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Characterization of Medicaid policy for immediate postpartum contraception☆,☆☆

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Abstract

Objective: Long-acting reversible contraception (LARC) is safe, effective and cost-saving when provided immediately postpartum but currently underutilized due to nonreimbursement by Medicaid and other insurers. The objectives of this study were to (a) determine which state Medicaid agencies provide specific reimbursement for immediate postpartum LARC and (b) identify modifiable policy-level barriers and facilitators of immediate postpartum LARC access.

Study Design: We conducted semistructured telephone interviews with representatives of 40 Medicaid agencies to characterize payment methodology for immediate postpartum LARC. We coded transcripts using grounded theory and content analysis principles.

Results: Three categories of immediate postpartum LARC payment methodology emerged: state Medicaid agency (a) provides separate or increased bundled payment (n = 15), (b) is considering providing enhanced payment (n = 9) or (c) is not considering enhanced payment (n = 16). Two major themes emerged related to Medicaid decision-making about immediate postpartum LARC coverage: (a) Health effects: States with payment for immediate postpartum LARC frequently cited improved maternal/child health outcomes as motivating their reimbursements. Conversely, states without payment expressed misinformation about LARC's clinical effects and lack of advocacy from local providers about clinical need for this service. (b) Financial implications: States providing payment emphasized overall cost savings. Conversely, states without reimbursement expressed concern about immediate budget constraints and potential adverse impact on existing global payment methodology for inpatient care.

Conclusions: Many states have recently provided Medicaid coverage of immediate postpartum LARC, and several other states are considering such coverage. Addressing misinformation about clinical effects and concerns about cost-effectiveness of immediate postpartum LARC may promote adoption of immediate postpartum LARC reimbursement in Medicaid agencies currently without it.

Implications: Medicaid policy for reimbursement of immediate postpartum LARC is evolving rapidly across the US. Our findings suggest several concrete strategies to remove policy-level barriers and promote facilitators of immediate postpartum LARC.

Keywords: Medicaid; Long-acting reversible contraception; LARC; Reimbursement; Immediate postpartum contraception

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1. Introduction

Rapid repeat pregnancy increases risks of complications such as preterm birth, stillbirth and low birth weight [1,2]. Populations covered by public insurance such as Medicaid are particularly vulnerable to unintended rapid repeat pregnancy within 18 months of a prior live birth [3].

Long-acting reversible contraception (LARC) devices (e.g., intrauterine devices and implants) are highly effective at preventing unplanned pregnancy [4]. When provided immediately postpartum — that is, after delivery and prior to hospital discharge — LARC has been linked to longer contraceptive coverage, fewer rapid repeat pregnancies and cost savings [5–10]. Unmet demand for postpartum LARC is high, as only 54–60% of women who request LARC postpartum actually receive it, often due to failure to return for outpatient postpartum care or early repeat pregnancy [11–13]. The well-documented benefits of immediate postpartum LARC have led to its endorsement by the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and Prevention [4,14].

Reimbursement practices, however, often limit LARC provision to outpatient settings, after discharge from the hospital. Most Medicaid programs and private insurers pay for all labor- and delivery-related care with a global fee under a single diagnosis-related group (DRG) code. Given the cost of each LARC device ($800–$1000) [15], providers' inability to obtain additional payment in the inpatient postpartum setting for LARC devices poses a significant barrier to the provision of postpartum LARC [16].

While some states have decided to permit additional payment for immediate postpartum LARC, other states have not. The objectives of this study were (a) to identify which Medicaid agencies allow specific billing for immediate postpartum LARC and (b) to characterize each agency's rationale for this policy and identify policy-level barriers and facilitators of immediate postpartum LARC access.

2. Methods

2.1. Sample population

We contacted Medicaid offices in each state and the District of Columbia (D.C.) by telephone or email on up to four occasions between October 2014 and March 2015. We requested to schedule a telephone interview with the Medicaid director or a designee with expertise in women's health services.

2.2. Instrument and interviews

The authors developed a semistructured interview guide based on review of recently published original research and editorials about immediate postpartum LARC [5–12,16,21,22] and conversations with Alicia Luchowski, the ACOG LARC Program Director. We revised the guide based on feedback from members of our institution's Program on Women's Health Effectiveness Research. We tailored the final interview guide to states providing, considering or not considering additional reimbursement for immediate postpartum LARC through fee-for-service Medicaid. The 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 (if applicable) and the agency's rationale for current reimbursement practices. We used probes from our guide to encourage elaboration, greater detail and clarification of responses [17]. One or two study authors (MHM, BI) conducted each semistructured telephone interview. We audio-recorded conversations with permission. For one state that declined audio-recording, the interviewer took and immediately transcribed extensive notes.

2.3. Qualitative analysis

Interviews were professionally transcribed verbatim and analyzed using Dedoose Version 5.3.12 (2014; Los Angeles, CA, USA: Sociocultural Research Consultants, LLC). Two authors (MHM, TC) identified themes using qualitative content analysis [18]. They developed the initial list of deductive codes based on a literature review and key sections of the interview guide. Using constant comparison, these two authors iteratively revised the codebook based on emergent themes identified during transcript review. They independently coded the initial 20% of the transcripts, resolving discrepancies through consensus. After intercoder agreement was established, a sole investigator coded each of the remaining interviews.

After the data collection and coding were complete, we grouped Medicaid agencies into one of three categories: (a) providing separate payment or increased bundled payment; (b) considering providing enhanced payment; or (c) not considering providing enhanced payment for immediate postpartum LARC devices. We 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 classified states based on their reimbursement of the cost of the LARC device, regardless of whether or not the physician insertion fee is provided, as the device cost is the major financial barrier to immediate postpartum LARC insertion. We initially determined a state agency's classification into one of these reimbursement categories by review of interview transcripts, and we confirmed classification in two ways: (a) by emailing interviewees to confirm their designated category (member checking); and (b) by reviewing Medicaid documentation available online and/or provided by interviewees (e.g., provider manual, provider bulletins and transmittals). For states with payment methodology for inpatient LARC, we corroborated the date of methodology implementation by reviewing agency documentation. Finally, we compared interviewees' titles to agency organization charts and characterized interviewees into four categories: senior