HHS Public Access

Author manuscript

Womens Health Issues. Author manuscript; available in PMC 2022 June 15.

Published in final edited form as:

Womens Health Issues. 2021 ; 31(6): 523–531. doi:10.1016/j.whi.2021.09.001.

Immediate Postpartum Long-Acting Reversible Contraception: Review of Insertion and Device Reimbursement Policies

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Abstract

Background: Previous assessment of statewide policies on long-acting reversible contraception (LARC) indicate that an increasing number of states are implementing policies specifically for provision immediately postpartum, supported by current clinical guidelines. Less is known about how state policies describe payment methodologies for the insertion procedure and device costs.

Methods: We conducted a systematic, web-based review of publicly available statewide policy language on immediate postpartum LARC among all 50 states. We examined the payor/s identified in the policy and policy type, if the policy included language on the global obstetric fee, whether providers and/or facilities were authorized to bill for procedure or device costs, and if the billing mechanism was identified as inpatient and/or outpatient services.

Results: Three-fourths of states (76%; $n = 38$) had statewide policies on immediate postpartum LARC. All policies identified Medicaid as the payor, although two also included non-Medicaid plans. Language allowing for reimbursement separate from the global obstetric fee for insertion procedures was present in 76% of states; 23 states permit it and 6 do not. Device cost reimbursement separate from the fee was identified in more state policies (92%); 31 states allow it and 4 do not. More policies included inpatient or outpatient billing mechanisms for device costs (82%; $n = 31$) than insertion procedures (50%; $n = 19$).

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Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Conclusions: Medicaid reimbursement policies for immediate postpartum LARC services vary by state reimbursement process, type, and mechanism. Observed differences indicate payment methodologies more often include the cost of the device than provider reimbursement (31 states vs. 23 states). Fewer than one-half of states offer reimbursement for provider insertion fees, a significant systems barrier to contraceptive access for women who choose LARC immediately postpartum.

Despite recent declines, unintended pregnancy, defined as a mistimed or unwanted pregnancy, is a persistent public health concern, with approximately 45% of pregnancies in the United States identified as unintended (Finer & Zolna, 2016). Further, the proportion of pregnancies that are unintended increases as the intervals between pregnancies decrease (Ahrens, Thoma, Copen, Frederiksen, Decker, & Moskosky, 2018), and short interval or rapid repeat pregnancies are associated with poor birth outcomes (Conde-Agudelo, Rosas-Bermudez, & Kafury-Goeta, 2006; Sackeim, Gurney, Koelper, Sammel, & Schreiber, 2019; Gemmill & Lindberg, 2013). Both unintended (Oduyebo et al., 2019) and rapid repeat pregnancies could be reduced by use of effective contraception (White, Teal, & Potter, 2015).

Long-acting reversible contraception (LARC), defined as contraceptive implants and intrauterine devices, has a failure rate of less than 1% and requires a single act for long-term use (American College of Obstetricians & Gynecologists, 2015; Trussell, 2011). Clinical guidelines and research indicate LARC is safe and effective (American College of Obstetricians and Gynecologists, 2016; Celen, Moroy, Sucak, Aktulay & Danisman, 2004; Wu, Moniz, & Ursu, 2018) and has high satisfaction (Hubacher, Spector, Monteith, & Chen, 2018) and continuation rates (Peipert et al., 2011), especially among women who have been appropriately counseled (American College of Obstetricians and Gynecologists, 2016) and are motivated to avoid rapid repeat pregnancy (Sackeim et al., 2019; Tocce, Sheeder, & Teal, 2012). Further, LARC use produces cost savings for the health care system as a method to decrease unintended pregnancy (Washington et al., 2015). Offering LARC to women after labor and delivery, before discharge, is convenient for women and providers when available in facilities after delivery (Rodriguez, Evans, & Espey, 2014). Postpartum visit attendance is lower among those with fewer resources (Bryant, Haas, McElrath, & McCormick, 2006), and sexual activity may resume before the traditionally scheduled 6-week postpartum check-up (Speroff & Mishell, 2008)—although the American College of Obstetricians & Gynecologists has recommended a shift from that standard (American College of Obstetricians & Gynecologists, 2018). By contrast, the most commonly used method—oral contraceptive pills (Daniels, Daugherty, Jones, & Mosher, 2015)—depends on users and has a failure rate of 9% owing, in part, to inconsistent or incorrect use (Trussell, 2011). Additionally, combined oral contraception is not recommended in the early postpartum period (<21 days postpartum) (Curtis, Tepper, et al., 2016), further emphasizing the potential role of immediate postpartum LARC in decreasing rapid repeat pregnancies.

Nonetheless, the use of LARC in the postpartum period varies by state, ranging from 7% to 38% (Boulet et al., 2016; Oduyebo et al., 2019); one study estimated that 6% of women used this method by 3 months postpartum (White et al., 2015). The uptake of immediate postpartum LARC (placement of LARC 10 minutes or less after placental delivery;

Jatlaoui et al., 2018) may be impacted by barriers such as billing for or reimbursement of insertion procedures and device costs (Aiken, Creinen, Kaunitz, Nelson, & Trussell, 2014). Most payors, including Medicaid, pay for labor and delivery admission services through a global obstetric fee, or based on a Diagnosis-Related Group (DRG) code, and do not typically reimburse for the contraceptive device or additional services such as insertion of a LARC device immediately after delivery (Aiken et al., 2014). To address this reimbursement challenge, several state Medicaid programs have implemented variable payment methodologies including reimbursement policies, billing codes, and guidance for immediate postpartum LARC insertion procedures and device costs (American College of Obstetricians & Gynecologists, 2020; Moniz et al., 2015). Such methodologies include allowances for hospitals and providers to bill costs separate from the global obstetric fee (i.e., billing outside, billing separate, or carving out from the DRG or bundled payment), and increasing or enhancing the fee to balance costs (i.e., billing within the DRG) (Moniz et al., 2015). Methodologies most often specify inpatient billing, or billing for services or devices before postpartum hospital discharge to decrease costs (Moniz et al., 2015). Among many state Medicaid programs considering payment methodologies for immediate postpartum LARC reimbursement, the financial impact of offering LARC immediately postpartum, both cost and cost-savings, is a driver of policy implementation (Moniz et al., 2015).

In 2016, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin on increasing access to LARC containing strategies for states to consider when focused on increasing access to LARC postpartum and immediately postpartum (CMS, 2016). The CMS bulletin provided guidance for states on reimbursement for insertion fees, unbundling the global obstetric fee, and removing additional administrative and logistical barriers to billing for LARC. The bulletin highlighted a range of state approaches to billing and reimbursement including lists of inpatient DRG codes, healthcare common procedure coding system codes, current procedural terminology codes, or *J* codes for claims processing, and modifier codes for additional reimbursement during routine visits.

The objective of this review was to summarize state-level policies on reimbursement for the insertion procedures and device costs of immediate postpartum LARC following the CMS bulletin publication, using abstracted information from publicly available policies that describes 1) payment methodologies (billing as separate from or enhancing the global obstetric fee), 2) entities authorized to bill (i.e., providers and/or facilities), and 3) mechanisms for billing (i.e., inpatient, outpatient, or both).

Methods

Study Design and Data Collection Process

A systematic, web-based review of publicly available state-level information on LARC was conducted for each state from October 2017 to May 2018. Search terms were used to identify LARC-related policy documents within each state (Table 1). Available state-level legislation, reports, toolkits, and other state health or agency-published documents were identified for data abstraction using search engines such as Google or Bing. All identified policy documents published by state agencies or state governments were examined for inclusion in the study. Both electronic copies of documents and the website link to the

information source were catalogued. Identified documents that did not specifically address a state policy targeting LARC were excluded. The broader dataset provided information for multiple LARC-focused health services research analyses. For the current study, all publicly available state documents on immediate postpartum LARC were examined.

Data Collection Process

A standardized search strategy was implemented during the eight-month study timeframe by dividing the United States into 2 groups of 25 states to organize the search process. Each group of states was searched separately and simultaneously by two abstractors (J.F.H. and O.S.). Each abstractor then independently cross-referenced the search findings of the other by completing double-data entry of source information. Study authors (J.F.H., O.S., and K.U.) further validated the abstracted information by randomly selecting then contacting nine state Health Department and Medicaid programs to confirm the accuracy of the extracted policy information. Information abstracted by state included 1) policy source/s (e.g., Medicaid bulletins, Medicaid guidance, State Plan Amendments, administrative rules, statutory provisions, provider bulletins, and marketplace notices), 2) verbatim text of all policies, 3) summary of policy text, and 4) date policies were enacted, adopted, or implemented, if available.

Definition of a State-based Policy

When developing the definition of state-based policy documents, study authors reviewed all documents that referred to or detailed reimbursement methods for immediate postpartum LARC (i.e., billing guides, Medicaid provider manuals, and Medicaid provider bulletins) as policies or containing policy language. Next, the study authors reviewed and excluded all documents that applied to women residing in specific geographic regions within a state or that were employer-based, such as larger commercial payors (e.g., regional plans, plans specific to certain geographic areas or plans specific to a group of employees or required membership). Policy documents authored by a state insurer such as Medicaid, an entity with the authority to create billing policies within the state, were included in the study as a primary source and categorized as describing state-based policies; all other non–state-based documents were excluded. When the policy document was authored by an entity without the authority to create billing policies but referenced a policy from an authorizing entity, the documents were categorized as an indirect reference, and relevant information referring to the statewide policy was categorized for review. Documents that were not primarily authored by a state or authorized entity (e.g., independent policy surveys or lists such as resources developed by Kaiser Family Foundation [Kaiser Family Foundation, 2015] or clinical membership organizations) were excluded from the study.

Data Summary Process and Classifications

Study authors (J.F.H., O.S., and K.U.) reviewed and created an initial dataset of all abstracted data on immediate postpartum LARC. Information summarized in the dataset included 1) a publicly available state-level policy on immediate postpartum LARC, 2) payor type and policy source of the immediate postpartum LARC information, and 3) methods for reimbursement of insertion procedures and device costs. Other study authors (C.D.K., E.M.O., and L.R.) examined the summary and verified all summary information from

the abstracted data sources. Discrepancies were reconciled among all study researchers to ensure consistency in the search strategy, data entry, data coding, and variable definitions.

Among the states with state-based policy language for immediate postpartum LARC, we classified reimbursement methods for insertion procedures and LARC device costs by 1) how the payment was billed (i.e., payment methodologies), 2) who was authorized to bill (i.e., provider, hospital, or both), and 3) the mechanism for billing (i.e., inpatient or outpatient billing). We identified variation in each reimbursement area, then grouped responses into categories. First, to define how the payment was billed, we grouped reimbursement as separate from the global obstetric fee when policies included information on payment methodologies of billing separate, outside, or in addition to the fee. Among documents that included information on the permissibility of separate billing, we identified when permissible (i.e., Yes), or not permissible (i.e., No). Second, we grouped by entity authorized to bill to reflect which entity was permitted to bill—physician/provider, facility/hospital, or both—as identified in the policy. Last, we categorized the mechanism for billing to indicate whether the process for submitting a claim for reimbursement was based on specific instruction for service provision, as inpatient or outpatient, depending on the policy language. Although the insertion was provided during the delivery hospitalization, some policies provided guidance for billing as an outpatient procedure within existing policies.

Statistical Methods

This policy analysis generated descriptive statistics, including counts and percentages. This study was determined to be public health practice and, therefore, did not require Institutional Review Board approval at the Centers for Disease Control and Prevention or the University of Illinois at Chicago.

Results

Among the 50 states, 38 (76%) had state-based policies or indirectly referenced policies (Table 2). Of those policies, three (8%) were described by indirect references. Among state-based policies, all identified Medicaid directly, and two (5%) also identified non-Medicaid plans or private plans as payors for reimbursable services.

Reimbursement for Immediate Postpartum LARC Insertion Procedures

Among states with reimbursement language for insertion procedures, payment methodologies, authorization to bill, and mechanism for billing varied (Table 3). Among the 38 state-based policies, language describing payment methodologies for insertion procedures separate from the global obstetric fee appeared in the policies of 29 (76%) states (Figure 1), with billing permissible in 23 of these 29 states (79%) but not permissible in 6 states (21%). Policy language on the entity authorized to bill for insertion procedures was noted among 23 of the 38 states (61%) with a policy. Among these 23 states, 7 (30%) authorized both the provider and delivery facility to bill, 14 (61%) authorized the provider only to bill, and 2 (9%) authorized the facility only to bill. The mechanism for billing of insertion procedures was identified in 19 of 38 state policies (50%). Among these 19 states, 7 (37%) had language on billing for insertion procedures as both inpatient or outpatient, 11

(58%) had language for inpatient billing only, and 1 (5%) had language on outpatient billing only.

Reimbursement for Immediate Postpartum LARC Device Costs

Similarly, variation was noted among states with reimbursement language for cost of the device. Thirty-five of 38 states (92%) included payment methodology language for device costs, with 31 of the 35 state policies (89%) containing language permitting billing separate from the global obstetric fee, and 4 (11%) state policies where billing was prohibited (Figure 2). Thirty-three of 38 states (87%) included language on the entity authorized to bill for the device cost. Among the 33 states with authorized entity billing language, 12 (36%) authorized both the provider and hospital to bill device costs, 2 (6%) authorized providers only, and 19 (58%) authorized hospitals only. Finally, 31 of 38 states (82%) included mechanism for billing language for device costs in the policy. Among these 31 states, 9 (29%) included language on billing costs as inpatient or outpatient, 13 (42%) specified billing as inpatient only, and 9 (29%) limited it to outpatient billing.

Discussion

More than two-thirds of states had policies specifically referencing immediate postpartum LARC, and all policies identified Medicaid as the payor, with very few denoting other insurers. Most states with immediate postpartum LARC policies allowed for billing of both insertion procedures and device costs separate from the global obstetric fee, although distinct differences among who was authorized to bill were observed. Although most of the states allowing billing for insertion procedures authorized the provider to bill for costs, when billing for the cost of the device, most often hospitals/facilities were authorized to bill rather than providers. Most state policies included language on the mechanisms for billing of device costs, whereas only one-half of state policies included language on billing of insertion procedures—and among those, the majority used inpatient billing. This finding highlights an opportunity for states to further examine whether payment methodologies fully capture reimbursement for procedures necessary for providing LARC. Overall, our results indicate that state policies for the reimbursement of immediate postpartum LARC insertion procedures and device costs vary substantially.

The 2016 CMS bulletin recommends payment strategies such as separating reimbursement from the global obstetric fee and removing other logistical and administrative barriers including acquisition and supply costs or other preauthorization requirements (CMS, 2016). Such payment strategies may offer opportunity to reimburse providers and facilities for device prices and procedure fees not included in the global obstetric fee, because the bundled fee may be inadequate for the provision of immediate postpartum LARC. However, the current literature on the benefits of bundled payments or global fees for medical services focuses on cost savings and improved health outcomes—for instance, in the surgery literature, bundled services generate cost savings and improve coordination of care without compromising patient outcomes (Agarwal, Liao, Gupta, & Navathe, 2020; Dietz et al., 2019; Glickman, Dinh, & Navathe, 2018). Similar evidence on the effectiveness of the global obstetric fee was not identified in the published literature, and this absence limits

this assessment of reimbursement for evidence-based procedures and services associated with quality labor and delivery care. In fact, bundling payments for pregnancy and postpartum services may inadvertently impact provision of other evidence-based care, such as developing a plan for the postpartum visit, an effort that may require multiple interactions between women and health care providers (American College of Obstetricians & Gynecologists, 2018). One reimbursement fee may affect the number of ongoing patient–provider interactions. In effect, although not assessed in the review, adequate health system and provider reimbursement may facilitate provision of quality care, supporting clinical guidelines and patient needs and preferences (American College of Obstetricians and Gynecologists, 2016). More research on the impacts of different payment methodologies could build the evidence on the costs and benefits of bundled versus enhanced, separate, or supplemental reimbursement.

Within states, challenges to implementation of reimbursement strategies include conveying the economic advantages to health systems (Moniz et al., 2015), recruiting and leveraging provider champions (Kroelinger et al., 2019), and promoting patient benefits and provider awareness (Moniz et al., 2015), while limiting the out-of-pocket costs for patients (Sonfield, Tapales, Jones, & Finer, 2015). Certain hospital systems, such as university or teaching hospitals, may be better equipped to address reimbursement challenges (Holden et al., 2018), such as efficient claims processing, maintenance of reimbursement rates, or inpatient billing (Moniz et al., 2015), because processes may be clearly defined that allow for hospital administration support (Moniz et al., 2016) and increased provider knowledge on reimbursement mechanisms (Hofler et al., 2017; Holden et al., 2018; Moniz et al., 2015). In piloting methods for reimbursement, facilities may develop a step-by-step approach to implementing immediate postpartum LARC programs that address finance and billing process challenges (Hofler et al., 2017) and logistical barriers to same-day insertion (Castleberry, Stark, Schulkin, & Grossman, 2019). Such a stepped approach may include partnering with facility pharmacies to ensure stocking of devices, then working with information technology departments to develop a billing and reimbursement system for both insertion procedures and device costs (Hofler et al., 2017). For example, Brown, Greenfield, and Rapkin (2020) describe how one state developed a two-phase pilot with the first phase consisting of stakeholder engagement and protocol development, and the second phase focused on implementation through partnership with a Perinatal Quality Collaborative, or network of providers and stakeholders in facilities, to document challenges in provider training and the reimbursement process. Pilot testing may address variability in the reimbursement process, allowing for scale-up across states. However, developing a reimbursement process that includes networking between facilities, clinics, and health departments can be challenging for smaller hospital systems or facilities in rural areas (Palm et al., 2020), adding complexity to statewide policy use.

Further complicating challenges of payment methodology implementation, in 2015, the upfront cost of a LARC device ranged from $598 to $703, depending on device type, and reimbursement of insertion procedures ranged from $71 to $135 (Trussell, Hassan, Lowin, Law, & Filonenko, 2015). In efforts to provide fuller access to immediate postpartum LARC, delivery facilities have developed alternate strategies to offset costs such as engaging in privately funded family planning residency programs to decrease costs

for insertion procedures (Ryan Residency Program, 2021), or participating in the 340B Drug Pricing Program, a program intended to offset costs and increase availability of comprehensive services for eligible patients (Health Resources & Services Administration, 2020). Although our review did not include specific cost information, future studies may consider cost–benefit, cost comparison, or cost effectiveness analyses to calculate more accurate expenditures and savings for provision of immediate postpartum LARC.

Observed policy differences indicate that payment methodologies more often include the cost of the device than provider reimbursement and may represent a reimbursement systems barrier. Providers are essential to LARC access. States that authorize them to bill and receive reimbursement for services such as insertion fees could allow for consistent implementation of policies across facilities and see decreases in observed disparities in accessing postpartum LARC. Provider champions can support implementation of reimbursement policies by providing the knowledge and experience to apply evidence in practice, using evidence to inform and promote reimbursement policy language, and engaging multidisciplinary stakeholders in discussion (Hill et al., 2019; Rodriguez et al., 2014; Hofler et al., 2017). Moreover, champions can communicate opportunities for systems changes at both the state and facility level leading to implementation of reimbursement policies (Okoroh et al., 2018). Champions promote provider awareness of the reimbursement process, timeliness, processing efficiencies, and can offer suggestions on sustainable reimbursement rate development accounting for billing structure (Hofler et al., 2017). Okoroh et al. (2018) describe a provider champion who functioned at the facility and state levels both as a clinical provider and state Medicaid medical director; this individual promoted statewide quality improvement efforts by leading a pilot at one facility to develop a tested, successful reimbursement process. Provider champions can both diffuse evidence-based guidance on best clinical practices to other providers (Curtis, Jatlaoui, et al., 2016; Curtis, Tepper, et al., 2016; Gavin et al., 2014) and promote the evidence at the facility leadership level to institute practice change such as provider billing for insertion procedures. Having a provider champion can be key to a successful reimbursement plan and scale-up to statewide policy (Kroelinger et al., 2019).

Because many insurance plans must now cover contraception without cost sharing, patient costs for LARC have decreased, and this cost reduction has been associated with increased use; enrollees in employer-sponsored health plans have been most affected by this change (Dalton et al., 2018; Heisel et al., 2018). However, Moniz et al. (2019) suggest that cost-sharing continues to exist for immediate postpartum LARC among some commercially insured women, impacting access to services. Ensuring all women can access the method of their choice is paramount to meet preventive health services recommendations (Gavin et al., 2014), improve reproductive autonomy through patient-centered counseling to reduce potential coercion (Mann, White, Rogers, & Gomez, 2019; Sznajder, Carvajal, & Sufrin, 2020), and address biases associated with more frequent offering of LARC to women with public insurance (Dehlendorf et al., 2010) rather than private insurance. Of note, all publicly available state policies identified Medicaid directly; we could not identify other publicly available non-Medicaid or private plans as payors for reimbursable services. This factor limits understanding of immediate postpartum LARC reimbursement among a significant proportion of health systems, payors, and provider services in care delivery.

Immediate postpartum LARC policies can be provided within a patient-centered framework that prioritizes individual patient preferences for method choice and counseling (Dehlendorf, Fox, Sobel, & Borrero, 2016) while also addressing the continued burden of cost for patients, as consumer needs drive implementation of services (Batra & Bird, 2015). Further research on how policy implementation impacts patient experiences for both the publicly and privately insured is warranted.

There are several limitations to this study. Although publicly available policies exist for many states, most statewide policies are specific to state Medicaid programs. Very few publicly available policies for private insurers are accessible for review, limiting the generalizability of our findings to Medicaid policies. Second, by limiting our review to publicly available policies, we may have missed nonpublic or unpublished policies. Third, because of the data collection time frame, some state policies may have been developed, amended, or repealed, potentially affecting our analysis. Fourth, we did not include policy review for the District of Columbia or any U.S. territories or freely associated states. Finally, our review did not include extraction of information on the adequacy of reimbursement or specific billing codes, limiting the study of policy differences necessary for a more detailed understanding of how billing and reimbursement operate within facilities. Authorizing language typically included grouped entities such as delivery facility or provider rather than specific hospital systems, provider groups, or companies, and therefore we could not analyze language beyond these broad categories to understand facility-specific barriers to LARC availability. Billing codes included in policy documents range from a list of DRG, healthcare common procedure coding system, current procedural terminology, or *J* codes but were inconsistently reported, and, therefore, excluded from the data classification scheme. Our findings on the variability in reimbursement methods provide a snapshot of state strategies across the US, from 2017 to 2018, regardless of these limitations.

Despite challenges of reimbursement and variable payment methodologies, states are implementing multiple strategies to address barriers in policy implementation (Kroelinger et al., 2019). To further support state efforts, from 2014 to 2018, the Association of State and Territorial Health Officials (2020) in partnership with the Centers for Disease Control and Prevention, the CMS, and the Office of Population Affairs convened a Learning Community to provide technical assistance to 26 states and one territory seeking to increase access to the full range of contraceptive options, and in particular, immediate postpartum LARC (Association of State and Territorial Health Officials, 2020; DeSisto et al., 2017; DeSisto et al., 2019; Kroelinger et al., 2019; Kroelinger et al., 2015; Rankin et al., 2016). The Learning Community activity has provided resources to support states in the immediate postpartum LARC implementation process (Kroelinger et al., 2019; DeSisto et al., 2019), including return on investment tools, revised modifier codes for billing, and broader payment strategies for billing and reimbursement to support implementation of state policies (Association of State and Territorial Health Officials, 2020). Additionally, state public health agencies, in partnership with Medicaid programs and individual facilities or hospital systems, are providing guidance to enhance or supplement the global obstetric fee for effective billing of device costs and insertion fees (Brown et al., 2020; Lacy, McMurtry, Scott, Barker, & Zite, 2020; Rodriguez et al., 2014; Steenland, Pace, Sinaiko, & Cohen, 2019), with payment reform pilots at individual facilities supported by state

Perinatal Quality Collaboratives and Managed Care Organizations (Hofler et al., 2017; Lacy et al., 2020; Steenland et al., 2019). For example, a recent policy change in one state to allow billing for immediate postpartum LARC separate from the global obstetric fee resulted in increases in receipt of LARC immediately postpartum among all women, and a significant decrease in short interval pregnancies among adolescents relative to what was expected without policy change (Steenland et al., 2019). States also reimburse outpatient LARC claims for inpatient insertions immediately after labor and delivery (Hill et al., 2019), offering alternative payment strategies for other states to consider during policy language revision or when existing policies offer less flexibility in billing for services.

Implications for Practice and/or Policy

Although our analysis found variations in state-based policies summarizing reimbursement of insertion procedures and device costs associated with immediate postpartum LARC, existing policies do provide guidance for facilities and providers on reimbursement and states are actively identifying payment strategies to address implementation challenges. A better understanding of policy impact on costs and benefits to providers and patients; the role of adequate reimbursement; and research on provider behaviors and biases, including the influence of champions, is necessary to ensure equitable access to immediate postpartum LARC. State policies provide the foundation for development of a broader system for reimbursement of insertion procedures and device costs for immediate postpartum LARC to support increased access for all who choose it.

Acknowledgments

Dr. Charlan Kroelinger had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Disclosure:

The authors report no conflict of interest. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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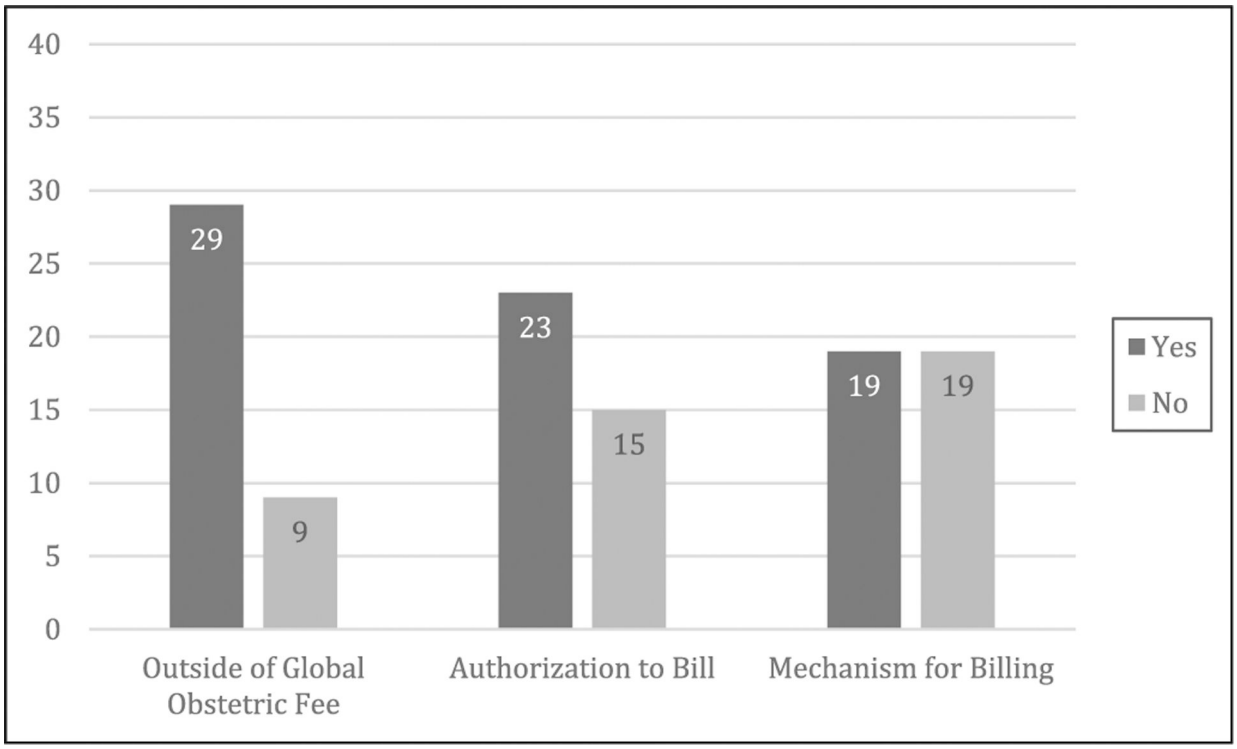

Figure 1.
Reimbursement for immediate postpartum long-acting reversible contraception insertion procedures (n = 38).

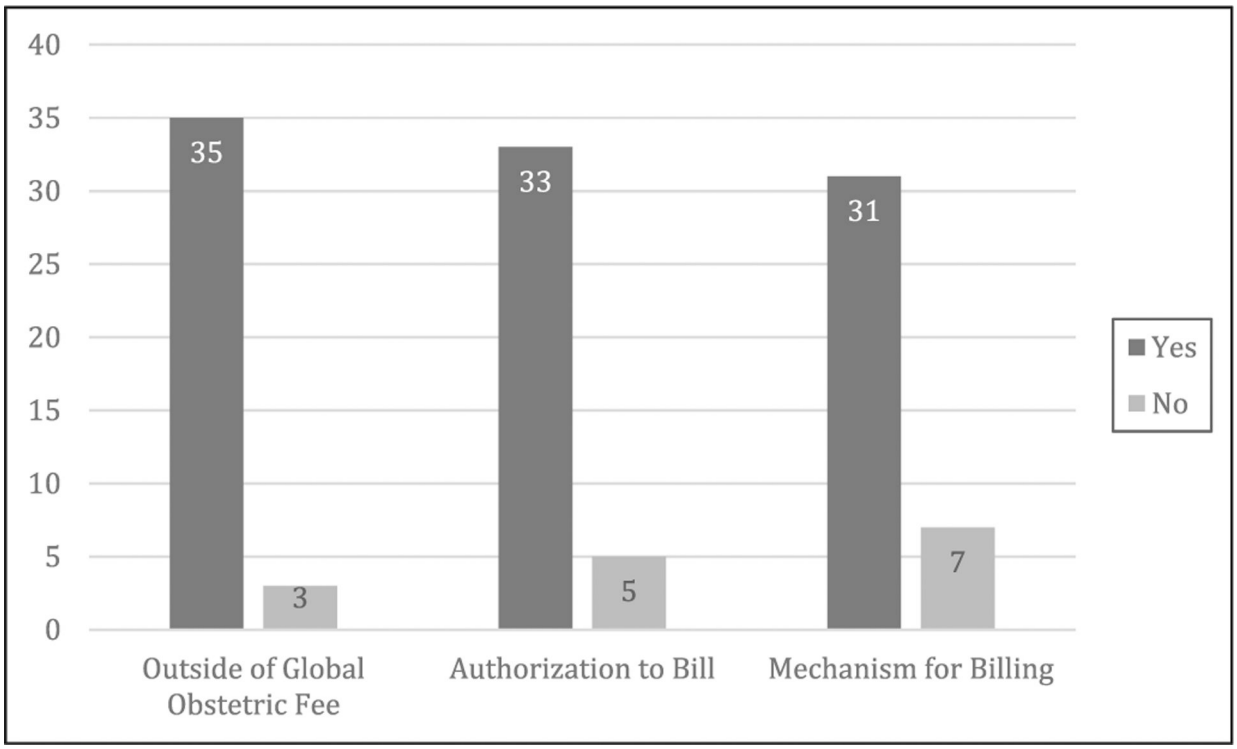

Figure 2.
Reimbursement for immediate postpartum long-acting reversible contraception device costs (n = 38).

Table 1

Summary of Search Terms Used for Data Collection and Abstraction of All Long-Acting Reversible Contraception Policies, 2017–2018

Individual Search Terms*
<state> AND <department of public health> AND (LARC OR IUD OR IMPLANT)
<state>, <department of public health>, (LARC OR IUD OR IMPLANT)
<state> AND (Medicaid OR (title x)) AND (LARC OR IUD OR IMPLANT)
<state>, (Medicaid OR (title x)), (LARC OR IUD OR IMPLANT)
<state> AND ((CMCS waiver) OR (family planning waiver) OR (1115 waiver)) AND (LARC OR IUD OR IMPLANT)
<state>, ((CMCS waiver) OR (family planning waiver) OR (1115 waiver)), (LARC OR IUD OR IMPLANT)
<state> AND ((community health center) OR (rural health center)) AND (LARC OR IUD OR IMPLANT)
<state>, ((community health center) OR (rural health center)), (LARC OR IUD OR IMPLANT)
<state> AND ((federally qualified health center) OR FQHC) AND (LARC OR IUD OR IMPLANT)
<state>, ((federally qualified health center) OR FQHC), (LARC OR IUD OR IMPLANT)
<state> AND ((health insurance exchange) OR regulatory agency) AND (LARC OR IUD OR IMPLANT)
<state>, ((health insurance exchange) OR (regulatory agency)), (LARC OR IUD OR IMPLANT)
<state> AND (Federal health exchange) AND (LARC OR IUD OR IMPLANT)
<state>, (Federal health exchange), (LARC OR IUD OR IMPLANT)
<state> AND ACOG AND (LARC OR IUD OR implant)†
<state>, ACOG, (LARC OR IUD OR implant)
<state> AND AWHONN AND (LARC OR IUD OR implant)
<state>, AWHONN, (LARC OR IUD OR implant)
<state> AND AAP AND (LARC OR IUD OR implant)
<state>, AAP, (LARC OR IUD OR implant)
<state> AND AAFP AND (LARC OR IUD OR implant)
<state>, AAFP, (LARC OR IUD OR implant)
<state> AND <PQC> AND (LARC OR IUD OR implant)
<state>, <PQC>, (LARC OR IUD OR implant)
<state> AND <Private Insurer> AND (LARC OR IUD OR implant)
<state>, <Private Insurer>, (LARC OR IUD OR implant)
<state> AND <state coalition/foundation> AND (LARC OR IUD OR implant)
<state>, <state coalition/foundation>, (LARC OR IUD OR implant)
<state> AND NFPRHA AND (LARC OR IUD OR implant)
<state>, NFPRHA, (LARC OR IUD OR implant)
<state> AND (National Family Planning Training) AND (LARC OR IUD OR implant)
<state>, (National Family Planning Training), (LARC OR IUD OR implant)
<state> AND Guttmacher AND (LARC OR IUD OR implant)
<state>, Guttmacher, (LARC OR IUD OR implant)
<state> AND (KFF OR (Kaiser Family Foundation)) AND (LARC OR IUD OR implant)
<state>, (KFF OR (Kaiser Family Foundation)), (LARC OR IUD OR implant)
<state> AND NARAL AND (LARC OR IUD OR implant)
<state>, NARAL, (LARC OR IUD OR implant)

Individual Search Terms*
<state> AND (paragard OR mirena OR skyla OR liletta)
<state>, (paragard OR mirena OR skyla OR liletta)

*The individual state name and abbreviation/s were included in subsequent searches and variations of search phrases were subsequently searched including acronyms, abbreviations, singular and plural terms, and common misspellings.

†Professional membership and independent research organizations were added to search terms as these organizations routinely develop guidelines, guidances, and policies for clinical and non-clinical members, or routinely conduct individual policy review of contraception use and access.

Table 2

Immediate Postpartum Long-Acting Reversible Contraception Statewide Policies by Payor Type and Policy Source, 2018 (N = 50 States)

State	Long-Acting Reversible Contraception Policy Characteristics		
	State-based Policy	Payor Type	Policy Source
Alabama	Yes	Medicaid	Medicaid guidance
Alaska	—*		—
Arkansas	—	—	—
Arizona	Yes	Medicaid	Medicaid guidance
California	Yes	Medicaid	Medicaid guidance
Colorado	Yes	Medicaid	Medicaid guidance
Connecticut	Yes	Medicaid	Medicaid guidance
Delaware	Indirectly referenced†	Medicaid	N/A‡
Florida	Yes	Medicaid	Medicaid guidance
Georgia	Yes	Medicaid	Medicaid guidance
Hawaii	Yes	Medicaid	Medicaid guidance
Idaho	—	—	—
Illinois	Yes	Medicaid	Medicaid SPA
Indiana	Yes	Medicaid	Medicaid guidance
Iowa	Yes	Medicaid	Medicaid guidance
Kansas	—	—	—
Kentucky	Indirectly referenced	Medicaid	Medicaid guidance
Louisiana	Yes	Medicaid	Medicaid guidance
Maine	Yes	Medicaid	Medicaid guidance
Maryland	Yes	Medicaid	Medicaid guidance
Massachusetts	Yes	Medicaid	Medicaid guidance
Michigan	—	—	—
Minnesota	—	—	—
Mississippi	Yes	Medicaid	Medicaid guidance
Missouri	Yes	Medicaid	Medicaid guidance
Montana	Yes	Medicaid	Administrative rule
Nebraska	—	—	—

State	Long-Acting Reversible Contraception Policy Characteristics		
	State-based Policy	Payor Type	Policy Source
Nevada	Yes	Medicaid	Medicaid guidance
New Hampshire	Indirectly referenced	Medicaid and other[§]	State marketplace notice
New Jersey	—	—	—
New Mexico	Yes	Medicaid	Medicaid guidance
New York	Yes	Medicaid	Medicaid guidance
North Carolina	Yes	Medicaid	Medicaid SPA
North Dakota	—	—	—
Ohio	Yes	Medicaid	Statutory provision
Oklahoma	Yes	Medicaid	Medicaid guidance
Oregon	—	—	—
Pennsylvania	Yes	Medicaid	Medicaid guidance
Rhode Island	—	—	—
South Carolina	Yes	Medicaid	Medicaid guidance
South Dakota	Yes	Medicaid	Medicaid guidance
Tennessee	Yes	Medicaid	Medicaid guidance
Texas	Yes	Medicaid and other	Medicaid guidance
Utah	Yes	Medicaid	Medicaid guidance
Vermont	Yes	Medicaid	Medicaid guidance
Virginia	Yes	Medicaid	Medicaid guidance
Washington	Yes	Medicaid	Medicaid guidance
West Virginia	Yes	Medicaid	Medicaid guidance
Wisconsin	Yes	Medicaid	Medicaid guidance
Wyoming	—	—	—

Abbreviations: IPP, immediate postpartum; LARC, long-acting reversible contraceptive; SPA, state plan amendment.

[*] The "—" indicates a state-based policy document was not available.

[†] The term "indirectly referenced" is a policy source described in a document from a state that cites the state source for reimbursement, although the indirect source may not be authorized to create billing policies.

[‡] The "N/A" indicates not available. The indirectly referenced source did not identify a policy source.

[§] The term "other" can include policies specific to non-Medicaid insurers including private insurance companies or bulletins targeting the insurance marketplace for non-Medicaid recipients.

Table 3

Specified Reimbursement Language in State Policies for Immediate Postpartum Long-Acting Reversible Contraception by Insertion Procedures and Device Costs, 2018 (n = 38 States)

State	Reimbursement for Insertion Procedures			Reimbursement for Device Costs		
	Separate from Global Obstetric Fee	Entity Authorized to Bill	Mechanism for Billing	Separate from Global Obstetric Fee	Entity Authorized to Bill	Mechanism for Billing
Alabama	—*	Both	Both	—	Hospital	Both
Arizona	—	—	—	Yes	Hospital	—
California	—	—	—	Yes	Hospital	Outpatient
Colorado	Yes	—	—	Yes	Hospital	Inpatient
Connecticut	—	—	—	Yes	Hospital	Outpatient
Delaware†	No	Provider	—	Yes	—	Outpatient
Florida‡	Yes	Provider	Inpatient	Yes	Provider	Inpatient
Georgia	Yes	Provider	—	Yes	Both	—
Hawaii	Yes	Provider	Inpatient	Yes	Both	Inpatient
Illinois	Yes	Provider§	Inpatient	Yes	Hospital	Inpatient
Indiana	No	—	Inpatient	Yes	—	Inpatient
Iowa	Yes	Both	Both	Yes	Both	Both
Kentucky†	Yes	Provider	—	—	—	—
Louisiana	Yes	Both	Both	Yes	Both	Both
Maine	—	Hospital	Inpatient	Yes	Hospital	Inpatient
Maryland	Yes	—	—	Yes	Hospital	—
Massachusetts	Yes	—	Inpatient	No	Hospital	Inpatient
Mississippi	Yes	Both	Both	Yes	Both	Both
Missouri	No	—	—	Yes	Provider	Outpatient
Montana	Yes	Hospital	Outpatient	Yes	Hospital	Outpatient
Nevada	Yes	Both	Both	Yes	Both	Both
New Hampshire†	Yes	Provider	—	Yes	Hospital	Inpatient
New Mexico	Yes‖	Provider	Inpatient	Yes	Both	Inpatient
New York	Yes	Provider	—	Yes	Hospital	Outpatient

State	Reimbursement for Insertion Procedures			Reimbursement for Device Costs		
	Separate from Global Obstetric Fee	Entity Authorized to Bill	Mechanism for Billing	Separate from Global Obstetric Fee	Entity Authorized to Bill	Mechanism for Billing
North Carolina	Yes	Provider	Both	No	Both	Both
Ohio	—	—	—	Yes	Hospital	Inpatient
Oklahoma	Yes	Provider	Inpatient	Yes	Hospital	Outpatient
Pennsylvania	—	—	—	Yes	Hospital	Outpatient
South Carolina	Yes	Both	Both	Yes	Both	Both
South Dakota	—	—	—	Yes	Hospital	Inpatient
Tennessee	Yes	Both	—	Yes	Both	Both
Texas	Yes	Provider	—	Yes	Both	Outpatient
Utah	No	—	—	No	Hospital	Inpatient
Vermont	No	—	Inpatient	No	—	Inpatient
Virginia	—	—	—	Yes	Hospital	Both
Washington	Yes	Provider	Inpatient	Yes	Both	—
West Virginia	Yes	Provider	—	Yes	Hospital	—
Wisconsin	No	—	Inpatient	—	—	—

States with no available statewide policy: Alaska, Arkansas, Idaho, Kansas, Michigan, Minnesota, Nebraska, New Jersey, North Dakota, Oregon, Rhode Island, and Wyoming.

[*] The "—" indicates a policy with no reimbursement requirement language identified.

[†] State with an indirectly referenced policy, defined as information from a source not authorized to create billing policies.

[‡] Reimbursement policies reported apply to Medicaid fee-for-service payors; Managed Care Organizations can negotiate reimbursement.

[§] Providers not employed by the hospital may bill for reimbursement for insertion procedures.

[‖] Provider insertion procedures are reimbursed separate from the global obstetric fee if patient delivery was vaginal.