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October 24, 2016

The Honorable Sylvia M. Burwell
Secretary of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Madam Secretary,

We write today to applaud the Department of Health and Human Services (HHS) for ongoing efforts to help women prevent unintended pregnancy and ask you to bolster those efforts by enhancing voluntary provider training on clinical and counseling skills related to women's contraception options. Over the past few years, access to affordable family planning and contraception has increased dramatically. HHS has also issued new guidance and undertaken several initiatives through the Centers for Medicare & Medicaid Services (CMS), the Office of Population Affairs (OPA), and the Centers for Disease Control and Prevention (CDC) to ensure women have access to the full range of options and providers have the guidance they need to provide quality family planning services. In order to keep pace with the changing landscape and maximize the positive impact of these policies, we must make certain that providers have the training and resources they need to provide quality patient counseling and effectively educate patients about the safety and effectiveness of all forms of contraception so that each woman can select the family planning method that best meets her medical needs and personal preference.

Even though the incidence of unintended pregnancy is at its lowest level in 40 years, nearly 45 percent of pregnancies in 2011 were unintended, a much higher rate than other developed countries.[1] The risk of unintended pregnancy among women living in poverty is still significantly higher than the national average.[2] Unintended pregnancies can lead to negative outcomes for both women and newborns, including poorer preconception maternal health, delayed prenatal care, increased risk of prematurity, and low birth weight.[3] More can and should be done to reduce these risks and empower women by increasing awareness of and access to a full range of contraceptive options.

In recent years, HHS has worked with Congress to significantly increase access to contraception for women across the United States. The Affordable Care Act has helped millions of women access no-cost contraceptive benefits, saving approximately $1.4 billion in out-of-pocket spending in 2013 alone.[4] Medicaid expansion has also increased access to reproductive health benefits and services for countless

[1] Lawrence B. Finer and Mia R. Zolna, "Declines in Unintended Pregnancy in the United States," *New England Journal of Medicine* 374 (2016): 843-52.
[2] Ibid.
[3] Centers for Medicare & Medicaid Services, "CMCS Maternal and Infant Health Initiative: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP" (2014), available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Maternal-and-Infant-Health-Initiative.pdf.
[4] Nora V. Becker and Daniel Polsky, "Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives after ACA Mandate Removed Cost Sharing," *Health Affairs* 34(7)(2015): 1204-11.

women. We also appreciate efforts under the Maternal and Infant Health Initiative to improve pregnancy planning by promoting the most effective and moderately effective forms of contraception.[5] Due in part to this Initiative, CMS has taken positive steps throughout 2016 to resolve reimbursement and administrative issues that complicate timely access. Historic billing and coding practices often do not factor-in the cost of contraception or allow for timely delivery of services, particularly for more expensive forms of contraception like long-acting reversible contraception (LARC), such as implants and intrauterine devices (IUDs). Yet LARCs are 20 times more effective at preventing pregnancy than birth control pills, and many women also report LARCs being a convenient birth control option, making them an important birth control option for women as they make personal reproductive health decisions.[6] Recognizing these issues, CMS sent a letter to state health officials in June 2016 and an informational bulletin in April 2016 encouraging them to establish Medicaid reimbursement policies that will help promote access to effective contraception.[7] CMS has also clarified that utilization controls often used by managed care plans to restrict access to certain drugs (e.g. fail-first policies, step therapy, prior authorization) are inappropriate in family planning contexts.[8] As a result, Medicaid enrollees cannot be deprived of timely access to the form of contraception that best meets their needs. We applaud CMS for these efforts and encourage you to vigorously monitor state compliance and ensure that reimbursement rates are sufficient for these services.

While we are encouraged by recent progress, enhanced provider training and creating more learning tools that do not increase burdens on providers would help bolster the effectiveness of these efforts. Evidence suggests that primary care, OB-GYN, and other providers who are likely to encounter women in search of reproductive health care could benefit from increased training on counseling techniques such as those recommended by CDC and OPA, the safety of various forms of contraception, and federal rules related to reimbursement. State initiatives that have included a strong provider training component have achieved remarkable results. For example, Colorado's Family Planning Initiative, which made the full range of contraception available to women at no cost, has gotten significant national attention for cutting unintended teen pregnancy rates by nearly half. Participating providers were trained on patient-centered counseling, the safety and effectiveness of different forms of contraception, and state Medicaid rules. Not only was the Initiative a huge success for women, it also resulted in millions of dollars in Medicaid savings.[9]

We therefore ask HHS to ensure that providers have the training and education resources they need to ensure women's access to quality family planning care. In particular, we ask HHS to focus provider resources on the following three issues:

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[5] Centers for Medicare & Medicaid Services, "CMCS Maternal and Infant Health Initiative: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP" (2014), available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Maternal-and-Infant-Health-Initiative.pdf.

[6] Brooke Winner et al, "Effectiveness of Long-Acting Reversible Contraception," *New England Journal of Medicine* 366(2012): 1998-2007.

[7] Centers for Medicare & Medicaid Services, *Dear State Health Official Letter #16-008* (June 14, 2016), available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf; CMS, *Informational Bulletin re: State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception* (Apr. 8, 2016), available at https://www.medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf.

[8] Centers for Medicare & Medicaid Services, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," *Federal Register* (May 6, 2016), available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

[9] Sabrina Tavernise, "Colorado's Effort Against Teenage Pregnancies is a Startling Success," *New York Times* (2015), available at http://www.nytimes.com/2015/07/06/science/colorados-push-against-teenage-pregnancies-is-a-startling-success.html.

- ***Patient-Centered Counseling***: Federal and state efforts to increase access to contraception should always strive to empower women and give them more choices—not to increase utilization of specific forms of contraception. Comprehensive, nonbiased, medically accurate counseling about the full range of contraceptive options is therefore crucial. HHS should ensure that all providers have access to contraceptive counseling training, such as that provided through Title X. CMS should require states to make sure provider reimbursement for comprehensive, medically accurate contraceptive counseling is sufficient and keeping pace with the transitions toward value based payment. Training should include guidance on how best to provide counseling that does not bias a patient's decision-making and support women's decisions to switch methods or cease using contraception.[10] In order to support those decisions, providers must also be trained on LARC removal.

- ***Gaps in Education about Safety & Effectiveness***: Studies have found that providers often have misconceptions about the safety of various forms of contraception. For example, a recent study conducted by the American College of Obstetricians and Gynecologists (ACOG) found that less than half of OB-GYNs believe an IUD can be inserted immediately following birth.[11] Less than half of OB-GYNs were aware that IUDs are appropriate for teenagers, even though the American Academy of Pediatrics recommends them as a first line contraceptive option that is appropriate for adolescents.[12] Recent studies suggest, however, that even a few hours of training can clarify these misconceptions.[13] HHS should explore strategies that increase providers' access to continuing medical education and latest medical recommendations and guidelines, including the newly released U.S. Medical Eligibility Criteria and Selected Practice Recommendations.

- ***Confusion about Reimbursement, Care Delivery, and Federal/State Laws***: Any training or education resources should also update providers about federal and state rules related to billing, reimbursement, and provision of services. For example, if a state adopts one of the suggested policies outlined in the June 2016 Dear State Health Official Letter that enables a provider to easily provide same-day LARC insertion or removal services, the state should also educate providers about the new policy and ensure providers put the policy into practice. Additionally, states should ensure that providers are informed about confidential billing options, and we encourage CMS to issue a memo on best practices. Finally, we are concerned that federal funding restrictions on abortion services create confusion amongst providers that complicates timely access to contraception. Restrictions like the Hyde Amendment generally require segregation between funding for abortion and other types of care. CMS has made clear, however, that the temporal proximity of an abortion has no bearing on Medicaid coverage for other types of care and services, including contraception. Thus, while providers can legally receive reimbursement for contraception provided after an abortion, many choose not to do so out of misplaced fear of legal consequences.[14]

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[10] Julia Strasser et al, "Long-Acting Reversible Contraception: Overview of Research & Policy in the United States," The George Washington University (2016), available at http://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/LARC_White_Paper_2016.pdf.

[11] "Intrauterine Devices (IUDs): Access for Women in the U.S.," Kaiser Family Foundation (2015), available at http://kff.org/womens-health-policy/fact-sheet/intrauterine-devices-iuds-access-for-women-in-the-u-s/.

[12] Alicia T. Luchowski et al, "Obstetrician-Gynecologists and Contraception: Practice and Opinions about the use of IUDs in Nulliparous Women, Adolescents and Other Patient Populations," *Contraception* 89(6)(2014): 572-77; Mary A. Ott et al, "Contraception for Adolescents," American Academy of Pediatrics Technical Report (2014), available at http://pediatrics.aappublications.org/content/134/4/e1257.

[13] Kristen M. Thompson et al, "Public Funding for Contraception, Provider Training, and Use of Highly Effective Contraceptives: A Cluster Randomized Trial," *American Journal of Public Health* 106(3)(2016): 541-46.

[14] Adam Sonfield, "Abortion Clinics and Contraceptive Services: Opportunities and Challenges," Guttmacher Policy Review 14(2)(2011): 2-7; Megan L. Kavanaugh et al, "Perceived and Insurance-Related Barriers to the Provision of

We appreciate the efforts HHS has already undertaken to work toward our shared goal of empowering women through access to contraception and preventing unintended pregnancies. By enhancing learning tools and voluntary training opportunities, we hope to build on the progress we have already been made by arming both providers and women with the information they need. We ask that HHS respond to this letter by December 23, 2016. We look forward to your response.

Sincerely,

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Member of Congress

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Member of Congress

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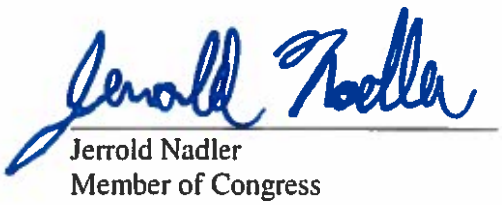
Contraceptive Services in U.S. Abortion Care Settings," *Women's Health Issues* (2011), available at https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2011.01.009.pdf.



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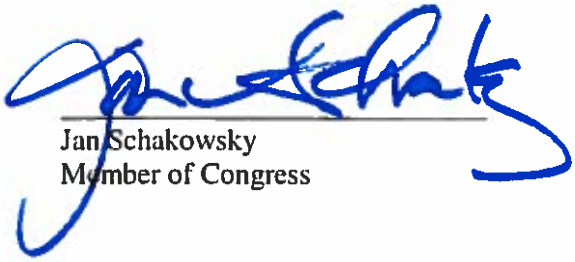

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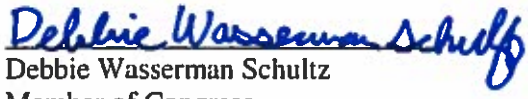

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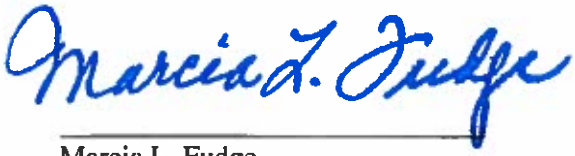

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