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Medicaid Administrator Experiences with the Implementation of Immediate Postpartum Long-Acting Reversible Contraception

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A B S T R A C T

Objective: This study sought to understand state Medicaid agencies' experiences with implementing payment for long-acting reversible contraception devices inserted immediately postpartum.
Methods: We conducted semistructured telephone interviews with Medicaid representatives from 15 agencies that have specific payment methodology for immediate postpartum long-acting reversible contraception (IPLARC). Interviews investigated agency experiences with IPLARC policy implementation. Interviews were audio-recorded and professionally transcribed. We analyzed data thematically using qualitative content analysis principles.
Results: Described implementation experiences fell into three major categories: 1) payer preparedness regarding payment challenges, 2) health care system awareness, attitudes, and readiness to implement IPLARC policy in clinical settings, and 3) ongoing practice improvement. Within the category of payer preparedness, major emergent themes included Medicaid's need to ensure efficient claims processing, maintain appropriate reimbursement rates, and alleviate perceived provider mistrust about payment. With respect to health care systems, themes emerged around raising clinician awareness of IPLARC coverage, managing provider misconceptions about IPLARC, and addressing gaps in provider IPLARC insertion expertise. Regarding practice improvement, a salient theme emerged around the limitations of Medicaid to engage in ongoing clinical implementation and evaluation efforts.
Conclusions: These findings suggest a multistakeholder implementation framework that can guide the growing number of Medicaid agencies newly implementing IPLARC policy. As more Medicaid programs remove reimbursement barriers to IPLARC, clinicians and hospital administrators have a crucial opportunity to address clinical barriers to IPLARC and ensure real-time access among beneficiaries who desire this safe and effective approach to contraception.

Presentation: Findings were presented as a poster at the North American Forum on Family Planning in Chicago, November 14–16, 2015 and as an oral presentation at the North American Primary Care Research Group's 43rd Annual Meeting, Cancun, Mexico, October 24–28, 2015.

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In the United States, one-third of repeat pregnancies are conceived in the 18 months after a live birth (Gemmill & Lindberg, 2013). These rapid repeat pregnancies are often unintended and are at increased risk of complications like miscarriage, preterm birth, stillbirth, and low birthweight (Conde-Agudelo, Rosas-Bermudez, & Kafury-Goeta, 2006; Rigsby, Macones, & Driscoll, 1998). Rapid repeat pregnancies disproportionately affect low-income women, who demonstrate very low rates of follow-up for postpartum care (Gemmill & Lindberg, 2013). In this group, immediate postpartum access to long-acting, reversible contraceptive methods (LARC; e.g., intrauterine devices [IUDs] and the contraceptive implant), is particularly beneficial (Rodriguez, Evans, & Espey, 2014). When provided to women who want them after delivery and before hospital discharge, LARC devices have been linked to longer contraceptive coverage, fewer rapid repeat pregnancies, and cost savings (Çelen, Möröy, Sucak, Aktulay, & Danışman, 2004; Guazzelli, de Queiroz, Barbieri, Torloni, & de Araujo, 2010; Han, Teal, Sheeder, & Tocce, 2014; Tocce, Sheeder, Python, & Teal, 2012a; Tocce, Sheeder, & Teal, 2012b).

Currently, a major barrier to immediate postpartum LARC (IPLARC) among Medicaid beneficiaries is the global fee for delivery-related care. Most Medicaid programs pay for all labor- and delivery-related care with a global fee under a single diagnosis-related group (DRG) code. Because LARC devices cost $800 to $1,000 (Planned Parenthood Federation of America, Inc., 2014), providers' inability to seek separate payment in the inpatient postpartum setting for LARC devices and their insertion poses a significant barrier to LARC use (Aiken, Creinin, Kaunitz, Nelson, & Trussell, 2014).

To date, 19 state Medicaid agencies have recognized this financial disincentive to immediate postpartum access to LARC methods and permit separate payment or additional bundled payment when LARC devices are provided to beneficiaries during the same hospitalization as a delivery. However, coverage has not translated seamlessly to increased access and use. The objective of this study was to acquire in-depth understanding about implementation experiences in states where Medicaid currently reimburses for IPLARC, to identify strategies for successful clinical implementation.

Materials and Methods

Study Sample

Between October 2014 and March 2015, we contacted the United States' 51 Medicaid agencies—one in each state and the District of Columbia (DC)—by telephone or email on up to four occasions. We requested a telephone interview with the Medicaid director or a designee with expertise in women's reproductive health services. At the time of the interview, Medicaid representatives provided verbal informed consent to participate. They did not receive any reimbursement for participation. Our study was deemed "not regulated" by the University of Michigan Institutional Review Board, because it constituted information gathering about organizations from organizational spokespersons or data sources.

We interviewed 40 Medicaid agencies, of whom 15 were found to provide separate or increased bundled payment for IPLARC devices. States with "separate" payment provide remuneration that is separate and distinct from the DRG-based payment, whereas states with "increased bundled payment" provide one, DRG-based payment that specifically increases due to IPLARC insertion. We thus 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 based this determination on reimbursement for devices, regardless of whether or not the clinician insertion fee is provided, because the cost of the device is the major financial barrier to IPLARC insertion (estimated device cost of $800–$1,000 vs. insertion fee of approximately $100). An initial determination was made based on transcript review and then confirmed in two ways: 1) by emailing interviewees to confirm their designated category (member checking), and 2) by reviewing Medicaid documentation available online and/or provided by interviewees (e.g., provider manual, provider bulletins and transmittals). This process of interview transcript review, member checking, and Medicaid documentation review yielded 15 interviewed states with reimbursement for IPLARC at the time of their interview—these agencies are the focus of the current study. Documentation review identified an additional three agencies that seem to provide reimbursement, but declined to participate in this study; additionally, one state that was considering reimbursement at the time of our interview has since implemented reimbursement (yielding a total of 19 states to date with specific payment for IPLARC).

Data Collection

The authors created a semistructured interview guide based on review of recently published original research and editorials about IPLARC (Aiken et al., 2014; Çelen et al., 2004; Chen et al., 2010; Kapp & Curtis, 2009; Ogburn, Espey, & Stonehocker, 2005). The guide was then revised based on feedback from Alicia Luchowski, the American College of Obstetricians and Gynecologists' LARC Program Director, and members of our institution's interdisciplinary Program on Women's Health Effectiveness Research. The final interview 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, the agency's goals for this policy, and facilitators and barriers to policy implementation. Probes from our guide were used to encourage elaboration, greater detail, and clarification of responses (Weiss, 1994). Conversations were audio-recorded with permission. For one state that declined audio-recording, the interviewer took and immediately transcribed extensive notes. Each semi-structured telephone interview was conducted by one or two research team members.

Data Analysis

Interviews were professionally transcribed verbatim and analyzed using Dedoose Version 5.3.12 (Sociocultural Research Consultants, LLC, Los Angeles, CA, 2014). Two authors identified themes using qualitative content analysis (Forman & Damschroeder, 2007). They developed the initial list of deductive codes based on a literature review and key sections of the interview guide. Using constant comparison, they revised the codebook iteratively based on emergent themes identified during transcript review. The initial 40% of transcripts were coded independently by these two authors, who resolved discrepancies through consensus. After intercoder agreement was established, the remaining interviews were coded by one investigator.