IMMEDIATE POSTPARTUM CONTRACEPTION

Summary

LARC placement in the hospital immediately following childbirth is safe, cost-saving, and associated with improved maternal and neonatal health outcomes.

In Minnesota, specific reimbursement for this service is needed to increase patient access and reduce unintended pregnancy.

Immediate postpartum LARC is supported as safe and effective by:

Centers for Disease Control and Prevention (CDC)

American College of Obstetricians & Gynecologists (ACOG)

American Academy of Family Physicians (AAFP)

Association of Certified Nurse Midwives (ACNM)[2,3]

Author
Emily Ewan
MD Candidate – Class of 2020
University of Minnesota Medical School
ewanx003@umn.edu

Long-acting reversible contraception (LARC) methods such as intra-uterine devices (IUDs) and subdermal contraceptive implants are among the most effective forms of contraception.[1] They can be safely placed immediately following childbirth prior to hospital discharge.[2]

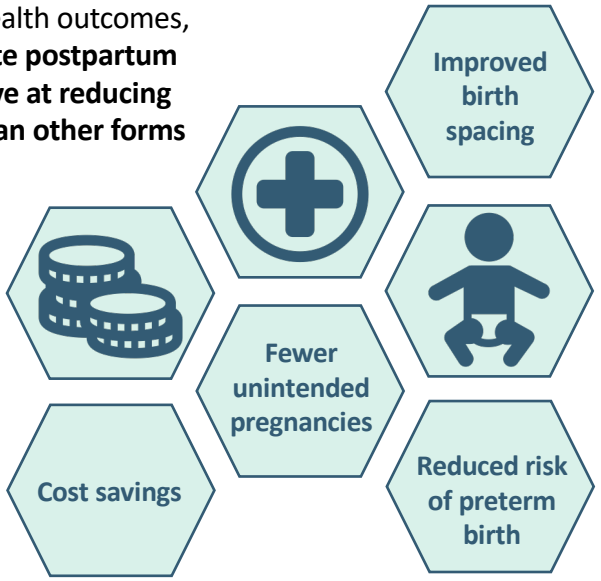
In the US, an estimated 45% of pregnancies are unintended, and one-third of all pregnancies are conceived within 18 months of delivery.[4] Ensuring access to contraception in the postpartum period will reduce unintended pregnancy, improve maternal and neonatal health outcomes, and reduce costs.[2,5-8]

Immediate postpartum LARC benefits patients, health systems, and payers

Rapid repeat pregnancy is associated with adverse maternal and neonatal health outcomes, including preterm birth**. Immediate postpartum LARC is significantly more effective at reducing short interpregnancy intervals than other forms of reversible contraception.**[9]

In one study, estimated savings for every $1 spent on a program for immediate postpartum LARC were **$3.54** at 24 months and **$6.50** at 36 months.[10]

Despite these benefits, postpartum LARC placement rates remain low at 13.5 per 10,000 deliveries.[11]



Reimbursement policy: An opportunity for reform

In Minnesota, the LARC device and placement procedure are covered by private and public insurers in the outpatient setting. However, in the hospital following delivery, no separate payment is provided outside the bundled reimbursement for labor and delivery. Lack of reimbursement disincentivizes hospitals and is a major barrier to postpartum LARC access for patients.[12]

Among support by growing numbers of state and federal health officials, both the CDC and Centers for Medicare and Medicaid Services have publicly encouraged consideration of unbundling labor and delivery services from postpartum LARC.[13,14]

In Minnesota

40%
of all pregnancies are unintended

58%
of pregnancies ending in birth are unintended

66.7%
of unplanned births are publicly funded

In 2010, the public cost of unintended pregnancies was

$332.6 million

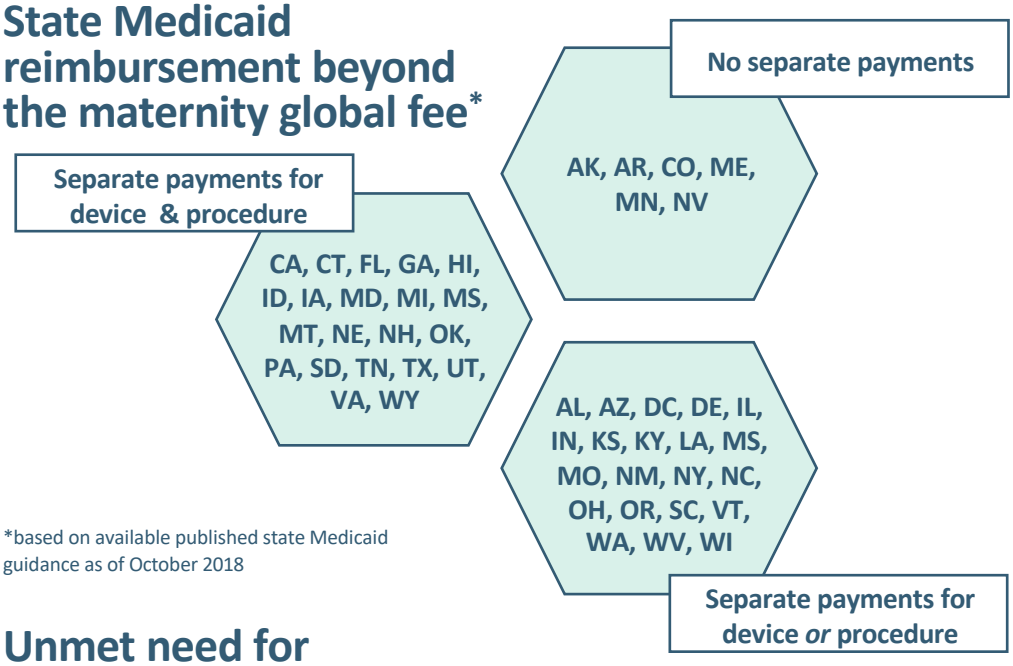
2010 data[21,22]

References

1. Knowledge for health project. Family planning: a global handbook for providers (2011 update). CCP and WHO, 2011.
2. Immediate postpartum LARC. Committee opinion no. 670. ACOG. Obstet Gynecol. 2016;128.
3. Curtis KM, et al. MMWR Recomm Rep. 2016;65:1-103.
4. Finer LB & Zolna MR. N Engl J Med. 2016; 374(9).
5. DeFranco EA, et al. Am J Obstet Gynecol. 2015;212(3).
6. Conde-Agudelo A. et al. JAMA. 2006;295.
7. Hussaini KS, et al. Matern Child Health J. 2013;17.
8. Human Services Office of Disease Prevention and Health Promotion. Healthy People 2020. 2015; Objective FP-5.
9. Brunson M, et al. Am J Obstet Gynecol 2017;217(1).
10. Han L, et al. Am J Obstet Gynecol 2014;211(1).
11. Moniz MH, et al. Obstet Gynecol 2017;129.
12. Aiken AR, et al. Contraception. 2014;90(5).
13. Center for Medicaid and CHIP Services Informational Bulletin. https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf.
14. The 6|18 Initiative. Centers for Disease Control and Prevention. Evidence Summary: Prevent Unintended Pregnancy.
15. ACOG LARC Program. Medicaid reimbursement for Postpartum LARC by State. https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC-Medicaid-Reimbursement.
16. Harney C, et al. Contraception 2017;95.
17. Potter JE, et al. Contraception. 2014;90(5).
18. Tang JH, et al. Contraception. 2013;88(1).
19. Ogburn JA, et al. Contraception 2005;72.
20. Wilcox A, et al. Matern Child Health J. 2016;20.
21. Kost K. Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002, New York: Guttmacher Institute, 2015.
22. Sonfield A & Kost K. Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010, New York: Guttmacher Institute, 2015.

Since 2012, 42 state Medicaid agencies have published guidance on separate reimbursement for immediate postpartum LARC outside the global fee.[15]

State Medicaid reimbursement beyond the maternity global fee*



*based on available published state Medicaid guidance as of October 2018

Unmet need for postpartum LARC

- **An estimated 34-38% of women desire or intend to use LARC after childbirth, but almost two-thirds of these women do not receive it**[16-18]
- **In one study, 16% of postpartum women who initially requested LARC conceived prior to device insertion**[19]

Delaying LARC placement until the first postpartum visit (typically 4-6 weeks after delivery) may miss those patients who are unable to attend their appointment due to lack of child care or transportation. A recent study found as many as one third of prenatal care recipients miss their first postpartum appointment.[20]

Even among women who are able to attend their first postpartum visit, almost half resume sexual activity before this, and half of those women report using no contraception during that time. [2]

Recommendations

- **Provide specific reimbursement for the LARC device (IUD or implant) when placement occurs in the hospital following delivery**
- **Provide specific reimbursement to the provider for LARC placement in the inpatient setting**
- **Support hospitals and providers to increase capacity to provide LARC postpartum**

It is imperative that these changes are made with an emphasis on patient-centered counseling and reproductive autonomy.

With reimbursement reform, we anticipate increased utilization of effective contraception in the postpartum period, leading to fewer unintended pregnancies, improved health outcomes, and decreased costs.