Contraception 90 (2014) 468–471

Commentary

# Advocating for immediate postpartum LARC: increasing access, improving outcomes, and decreasing cost☆,☆☆,★

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Received 25 March 2014; revised 29 June 2014; accepted 1 July 2014

Unintended pregnancy, endemic in the United States (US), carries significant health and economic consequences and disproportionately affects poor women and women of color [1,2]. Rapid repeat pregnancy—defined as a pregnancy within 12 to 18 months after delivery—can occur if women are unsuccessful at initiating contraception [3]. Improving postpartum initiation of effective contraception including long-acting reversible contraception (LARC), the intrauterine device (IUD) and contraceptive implant, is a key strategy to reduce unintended pregnancy and health inequities. However, nonreimbursement by insurers for both LARC devices and the immediate insertion procedure, is a critical barrier to the provision of postpartum LARC during the hospital admission for a birth. Recently, coalitions in three states have successfully advocated for modification of Medicaid policy to allow reimbursement for immediate postpartum placement, both for the devices and the insertion procedure, separate from the global fee for delivery. By removing a key financial barrier, these policy changes signal an important advance in provision of the most effective forms of immediate postpartum contraception.

Immediate postpartum LARC insertion is safe and supported by recent clinical guidelines [4,10]. According to the US Medical Eligibility Criteria for Contraceptive Use, both the levonorgestrel (LNG) IUD and copper IUD may be inserted prior to hospital discharge after vaginal or cesarean delivery in both breastfeeding and nonbreastfeeding women. Expulsion rates appear to be lower with postplacental (within 10 min of placental delivery) insertion than with later insertion (>10 min postplacental and up to 72 h postpartum) [4]. The contraceptive implant may be placed after either type of delivery in nonbreastfeeding and breastfeeding women prior to hospital discharge [4] (Table).

The immediate postpartum period provides an ideal opportunity for contraceptive initiation: women are often highly motivated to start a contraceptive method, and the inpatient setting is convenient for the woman and her provider. Immediate insertion of these methods reduces the risk of unintended pregnancy. Although women may plan to begin a method at the 6-week visit, ovulation can occur as early as 3 weeks postpartum and can lead to unintended pregnancies [3]. Despite the known importance of preventing rapid, repeat pregnancy, many postpartum women currently leave the hospital without initiating contraception.

Reducing unintended pregnancy rates by improving postpartum contraception is a public health imperative that makes fiscal sense. Rapid, repeat pregnancy is associated with maternal and neonatal morbidity, as well as increased costs [3]. Public insurance programs, predominantly Medicaid, fund nearly half of all births each year in the US. In 2008, these programs funded 2 million births, over half of which were unintended [5]. On average, each publicly funded birth, including costs for services ranging from prenatal, postpartum and neonatal care through the infant's first birthday, cost the public US$12,613 [5]. The national costs of unintended pregnancy are significant. In 2008, state and federal governments spent US$12.5 billion for unintended births [5].

The health, social and economic benefits of publicly funded family planning programs are well established. Every dollar spent on contraception prevents unintended pregnancy and associated health risks and saves an estimated US$5.68 in Medicaid expenses [5]. Despite the far-reaching benefits of contraception, access to services remains a major issue

☆ Financial disclosures: MIR has no financial disclosures.
☆☆ MLE received grant funding from Wyeth Pharmaceuticals for women's health policy research, specifically increasing LARC use in low-income populations.
★ EE has no financial disclosures.
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http://dx.doi.org/10.1016/j.contraception.2014.07.001
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Table
Medical eligibility criteria for LARC use in the postpartum

| Condition: Postpartum | Implant | LNG IUD | Cu IUD |
|---|---|---|---|
| Non breast-feeding women (any time in the postpartum) | 1 | | |
| Breastfeeding women (with or without risk factors for VTE) | | | |
| <30 days | 2 | | |
| >30 days | 1 | | |
| Breastfeeding or nonbreastfeeding women, including post cesarean delivery | | | |
| 10 min after delivery of the placenta | | 2 | 1 |
| 10 min after delivery of the placenta to <4 weeks | | 2 | 2 |
| >4 weeks | | 1 | 1 |
| Puerperal sepsis | | 4 | 4 |

1=a condition for which there is no restriction for the use of the contraceptive method, 2=a condition for which the advantages of using the method generally outweigh the theoretical or proven risks, 3=a condition for which the theoretical or proven risks usually outweigh the advantages of using the method,4=a condition that represents an unacceptable health risk if the contraceptive method is used.

across the US. A recent California cohort study demonstrated the unmet need for postpartum contraception and its association with rapid, repeat pregnancy [6]. Records of over 117,000 women covered by the state's Medicaid program were analyzed for contraceptive use within 90 days of delivery and repeat pregnancy within 18 months. Only 41% of the women had contraception claims within 90 days of delivery, and four in 10 became pregnant within 18 months [6]. There are multiple barriers to initiation of postpartum contraception including lack of insurance coverage following delivery and difficulty finding time to return for an office visit [7]. For women in this study with Medicaid, who were clinically stable, provision of immediate postpartum LARC would have removed these obstacles.

Placing LARC devices immediately postpartum is not currently a widespread practice. Advantages of LARC insertion outweigh potential and proven disadvantages [8]. The key disadvantage to immediate postpartum IUD insertion is an increased risk of expulsion; this risk is mitigated by IUD placement within 10 min of placental delivery [8]. Expulsion rates vary considerably depending on both the timing of the placement, and the technique used [9]. For placement within 10 min of placental delivery, one study reported an expulsion rate of 12.3% at 12 months. This contrasts with an expulsion rate of 3.3–9.2% for IUDs placed at 6 to 8 weeks postpartum [10,11]. Even with a higher expulsion rate, placement of immediate post partum IUDs is an effective strategy to prevent unintended pregnancy and save costs [7]. This is due to the high loss to follow up at the 6-week postpartum visit when IUDs are typically placed [7,12]. A study from New Mexico demonstrated that only 60% of postpartum women who requested an IUD actually obtained one. Key barriers to obtaining the IUD were failure to return for a 6-week visit and early repeat pregnancy [12]. A second study reported that only 54% of women with Medicaid who requested an IUD postpartum received one [7].

The benefits of immediate postpartum initiation of contraception outweigh the possible impact on breastfeeding. Although data are limited, the progestin implant and LNG IUD appear safe in breastfeeding women and do not appear to impede initiation or continuation of breastfeeding or impact infant growth and development [4,10]. A randomized trial compared postpartum insertion of the progestin implant within 3 days of delivery with standard insertion at 4 to 8 weeks postpartum; no difference between groups with respect to lactogenesis or lactation failure was noted [13]. A different study compared breast milk composition between two groups: a cohort using the progestin implant and another using a nonhormonal IUD [14]. Breast milk composition and quantity (measured by total protein, fat, and lactose content) did not differ between the groups [14]. At 3-year follow-up, neonates from each group were examined [15]. There was no difference in body length, biparietal head circumference and body weight between the groups [15].

While multiple barriers discourage immediate postpartum LARC initiation, arguably the most important is the cost. The device and procedure that are covered in an outpatient clinic visit by most insurers, public and private, are not typically reimbursed in addition to the global fee for delivery, if provided during the inpatient delivery admission. Most Medicaid programs and private insurers pay for all services provided during a labor and delivery admission with a global fee under a single diagnosis related group code. These programs do not typically reimburse for additional services, such as the LARC devices themselves or the insertion procedures.

Six states have changed Medicaid practices to reimburse for LARC initiation prior to hospital discharge separate from the global fee for delivery. Three states highlighted here—South Carolina, New Mexico and Colorado—led the way in creating reimbursement policies that facilitate the provision of immediate postpartum LARC. We briefly review how these policy changes were accomplished as an example to others working to improve postpartum contraceptive access.

In each state, effecting policy change required physician advocates and data to demonstrate the potential for improved health and cost savings of providing immediate postpartum contraception. In addition, collaborating with billing experts at the state Medicaid office to determine how to code and be reimbursed for the service was essential. Policy change in South Carolina was the result of ongoing coalition work under the aegis of a perinatal collaborative developed in the state to improve maternal and child health. The collaboration of multiple stakeholders identified access to effective postpartum contraception as a critical strategy to improve health outcomes. The South Carolina Department of Health and Human Services (DHHS) recognized the importance of providing reimbursement for effective contraceptive methods to facilitate access. Health care providers and other advocates in South Carolina worked with their State

Medicaid office to provide reimbursement for both the LARC device and the insertion fee, using a supplemental billing code (J code with family planning modifier) to the obstetrical global fee (16). DHHS is collaborating with the Centers for Disease Control and Prevention and the Center for Medicaid Services to determine how this policy change impacts Medicaid outcomes and expenditures.

Similar to underserved women across the nation, a large percentage of women in New Mexico rely on Medicaid for obstetric and contraceptive care and have an unmet need for postpartum contraception. A study of postpartum women in New Mexico who desired an IUD at the 6-week postpartum visit found that at least 40% did not receive one [12].

Three University of New Mexico Obstetrics and Gynecology faculty contacted the state Human Service/Medical Assistance Division and identified the program manager as well as the medical director of New Mexico Medicaid. After outlining the advantages and disadvantages of immediate postpartum LARC initiation, as well as New Mexico data indicating a high no-show rate for the postpartum visit, these individuals agreed to work with university hospital to identify a mechanism for billing the LARC device outside the global delivery fee. Hospital and state stakeholders worked together on the process; several months were required to develop a successful model from specific postpartum storage of Medicaid LARC devices to appropriate coding and submission of a bill that would be accepted and reimbursed by state Medicaid. In September 2013, the New Mexico Human Services Division released guidance on Medicaid reimbursement across New Mexico for LARC methods and insertion during the delivery hospitalization. As in South Carolina, a supplemental code to the global obstetrical fee was used. Since then, a rapid implementation of immediate postpartum IUD and implant insertion has occurred at the University of New Mexico Hospital.

From recent personal communications (EE) it appears that only the University of New Mexico Hospital is placing LARC immediately postpartum, but obstetrician–gynecologists at other hospitals are currently engaged with state Medicaid to develop the reimbursement mechanisms needed to initiate this service. University of New Mexico obstetrician–gynecology faculty members are also working to create a dialog with private payers about reimbursing for immediate postpartum LARC.

In Colorado, two privately funded pilot projects offered immediate postpartum LARC insertion to women at no cost. Not only was the demand high for the devices immediately postpartum, but a cost analysis revealed savings of US$2.3 million over 2 years for every 1000 women covered by Medicaid [16–18]. This evidence was used by physician advocates to demonstrate the health benefits and the cost savings of a policy change. The results from these two pilot projects helped influence Colorado officials to change Medicaid policy and begin reimbursement for both the LARC device and insertion immediately postpartum. Implemented in October 2013, Medicaid reimbursement changes made Colorado the third state to improve postpartum LARC access and to provide a model for private payers.

As these states illustrate, modification of Medicaid policy to reimburse for provision of immediate postpartum LARC, in addition to the global fee, is feasible, and an important first step in improving access. These policy changes signal an important advance not only for the women with Medicaid living in these states but also for women nationally. Medicaid policy changes in South Carolina, New Mexico and Colorado serve as models for other state Medicaid programs and for private insurers as well. Medicaid reimbursement policy often sets a precedent for private insurance; changes in insurance coverage and reimbursement under Medicaid can influence private insurance to mirror these benefits. Reimbursement changes in the private sector will further improve access and decrease costs.

The American College of Obstetricians and Gynecologists (ACOG) LARC Program works to reduce unintended pregnancies by providing information and clinical guidance on LARC methods to increase access to the full range of contraceptive methods. Improving access to postpartum LARC is a prime focus of ACOG's LARC Work Group, and resources to assist advocacy efforts by women's health providers are available on the program Website: www.acog.org/goto/larc. ACOG has also been working in partnership with the Centers for Disease Control and Prevention and others to educate providers and policymakers about the safety and promise of immediate postpartum LARC, and participated in a March 2014 Webinar and open-microphone call for state Medicaid Medical Directors to discuss issues related to immediate postpartum LARC initiation and reimbursement. A toolkit designed to assist providers and other advocates with "lessons learned" and tips for collaborating with state Medicaid offices is also being developed.

In states where Medicaid covers immediate postpartum contraception and hospitals have developed the pathway for reimbursement, training provider staff on immediate IUD insertion becomes essential. Unlike implant insertion, which does not vary with timing, immediate postpartum IUD insertion is a learned skill. The ACOG LARC Work Group and others in the family planning community are developing materials and programs to meet the training needs associated with immediate postpartum IUD insertion (see http://gaobgyn.com/resources/category/newsletters/ April issue).

Access to and effective use of contraception is the critical foundation for empowering women, improving health outcomes, and saving money. Advocating for expansion of immediate postpartum contraception is an essential strategy to reduce unintended pregnancy and rapid, repeat pregnancy rates.

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