

## Themes from Key Informant Interviews

*This summary provides an overview of key themes that emerged from key informant interviews with state health officials, state Medicaid directors, staff from state health and Medicaid agencies, health care providers including physicians and pharmacists, hospital administrative staff, researchers, representatives of health care professional associations, and community advocates in states participating in the ASTHO LARC Learning Community.*

### Medicaid Policies: General Themes and Observations

Most states very recently implemented the Medicaid changes and are in either early training stages or haven't taken additional steps yet. The actual type of Medicaid payment/reimbursement structure for postpartum LARC varies from state to state. Some states are paying for postpartum LARC as an add-on payment in addition to the "global delivery fee." Other states allow postpartum LARC to be covered as part of a "diagnosis-related group" or DRG.<sup>1</sup>

### Keys to Success

**Establish and leverage positive relationships between the state health agency and Medicaid.** This will facilitate a quicker, smoother policy development and enactment process.

**Identify provider champions.** These providers may be a physician, nurse practitioner, midwife, or pharmacist who can help keep efforts focused and coordinated within their facility, and can also be advocates with their peers across the state.

**Get buy-in from all stakeholders.** At the state level, engaging and getting buy-in from a diverse group of stakeholders is critical for coordinated, comprehensive efforts to provide information and implementation support. At the local/facility level, buy-in from all members of the care team is critical for successful planning and implementing a postpartum LARC program, particularly for logistical and billing considerations. Key care team members should include: hospital leadership, head nurses, unit leaders on labor & delivery, mother & baby, pharmacy (which orders and stocks the LARC devices) and the hospital billing department.

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<sup>1</sup> The DRG system classifies any inpatient stay into **groups** for the purposes of payment. The **DRG** classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 **groups** for the purpose of Medicare reimbursement. Hospitals are paid a fixed rate for inpatient services corresponding to the DRG group assigned to a given patient. (SOURCE: [http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Diagnosis-related%20group%20\(DRG\).aspx](http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Diagnosis-related%20group%20(DRG).aspx))

**Identify and address provider concerns:** Provider concerns or resistance to offering LARC postpartum usually relate to misperceptions about significantly elevated expulsion rates, to hormone implant effects on breast milk production.

**Communicate with all stakeholders that the program exists.** Within the hospital, this may involve writing articles for the hospital webpage or other provider communications such as emails to physicians, residents, attending physicians, nurse midwives, and others. Across communities and the state, key partners include state leadership (e.g., the Governor and state legislators), local public health agencies, safety net providers and the general healthcare community.

**Understand and engage patients.** Understanding each unique hospital's patient population is important for assessing the level of need for postpartum LARC services, as well as perceptions and barriers to women choosing LARCs. Coordinating with prenatal, antenatal, and interconception care providers is important to provide women with information they need to make informed decisions before they deliver.

### Barriers and Challenges

**Addressing stakeholder perceptions and beliefs about LARC.** For providers, these mostly relate to higher expulsion rates. In some states, certain health systems don't offer LARC services for faith-based reasons.

**Raising awareness and promoting postpartum LARC as a covered service.** Engaging partners like state professional associations, ACOG chapters, and state OB/GYN societies may help spread the word among their members. In addition, finding provider champions who can lead efforts to implement postpartum LARC programs in their facility has been a challenge.

**Understanding and implementing Medicaid reimbursement policies and processes.** Some states have encountered challenges with the actual billing process. In addition, the actual reimbursement policy in each state varies, and getting clarification on the details of the policy (for example, if LARC is reimbursed outside of the DRG or not) has been challenging in some cases.

**Addressing logistical challenges to implementing postpartum LARC programs.** Stakeholders with experience implementing postpartum LARC program described a number of logistical challenges including: (1) Stocking LARC devices by getting buy-in from multiple departments including pharmacy; (2) Educating hospital claims departments and managed care providers about the process for billing for in-patient postpartum LARC insertion; and (3) Educating health care providers and clearing up myths about postpartum LARC insertion.

### Technical Assistance Needs/Requests

**Understanding Medicaid policies and the billing/revenue process.** State Medicaid agency directors and staff, as well as hospital administrative staff, are interested in learning more from other states about the specific details about their Medicaid policy and how their payment process works, as well as if and how other states are working with private payers to cover postpartum LARC.

**Addressing LARC device cost.** This will involve addressing federal regulatory barriers to bringing down cost (for example, expanding 340B program eligibility to include immediately postpartum women), as well as supporting managed care entities in seeking greater reimbursement in the inpatient setting.

**Implementation tools and resources.** A comprehensive “A to Z Guide” for implementing a postpartum LARC program in the inpatient setting will be a critical resource, and should include best practices for implementing a postpartum LARC program and steps for key logistical components of a program including stocking, storing, and billing. Several states have developed materials and resources that could be useful as models.

**Provider training.** The content of the trainings should address common concerns and misperceptions among providers about LARCs (for example, impact of hormone IUDs and implants on lactation, higher IUD expulsion rates when inserted immediately postpartum, etc.), legal/liability concerns, and didactic and hands-on training for providers to practice the actual IUD insertion procedure. A variety of training videos and modules exist, but more are needed.

**Educational materials.** Several key stakeholder groups to target for outreach and education include physicians, non-physician health care team members, hospital billing departments, and the general public/pregnant women/at-risk women.

**Evaluation support.** Types of support that would be useful include providing a team of evaluation experts to conduct site visits and conduct an evaluation at the local and/or state level, as well as technical assistance in developing a statewide monitoring and evaluation system to track impact of the initiative over time. Types of indicators and outcomes of interest include: (1) Uptake and patient demand for postpartum LARC services; (2) Claims data; and (3) Cost-benefit analyses.