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Advancing Person-Centered LARC Access among the Medicaid Population

Preface: During the completion of this project, the COVID-19 pandemic hit the United States in full force. The virus has drastically impacted the way that those enrolled in Medicaid seek and receive sexual and reproductive healthcare. By disrupting global supply chains, closing clinics, and re-allocating funds, COVID-19 has introduced new challenges to Medicaid stakeholders interested in advancing contraceptive access (Ahmed & Cross, 2020; Jalan, 2020). The pandemic has also highlighted the sexual and reproductive health inequities that are discussed in this report. As the Medicaid program re-evaluates its service delivery in light of COVID-19, we have an opportunity to address these inequities and improve care for all individuals.

In the United States, almost half of all pregnancies are unintended or unplanned (Centers for Disease Control, 2019). Unintended pregnancies commonly perpetuate a cycle of disadvantage for women by disrupting academic and career trajectories. Unintended births are also associated with adverse maternal and neonatal outcomes and come at a high cost to the healthcare system (Woo et al., 2017). In response, multiple stakeholders have worked to improve access to Long-Acting Reversible Contraception (LARC). LARC is a highly effective method of contraception that has been shown to have high use satisfaction and few contraindications (ACOG Committee on Practice Bulletins-Gynecology, 2017). Despite efforts undertaken by multiple stakeholder groups, disparities in access to LARC continue to exist, particularly for the Medicaid population (Vela et al., 2018). The Medicaid population has been affected by reproductive health injustices, which frequently intersect with racial health inequities (Thorburn et al., 2005; Yee et al., 2011). The goal of any family planning program is to ensure that individuals have knowledge of and access to the type of contraception that best aligns with their individual priorities and values (Holt et al., 2020). This report does not endorse LARC over any other contraceptive method. Instead, we recognize that barriers to accessing person-centered LARC services are more salient for certain populations, such as those enrolled in Medicaid, than they are for others. This report provides an overview of the persistent challenges that Medicaid stakeholders face regarding access to LARC. We also identify strategies to overcome these barriers while ensuring that individual preferences are respected.

The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity and the engagement of patients, families, and communities.



Long-Acting Reversible Contraception (LARC) comes in two forms: the Intrauterine Device (IUD) and the etonogestrel single-rod contraceptive implant. Compared to other reversible contraceptive methods, LARC does not require ongoing effort by the individual or clinician for effective use, which reduces adherence issues and cost. LARC is safe and highly effective for most women, including adolescents, women in the postpartum period, and nulliparous women (ACOG Committee on Practice Bulletins-Gynecology, 2017).

Less than 12 percent¹ of the approximately 19.4 million individuals of child-bearing age enrolled in Medicaid use LARC (Wachino, 2016). Barriers to LARC access exist for all Medicaid payment models including fee-for-service (FFS) and managed care. Challenges to LARC access also occur in both inpatient and ambulatory care settings and differ for certain subgroups, such as adolescents. Since the Center for Medicaid and CHIP Services (CMCS) launched its Maternal Health Initiative in 2014, many state Medicaid agencies and Medicaid managed care organizations (MCOs) have implemented policies and programs aimed to improve LARC utilization among their enrollees (Wachino, 2016; Rosenzweig et al., 2017). Efforts to improve access continue today. In 2018, 89 percent of Medicaid MCOs identified women's health as a priority issue. Surveyed health plans specifically highlighted adoption of LARC as a common challenge (Institute for Medicaid Innovation, 2019). To elevate LARC as a viable and equitable contraceptive option for the Medicaid population, continued collaboration of stakeholders from different sectors of the healthcare system is necessary. This report highlights three case studies of LARC initiatives, two led by Medicaid health plans and one led by a nonprofit organization, to provide stakeholders with useful information to consider when developing a LARC initiative. In acknowledgment of the wealth of existing resources on equitable LARC access, it also includes a resource list in the appendix.

Using a Reproductive Justice Framework

“Reproductive justice” is defined as the human right to have a child, or not have a child, and to parent in a safe, sustainable environment to allow families to thrive (Ross and Solinger, 2017). Using a reproductive justice framework to advance LARC as an equitable contraceptive option among other shorter-acting and barrier methods is not only ethical but also promotes high-value care. LARC programs must be grounded in respect for individual preferences and bodily autonomy.

Respecting Individual Preferences and Preventing Coercion

Studies show that when women feel coerced or pressured to use a certain form of contraception, they are less likely to do so (Dehlendorf et al., 2014). The landmark CHOICE study enrolled more than 9,000 women who were provided scripted counseling on all contraceptive methods and then offered their desired method free of charge. Seventy-five percent of participants chose a LARC method, and 86 percent of those who chose LARC continued to do so after one year. In contrast, 55 percent of women who chose a shorter-acting method of contraception had discontinued their method by one year (Birgisson et al., 2015; Secura et al., 2010). Like many of the successful initiatives that this report highlights, the CHOICE study improved LARC utilization through an initiative that improved access to all forms of contraception. This included comprehensive counseling on all contraceptive methods and the option to not use any form of contraception. Individuals could also have their LARC removed free of charge. In addition to improving contraceptive coverage equity, respecting patient preferences means that individuals have the option to discontinue their method of birth control when they choose.

¹ Although outcomes for LARC uptake are presented throughout this report, there is currently no benchmark for LARC utilization rates because of the need to respect individual preferences. High benchmarks may unintentionally result in coercive practices and are therefore inappropriate (Planned Parenthood Federation of America & Mannatt Health, 2019)

Some state Medicaid agencies and health plans have historically adopted policies to prevent LARC removal without medical necessity, and this can hinder high-quality reproductive healthcare. Inadequate reimbursement for LARC removal has also been found to discourage timely removal (Strasser et al., 2017). Family planning providers may also be hesitant to remove a LARC device early, citing concerns for unintended pregnancy over concerns for patient autonomy. These biases more frequently affect poor women and women of color (Isley et al., 2019). By not addressing provider bias and the need for timely LARC removal, providers, health plans, and state Medicaid agencies may inadvertently foster structural racism and thereby perpetuate reproductive injustices among the Medicaid population.

Acknowledging Historical and Social Context

Medicaid stakeholders must also acknowledge the nefarious history of reproductive and contraceptive coercion in the United States. Government-sponsored sterilization and forced use of LARC have been used as forms of population control against poor and Black women into the 21st century. Many Black women still experience the negative repercussions of these racist practices and are wary of LARC or the information provided to them by the healthcare system (Thorburn et al., 2005). Black women in particular are more likely to feel coerced by clinicians to choose a LARC method over other forms of contraception (Yee et al., 2011; Dehlendorf et al., 2014). Diligence is needed among all Medicaid stakeholders to proactively address historic inequities and the ongoing institutionalized racism in the U.S. medical system.

Sexual and reproductive health choices and outcomes are associated with a wide variety of social factors, many of which are not yet fully understood (Wilkinson et al., 2019; Maness & Buhi, 2016). Contraceptive preference is influenced by histories of trauma, all forms of racism, educational opportunities, and cultural values in addition to factors that influence daily living conditions such as housing status, transportation options, and access to food (Finer & Zolna, 2014, Maness & Buhi, 2016). Also, individuals who do not identify as cisgender women, or who require contraception for reasons other than pregnancy prevention, often feel excluded by LARC initiatives that do not consider or address their needs (Charlton et al., 2019). To advance reproductive justice and respect the bodily autonomy of all individuals, Medicaid stakeholders must also consider the context in which their enrollees live.

Improving LARC Access in the Ambulatory Care Setting

In the ambulatory care setting, common challenges to LARC reported by Medicaid stakeholders are frequently grouped into administrative and logistical barriers. Administrative barriers commonly occur in the payer context when LARC is not adequately reimbursed or covered. Logistical barriers more often occur in the provider setting where it can be difficult to stock LARC devices and provide all of the necessary LARC-related services in a timely and patient-centered way (Orris et al., 2019; Wachino 2016). Ideally, a person who is interested in a LARC method receives comprehensive counseling and has the device inserted on the same day. When LARC is the desired method of contraception, same-day LARC insertion is considered a medical best practice because it reduces barriers to care that a person might experience when returning for a second visit, such as taking time off work and traveling long distances to a clinic (ACOG Contraceptive Working Group, 2015). Same-day insertion may be especially important for the Medicaid population, who more frequently than others experience barriers to accessing care (Huang, 2019).

Reducing Administrative Challenges

Federal Medicaid law prohibits the use of certain utilization management techniques, such as quantity limits, prior authorization, and step therapy in the provision of family planning services. The Patient Protection and Affordable Care Act (ACA) requires coverage of all Food and Drug Administration-approved contraceptive methods without cost-sharing (McCaman, 2019). However, state Medicaid agencies and health plans may need to take extra steps to ensure that all forms of contraception are available to their enrollees in an equitable manner. Examples of this include allowing coverage of an extended supply of contraception (one year or thirteen units) and covering male methods of contraception, such as condoms or a vasectomy (McCaman, 2019).

Evidence shows that increasing reimbursement for LARC-related services is a concrete strategy to improve LARC access among the Medicaid population. In 2014, the Louisiana Department of Health increased Medicaid reimbursement rates for LARC devices to the wholesale acquisition cost (approximately a 60% increase). A cross-sectional study showed that in the year following this change, there was a two-fold likelihood that LARC utilization would increase among all sub-groups (Goldins et al., 2019). This study unfortunately did not assess LARC removal rates or patient satisfaction, but it did highlight the importance of adequate reimbursement. Given the numerous barriers to LARC access, the Louisiana Department of Health also offers resources to concurrently address logistical barriers. The Louisiana LARC Program includes resources on training, stocking, and billing (Louisiana LARC Program, n.d.). The American College of Obstetricians and Gynecologists (ACOG) LARC Program, the Association of State and Territorial Health Officials (ASTHO), and various individual states have also created guides to help clinicians decrease billing and coding errors to ensure timely reimbursement; relevant weblinks are located in Appendix A. These supplementary resources, in addition to the reimbursement increase, are likely necessary pre-conditions for improved access.

State Medicaid agencies and health plans may be constrained by the associated costs with improved LARC reimbursement. In response, the California state Medicaid program (Medi-Cal) implemented an innovative approach to tackling this problem (DHCS, 2019) by allocating a portion of their revenue from a tobacco tax to the California Department of Health Care Services (DHCS). DHCS uses these funds to improve family planning services for Medicaid enrollees by requiring Medi-Cal health plans to provide fixed-dollar add-on amounts for certain family planning services. This includes LARC devices, LARC insertion procedures, and LARC removals. Other forms of contraception are also included, which likely helps to ensure that preferences for care are respected (State of California, 2020).

Reducing Logistical Challenges

Stocking LARC is challenging. The devices themselves can cost upwards of \$1,000, which might limit a clinic's ability to purchase the devices upfront and have them available for same-day insertion. The payment model for coverage of LARC also varies, which influences how and if LARC devices can be stocked. LARC can be covered as a medical benefit or a pharmacy benefit (or both). The advantages and disadvantages of each route are highlighted in Table 1.



Table 1. Benefits and Disadvantages of LARC Reimbursement as a Medical vs. Pharmacy Benefit

Medical Benefit The “Buy and Bill” Method	Pharmacy Benefit The “White Bagging” Method
<p>Clinician purchases the device prior to insertion and bills post-administration.</p> <p>Benefits</p> <p>LARC is on hand for same-day insertion.</p> <p>Disadvantages</p> <p>Requires significant capital upfront.</p>	<p>Clinician prescribes and then orders the device from a pharmacy.</p> <p>Benefits</p> <p>Avoids high upfront costs for stocking.</p> <p>Disadvantages</p> <p>Requires a follow-up appointment and prevents same day insertion.</p> <p>Risk of individual not returning for insertion; placing potential financial burden on clinician if the device cannot be returned.</p>

Source: Adapted from Orris, A., Mauser, G., Bachrach, D., & Grady, A. (2019). A toolkit for states enhancing access to family planning services in Medicaid : ManattHealth. https://www.manatt.com/Manatt/media/Documents/Articles/Arnold-Ventures_Family-Planning-Toolkit_FINAL.PDF

Many state Medicaid agencies and health plans offer LARC via both routes to encourage innovation and context for specific care. For example, Texas Medicaid covers LARC as both a medical and pharmacy benefit. Providers participating in the Texas Family Planning Program may use the “buy and bill” method and purchase LARC devices upfront at a subsidized rate (Orris et al., 2019). Texas Medicaid also contracts with specialty pharmacies. This form of “white bagging” allows providers to order and return unopened LARC devices without suffering the cost (Vela et al., 2018). States and health plans can also negotiate with specialty pharmacies and LARC device manufacturers to receive discounted rates on products purchased in bulk (Armstrong et al., 2015). ACOG developed the LARC Quick Coding Guide, which reviews the options for discounted pricing, including information about LARC coverage under the 340B program, which provides discounts to drugs and devices (such as LARC) to qualifying clinics in the outpatient setting. Currently, only one LARC device is covered under the 340B program, which may prevent some clinics from offering the full range of LARC options and thereby prevent equitable reproductive healthcare (Armstrong et al., 2015). The guide is available in Appendix A.

The AmeriHealth Caritas D.C. case study highlights an innovative approach to address stocking and reimbursement challenges. AmeriHealth Caritas D.C. and Stellar Rx developed LARC units that can store and dispense LARC devices within an outpatient clinic for same-day insertions. When properly installed, the units overcome administrative and logistical barriers commonly faced by clinics. The LARC devices are automatically reimbursed, and clinicians can still bill separately for the LARC insertion procedure. The units require adequate space and internet requirements to function properly, which frequently has been cited as a barrier to adoption. The initiative required collaboration with all clinic staff, and misconceptions and biases about LARC also needed to be addressed.



Developing LARC Units to Address Stocking and Billing Issues

Organization: AmeriHealth Caritas D.C.

Type of Organization: Medicaid Managed Care Organization

Location: Washington, D.C.

Overview

AmeriHealth Caritas D.C. recognized that the high cost of LARC devices disincentivized clinics from stocking the devices in-house to allow for same-day insertions. The health plan also wanted to provide re-assurance that devices covered by AmeriHealth would be adequately reimbursed in a timely manner. In response, AmeriHealth Caritas D.C. partnered with Stellar Rx to develop a Pyxis® -like unit for LARC devices. The unit acts as a specialty pharmacy and uses an electronic monitoring system to ensure that it is always adequately stocked.

Innovation

The LARC units overcome stocking challenges. When properly installed, the unit can dispense a LARC device that can be inserted on the same day as a visit to the clinic. The units and devices come at no upfront cost to the clinic. Clinicians can bill AmeriHealth Caritas D.C. separately for the insertion procedure but do not need to bill for the device itself, which eliminates the potential for billing and coding errors.

Outcomes to Date

- Units are currently available at two outpatient clinics in D.C.
- Since the installation of the units in 2017, approximately 8-10 LARC devices per month have been inserted and reimbursed using the onsite stocking unit.
- No issues with device or procedure reimbursement have been reported.

Key Lessons Learned

- Adequate space for the unit and reliable internet requirements that were needed to ensure the onsite stocking unit could function properly were barriers to adoption.
- Individuals and clinicians had misconceptions about LARC that needed to be addressed before the intervention could achieve its desired impact.
- Clinic staff required extensive training and re-assurance about how the onsite stocking units functioned, as many were worried about patient confidentiality and the reimbursement process.
- Ongoing communication was necessary to ensure that all administrative staff, clinicians, and patients knew about the intervention and the process to check the insurance status of all patients coming in for a LARC insertion.

Future Directions

AmeriHealth Caritas D.C. is continuing to work with clinicians, clinic staff, and patients to ensure that the innovation is used to its fullest potential. The MCO would like to eliminate targeted marketing and provide access to the LARC for all women in DC for whom the LARC is their preferred method of family planning. As the units become better integrated, the health plan plans to scale-up monitoring and evaluation efforts to better understand the innovation's impact. This may also include understanding patients' experiences and satisfaction.

Engaging the Healthcare Workforce

Clinicians who do not regularly perform LARC procedures may feel less confident offering LARC as a contraceptive method (Vela et al., 2018; Rosenzweig et al., 2017). Since Medicaid MCOs rely heavily on clinicians to inform individuals of the family planning services available to them (Rosenzweig et al., 2017), state Medicaid agencies and health plans can leverage available educational, evidence-based resources to improve clinicians' comfort levels. For example, the Colorado Initiative was developed to improve IUD insertion rates for women seeking care at Title X clinics in Colorado. In addition to raising reimbursement rates, the program offered training for clinicians on contraceptive counseling and LARC insertion and removal techniques. Over a four-year period, the LARC utilization rate increased from 0.8 percent to 8.6 percent and demonstrated decreases in pre-term birth and low birthweight (Goldwaite et al., 2015). The ACOG LARC Program has resources and training opportunities available to all clinicians, including OB/GYNs, midwives, and primary care.

Engaging the healthcare workforce is also essential to promoting reproductive justice. Addressing issues of provider bias may increase the quality of contraceptive counseling and willingness to remove a LARC upon a patient's request (Dehlendorf et al., 2010; Mann et al., 2019). Tiered-effectiveness counseling—or contraceptive counseling that focuses predominantly on method efficacy and therefore promotes LARC as a highly efficacious first-line choice—is commonly used by family planning providers (Brandi and Fuentes, 2020). However, this approach often increases the likelihood that a patient will feel pressured to choose LARC over another method (Dehlendorf et al., 2016). In lieu of a single contraceptive counseling approach, clinicians can leverage a wide range of person-centered communication techniques that can adapt to a diverse array of patient preferences and values (Brandi and Fuentes, 2020; Dehlendorf et al., 2014). Although there is no one-size-fits-all approach, resources on person-centered contraceptive counseling are available in Appendix A.

The UPMC *for You* case study highlights how a health plan can engage clinicians to improve knowledge and confidence about LARC. UPMC *for You* collaborated with UPMC Health System who developed a training on LARC-related services for all clinicians and office staff. The health plan also altered reimbursement policies to help clinics overcome administrative and logistical challenges associated with LARC insertion. The training allowed clinicians to collaborate with health plan staff and learn about the reimbursement process. Collaboration helped reduce concerns about adequate and timely payment for LARC-related services. UPMC Health System partnered with the Reproductive Bridges Coalition to ensure that the training emphasized person-centered care.



Engaging and Training Clinicians to Improve Access to LARC

Organization: UPMC *for You*

Type of Organization: Medicaid Managed Care Organization

Location: Pennsylvania

Overview

UPMC *for You*, an affiliate of UPMC Health Plan, offers care to individuals enrolled in Medicaid in 40 counties of Pennsylvania. When LARC is the appropriate and desired choice of the individual enrollee, UPMC *for You* aims to reduce potential barriers to LARC utilization. The health plan has focused its efforts on training clinicians and changing LARC reimbursement policy in both inpatient and outpatient settings.

Innovation

Clinician Training: The clinician training was created in collaboration with UPMC Health System and offered a unique opportunity for the payer and the clinician to come together to achieve a common goal. Four, one-day training sessions were conducted aimed at both clinicians and office staff. They consisted of both didactic and hands-on technical training for person-centered counseling, LARC insertion, and LARC removal. The training was modeled after resources developed and taught by the Reproductive Bridges Coalition (Appendix A) and emphasized best practices for person-centered contraceptive care (Dehlendorf et al., 2014; Dehlendorf et al., 2016). The training also provided an opportunity for healthcare workers to better understand the billing processes for LARC and the new reimbursement process by UPMC *for You*.

Overcoming Reimbursement Barriers: Historical payment policy does not reimburse LARC outside of the hospital's All Patients Refined Diagnosis-Related Groups (APR-DRG) payments or separately from Prospective Payment Rates (PPR) to Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). This makes it difficult for clinics to invest in stocking costly LARC devices and reduces the incentive for clinicians to dedicate the extra time and resources needed to perform LARC insertions. To remove these financial disincentives, UPMC *for You* established and implemented the following payment policy:

- UPMC *for You* provides separate payment for LARC devices outside of the APR-DRG amount previously made to hospitals for postpartum LARC insertion.
- UPMC *for You* provides separate payment for LARC devices outside of the PPR payment rate to FQHCs and RHCs for LARC insertion.

Outcomes to Date

- Completion of four full-day LARC trainings throughout the UPMC system.
- Increase in immediate postpartum LARC insertions utilizing the new policy that allowed for reimbursement of LARC-related services outside of the global maternity payment.
- Increased provider confidence in using LARC in the in-patient and outpatient settings.

Key Lessons Learned

- Engaging clinicians is important to increase confidence in the insertion and removal of LARC devices.
- It was important to also focus on addressing LARC stocking and inventory challenges. Barriers to care still exist if individuals are unable to obtain a LARC device on the same day as their visit.
- Multi-disciplinary work is essential. UPMC *for You* worked with pharmacy, billing, and administrative staff.

Future Directions

In the future, UPMC *for You* is interested in expanding the training to more explicitly discuss inventory and billing challenges with healthcare providers. UPMC Health Plan will evaluate the impact of its initiatives in greater detail to continue to improve health outcomes for its enrollees.

Improving LARC Access in the Immediate Postpartum Setting

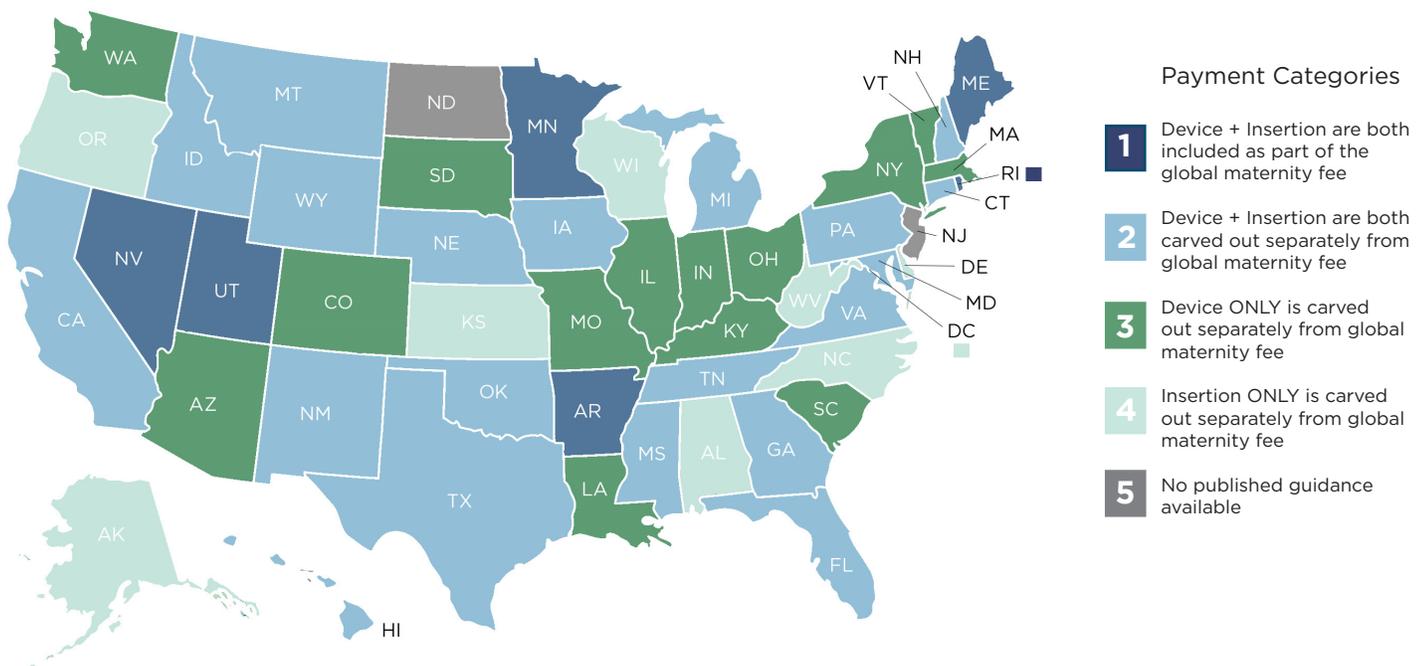
Approximately 36 percent of pregnancies occur within 18 months of a previous live birth, and at least 70 percent of these short-interval pregnancies are unintended (Oduyebo et al., 2019). Immediate postpartum LARC insertion refers to the provision of an IUD or contraceptive implant immediately after childbirth and before hospital discharge. It has been found to be a safe and effective option for most patients (ACOG Committee on Obstetric Practice, 2016b). The National Quality Forum has identified LARC insertion immediate postpartum as a metric of high-quality care (U.S. Department of Health and Human Services, n.d.). LARC placement can also occur at a postpartum visit in the outpatient setting, but 40 percent of women do not receive postpartum care because of problems with transportation, childcare, employment, and other barriers (White et al., 2015). For the Medicaid population, this poses a particular challenge, as many women lose coverage 60 days postpartum and may be unable to afford LARC without any form of insurance coverage (Wilkinson et al., 2019). Similarly, individuals who chose postpartum LARC may be unable to access LARC removal services at the time they choose, which obstructs reproductive justice.

Variation by State

Over the past decade, many State Medicaid Agencies have altered their reimbursement policies for immediate postpartum LARC to improve access. Currently, the majority of states provide specific reimbursement for the LARC device, insertion, or both outside of the global maternity payment (Moniz et al., 2015). Reimbursement models as of June 2020 are shown in Figure 1. The rates of postpartum LARC use also vary greatly by state (Oduyebo et al., 2019). Evidence suggests that Medicaid MCOs generally follow the reimbursement policies set by the state, including reimbursement for immediate postpartum LARC (Rosenzweig et al., 2017) but may offer more generous benefits or initiatives such as those highlighted in this report.



Figure 1. State Variation in Immediate Postpartum LARC Reimbursement for Medicaid



Source: Adapted from American College of Obstetricians and Gynecologists Long-Acting Reversible Contraception Program. Medicaid (2019). Medicaid Reimbursement for Postpartum LARC by State. <https://www.acog.org/programs/long-acting-reversible-contraception-larc/activities-initiatives/medicaid-reimbursement-for-postpartum-larc>; Kaiser Family Foundation. (2015). Medicaid Coverage of Intrauterine Devices (IUDs) & Implants and Reimbursement Policy. <https://www.kff.org/womens-health-policy/state-indicator/medicaid-coverage-of-intrauterine-devices-iuds-implants-and-reimbursement-policy/>

Addressing Implementation Challenges

Despite an enabling policy environment, logistical barriers frequently prevent LARC from being a viable contraceptive option in the immediate postpartum period. A qualitative study by Hofler et al. (2017) worked with ten Georgia hospitals who were all trying to implement immediate postpartum LARC. They found that the key steps for successful implementation of immediate postpartum LARC include:

- Designating champions for the initiative.
- Developing a team of relevant departments, including billing and coding, nursing staff, obstetric providers, pharmacy, and administrators.
- Obtaining financial reassurance from payers.
- Ensuring hospital administration awareness.

Participant responses on key steps for immediate postpartum LARC implementation were grouped into three stages based on the National Implementation Research Network's Stages of Implementation Framework (Table 2).



Table 2 . Key Implementation Phases for Immediate Postpartum LARC

Stage 1	Stage 2	Stage 3
Exploration	Installation	Implementation & Sustainability
This stage involves assessing the project needs and organizing hospital resources prior to launching the initiative	This stage involves performing the necessary tasks to begin to offer immediate postpartum LARC services	This stage involves rolling out and adapting the program as needed

Source: Adapted from Hofler, L., Cordes, S., Cwiak, C., Goedken, P., Jamieson, D., & Kottke, M. (2017). Implementing immediate postpartum long-acting reversible contraception programs. *Obstetrics and Gynecology*, 129(1), 3-9. <https://doi.org/10.1097/AOG.0000000000001798>; Postpartum Contraceptive Access Initiative (PCAI). (2017). <https://pcainitiative.acog.org/>

The ACOG Postpartum Contraceptive Access Initiative (PCAI) uses this framework, and the PCAI website (weblink is available in Appendix A) presents the research findings, in a user-friendly manner. Within each stage, key implementation steps are presented and organized by department (clinical, pharmacy, finance or billing, and information technology). PCAI also offers comprehensive trainings, technical assistance, and implementation support to interested stakeholders to ensure that all patients can access the full range of postpartum contraceptive methods before they leave the hospital after a delivery.

Maternal health programs in some states have used similar implementation approaches to improve immediate postpartum LARC access (Brown et al., 2020; Harper et al., 2020; Lacy et al., 2020; Palm et al., 2020). In these states, hospital systems have experienced challenges in configuring their billing systems to receive reimbursement for immediate postpartum LARC. For instance, when a state Medicaid program or health plan had an explicit policy for reimbursement carve-out, the hospital frequently did not receive full payment for a variety of reasons, including incompatibility of Medicaid billing mechanisms with automated billing processes, inaccurate coding, and poor communication between hospitals and payers (Brown et al., 2020). For safety-net hospitals and hospitals in rural areas, these challenges frequently prevented immediate postpartum LARC access for those enrolled in Medicaid (Palm et al., 2020).

Hospitals who were successful in implementing immediate postpartum LARC programs collaborated with health plans (Harper et al., 2020; Hofler et al., 2017; Lacy et al., 2020). The subsequent case study highlights the importance of a collaborative approach to fully implement immediate postpartum LARC services. Choose Well, an initiative led by the nonprofit New Morning Foundation (SC), brought together multiple stakeholders to support implementation of immediate postpartum LARC programs across South Carolina.



Collaboration to Improve Immediate Postpartum LARC Implementation

Organization: New Morning Foundation: Choose Well Initiative

Type of Organization: Collaborative initiative between multiple stakeholders

Location: South Carolina

Overview

Choose Well, an initiative by the New Morning Foundation, is a statewide contraceptive access initiative intended to reduce unintended pregnancies and improve maternal and childhood outcomes in South Carolina. The initiative has brought together 170 clinics, payers, clinicians, community organizations, and other relevant stakeholders to address system-wide contraceptive service challenges. The program aims to reduce unintended pregnancy in South Carolina by 25 percent by 2022. In 2012, South Carolina became the first state to allow Medicaid to reimburse hospitals for immediate postpartum LARC insertion outside the direct global payment. As Choose Well began in 2017, a collaborative approach was taken to empower partnering hospitals to implement and scale-up immediate postpartum LARC access.

This case study does not capture the full scope of the Choose Well Initiative and focuses pre-dominantly on the work within hospital partner groups working on improving access to Immediate Postpartum LARC. More information on Choose Well can be found at <https://www.ChooseWellsc.org> and <https://newmorning.org/>

Innovation

Choose Well discovered that hospitals were not fully implementing immediate postpartum LARC-related services and were also not receiving adequate reimbursement for those services, despite the 2012 policy change that carved out reimbursement from the global maternity payment. Choose Well funded an obstetrics navigator within each hospital system. The navigator's role was to provide person-centered contraceptive counseling on all methods of contraception and act as a champion for improving access to highly and moderately effective contraceptives. As the navigators strengthened the implementation of immediate postpartum LARC services, reimbursement issues emerged. To address the reimbursement issues, Choose Well convened meetings with state Medicaid agency leadership, Medicaid fee-for-service members, Medicaid MCO revenue and billing staff, and hospital staff members. Each MCO was tasked with re-configuring their system to reimburse for the device within 30 days. This required working with the pharmacy and billing staff of individual hospitals.

Outcomes to Date

- Creation of a standardized submission process to process claims for all Medicaid MCOs.
- Hospitals involved in the initiative are now able to track reimbursements for LARC-related services on a monthly basis, which also strengthens the revenue flow to partner hospitals.
- Quantitative analysis by Steenland et al. (2019) showed a 5 percent increase in postpartum LARC use between 2010 and 2017. These findings were accompanied by subsequent decreases in short-interval births (Liberty et al., 2020).

Key Lessons Learned

- The collaborative approach taken by Choose Well has strengthened the relationships among different stakeholders of the healthcare community.
- It was important that the initiative included partners from hospitals and clinics in addition to community organizations, payers, and policymakers.
- The multi-disciplinary nature helps support the sustainability of the initiative.

Future Directions

Choose Well is committed to improving equitable access to all forms of contraception, including LARC. By providing the tools and resources necessary, the program will continue to empower South Carolinians to “choose well” for their reproductive health. The initiative will use a rigorous monitoring and evaluation component in order to understand the program's efficacy and strengthen future work.

Reproductive Justice in the Postpartum Period

Like the ambulatory care setting, immediate postpartum LARC services can promote high-quality contraceptive care by using a reproductive justice framework. This includes providing person-centered contraceptive counseling and adequate options for LARC removal. Qualitative research has shown that in the immediate postpartum period, women frequently feel pressured to choose LARC because of coercive contraceptive counseling, perceived barriers to LARC removal, and the timing of contraceptive counseling that may occur during or shortly after delivery (Mann et al., 2019). Several state Medicaid programs have focused on addressing these issues. An immediate postpartum LARC implementation program in North Carolina trained clinicians and staff on the historical context of contraceptive coercion and LARC (Harper et al., 2020). The Tennessee Initiative for Perinatal Quality Care (TIPQC) asks clinicians to document the preferred postpartum contraception for all individuals prior to hospital admission (Lacy et al., 2020). However, for individuals who experienced barriers to accessing high-quality prenatal care or who opt to give birth outside of a hospital setting, this may not be possible. TIPQC also focused on LARC removals. Clinicians are reminded that LARC removal for women enrolled in the Tennessee Medicaid Program (TennCare) should be done when desired, and reimbursement for removal is provided by TennCare. Women in danger of losing coverage were given information on community resources where they could have their LARC removed at no cost (Lacy et al., 2020).

Improving LARC Access for Adolescents

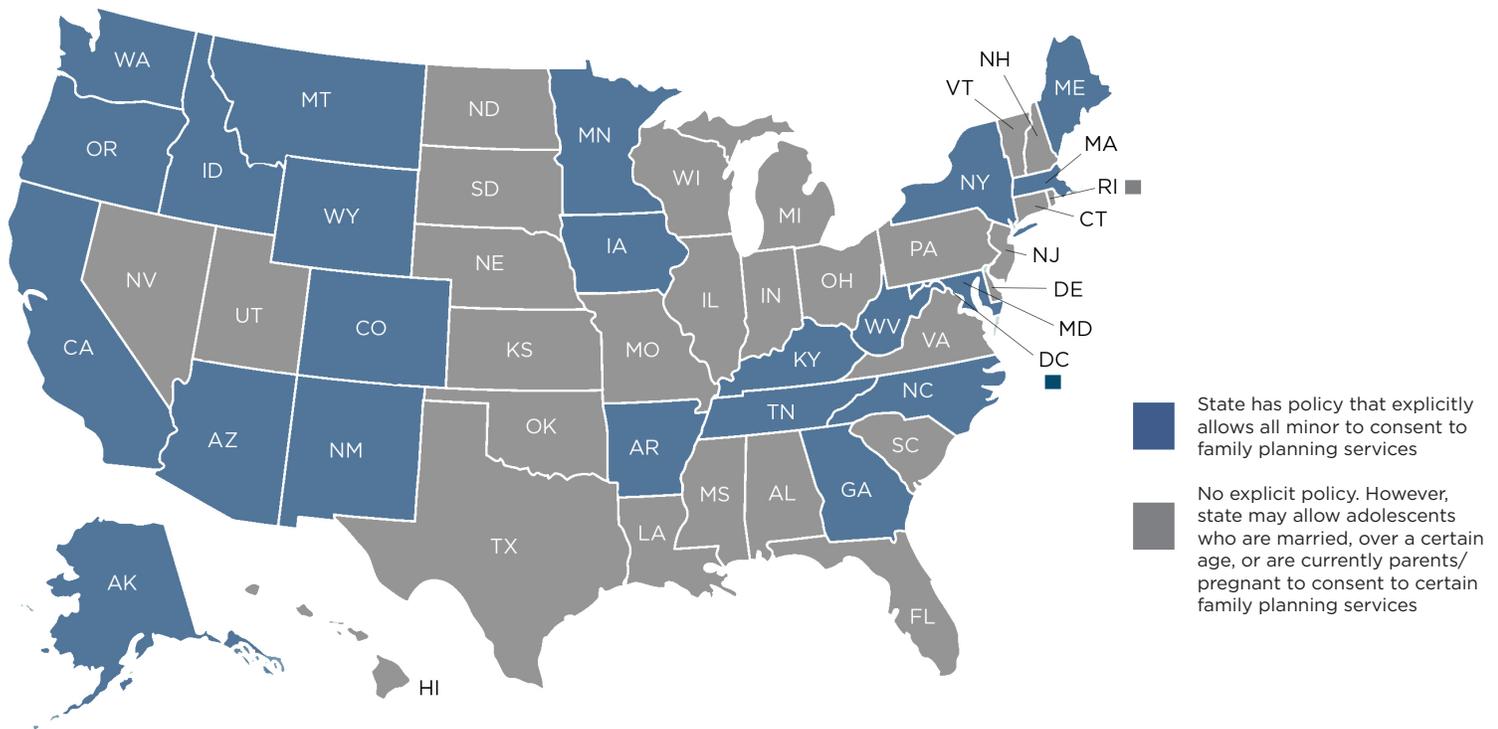
Adolescents are an important subgroup who face unique barriers in accessing LARC. About half of high school students in the United States are sexually active. Each year, 750,000 adolescents between the ages of 15 and 19 become pregnant. Despite being safe and highly effective, IUDs or contraceptive implants are used by less than 10 percent of U.S. teenagers (AAP Committee on Adolescents, 2014; ACOG Committee on Adolescent Health, 2012). Studies show that adolescents who choose an IUD have a positive experience and have lower rates of discontinuation compared with shorter-acting methods of birth control (Bayer et al., 2012). In the adolescent population, access challenges include concerns about the cost of LARC, fears about breach of confidentiality, inaccessible clinic hours, lack of knowledge of available methods, and misinformed or inadequately trained staff to address teen issues (Kavanaugh et al., 2013). Research has shown that adolescents ages 15 to 19 have less knowledge of LARC than older individuals do (Vyas et al., 2018). Unfamiliarity with LARC among adolescents has been associated with decreased likelihood to choose a LARC method (Paul et al., 2020). Teens also share misconceptions about LARC's side effects, safety, and comfort, which reflects racial, cultural, and social influences (Vyas et al., 2018; Daley, 2014).

Ensuring Confidentiality

Currently, 23 states and the District of Columbia have explicit policies allowing minors to consent to family planning services without parental involvement (Figure 2). Title X-funded family planning clinics are also required to provide confidential care to adolescents (AAP Committee on Adolescents, 2014). Confidentiality can unintentionally be broken when an explanation of benefits (EOB) is sent to an adolescent's home. Many payers have removed the requirement of an EOB for sensitive services such as family planning, sexually transmitted infections, and pregnancy-related care. Clinicians and staff share this protective policy with their teenage patients to build trust and reduce privacy concerns. Using shielded language when speaking to adolescents over the phone can also help (ACOG Committee on Adolescents, 2014). Since adolescents are less likely than older people to be aware of their contraceptive options—and frequently have little to no knowledge of LARC—concurrent initiatives aimed to educate adolescents about their sexual and reproductive health are essential (ACOG Committee Opinion on Adolescents, 2012; AAP Committee on Adolescents, 2014). Parents and guardians are not necessarily adversaries to adolescent sexual health; in many instances, familial involvement can improve care (AAP Committee on Adolescents, 2014). For example, an initiative in Rochester, New York, improved access to LARC for adolescents by educating the adults who most frequently interacted with teens (Aligne et al., 2020). The AAP provides resources on how clinicians can empower teens and their families to discuss sexual health needs; relevant weblinks are available in the appendix.



Figure 2. States Allowing Minors to Consent to Contraceptive Services (2020)



Source: Adapted from Guttmacher Institute. (2020). Minors' access to contraceptive services, <https://guttmacher.org/state-policy/explore/minors-access-contraceptive-services>

Tailoring Care for Adolescents

Adolescent reproductive health needs differ from those of older individuals. During adolescence, many teens begin to explore their sexuality and sexual preferences and require healthcare that reflects this developmental stage (AAP Committee on Adolescents, 2014). Because many teens are also in school full time and rely on their parents and guardians for transportation, Medicaid stakeholders might need to use creative approaches to effectively engage adolescents. Youth-friendly locations and health plans make use of the following best practices (Kavanaugh et al., 2013; AAP Committee on Adolescents, 2014; Holt et al., 2020):

- Availability for walk-in appointments, including during weekend/evening hours.
- Dedicated "adolescent only" hours and days.
- Use of social media and text messaging to reach clients with educational materials and appointment reminders.
- Dedicated or specifically trained staff to meet the needs of adolescents.
- Clinics that can be reached by public transportation.
- In-network clinics for teens also include sites such as school-based health centers and other teen-accessible sites (such as pediatric offices that are able to insert LARC) that can provide all contraceptive methods without a referral.

Explicit provisions for LARC removal during potential lapses in care, such as when an adolescent transitions from pediatric to adult care or if school-based health centers are closed for the summer, are necessary to promote reproductive justice (Holt et al., 2020). The adolescent population is also more likely to report pregnancy ambivalence—or mixed feelings about the risk and perception of becoming pregnant (Higgins et al. 2012). These feelings might shape the way that teens navigate reproductive health services. Adolescents also frequently engage in sexual activity more spontaneously than adults do and have lower perceptions of pregnancy risk from each sexual encounter (Daley, 2014). Qualitative research suggests that young adolescents with lower economic and academic opportunities report higher levels of pregnancy ambivalence and lower perceptions of perceived pregnancy risk than do youths with greater economic and academic opportunities. These youth are less likely to use any form of contraception, much less a LARC (Vyas et al., 2018). This suggests that reducing disparities among contraceptive use in adolescents may also require addressing the ways adolescents navigate complex social, economic, and cultural barriers to sexual and reproductive wellness.

Understanding the Business Case for LARC

Approximately half of all births are publicly funded, and government expenditure on maternity care is estimated at over \$20 billion annually (Centers for Disease Control, 2018). Despite this, it can be difficult to make the business case for LARC at the Medicaid MCO level. Health plans frequently cite churn as an issue that makes promoting LARC difficult. Churn occurs when an enrollee transitions between different types of coverage or becomes uninsured. Churn can be especially problematic for immediate post-partum LARC as any potential cost-savings may not be fully realized if members are dropped from Medicaid coverage shortly after delivery or churn into another plan (Rosenzweig et al., 2017).

Making the business case for LARC in the outpatient setting is relatively straightforward. Over half (54%) of childless adult females enrolled in a Medicaid MCO remain enrolled for more than two years (Figure 3). Economic models have shown that in comparison to shorter-acting methods, LARC methods become cost-saving within three years after insertion—even when including early discontinuation rates (Centers for Disease Control and Prevention, n.d.). However, those savings may not be realized by the health plans if an individual loses coverage or moves into a different health plan.



Figure 3. Average Enrollment Duration for Females in Medicaid Managed Care (2018)

	Enrolled for less than 6 months	Enrolled for 6-12 months	Enrolled for more than 1 but less than 2 years	Enrolled for 2 or more years	Not applicable. We do not enroll this population.
Pregnant women	0%	33%	40%	27%	0%
Parents	0%	14%	29%	43%	14%
Childless adults	0%	0%	38%	54%	8%
Aged, blind, and disabled	0%	0%	14%	86%	0%
Medicare and Medicaid eligible	0%	0%	21%	72%	7%

Source: Moore, J., Adams, C., & Tuck, K. (2019). Medicaid access & coverage to care in 2018. Institute for Medicaid Innovation, Washington D.C. https://www.medicaidinnovation.org/_images/content/2019_Annual_Medicaid_MCO_Survey_Results_FINAL.pdf

The cost savings of immediate post-partum LARC at the MCO level is more elusive—but feasible. Most pregnant women are enrolled in a single health plan for at least one to two years (40%); however, a significant proportion (27%) report enrollment for more than two years. Data suggest that half of women have had unprotected sex prior to the six-week postpartum visit, which increases the risk of an unintended short-interval pregnancy (Connolly et al, 2005). Studies using decision-making analyses have compared immediate postpartum LARC insertion to routine insertion at the six-week postpartum visit. Garipey et al. (2015) found the cost savings of immediate postpartum LARC to be \$1,263 per pregnancy prevented. Similarly, another model predicted that immediate postpartum LARC services would prevent 88 pregnancies per 1,000 women over a two-year period. For every 1,000 women, the cost-savings of immediate postpartum LARC compared to routine postpartum LARC insertion was estimated at \$282,540, with a gain of ten quality-adjusted life years (Washington et al., 2015). Both models include the number of women who present to the routine postpartum visit and are already pregnant because they were unable to receive effective contraception immediately post-partum. They also assume an 80 percent or higher post-partum follow-up rate, which for the Medicaid population is typically closer to 40 percent. This suggests that the per pregnancy prevented cost savings could be much higher (Garipey et al, 2015; Washington et al., 2015; White et al., 2015). Furthermore, women who have an immediate postpartum LARC insertion are more likely to continue using the device at 12 months than are those who initiate the method later in the postpartum period (Crocket et al., 2017). Current analyses also do not consider other costs associated with unintended pregnancy such as advanced clinical care for high-risk neonates. More research is needed to better understand the impact of churn on the valuation of LARC from a MMCO cost-benefit perspective; however, the overall value of LARC exists even without an obvious financial return.

Looking Ahead: Opportunities for Improving LARC Access in Medicaid

Improving access to LARC among the Medicaid population will require collaboration from multiple stakeholders to address persistent logistical, administrative, and implementation barriers. The case study provided by AmeriHealth Caritas D.C. highlights overcoming challenges with stocking and reimbursement. The provider training created by UPMC *for You* showcases how health plans and providers can work together to improve access. Choose Well is a unique initiative that demonstrates the power that collaboration can have on the implementation of immediate postpartum LARC programs. Each case study, along with the evidence presented, stresses the need to ground enthusiasm for LARC in reproductive justice. The broader social determinants of health that influence family planning decisions must also be considered, especially when working with subgroups such as adolescents. To further support the development of equity-centered LARC access, this report considers the following clinical, research, and policy opportunities.



Clinical Opportunities

Increase the number of training opportunities specific to LARC services for all healthcare workers

Research suggests that clinicians and healthcare staff are often misinformed or ill-prepared to offer LARC services, especially to adolescents and women in the immediate postpartum period. In addition to clinical knowledge, clinicians and staff might also benefit from information about the LARC reimbursement process in a particular state or Medicaid health plan and the importance of person-centered care.

Develop and disseminate best-practice tools for contraceptive counseling that place patients' preferences at the center of care.

Research shows that women are less likely to choose a LARC method and be less engaged in care when they feel coerced or pressured to choose a particular method. Even today, unintentional reproductive coercion by clinicians is a common phenomenon. Many tools for contraceptive counseling already exist but do not yet reflect the breadth of cultural and social preferences for care. The subsequent utilization of such tools has the potential to improve care.



Research Opportunities

Further investigate the potential for cost savings secondary to improved LARC access within Medicaid managed care

Despite high rates of churn in the Medicaid program, research has shown that LARC is cost-saving at the state and federal levels and likely at the MCO level also. More research is needed to fully understand the cost savings of LARC utilization within an individual health plan.

Consider conducting further research to better understand patients' preferences for contraception.

Despite initial research that examines the social, racial, and cultural preferences for reproductive healthcare, much is still unknown. Future work might help to better understand the pregnancy ambivalence experienced by low-income adolescents and other social factors associated with low rates of contraception use. This has the potential to improve training for clinicians and educational tools for all enrollees.

Identify potential improvements in data collection and dissemination on contraceptive use.

To identify disparities to contraceptive access—and LARC in particular—high-quality data collection is necessary at the state, health plan, and clinician levels. Future data collection might look beyond LARC insertion rates and include metrics on the social determinants of health, adequate contraceptive counseling, removal rates, and patient satisfaction.



Consider increasing reimbursement for LARC-related services, including device removal.

Increased reimbursement for LARC has been shown to improve access and subsequent LARC utilization. Changing the timing and structure of LARC reimbursement rates might also help to address stocking and inventory issues experienced among clinics. Reimbursement for device removal can help prevent reproductive coercion and promote high-value care

Consider unbundling LARC-related services from the global maternity fee.

Providing specific reimbursement for LARC devices and insertion in the immediate postpartum period could be an important first step to improving access and reducing the negative health outcomes associated with short-interval, unintended pregnancy. However, evidence from multiple states shows that to adequately implement immediate postpartum LARC programs, hospitals and health plans must collaborate. In addition, policies may need to be adopted to include coverage for individuals opting to deliver in non-hospital settings.

Appendix A. LARC-Related Resources

Resource	Where to Find
General	
CDC Medical Eligibility Criteria (MEC)	https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html
ACOG Long-Acting Reversible Contraceptive Program	https://www.acog.org/programs/long-acting-reversible-contraception-larc
Bedsider	https://www.bedsider.org/
Guttmacher Institute	https://www.guttmacher.org/
Clinician Education	
Reproductive Bridges Coalition: Day of Learning Events	https://reproductivebridgescoalition.com/daysoflearning/current-best-practices-for-contraceptive-provision/
University of California San Francisco (UCSF) Beyond the Pill: Improving Access to Contraception	https://beyondthepill.ucsf.edu/new-online-training
Coding and Billing	
UCSF Intrauterine Devices & Implants, A Guide to Reimbursement	https://larcprogram.ucsf.edu/
ACOG LARC Program: Quick Coding Guide	https://www.acog.org/education-and-events/publications/larc-quick-coding-guide
State-level Policy	
Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States	https://www.manatt.com/Manatt/media/Documents/Articles/Arnold-Ventures_Family-Planning-Toolkit_FINAL.PDF
ASHTO Toolkits & Guides to Increasing Access to Contraception	https://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Toolkits-and-Guides/
Immediate Postpartum LARC	
Young Women's Health & Young Men's Health	https://youngwomenshealth.org/ https://youngmenshealthsite.org/
American Academy of Pediatrics: Adolescent Sexual Health	https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/Contraception.aspx
Power to Decide: Teen Talk	https://powertodecide.org/teen-talk
Person-Centered Care & Contraceptive Equity	
"LARC Statement of Principles" by SisterSong: Women of Color Reproductive Justice Collective and the National Women's Health Network	https://nwhn.org/wp-content/uploads/2019/03/LARC-Statement-of-Principles-1-1.pdf
Increasing Access to LARC & Protecting Patient Autonomy: A Resource for Evaluating LARC Public Policy Initiatives," by the National Institute for Reproductive Health and the National Women's Health Network	https://www.nirhealth.org/wp-content/uploads/2019/04/NIRH_NWHN_2019_Increasing-Access-to-LARC-Protecting-Patient-Autonomy.pdf
"Contraceptive Equity in Action: A Toolkit for State Implementation," by the National Health Law Program (NHELP)	https://healthlaw.org/resource/contraceptive-equity-in-action-a-toolkit-for-state-implementation/
"An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program," by the National Health Law Program (NHELP)	https://healthlaw.org/resource/an-advocates-guide-to-reproductive-and-sexual-health-in-the-medicaid-program/
"Measuring Quality Contraceptive Care in a Value-Based Payment System," by Planned Parenthood Federation of America & Manatt t Health	https://www.manatt.com/Insights/White-Papers/2019/Measuring-Quality-Contraceptive-Care-in-a-Value
UBC Birth Place Lab	https://www.birthplacelab.org/
Black Mammals Matter Alliance	https://Blackmammasmatter.org/

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Reviewers

Prior to publication of the final report, the Institute for Medicaid Innovation sought input from independent clinical, scientific, and policy experts as peer reviewers who do not have any financial conflicts of interest. However, the conclusions and synthesis of information presented in this report do not necessarily represent the views of the individual peer reviewers or their organizational affiliation(s).

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