

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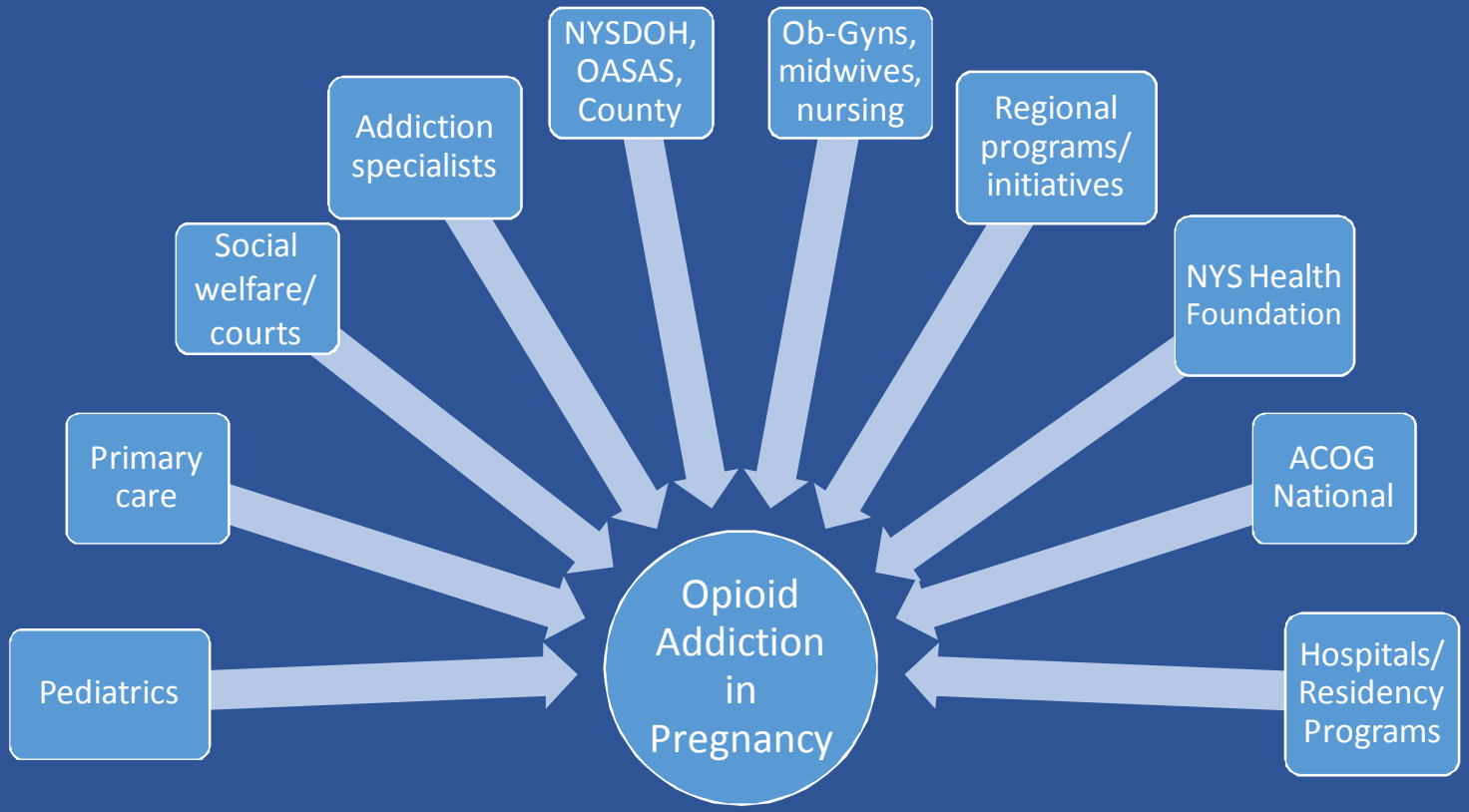
Opioid Addiction in Pregnancy



ACOG District II Opioid Addiction in Pregnancy Task Force

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Enhancing Access to LARC

- Administrative & Infrastructure Support Checklist
- Contraceptive Counseling Algorithm
- Dispelling Myths Fact Sheet
- Web-based Resource Summary

CONTRACEPTIVE COUNSELING & REPRODUCTIVE LIFE PLANNING

ACOG LARC Program Contraceptive Counseling Resource Digest
ACOG LARC Program Webinar: Contraceptive Counseling and LARC Uptake
Bedsider
CDC United State Medical Eligibility Criteria (US MEC) 2016
CDC and the US Office of Population Affairs Recommendations
NYCDOHMH Sexual & Reproductive Health Care Best Practices for Adolescents & Adults
NYS Partnership for Maternal Health (NYSPMH) Preconception Care Letter
The One Key Question® Initiative

OVERCOMING LARC PLACEMENT BARRIERS & CHALLENGES

ACOG Clinical Challenges of LARC Methods Committee Opinion
ACOG District II Immediate Postpartum LARC Insertion video
ACOG LARC Program Immediate Postpartum Resources
ACOG LARC Program Webinar: LARC Myths: Addressing Misconceptions about IUDs and Implants
Association of Reproductive Health Professionals. "Birth Control: Dispelling Common Myths about Intrauterine Contraception." Patient Fact Sheet
Journal of Adolescent Health Myths and Misconceptions about LARC article

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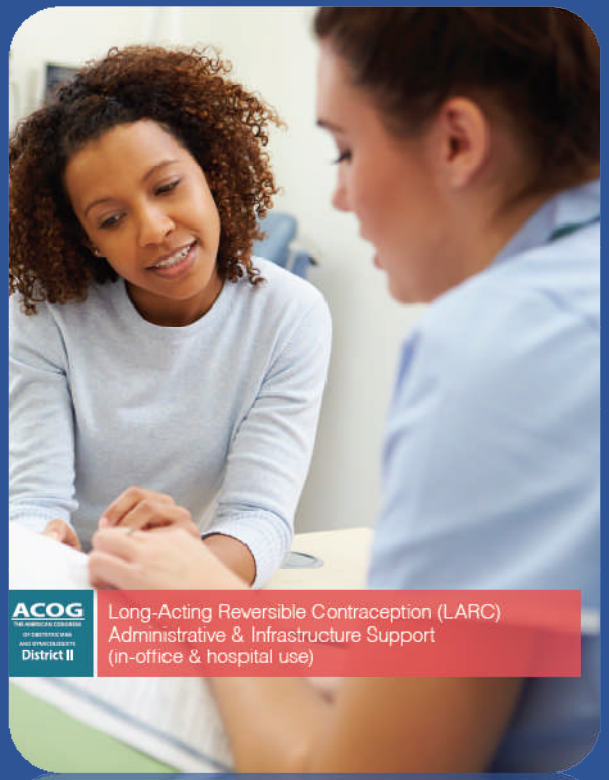
Administrative & Infrastructure Support



Provider/Support Staff Education & Training:[1]

- ☑ Adopt best practices for LARC insertion and develop a protocol that allows for proper insertion technique and patient safety, including how to address potential complications.
- ☑ Ensure providers and support staff are appropriately trained and make certain providers are knowledgeable and comfortable with LARC insertion techniques – in the office and immediately postpartum.
  - – Offer continuing education on current practice guidelines and insertion techniques.
- ☑ Identify physician and nurse champions within your office and hospital setting who can facilitate administrative coordination and ensure that clinical staff receive adequate training.
- ☑ Create a protocol for offering patient education and obtaining informed consent. Train all staff on the protocol (i.e., how to address patient concerns and dispel any myths).
- ☑ Be knowledgeable about billing/coding and claim submission for provider services and device reimbursement.

  Have a quick LARC coding guide available for reference.
- ☑ Research coverage details of the various insurance plans and create a quick reference guide (i.e., chart/grid with plans' coverage details) for office staff to quickly access (*see coverage & reimbursement*).
- ☑ Create order sets for providers to use when conducting an insertion to ensure the supplies, device, and procedure are appropriately coded.

**It may be useful to develop "insertion packages" that contain all the supplies needed for device insertion (i.e., for implant insertion, a pen to mark the site, a needle and syringe for injection of lidocaine, alcohol/betadine, 2x2 sponges, bandage or arm wrap, etc.)*

Coverage & Reimbursement of LARC:

DEVICE COST AND REIMBURSEMENT

The cost of the LARC device to the provider depends on whether or not the provider organization qualifies for 340B pricing. Organizations eligible for 340B pricing include: Title X family planning clinics, federally qualified health centers (FQHCs), student health services, school-based health centers, and disproportionate share hospitals.

NEW YORK STATE MEDICAID COVERAGE OF LARC[4]

Medicaid Managed Care (MMC)

- New York State has a **free access policy** for patients enrolled in a Medicaid Managed Care (MMC) plan. This allows for access to family planning and reproductive services from either a provider in the patient's plan or from any Medicaid Participating provider outside of the patient's plan. The **free access policy** does not require Medicaid Managed Care enrollees to obtain a referral from their primary care provider or to obtain pre-authorization.
- The New York State Department of Health requires MMC plans to implement mechanisms to pay hospitals for immediate postpartum LARC separate from reimbursement for the inpatient stay.

Fee-For-Service (FFS)

The total reimbursement amount under fee-for-service depends on the type of facility where the provider practices.

- The cost of LARC is paid to federally qualified health centers (FQHCs) separate from the Prospective Payment System (PPS) rate.
- Most Article 28 facilities *(facilities established, operated, and regulated under Public Health Law Article 28; physician offices are not regulated under Article 28)* use NYS's Medicaid Ambulatory Patient Group (APG) payment methodology. The cost of LARC is paid separately from the APG payment.
  - – Coverage and payment for postpartum LARC is separated from the inpatient APG-Diagnosis Related Group (DRG) reimbursement so in addition to the service, facilities bill and get reimbursed for the device separately.

LARC Carve-Out for FQHCs

- A clinic designated as a FQHC must be enrolled in the Medicaid program with the category of service of 0163 (ordered ambulatory diagnostic and treatment center) or 0292 (hospital-based ordered ambulatory) in order to bill separately for the cost of LARC.
- LARC procedure codes carved out of FQHCs may be billed to Medicaid FFS as an ordered ambulatory service on a separate claim from the clinic's PPS claim for the insertion of a device or removal and insertion of a new device.

COMMERCIAL PLANS

- Most commercial plans must cover LARC methods without cost-sharing. Patients cannot be asked to pay upfront costs and then be reimbursed. *No cost-sharing means that patients should not have any out-of-pocket costs, including payment of deductibles, co-payments, co-insurance, or other charges for coverage of contraception, including LARC.*
- Under the current protections of the Affordable Care Act (ACA), all new insurance plans are required to cover at least one form of all 18 FDA-approved methods of birth control (IUDs and implants included) for women without cost-sharing. NOTE: There are a limited number of commercial plans where the ACA coverage requirements do not apply (i.e., grandfathered plans- purchased before March 23, 2010).[5]

Contraceptive Counseling Algorithm & Myths and Misconception Fact Sheet

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Contraceptive Counseling & Reproductive Life Planning:[1,2,3,4]
Suggestions for Getting Started

"Would you like to become pregnant within the next year?"

Yes — *"for pregnant patients, follow the "yes" column guidance*

Counsel on **preconception care** and all forms of postpartum contraception, including LARC methods, to allow for informed decision-making

- Discuss medically appropriate contraception in the postpartum period based on patient need (i.e., HIV positive, or chronic illnesses)

**offer patient educational materials on available methods*

- Offer comprehensive contraceptive counseling during prenatal care, including immediate postpartum LARC options
  - include: benefits of reducing unintended pregnancy and lengthening interpregnancy intervals
- Determine the appropriate information sharing strategy within your hospital system (i.e., EMR, fax) and transfer patient's contraceptive plans to the hospital

No

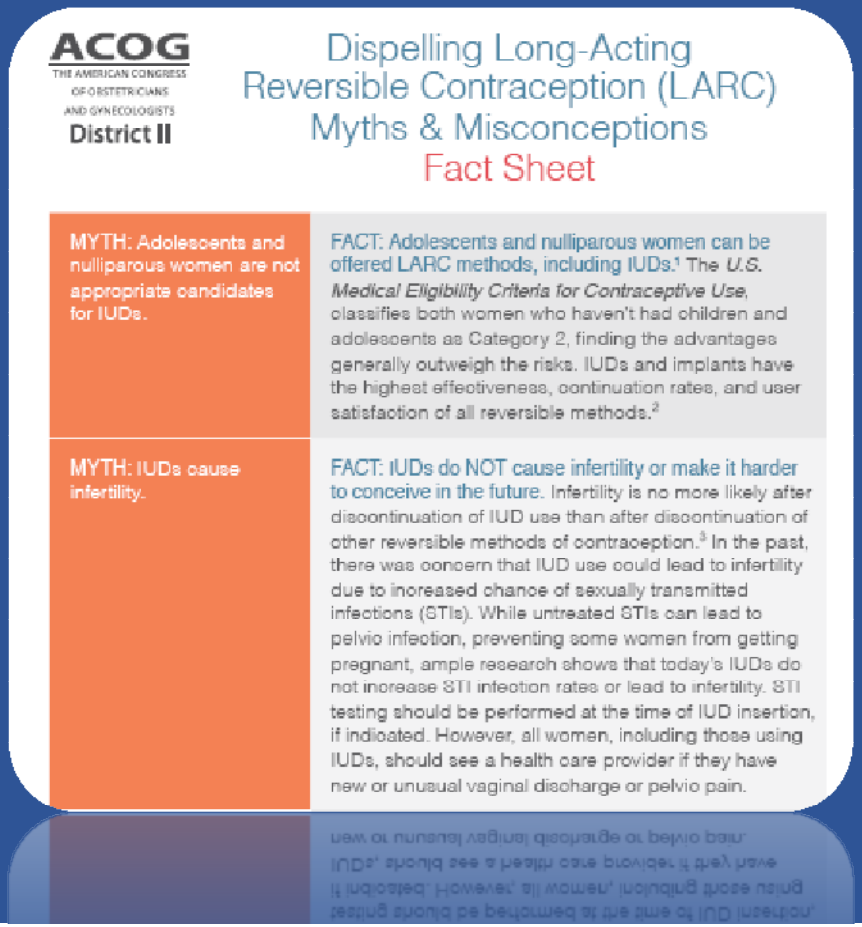
Counsel on all forms of **contraception**, including LARC methods, to allow for informed decision-making

- Discuss medically appropriate contraception based on patient need (i.e., HIV positive, or chronic illnesses)

**offer patient educational materials on available methods*

- Review all methods of contraception with all appropriate candidates, including IUDs and implants for nulliparous women and adolescents
- All methods of contraception, including IUDs and implants may be initiated the same day as the patient visit (if pregnancy can reasonably be excluded)
- Screen for STIs at the time of IUD insertion, if positive, treat the infection without removal of the IUD
  - Provide counseling on STI risk reduction

- Review contraception benefits, effectiveness, risks (e.g. expulsion rates for IUDs), expected changes to bleeding patterns, potential side effects, and contraindications.
- Discuss the details for accessing the selected method of contraception, including costs, insurance coverage, and hospital procedures (as needed for postpartum LARC).
- Offer an opportunity for patients to ask questions and discuss a plan should they not be satisfied with their choice
  - Address any patient concerns and dispel myths as needed.
  - Although uncommon, possible LARC complications should be included in the informed consent process.



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Dispelling Long-Acting Reversible Contraception (LARC) Myths & Misconceptions
Fact Sheet

MYTH: Adolescents and nulliparous women are not appropriate candidates for IUDs.	**FACT:** Adolescents and nulliparous women can be offered LARC methods, including IUDs.[1] The *U.S. Medical Eligibility Criteria for Contraceptive Use*, classifies both women who haven't had children and adolescents as Category 2, finding the advantages generally outweigh the risks. IUDs and implants have the highest effectiveness, continuation rates, and user satisfaction of all reversible methods.[2]
MYTH: IUDs cause infertility.	**FACT:** IUDs do NOT cause infertility or make it harder to conceive in the future. Infertility is no more likely after discontinuation of IUD use than after discontinuation of other reversible methods of contraception.[3] In the past, there was concern that IUD use could lead to infertility due to increased chance of sexually transmitted infections (STIs). While untreated STIs can lead to pelvic infection, preventing some women from getting pregnant, ample research shows that today's IUDs do not increase STI infection rates or lead to infertility. STI testing should be performed at the time of IUD insertion, if indicated. However, all women, including those using IUDs, should see a health care provider if they have new or unusual vaginal discharge or pelvic pain.

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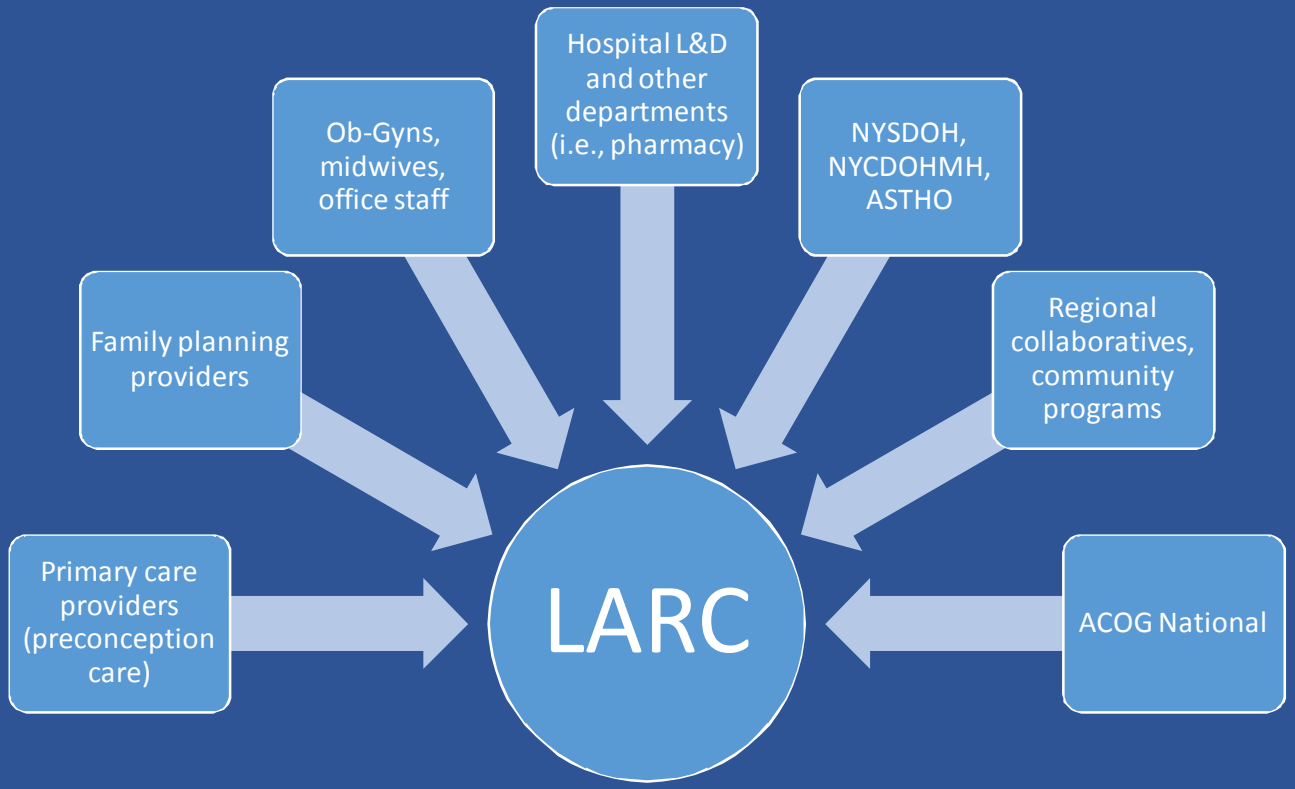
Enhancing Access to LARC



ACOG District II LARC Task Force

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Safe Motherhood Initiative

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Maternal Mortality Reviews

Partnering with NYS Department of Health:

- Multi-disciplinary, clinical committee; convenes to review cases
- Discuss and review each case and come to consensus on the cause and preventability of the death
- Release a comprehensive report on maternal mortality will be released; action alerts; utilize information to guide quality improvement process and policy

Partnering with NYC Department of Health and Mental Hygiene

- Assisting with maternal mortality surveillance process

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Maternal Mortality—SMI Next Steps

Implementation next steps:

- Focus on hemorrhage in partnership with NYSDOH and hospital associations
- Continue in-person meetings– next meeting July 25 NYU

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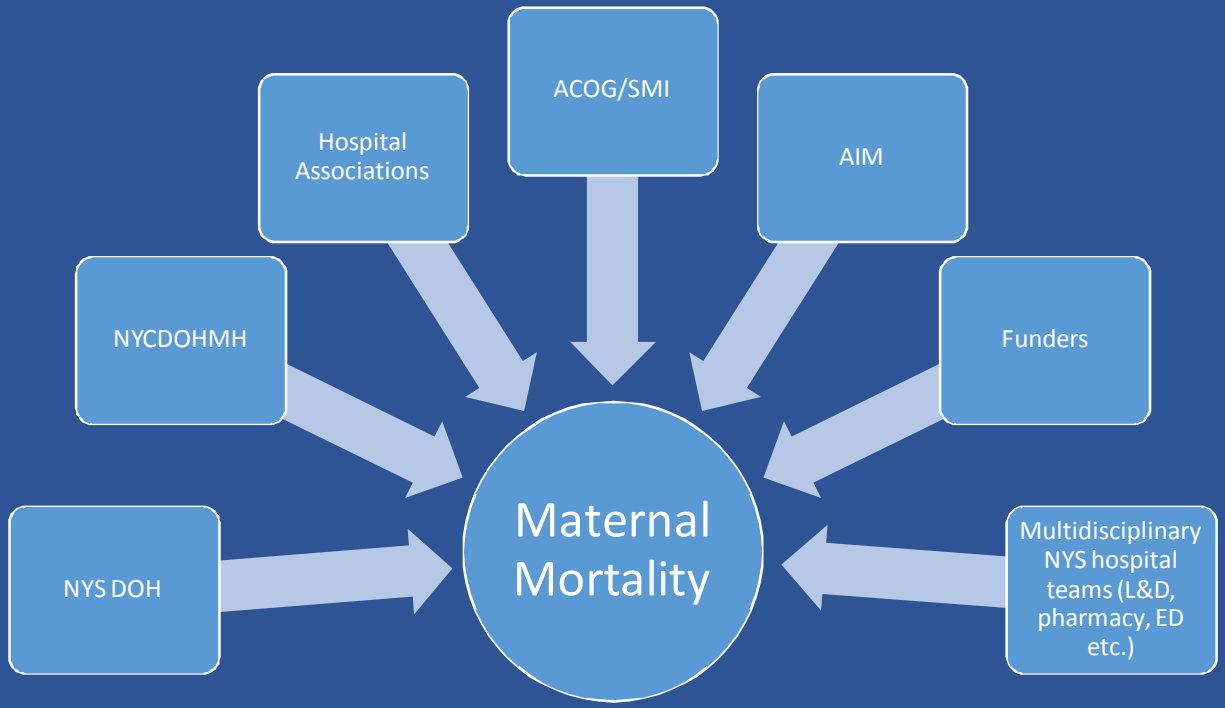
Maternal Mortality Reviews & Quality Improvement Efforts



ACOG District II Safe Motherhood Initiative Committee

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A Look Ahead …

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Questions?

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