

Policy change is not enough: engaging provider champions on immediate postpartum contraception

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Based on the 2006–2010 National Survey of Family Growth, 38% of pregnancies, after a previous birth, were mistimed or unwanted.¹ These unintended pregnancies are significantly more likely to have short interpregnancy intervals (<18 months apart) compared with pregnancies reported as intended (unadjusted odds ratios, 4.3 and 1.8, respectively).¹ Short interpregnancy intervals also increase risks for poor maternal and infant outcomes,^{2–4} which makes the reduction in short-interval unintended pregnancies a public health priority.

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THE PROBLEM: States with Medicaid payment reform policies, which allow reimbursement for immediate postpartum long-acting reversible contraception devices and insertion, have found that policy changes alone are not sufficient to ensure access to these highly effective contraceptive methods.

A SOLUTION: Recruiting, training, engaging, and supporting provider champions, whether at the state, local, facility, or at multiple levels, are important components of the multipart strategy to implement state-level Medicaid payment reform policies that allow reimbursement for immediate postpartum long-acting reversible contraception insertions.

Long-acting reversible contraceptive methods (LARC [ie, contraceptive implants and intrauterine devices (IUD)]) are effective contraceptive strategies to promote optimal interpregnancy intervals, reduce unintended pregnancies, and improve maternal and child outcomes.^{5–7} These methods have failure rates of <1% for 3–10 years, depending on the method.^{8,9} Although only an estimated 11% of parous US women, 15–44 years old, use LARC,¹⁰ use among postpartum women is higher (7–31%).¹¹ Therefore, providing LARC immediately after birth can further improve effectiveness. However, reasons for low immediate postpartum LARC uptake are complex. For instance, a survey of 1221 obstetricians/gynecologists found that, although almost all offered IUDs, fewer offered implants, with 32% of respondents citing lack of insertion training as a barrier to offering the implant.¹² Additionally, a major system-level barrier to immediate postpartum LARC insertion is its high cost, which historically has not been reimbursed outside of the bundled obstetrics delivery rate.^{13,14} To address this, several state Medicaid programs recently established policies and issued guidance to support inpatient reimbursement of LARC insertion and device placement

immediately after delivery.^{13,15,16} However, experiences of early adopting states revealed that reimbursement policy change alone was insufficient to overcome access barriers.¹⁷ Rather, additional provider and systems barriers must be addressed, as components of a multipart strategy, that leads to immediate postpartum LARC uptake in birthing facilities across states.

This call to action summarizes the experiences in 2 states regarding immediate postpartum LARC insertion policy implementation, with a focus on the provider champion's role in policy implementation. We describe trends in immediate postpartum LARC adoption in Iowa and Louisiana 1 year before and after state Medicaid reimbursement policy changes that occurred in February and June of 2014, respectively^{16,18,19} (Table 1; for other states with LARC reimbursement policy changes, please see reference 16 and <http://www.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception/Resources-Map/>). Although these results cannot be generalized beyond the participating states, this information may benefit other states as they consider adopting reimbursement policies to increase immediate postpartum LARC uptake at birthing facilities.

TABLE 1

Summary of the 2014 revised Medicaid policies from Iowa and Louisiana to provide immediate postpartum long-acting reversible contraception reimbursement¹⁷⁻¹⁹

Iowa's policy (March 2014)	Louisiana's policy (June 2014)
1. Medicaid will cover the cost of inserting intrauterine devices and other long-acting reversible contraception devices before the beneficiary leaves the hospital after delivery.	1. Medicaid will cover the cost of inserting intrauterine devices and other long-acting reversible contraception devices before the beneficiary leaves the hospital after delivery.
2. Payment for these services is allowed for both practitioners and hospitals.	2. Payment for these services is allowed for both practitioners and hospitals.
3. Practitioners who provide this service in the hospital setting will need to bill with the appropriate place of service code.	3. Practitioners who provide this service in the hospital setting will need to bill as an add-on service in addition to their professional services rate.
4. For hospitals that provide this service, this payment will be separate from the diagnosis-related group payment for the inpatient admission that is associated with the delivery.	4. Hospitals that provide this service will need to bill as an add-on service in addition to their daily per diem rate for the inpatient hospital stay or diagnosis-related group rate.

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Methods for monitoring immediate postpartum LARC adoption

Quantitative approach. Women with Medicaid-paid claims for deliveries in Iowa and Louisiana during the 12 months before and 12 months after reimbursement policy implementation (March 2014 in Iowa and July 2014 in Louisiana) were included. In 2014, 38.4% (n=15,212) of Iowa's 39,013 resident births and 66.7% (n=42,682) of Louisiana's 64,038 resident births were reimbursed by Medicaid.

Medicaid databases were queried for paid claims with International Classification of Diseases, 9th Revision, Clinical Modification Diagnosis and Procedure codes or Current Procedural Terminology codes for a LARC insertion, prescription claims for National Drug Codes for copper or hormonal IUD and hormonal implants (collectively, LARC devices), or Healthcare Common Procedure Coding System codes for LARC devices (Table 2). Claims were restricted to

those with dates of service within 3 days of an inpatient live birth delivery, which is consistent with the National Quality Forum recommended measure #2902.²⁰ The immediate postpartum LARC claims were linked to birth certificate records for validation, which resulted in mother/infant dyad records matched from the mother's and infant's Medicaid records to the birth certificate (University of Louisiana Monroe, Office of Outcomes Research and Evaluation, High Risk Pregnancy Registry Matching Process White Paper, unpublished data, 2014).^{21,22} Linked data were used to de-duplicate claims and validate delivery for Medicaid patients. We categorized facilities by geographic location (urban vs rural) and facility type (community vs academic/teaching hospital). We defined academic/teaching hospital as a flagship facility or major affiliate of a medical school (ie, academic health or medical center).²² We identified 76 birthing hospitals in Iowa (2014), 1 of which was a teaching hospital, and 56 birthing hospitals in Louisiana (2014) and 8 were teaching hospitals.

Statistical methods. To examine immediate postpartum LARC uptake during the 12 months before and after the reimbursement policy release date, we calculated the mean of the monthly insertion counts and compared the monthly within-state means before and after policy implementation using paired, 1-sample *t*-tests ($\alpha=.05$). Graphic representations of the monthly insertion counts were scaled based on the maximum count for each state. This was a retrospective de-identified analysis approved by Iowa's Research and Ethics Review Committee and considered exempt from Louisiana's Department of Health's Institutional Review Board. The Centers for Disease Control and Prevention determined that the staff members at the Centers for Disease Control and Prevention were not engaged in human subject research.

Qualitative data sources. In 2014, the Association of State and Territorial

TABLE 2

Codes used to identify immediate postpartum long-acting reversible contraception in the inpatient Medicaid claim files within 3 days of an inpatient claim for a delivery

Code type	Codes
Clinical Modification Diagnosis and Procedure Codes	69.7, V25.11, V25.5
Current Procedural Terminology Codes	11981, 58300
National Drug Codes	J7300, J7301, J7302, J7306, J7307, Q0090, S4981, S4989
Healthcare Common Procedure Coding System Codes	50419042101, 50419042301, 00052027201, 00052027401, 00052433001, 51285020401, 51285020402, 50419042201

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