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Reimbursement for Immediate Postpartum Contraception Outside the Global Fee:

Improving Outcomes and Reducing Costs for Moms and Babies

Summary

Immediate postpartum contraception refers to the provision of an intrauterine device or contraceptive implant immediately after childbirth, during the delivery hospitalization. Providing specific reimbursement for this service can be an important first step to increase patient access, improve birth spacing, reduce unintended pregnancies, and promote better outcomes for our healthcare system.

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Background

Immediate postpartum long-acting reversible contraception (LARC) refers to the insertion of an intrauterine device (IUD) or contraceptive implant immediately after childbirth, before hospital discharge.

Both IUDs and contraceptive implants may be placed prior to hospital discharge after vaginal or cesarean births.[1] This approach is supported as safe and effective by the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the Association of Certified Nurse Midwives.[2,3] Furthermore, the National Quality Forum has identified LARC provision during the delivery hospitalization as a metric of high quality contraceptive care.[4]

Although placement can occur at a postpartum follow-up office visit, the immediate postpartum period—in the hospital—can be an ideal opportunity to initiate contraception for interested women.

An estimated 40% of women do not receive outpatient postpartum care, often due to transportation, childcare, and employment barriers.[5] And even when women do return for care, they may have already conceived prior to this visit.[6] Indeed, in one study of postpartum women who initially requested LARC, 16% conceived prior to having their device placed.[7] In addition, women who gain eligibility for Medicaid due to pregnancy often lose that coverage at 60 days postpartum and, in the absence of insurance coverage, may no longer be able to afford LARC placement. In fact, nearly half of all delivering women experience a period of uninsurance in the six months after delivery.[8]

Despite evidence that immediate postpartum LARC is associated with better outcomes for patients, improved population health and decreased healthcare costs, LARC placement during the delivery hospitalization remains rare (13.5 per 10,000 deliveries).[9]

A key barrier is non-reimbursement by public and private insurers for both LARC devices and the immediate postpartum insertion procedure.

> **“Inpatient insertion is safe, convenient and prevents a separate procedure for women.”**

The Triple Aim

Immediate postpartum LARC holds promise to help meet the Triple Aim of improving patient experience of care, improving population health outcomes, and reducing healthcare costs.[10] IUDs and implants provided immediately after childbirth to interested women can have the following potential advantages:

Better Patient Experience:
Inpatient insertion is safe, convenient and prevents a separate procedure for women. Immediate postpartum LARC is in line with many patients' preferences and addresses a high unmet demand for postpartum IUDS and implants.[11]

Better for Population Health:
LARC methods are highly effective at preventing unintended pregnancy (failure rate <1% vs. 8-18% with other reversible methods). There is growing evidence that inpatient postpartum LARC reduces short interval pregnancy rates. Tocce, et al., found that within 12 months of delivery, only 2.6% of immediate postpartum LARC recipients had experienced repeat pregnancy, compared to 18.6% of other adolescents in their cohort.[12]

Better for Payers & Healthcare Systems:
Numerous cost-effectiveness analyses have demonstrated that immediate postpartum LARC is a high value service, with potential savings for payers and healthcare systems compared to outpatient LARC placement.[13-17] Han, et al., found for every dollar spent on immediate postpartum implants, payers would save $0.79, $3.54, and $6.50 at 12, 24, and 36 months.

Given the potential health and economic benefits to both individuals and society, it is a missed opportunity to not provide immediate postpartum LARC services to interested patients.

It is important to recognize that the ultimate goal of contraceptive policies is not that women choose a specific contraceptive method, but that all women are able to either limit fertility or pursue pregnancy and parenthood according to

Figure 1. Postpartum LARC Can Meet the Triple Aim

their own wishes. Ideally, contraceptive care and policy would enable women to access all evidence-based contraceptive options, including immediate postpartum LARC insertion as well as LARC removal at the time of a woman's choosing. Nearly half of women experience a gap in insurance coverage after childbirth and may face barriers to both LARC insertion and removal. Patient-centered counseling and shared decision-making is essential to ensure that a woman can make contraceptive decisions that align with her preferences and reproductive goals.

Reimbursement Policies For Immediate Postpartum LARC

Currently, most private insurers and Medicaid programs pay a bundled rate for all services provided during a labor and delivery admission with a global fee under a single Diagnosis Related Group (DRG) code. Typically, the LARC device and the placement procedure, which are covered in an outpatient clinic visit by most public and private insurers, are not reimbursed in addition to this global fee for delivery if placed immediately postpartum in the hospital.[1,18]

However, a growing push by leaders in public health, Medicaid, and provider communities to expand access to immediate postpartum LARC has led to 37 states to date revising their Medicaid reimbursement policies for postpartum LARC. States have implemented changes to their Medicaid policies to reimburse immediate postpartum LARC separate from the global fee for delivery. These Medicaid policy changes can serve as models for other state Medicaid programs and private insurers alike (Table 1).

Many federal and state leaders and health officials have publicly encouraged payers to revise their immediate postpartum LARC reimbursement systems. For instance in April 2016, the Centers for Medicare and Medicaid Services released an informational bulletin encouraging payers to consider "reimbursing for immediate postpartum insertion of LARC by unbundling payment for LARC from other labor and delivery services".[20] Meanwhile the Association of State and Territorial Health Officials is operating an Increasing Access to Contraception Learning Community of 27 states focused on enhancing access to LARC, including in the inpatient setting. In addition the CDC's 6|18 Initiative encourages payers to "reimburse for immediate postpartum insertion of LARC by unbundling payment for LARC from other postpartum services".[21]

Reimbursement changes can improve access to safe, reliable, and effective contraceptive options for women and decrease healthcare costs.

Medicaid Reimbursement Policy		States Using This Approach[18, 19]
Device	Insertion	
Part of Maternity Global Fee	Separate Payment for Procedure	Alabama, District of Columbia, North Carolina, Oregon, West Virginia, Wisconsin
Part of Maternity Global Fee	Part of Maternity Global Fee	Alaska, Arkansas, Colorado, Maine, Michigan, Minnesota Nevada, New Hampshire, Utah, Vermont
Separate Payment for Device	Separate Payment for Procedure	California, Connecticut, Florida, Georgia, Hawaii, Idaho, Iowa, Maryland, Mississippi, Montana, Nebraska, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Wyoming
Separate Payment for Device	Part of Maternity Global Fee	Arizona, Delaware, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Missouri, New Mexico, New York, Ohio, South Carolina, Washington

Table 1. Examples of Innovative Payment Approaches to Enhance LARC Access *As of January 2018*

Unintended Pregnancy in Michigan

50.5% of all pregnancies and **81%** of teen pregnancies were unplanned

72% of unintended births were publicly funded

The public cost of unintended pregnancies in Michigan was **$662.0 million**

2010 Data

Michigan — An Opportunity To Improve LARC Access

Approximately 50.5% of all pregnancies and 81% of teen pregnancies in Michigan are unplanned.[22] In 2010, 55% of unintended pregnancies in Michigan resulted in births, 31% in abortions, and the remainder in miscarriages.[23]

These unmet contraceptive needs result in significant public costs. In 2010, 36,600 or 72% of unintended births in Michigan were publicly funded (compared to 68% nationally). In our state in 2010, the public cost of unintended pregnancies was $662.0 million ($485.1 million paid by the federal government and $177.0 million paid by the state).

Recommendations

1. Consider providing specific reimbursement to the professional for LARC (IUD or implant) insertion in the hospital setting immediately post-delivery
2. Consider allowing adequate reimbursement to facilities for the LARC device when provided in the inpatient setting immediately post-delivery
3. Emphasize that LARC insertion is a decision to be carefully considered between patient and provider

Expected Outcomes and Feasibility

With changes in reimbursement, we expect that LARC utilization will increase, which will decrease unplanned pregnancy rates and increase the interpregnancy interval, leading to decreased preterm birth risk and overall reductions in healthcare costs. The feasibility of implementation is high.

Outcome Measures:

- Trends in utilization of inpatient and outpatient LARC in the postpartum setting.
- Patient experience of care.
- Discontinuation rates, expulsion rates, and rare adverse outcome rates (perforation, infection).
- Short interval pregnancies and unintended pregnancies by 12 and 18 months intervals post-index delivery.
- Preterm births.
- Cost-savings.

PWHER
PROGRAM ON WOMEN'S HEALTHCARE EFFECTIVENESS RESEARCH

The Program on Women's Healthcare Effectiveness Research (PWHER) is an interprofessional women's health services research group housed within the Department of Obstetrics and Gynecology and the Institute for Healthcare Policy and Innovation (IHPI) at the University of Michigan.

Drs. Michelle H. Moniz, MD, MSc and Vanessa K. Dalton, MD MPH are investigators with nationally recognized expertise in immediate postpartum LARC policy and implementation. They can provide technical support in evaluating reimbursement policy, implementing immediate postpartum LARC services at hospitals around the state, and evaluating impact on pregnancy and birth outcomes and birth-related spending.

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