Characterization of Medicaid policy for immediate postpartum contraception☆,☆☆

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Abstract

Objective: Long-acting reversible contraception (LARC) is safe, effective and cost-saving when provided immediately postpartum but currently underutilized due to nonreimbursement by Medicaid and other insurers. The objectives of this study were to (a) determine which state Medicaid agencies provide specific reimbursement for immediate postpartum LARC and (b) identify modifiable policy-level barriers and facilitators of immediate postpartum LARC access.

Study Design: We conducted semistructured telephone interviews with representatives of 40 Medicaid agencies to characterize payment methodology for immediate postpartum LARC. We coded transcripts using grounded theory and content analysis principles.

Results: Three categories of immediate postpartum LARC payment methodology emerged: state Medicaid agency (a) provides separate or increased bundled payment (n = 15), (b) is considering providing enhanced payment (n = 9) or (c) is not considering enhanced payment (n = 16). Two major themes emerged related to Medicaid decision-making about immediate postpartum LARC coverage: (a) Health effects: States with payment for immediate postpartum LARC frequently cited improved maternal/child health outcomes as motivating their reimbursements. Conversely, states without payment expressed misinformation about LARC’s clinical effects and lack of advocacy from local providers about clinical need for this service. (b) Financial implications: States providing payment emphasized overall cost savings. Conversely, states without reimbursement expressed concern about immediate budget constraints and potential adverse impact on existing global payment methodology for inpatient care.

Conclusions: Many states have recently provided Medicaid coverage of immediate postpartum LARC, and several other states are considering such coverage. Addressing misinformation about clinical effects and concerns about cost-effectiveness of immediate postpartum LARC may promote adoption of immediate postpartum LARC reimbursement in Medicaid agencies currently without it.

Implications: Medicaid policy for reimbursement of immediate postpartum LARC is evolving rapidly across the US. Our findings suggest several concrete strategies to remove policy-level barriers and promote facilitators of immediate postpartum LARC.

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1. Introduction

Rapid repeat pregnancy increases risks of complications such as preterm birth, stillbirth and low birth weight [1,2]. Populations covered by public insurance such as Medicaid are particularly vulnerable to unintended rapid repeat pregnancy within 18 months of a prior live birth [3].

Long-acting reversible contraception (LARC) devices (e.g., intrauterine devices and implants) are highly effective at preventing unplanned pregnancy [4]. When provided immediately postpartum — that is, after delivery and prior to hospital discharge — LARC has been linked to longer contraceptive coverage, fewer rapid repeat pregnancies and cost savings [5–10]. Unmet demand for postpartum LARC is high, as only 54–60% of women who request LARC postpartum actually receive it, often due to failure to return for outpatient postpartum care or early repeat pregnancy [11–13]. The well-documented benefits of immediate postpartum LARC have led to its endorsement by the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and Prevention [4,14].

Reimbursement practices, however, often limit LARC provision to outpatient settings, after discharge from the hospital. Most Medicaid programs and private insurers pay for all labor- and delivery-related care with a global fee under a single diagnosis-related group (DRG) code. Given the cost of each LARC device ($800–$1000) [15], providers’ inability to obtain additional payment in the inpatient postpartum setting for LARC devices poses a significant barrier to the provision of postpartum LARC [16].

While some states have decided to permit additional payment for immediate postpartum LARC, other states have not. The objectives of this study were (a) to identify which Medicaid agencies allow specific billing for immediate postpartum LARC and (b) to characterize each agency’s rationale for this policy and identify policy-level barriers and facilitators of immediate postpartum LARC access.

2. Methods

2.1. Sample population

We contacted Medicaid offices in each state and the District of Columbia (D.C.) by telephone or email on up to four occasions between October 2014 and March 2015. We requested to schedule a telephone interview with the Medicaid director or a designee with expertise in women’s health services.

2.2. Instrument and interviews

The authors developed a semistructured interview guide based on review of recently published original research and editorials about immediate postpartum LARC [5–12,16,21,22] and conversations with Alicia Luchowski, the ACOG LARC Program Director. We revised the guide based on feedback from members of our institution’s Program on Women’s Health Effectiveness Research. We tailored the final interview guide to states providing, considering or not considering additional reimbursement for immediate postpartum LARC through fee-for-service Medicaid. The guide covered topics such as whether or not the state provides reimbursement for early postpartum contraception within fee-for-service Medicaid, details about this LARC reimbursement policy (if applicable) and the agency’s rationale for current reimbursement practices. We used probes from our guide to encourage elaboration, greater detail and clarification of responses [17]. One or two study authors (MHM, BI) conducted each semistructured telephone interview. We audio-recorded conversations with permission. For one state that declined audio-recording, the interviewer took and immediately transcribed extensive notes.

2.3. Qualitative analysis

Interviews were professionally transcribed verbatim and analyzed using Dedoose Version 5.3.12 (2014; Los Angeles, CA, USA: Sociocultural Research Consultants, LLC). Two authors (MHM, TC) identified themes using qualitative content analysis [18]. They developed the initial list of deductive codes based on a literature review and key sections of the interview guide. Using constant comparison, these two authors iteratively revised the codebook based on emergent themes identified during transcript review. They independently coded the initial 20% of the transcripts, resolving discrepancies through consensus. After intercoder agreement was established, a sole investigator coded each of the remaining interviews.

After the data collection and coding were complete, we grouped Medicaid agencies into one of three categories: (a) providing separate payment or increased bundled payment; (b) considering providing enhanced payment; or (c) not considering providing enhanced payment for immediate postpartum LARC devices. We defined separate or increased bundled payment as a payment consistently made because of LARC insertion, commensurate with the cost of LARC devices and provided in addition to usual payment for delivery-related care. We classified states based on their reimbursement of the cost of the LARC device, regardless of whether or not the physician insertion fee is provided, as the device cost is the major financial barrier to immediate postpartum LARC insertion. We initially determined a state agency’s classification into one of these reimbursement categories by review of interview transcripts, and we confirmed classification in two ways: (a) by emailing interviewees to confirm their designated category (member checking); and (b) by reviewing Medicaid documentation available online and/or provided by interviewees (e.g., provider manual, provider bulletins and transmittals). For states with payment methodology for inpatient LARC, we corroborated the date of methodology implementation by reviewing agency documentation. Finally, we compared interviewees’ titles to agency organization charts and characterized interviewees into four categories: senior
agency leadership (e.g., Medicaid director, medical director), senior program leadership (e.g., family planning program manager; pharmacy program manager), department policy advisors (e.g., senior policy analyst) and others (e.g., benefits specialist, nurse consultant).

3. Results

3.1. Interviewees

Between November 2014 and March 2015, we conducted interviews with Medicaid representatives from 39 states and D.C. (7–43 min in length). Most interviews were conducted with one Medicaid agency representative, but occasionally an agency decided to have other individuals present (up to four). One state agency was unable to complete a telephone interview but provided a detailed email response and is included in our sample. Interviewees represented a variety of Medicaid administrators (42% senior agency leadership, 22% senior program leadership, 19% departmental policy advisors, 17% other). Eleven states declined interviews or did not respond to our email invitations.

3.2. Categories of payment methodology

Our review of publicly available documentation for agencies declining interviews suggested that three states (Alabama, Iowa and New York) provide payment for immediate postpartum LARC. We were unable to categorize the remaining uninterviewed states. The remainder of the results reported here focus on the interviewed agencies.

Initial categories of payment methodology for interviewed agencies were determined based on review of interview transcripts. In our confirmatory member checking process, all 40 interviewed agencies were emailed; 17 replied with 15 confirming our category designation (2 agencies that initially reported covering immediate postpartum LARC reported via email that they do not cover this service). Agency documentation of coverage was available for 11 states designated as currently providing payment.

Ultimately, interviewed agencies were characterized as (a) providing separate or increased bundled payment \((n = 15)\), (b) considering providing payment in the future \((n = 9)\) or (c) not considering providing enhanced payment for immediate postpartum LARC \((n = 16)\) (see Fig. 1). South Carolina, the first state to provide additional payment for immediate postpartum LARC, implemented their policy in 2012. Since then, at least 14 additional Medicaid agencies have implemented payment methodology to reimburse for immediate postpartum LARC (see Fig. 2).

Among states with separate or increased bundled payment methodology, 12 agencies provide separate payment, while three agencies provide increased bundled payment for immediate postpartum LARC devices. For those states providing separate payment, a claim for insertion of a LARC device prompts payment for the device, occasionally with additional payment for the device’s insertion. For those states providing increased bundled payment, insertion of a LARC device in the inpatient setting triggers some increase in the bundled single payment made for all delivery-related care. Among states considering inpatient LARC coverage, three anticipated reimbursement implementation dates in early 2016. One state agency (Illinois) considering coverage at the time of our interview recently released documentation suggesting that it will begin providing separate payment in July 2015; we have designated the agency accordingly in Figs. 1 and 2, but quoted comments are listed as from an agency considering payment in order to reflect the agency’s status during the study period. Finally, among states in the not considering group, six reported that they had never heard of payment methodology for immediate postpartum LARC, and four agencies described prior consideration and rejection of additional payment.

3.3. Decision-making about immediate postpartum LARC coverage

During interviews, three key themes emerged related to decision-making about immediate postpartum LARC coverage: health effects on Medicaid beneficiaries, financial implications and competing demands in the policy environment (see conceptual model in Fig. 3 and supplemental quotes in Table 1a, b, c). Responses were often thematically similar between interviewees in agencies who are considering and those who are not considering providing payment for inpatient LARC. We therefore often group their responses as from “agencies without payment.”

3.3.1. Health effects on Medicaid beneficiaries

State officials from agencies with payment methodology for immediate postpartum LARC spoke at length about its health benefits. They described existing data on the health benefits of immediate postpartum LARC as compelling and influential in their decision-making. Interviewees characterized inpatient LARC payment methodology as a means to improve birth spacing among beneficiaries desiring LARC, especially among vulnerable populations such as adolescents and racial–ethnic minorities. They described inpatient LARC payment methodology as a tool for clinicians to improve obstetric and birth outcomes (“We felt like we could really have a positive impact on a lot of the obstetrical issues here in the state if we were to introduce this as another option for providers”). Many described local clinicians as key to promoting the agency’s understanding of the clinical need for and benefits of immediate postpartum LARC.

Conversely, states without enhanced payment for immediate postpartum LARC less frequently mentioned health effects of such payment methodology. If health effects were mentioned, these interviewees tended to describe the medical community as uncertain about whether or not immediate postpartum LARC was beneficial. Interviewees also expressed concern for harm due to intrauterine device expulsion or due to adverse LARC hormonal effects on
breastfeeding or postpartum depression. When discussing uncertainty about clinical effects of LARC, interviewees almost always mentioned that clinicians in their state had not approached them to report clinical need for immediate postpartum LARC.

3.3.2. Budget implications

All interviewees described consideration of the financial implications of immediate postpartum LARC payment. Interviewees in states with payment methodology emphasized anticipated financial returns of immediate postpartum LARC coverage. They stated emphatically that coverage would be cost-saving (“there’s a clear cost saving and there’s no question that it’s cost saving”). They described decision-making guided by “common sense” and general calculations comparing LARC device costs to that of an unplanned pregnancy.

Conversely, interviews with agencies without payment consistently mentioned early expenditures and immediate fiscal impact. Many interviewees in these agencies expressed concern about upfront costs exceeding funds currently available (“what do we have today that we can pay for?”). These interviewees often expressed understanding that immediate postpartum LARC could be cost-effective in the long-term but expressed facing an imperative to achieve cost neutrality rapidly. Cost was more often framed as a major factor in the decision about whether or not to implement this benefit (“the biggest issue is the financial impact”). Many interviewees stated that uncertainty about total costs to the state Medicaid agency was an obstacle to advocating within their agency for inpatient LARC payment methodology. Another frequently cited financial consideration was potential for effects on current reimbursement practices for hospital-based care. States without payment for inpatient LARC often characterized separate payment as inconsistent with current payment methodology for inpatient care, sometimes forcefully underscoring its potential to undermine the ideology behind a global payment (“There may be other ways to improve access outside of dismantling the payment system”). They reported concerns that creating a separate payment for LARC devices might set an undesired precedent for “carve out” payments. As one interviewee elaborated, “We don’t have a methodology for itemizing. If we pull one piece out of one DRG, it might please the ObGyns, but other providers might say ‘You did this for LARC. We want you to do this for X, Y, Z.’” This concern was cited as the major
reason that states who had previously considered additional payment for immediate postpartum LARC ultimately decided not to implement such payment.

3.3.3. Competing demands in policy environment

In states without payment methodology, interviewees cited many other competing priorities (e.g., Medicaid expansion, payment reform, high-need beneficiaries) that drew attention and resources away from conversations about immediate postpartum LARC. Some interviewees overcame this by aligning immediate postpartum LARC with other priority issues (e.g., reducing prematurity rates or neonatal abstinence syndrome).

4. Discussion

Increasingly, Medicaid agencies are removing policy-level barriers to immediate postpartum LARC. Our findings suggest that decision-making regarding Medicaid payment for immediate postpartum LARC is often driven by Medicaid administrators’ perceptions of health benefits and cost savings and is inhibited by their perceptions of health risks, uncertainty about financial implications and potential for negative impact on existing bundled payment methodology.

These findings have important implications for women’s health clinicians and advocates of immediate postpartum LARC:

1. Accurate understanding of the clinical benefits of immediate postpartum LARC may be necessary for agencies to adopt inpatient payment approaches. Many policymakers expressed concerns about LARC’s safety. Some policymakers may be unaware or unaccepting of medical literature [4,14,19,20] documenting LARC’s safety and efficacy in postpartum women and the clinical community’s affirmation of immediate postpartum LARC [4,8,10,16,20–23].

One crucial next step is to address information gaps regarding LARC safety and clinical benefits for postpartum women desiring these methods. ACOG’s LARC program maintains a webpage with tools for challenging barriers to reimbursement for immediate postpartum LARC initiation, which could serve as an accessible resource for policy makers (http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Coding-and-Reimbursement-for-LARC)[24]. Likewise, the Association of State and Territorial Health Officers has established a learning community for states seeking to implement immediate postpartum LARC (http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-
In addition to these national efforts, clinicians play a critical role as local champions for policy change, as our interviewees often described providers as uniquely well positioned to educate Medicaid agencies about the importance and benefits of immediate postpartum LARC. Such efforts may be most successful when clinician advocates seek to align immediate postpartum LARC with their local Medicaid agency’s other stated priorities and goals.

Available literature documenting cost-effectiveness may help address policymakers’ uncertainty about the financial impact of immediate postpartum LARC. Published financial analyses suggest that immediate postpartum LARC is cost-effective, with one study estimating savings of US$2.3 million over 2 years per every 1000 Medicaid-eligible women [6,26,27]. An additional simulation analysis does not address immediate postpartum LARC specifically but does document net savings from the payers’ perspective with policies that expand access to Medicaid-funded family planning [28]. Advocates for expanded Medicaid coverage of immediate postpartum contraception should seek to disseminate these data to local policy makers because, in our interviews, perceived uncertainty about financial effects was a reported barrier to immediate postpartum LARC coverage. This current study’s findings also suggest that some policymakers may be persuaded by a simple comparison between the LARC device cost (estimated wholesale acquisition cost US$600–$775) and the cost of a publically funded birth following an unplanned pregnancy (US$11,647) [29]. Emerging data on financial outcomes from states with newly implemented immediate postpartum LARC reimbursement may serve as additional advocacy tools. As these data become available, it may be particularly important to compare cost and utilization outcomes in states with different payment methodologies (separate payment for device + insertion vs. separate payment for device alone vs. increased bundled payment).

Efforts to promote immediate postpartum LARC coverage in states currently without it may benefit from applied examples from states that have already implemented inpatient LARC payment approaches. Multiple states have already implemented separate payment for immediate postpartum LARC without apparent adverse consequences to a general strategy of global payment for inpatient services. Furthermore, Medicaid already carves out postpartum sterilization as a procedure that may be billed separately from the global fee, presumably in order to remove a financial disincentive to providers offering this service to women who desire it. Absence of similar provisions for reversible long-acting contraception may hinder women’s access to a highly effective means of spacing their births and may eliminate an important option for women who have completed childbearing but do not desire sterilization [16].

These findings should be interpreted in light of our study’s limitations. The accuracy of our results depends on interviewees’ familiarity with their agency’s LARC reimbursement practices; however, we corroborated interview
### Table 1
Additional quotations illustrating factors considered during Medicaid decision-making process about immediate postpartum LARC payment methodology.

#### Health effects on Medicaid beneficiaries

<table>
<thead>
<tr>
<th>Category</th>
<th>States with payment</th>
<th>States considering</th>
<th>States not considering</th>
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<tr>
<td><strong>Unplanned and teen pregnancy</strong></td>
<td>&quot;In our state, 50% of the moms miss that six-week postpartum visit. So the next time the doctor saw the mom, it was with an unwanted pregnancy. It’s sometimes overwhelming to see the number of women that have repeat births within a year, and I think that’s probably the most compelling reason that we continue to work on this benefit.&quot;</td>
<td>&quot;We looked at a lot of the research... with the teen cohort that had the Nexplanon products, showing that they essentially had no repeat pregnancies in 18 months. The statistics on that really talk.&quot;</td>
<td>&quot;We think it’s important that moms are referred for postpartum care outside of the hospital, and it seems in some ways that just doing the LARC in the hospital is kind of giving up and saying, well, the mom is not going to make it to postpartum care anyway.&quot;</td>
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<td><strong>Overall health effects</strong></td>
<td>&quot;The data is pretty compelling... it really demonstrates the need to implement policy such as this to improve the lives of women and children.&quot;</td>
<td>&quot;There are... differences of opinion about the effectiveness of immediate placement of the IUDs after the birth, as far as how well they stay in and some of the risk associated with it, as opposed to delivery of those devices at some other time.&quot;</td>
<td>&quot;Some of those LARCs have hormonal inclinations with women who already have problems with postpartum depression or you know postpartum blues or whatever, that could increase the possibility of them being completely off-kilter.&quot;</td>
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| **Budget implications**         | "It made sense that we were going to be able to save money with unwanted pregnancies."
| **Appreciation of cost savings**| "When the statisticians don’t have anything to use as a predictive model, it’s difficult to forecast the usage of this and the cost of it. But it makes sense that costs will go down as this policy is used."
| **Focus on immediate fiscal impact** | "It’s just more the discussion of, yeah, if we pay, you know, $800 up front, we’re going to avoid a $12,000 delivery."
| **Role of cost in decision-making** | "I mean, in theory, it shouldn’t add any cost, because that’s something that we cover already."
| **Perceived effects on bundled payment methodology** | "Family planning services, the federal government provides 90% of the funding; state contributes 10%. So even if the devices are quite expensive... the state dollars are not budget-busters." | "It is, you know, the right policy, it’s just whether we can afford to do it right now or not."
| **Role of cost in decision-making** | "Our legislative office does not ever allow us to consider potential future cost savings in the fiscal impact."
| **Perceived effects on bundled payment methodology** | "Any initiatives that we would undertake would need to be cost neutral."
| **Role of cost in decision-making** | "It’s very difficult to do without being able to justify it with immediate cost savings."
| **Perceived effects on bundled payment methodology** | "As far as the decision, that’s just going to be budget." |
| **Role of cost in decision-making** | "Primary is always money, and so that was the major thing, you know the major reason why it wasn’t incorporated at that time. Money.

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findings with the state’s written documentation of inpatient LARC reimbursement practices. Our in-depth interviews gleaned individual perspectives and may not represent the full range of opinions within a given agency. There are great variations in structure, resources and beneficiary populations across different Medicaid agencies, and we unfortunately were not able to conduct telephone interviews with every state. Our study focused on fee-for-service Medicaid and did not address reimbursement policy in Medicaid-managed care settings. Finally, our findings reflect the views of Medicaid administrators and may not reflect the perspectives of other stakeholders.

Our study documents that increasing numbers of state agencies are adopting Medicaid reimbursement for immediate postpartum LARC. However, a concerning number of states do not currently cover this service, despite its known effectiveness and cost savings. To be sure, removing reimbursement barriers to immediate postpartum LARC will not alone guarantee access for postpartum women, but it is a necessary first step before clinical implementation challenges (such as provider training, device stocking and determination of the most suitable patients) can be addressed. Efforts to remove reimbursement barriers should focus on clearly communicating to policymakers the clinical benefits and cost-effectiveness of immediate postpartum LARC in women who desire it.

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