

# Long-Acting Reversible Contraception Learning Community Year Two In-Person Meeting Report



Oct. 19–20, 2015, Arlington, VA



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**Immediate Postpartum Long-Acting Reversible Contraception Learning Community  
Year Two In-Person Meeting  
Oct. 19-20, 2015**

**EXECUTIVE SUMMARY**

The Association of State and Territorial Health Officials, with support from the Centers for Disease Control and Prevention’s Division of Reproductive Health (CDC), convened year two of the Immediate Postpartum LARC Learning Community to assist selected states in implementing and sustaining immediately postpartum LARC initiatives. The learning community will bring together 13 states over the project year to provide scientific and technical assistance and identify promising practices in increasing utilization of LARC immediately postpartum.

**Overview of methods:**

Preparation for year two of the LARC learning community involved three phases: (1) Identifying Cohort II states to participate in the learning community; (2) Hosting a year two in-person meeting with both Cohort I and Cohort II states; and (3) Developing five webinars that continue to be tools for disseminating information from each domain. This report summarizes each of these phases and outlines key findings and themes related to current state successes, challenges, and technical assistance needs, organized around eight domains.

**State Identification:**

ASTHO, in collaboration with CDC’s Division of Reproductive Health, identified seven Cohort II states to participate in year two of the learning community: Delaware, Indiana, Louisiana, Maryland, Montana, Oklahoma, and Texas. Cohort II states joined Colorado, Georgia, Iowa, Massachusetts, New Mexico, and South Carolina (Cohort I). The majority of learning community states have Medicaid policies in place for LARC device reimbursement in an in-patient setting—a necessary precursor for sustainable immediate postpartum LARC initiatives.

**LARC Learning Community In-Person Meeting:**

On October 19 – 20, 2015, ASTHO convened a two-day in-person meeting with the 13 learning community states, CDC, and other national partners. Members of state teams included key leaders, decisionmakers, and others considered essential to implementing LARC statewide.

**KEY THEMES FROM THE LEARNING COMMUNITY IN-PERSON MEETING BY DOMAIN:**

As a result of year one key informant interviews and state experiences, successes, and challenges around immediate postpartum LARC implementation, [eight domain areas](#) were established.

**Domain 1: Provider Training**

Participants cited provider training on LARC counseling and insertion as crucial to increasing LARC use. States have begun to provide healthcare professionals with the training and tools needed to confidently and comfortably insert LARC immediately postpartum. States have also requested successful examples of provider training.

**Domain 2: Reimbursement and Sustainability**

The majority of states have Medicaid policies in place for immediate postpartum LARC. Participants stressed the importance of collaboration and partnership between state Medicaid and public health agencies to increase access to LARC immediately postpartum. Many states reported difficulty in implementing policies due to a myriad of factors, including a lack of awareness among providers about policy changes around immediate postpartum LARC reimbursement, misperceptions regarding immediate postpartum LARC insertion, and lack of provider training. Additionally, Medicaid policies vary from state to state, making it difficult to provide standardized guidance to providers and hospitals on immediate postpartum LARC insertion and payment reimbursement.

### **Domain 3: Informed Consent and Ethical Concerns**

States reported ongoing concerns with informed consent and confidentiality for inpatient LARC insertion, indicating the need for standardized consent processes and protocols. States recognized the need for patient-centered counseling for the purposes of consent and information-sharing on contraceptive choice and reproductive justice.

### **Domain 4: Stocking and Supply**

Cohort I states reported ongoing challenges with stocking and supplying LARC. Cohort II states also cited this as a major barrier to immediate postpartum LARC implementation. States reported that offering LARC in an inpatient setting is significantly more expensive than in outpatient settings, because the devices may not be covered under HRSA's 340B Drug Pricing Program. Rural hospitals, in particular, cited difficulties in stocking LARC devices due to rising costs and budgetary constraints.

Upfront costs and concerns about reimbursement continue to be a barrier for physician and pharmacy buy-in. Many states reported that providers were highly motivated to figure out how to provide inpatient LARC through avenues such as [white bagging](#), a method of stocking LARC devices in an outpatient clinic that directly charges the device to the individual patient's insurance instead of to the provider.

### **Domain 5: Patient Outreach**

Participants stated that well-respected LARC champions in their states were critical to accepting and spreading information on LARC use immediately postpartum, noting that strong leadership helped states implement Medicaid reimbursement policies. These champions are often healthcare providers who serve as leaders in LARC efforts and liaisons with other providers, sharing information and addressing LARC misperceptions. Political will, community enthusiasm, and support from providers have garnered widespread professional clinical and public health interest in expanding LARC access.

### **Domain 6: Stakeholder Partnerships**

States also identified broad coalitions of partners who helped establish statewide priorities and goals, coordinated stakeholder efforts, and supported outreach and communication with key players. Identifying a LARC champion who could disseminate accurate and timely information to other stakeholders and decision makers proved to be a challenge for some states. Along similar lines, states identified a need for immediate postpartum LARC information to disseminate to stakeholders, providers, and the community, particularly regarding new LARC policies. Finally, participants noted the importance of federal agencies and national organizations in providing support for immediate postpartum work in their states.

### **Domain 7: Service Locations**

States identified persistent difficulties in reaching priority populations, particularly in rural areas where LARC access is minimal. In discussion, states in both cohorts suggested trying to reach providers and women in rural areas by developing outreach plans that incorporate telemedicine and mobile units for education and services, as well as training for providers in rural areas.

### **Domain 8: Data, Monitoring, and Evaluation**

Almost all of the states in the learning community reported challenges with collecting and analyzing data. Some states have taken steps to develop quality measures and evaluation plans to capture and document LARC successes in their states. Data on immediate postpartum LARC device insertion (e.g. number of insertions), expulsion rates, and removals have helped states enhance their knowledge of postpartum LARC use and billing, as well as misconceptions about LARC use.

### **TECHNICAL ASSISTANCE**

Cohort I and II states identified a number of technical assistance needs throughout the meeting. Almost all states identified needing to build the evidence base to support LARC insertion immediately postpartum. This includes being able to access data sets as well as guidance on data collection and analysis to support LARC initiatives. In addition, states requested guidance on conducting cost analysis of LARC use in their states to build the business case for LARC. States also mentioned the need for guidance to develop Medicaid policies and other financing options, as well as resources for LARC insertion and use.

As LARC insertions immediately postpartum increase, states reported an ongoing interest in developing educational and informational resources to support LARC, including raising awareness, gaining buy-in, and establishing implementation protocols, provider training, and best practices. States also requested additional messaging and communication tools to address myths about LARC usage and alleviate provider concerns (e.g., effect on breastfeeding, expulsion rates, etc.). Finally, states asked for guidance on creating online toolkits both for clinical and community use to implement immediate postpartum LARC payment policies.

### **NEXT STEPS**

States and partners left the in-person meeting with several next steps. Cohorts I and II identified short, medium, and long-term steps that they can take to increase access to immediate postpartum LARC insertions in their states. Next steps include continued action planning and goal setting, developing and maintaining collaborative relationships, exploring additional financing options, supporting provider training, and engaging in outreach and communication activities related to LARC policies. ASTHO and national partners will continue to provide technical assistance and facilitate peer-to-peer support by providing learning opportunities on specific topics of interest, coordinating peer group calls, and connecting with federal and national partners to develop and build technical assistance plans with states.

Findings from the meeting will inform the content and structure of the learning community over the course of the project. The ASTHO team will evaluate the effectiveness of the learning community and support evaluation of immediate postpartum LARC uptake in states since Medicaid reimbursement policy implementation. ASTHO will continue to work closely with the 13 state teams and federal and national partners to facilitate an impactful, productive learning community. Identifying best practices and technical assistance opportunities will help advance immediate postpartum LARC initiatives in participating states and support increased access at the national level.



Additional resources and information, including presenters' slides may be found at:  
<http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/>

## BACKGROUND

One-half of pregnancies in the United States are unintended. Unintended pregnancy is associated with an increased risk of preterm birth<sup>1</sup> and other negative infant outcomes. One in nine infants are born prematurely in the United States, and preterm birth-related causes of death account for 35 percent of all infant mortality.<sup>2</sup> Unintended pregnancies also result in delivery of low birth weight babies, and are associated with late access to prenatal care and a decreased likelihood of breastfeeding.<sup>3</sup> Approximately half of unintended pregnancies in the United States are caused by contraceptive failure.<sup>4</sup> Long-acting reversible contraception (LARC) is safe and highly effective in preventing unintended pregnancies.<sup>5</sup> Unlike other forms of birth control, such as barrier methods, birth control pills, and sterilization, LARC requires no user intervention, works over long periods of time, and can be reversed. LARC includes intrauterine devices (IUDs) and contraceptive implants that prevent ovulation, egg fertilization, or implantation.<sup>6</sup>

Under the current standard of care, postpartum contraception, including LARC, is typically provided at the 4-6 week postpartum visit, but attendance at this visit is variable, especially for younger and low-income women with documented barriers.<sup>7</sup> The immediate postpartum period after delivery and before hospital discharge can be an opportune time to offer and provide LARC, since women are actively engaged with the healthcare system during labor and delivery.<sup>8</sup> Recent clinical guidelines recommend IUD placement in the first 48 hours post-delivery, ideally within 10 minutes of placental delivery to minimize expulsion rates.<sup>9</sup> Furthermore, risk of rapid repeat pregnancies is decreased when LARC is initiated within the immediate postpartum period.<sup>10</sup>

While providing immediate postpartum LARC may increase uptake of effective contraception, barriers to insertion persist across birthing facilities. The high cost of LARC devices and associated procedures (e.g., LARC insertion and removal) are not fully reimbursed by many payers when placed immediately postpartum.<sup>11</sup> While hospitals bill for all labor and delivery costs using a single bundled Diagnosis-Related Group (DRG) code, existing policies may prevent hospitals from being reimbursed for a LARC device or, in some states, the procedure to place it, immediately after a woman gives birth.<sup>12</sup> Among patients, there are many myths and misconceptions about the use and health effects of LARC. Although not supported by evidence, IUDs have been associated with abortion, pelvic inflammatory disease, ectopic pregnancies, and infertility.<sup>13</sup> Furthermore, providers and patients may also be burdened and discouraged by misperceptions and misinformation that multiple visits and certain tests are required for placement. States in the learning community are taking steps to address these barriers and increase overall access to immediate postpartum long-acting reversible contraception.

## CURRENT LARC-RELATED INITIATIVES

ASTHO, federal agencies, and other national organizations are conducting a number of activities related to LARC and the LARC Learning Community.

**ASTHO:** In 2014, [ASTHO](#) launched the [LARC Learning Community](#), a multi-state collaborative, to assist state health agencies in implementing LARC policies, focusing on immediate postpartum insertion. ASTHO's [Healthy Babies Subcommittee](#) chose to focus its 2016 efforts on addressing policy barriers to LARC access and administration. The Subcommittee, comprised of state health officials and maternal and child health experts from state and federal agencies and organizations, has prioritized LARC as a focus area. ASTHO supports the [Infant Mortality CoIIN](#) on their pre- and interconception health learning

network by providing expertise and technical assistance to promote optimal women's health before, after, and in-between pregnancies, during postpartum visits, and adolescent well visits. ASTHO frequently provides updates on the ASTHO LARC Learning Community and state-specific technical assistance as requested.

**American Congress of Obstetricians and Gynecologists (ACOG):** [ACOG](#) continues to improve and expand its [LARC Program and Work group](#), which creates, reviews, and revises clinical and educational materials and tools; advocates on behalf of providers and patients to ensure access to LARC methods; creates educational and practice support tools related to LARC; advocates for reimbursement and coverage for LARC methods; and conducts research on LARC knowledge, attitudes, and practice patterns.

**Association of Maternal and Child Health Programs (AMCHP):** From March 2014 – June 2015, [AMCHP](#), with funding support from the Council of State and Territorial Epidemiologists and CDC's Division of Reproductive Health, engaged a [Community of Practice for Return on Investment](#). As a response to the needs identified by the group, AMCHP created the [Economic Analyses of LARC Programs](#) to assist maternal and child health professionals in the process of developing and implementing an ROI analysis.

**Centers for Disease Control and Prevention (CDC):** The [CDC's 6 | 18 Initiative](#) is focusing on six common and costly health conditions (i.e. [pregnancy](#)) and 18 proven scientific interventions to start discussions with purchasers, payers, and providers. Jointly, CDC and the Office of Population Affairs (OPA) developed recommendations for [providing quality family planning services recommendations for primary care providers](#).

**Center for Medicaid and Medicare Services (CMS):** The [Center for Medicaid and CHIP Services](#) established the [Maternal and Infant Health Initiative](#), promoting the use of effective methods of contraception to improve pregnancy timing and spacing. The initiative's goal is to increase by 10 percentage points the rate of postpartum visits among pregnant women in Medicaid and CHIP in at least twenty states over a 3-year period; and to increase by 15 percentage points use of the most and moderately effective methods of contraception in at least twenty states over a 3 year-period.

**National Family Planning and Reproductive Health Association (NFPRHA):** [NFPRHA](#) strives to protect and expand access resulting from the Affordable Care Act (ACA) contraceptive coverage requirement and works to improve public and private health insurance for coverage of contraceptives. NFPRHA continues to support expanding access to LARC devices, including supporting the American Academy of Pediatrics' new recommendations on LARC among adolescent girls and providing [guidance](#) on reimbursement for LARC devices.

**Office of Population Affairs (OPA):** [OPA](#) developed standards for family planning services and is encouraging access to LARC methods using multiple strategies, including grants supplements, webinars, funding announcements, public support, and support for innovative practices. Jointly, OPA and CDC developed recommendations for [providing quality family planning services recommendations for primary care providers](#).

## **OVERVIEW AND METHODS FOR LARC LEARNING COMMUNITY**

In preparation for year two of the LARC learning community, ASTHO and CDC worked together to identify states to join Cohort II, formally invited both Cohort I and Cohort II states to participate in the learning community, and held the LARC Learning Community Year Two In-Person Meeting. Each of these phases is briefly described below. In-depth findings from the in-person meeting are included in the remaining sections of this report.

**State Identification:** ASTHO, in collaboration with CDC, worked together to identify Cohort II states to participate in year two of the learning community. Criteria for participation in the learning community included the following: 1) Current Medicaid policy or other payment policy in place for immediate postpartum LARC; 2) A core team of four members, including the state Maternal and Child Health Director/Title V or Title X Director, Medicaid representative, provider representative/provider champion, and an additional representative critical to LARC in the state; 3) Identified technical assistance needs; 4) Participation in the in-person kick-off meeting, five virtual learning sessions over the project year, and key informant interviews. Based on the aforementioned criteria, ASTHO and CDC selected seven states to participate in year two of the learning community: Delaware, Indiana, Louisiana, Maryland, Montana, Oklahoma, and Texas.

## **LARC LEARNING COMMUNITY LAUNCH**

ASTHO, with support from CDC and partnerships with ACOG, AMCHP, CMS, NFPRHA, and OPA, convened year two of the Immediate Postpartum Long-Acting Reversible Contraception (LARC) Learning Community to help selected states implement LARC initiatives. In addition to Colorado, Georgia, Iowa, Massachusetts, New Mexico, and South Carolina (Cohort I), ASTHO welcomed Delaware, Indiana, Louisiana, Maryland, Montana, Oklahoma, and Texas (Cohort II) to the learning community. Over the next year, ASTHO will provide technical assistance to these 13 states and identify promising practices to increase access to immediate postpartum LARC, key informant interviews will be conducted with both cohorts to further explore successes and challenges related to LARC implementation, and the ASTHO team will hold five virtual learning sessions over the project year to facilitate state-to-state sharing and establish a state peer-to-peer network for information exchange on LARC activities.

## **YEAR TWO LAUNCH OVERVIEW AND APPROACH**

The learning community aims to identify and document technical assistance needs, promising practices, and barriers impacting access to immediate postpartum LARC uptake. Information collected during the learning community will be widely disseminated to support immediate postpartum LARC initiatives. The year two learning community in-person meeting aimed to:

- Create an opportunity for multi-disciplinary teams to evaluate their immediate postpartum LARC progress, identify priorities for the next year, and develop short and medium-term action steps.
- Improve states' capacity to successfully implement immediate postpartum LARC by facilitating state-to-state sharing of promising strategies and common challenges.
- Highlight Cohort I lessons learned and goals for the future.
- Discuss Cohort II policies, progress, and technical assistance needs.
- Utilize a strengths, weaknesses, opportunities, and threats analysis and develop action plans for the upcoming year.

- Examine progress on the [eight domains](#) of the learning community and identify learning opportunities.

Seventy participants from 13 states attended the two-day in-person meeting, along with federal and national partners and ASTHO staff. Day one opened with an overview of the learning community and highlights from states' successes and technical assistance needs around the eight domains, as well as Cohort I activities over the past year. Cohort II states presented on their experiences and challenges regarding increasing access to immediate postpartum LARC. These presentations were followed by group discussions where participants convened in one of five facilitated peer groups to discuss lessons learned and partnership opportunities to improve immediate postpartum LARC in their states. The peer groups included: logistical challenges to implementation (two groups), patient and provider education, Medicaid policies and procedures, and leadership and systems. Day one ended with facilitated individual state team time to identify strengths, opportunities, weaknesses, and threats for implementing immediate postpartum LARC and goals for the upcoming year, followed by a final state report out.

Day two began with a presentation on the evaluation methods that will be employed over the next year of the learning community. Cohort I states presented successes from year one and discussed goals for the upcoming year. Cohort I and II states were paired to discuss short and medium-term actions that states, federal/national partners, and ASTHO can take to increase access to immediate postpartum LARC. The meeting concluded with a final state report out, comments, and next steps.

### **CURRENT STATE POSTPARTUM LARC INITIATIVES**

The 13 states participating in the LARC learning community vary by location, size, geography, number of births, population characteristics, and organization of maternity services, but all have significant numbers of pregnant women covered by Medicaid. The majority of states in the learning community currently have Medicaid coverage for immediate postpartum LARC.

- State data on population can be found here: <https://www.census.gov/quickfacts/table/PST045215/00>
- State data on total number of live births can be found here: <http://kff.org/other/state-indicator/number-of-births/>
- State data on total number of unintended pregnancies can be found here: <https://www.guttmacher.org/sites/default/files/pdfs/pubs/StateUP10.pdf>
- State data on number of Medicaid covered births can be found here: <http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/>

#### **Colorado**

**Population (2015):** 5,456,574

**Total Number of Live Births (2014):** 65,830

**Total Number of Unintended Pregnancies (2010):** 43,000

**Percent of Medicaid Covered Births (2010):** 36.8 percent

**Medicaid Reimbursement Policy:** Effective for dates of service on or after October 1, 2013, the Department updated the Colorado Medical Assistance Program's policy to include reimbursement for long-acting reversible contraception provided in a hospital. This temporary process enables hospital

providers to be reimbursed for these devices immediately following delivery. The Department will revert to the normal claims process when APR-DRG is implemented in early January 2014.

**State-Specific LARC Initiatives:** Fourteen local foundations are investing in LARC work with state-sponsored legislation to support LARC initiatives. Over the past year, Colorado has seen strengthened collaboration between the Department of Public Health & Environment and the Department of Health Care Policy and Financing. Interest in expanding access to immediate postpartum LARC has gained momentum in the state.

### **Delaware**

**Population (2015):** 945,934

**Total Number of Live Births (2014):** 10,972

**Total Number of Unintended Pregnancies (2010):** 11,000

**Percent of Medicaid Covered Births (2010):** 25.9 percent

**Medicaid Reimbursement Policy:** Effective July 15, 2015, the Delaware Medical Assistance Program will reimburse for LARC devices through the Medicaid pharmacy benefit. A LARC device prescription is processed through a specialty pharmacy and the pharmacy buys and bills for Medicaid directly. The LARC is shipped to the facility, including hospitals, for immediate postpartum placement.

**State-Specific LARC Initiatives:** Delaware has five birthing facilities in the state and is leveraging the power of partnerships and collaboration between the Division of Public Health, Medicaid and Medical Assistance, Upstream USA, and the Delaware Healthy Mother and Infant Consortium. The state has seen immense political will and support for LARC in an effort to improve birth intention and maternal and infant health outcomes.

### **Georgia**

**Population (2015):** 10,214,860

**Total Number of Live Births (2014):** 130,946

**Total Number of Unintended Pregnancies (2010):** 119,000

**Percent of Medicaid Covered Births (2010):** 41.9 percent

**Medicaid Reimbursement Policy:** Effective April 1, 2014, the Georgia Department of Community Health's Medicaid program will reimburse for LARC devices inserted immediately postpartum in an inpatient hospital setting. Coverage is considered an add-on benefit and is not included in the DRG reimbursement process.

**State-Specific LARC Initiatives:** Since year one of the learning community, Georgia had many successes in provider trainings and incorporating immediate postpartum LARC into their perinatal quality collaborative. Georgia also began conversations with the Georgia Hospital Association on facilitation of immediate postpartum LARC and worked with managed care organizations on billing logistics for immediate postpartum LARC for hospital staff.

### **Indiana**

**Population (2015):** 6,619,680

**Total Number of Live Births (2014):** 84,080

**Total Number of Unintended Pregnancies (2010):** 55,000

**Percent of Medicaid Covered Births (2010):** 46.6 percent

**Medicaid Reimbursement Policy:** Effective June 1, 2015, the Indiana Health Coverage Programs will allow separate reimbursement for LARC devices implanted at an inpatient hospital or birthing center. Separate reimbursement applies to the LARC device only. Reimbursement for all other related services,

procedures, supplies, and devices continue to be included in the inpatient hospital DRG or the birthing center all-inclusive reimbursement amount.

**State-Specific LARC Initiatives:** Indiana currently has 92 birthing hospitals in the state. The Indiana Perinatal Quality Improvement Collaborative (IPQIC) Subcommittee of Preconception and Inter-Conception Care recommended expanding access to postpartum LARC by developing tools for healthcare providers to help facilitate billing and coding. The IPQIC Education committee began addressing these recommendations. Future plans include developing a tool kit for providers with the latest information on LARC use and billing, as well as educational information for consumers on the LARC option.

### **Iowa**

**Population (2015):** 3,123,899

**Total Number of Live Births (2014):** 39,687

**Total Number of Unintended Pregnancies (2010):** 23,000

**Percent of Medicaid Covered Births (2010):** 40.5 percent

**Medicaid Reimbursement Policy:** Effective March 1, 2014, insertion of IUDs and other LARC devices following delivery and before the patient leaves the hospital were approved. Payment for these services will be allowed for both practitioners and hospitals. For practitioners providing this service in the hospital setting, they will need to bill with the appropriate place of service code. For hospitals, in instances where LARC services are provided to an inpatient, the claim for these services must be submitted as an outpatient claim, separate from the inpatient claim for delivery. Inpatient claims will pay normally under the DRG methodology. The outpatient claim for the LARC device will pay on a fee schedule basis for the HCPCS Level II procedure code billed. This payment will be separate from the DRG payment for the inpatient admission associated with delivery.

**State-Specific LARC Initiatives:** Since the start of the learning community, Iowa has seen many successes including unbundling immediate post-partum LARC insertion fees, developing an evaluation plan, and obtaining claims data to assess benefit uptake. Iowa worked with providers, hospitals, and health plans to increase access to immediate postpartum LARC.

### **Louisiana**

**Population (2015):** 4,670,724

**Total Number of Live Births (2014):** 64,497

**Total Number of Unintended Pregnancies (2010):** 53,000

**Percent of Medicaid Covered Births (2010):** 69.0 percent

**Medicaid Reimbursement Policy:** Effective June 20, 2014, hospitals will receive an additional payment when the insertion of long-acting reversible contraception for women newly post-partum occurs prior to discharge. Payment for LARC will be equal to the fee on the durable medical equipment (DME) fee schedule and will be in addition to the hospital's per diem payment.

**State-Specific LARC Initiatives:** Louisiana successfully changed their Medicaid policy, including adding LARC as a Medicaid benefit, removing preauthorization for LARC, prohibiting step therapy for devices and procedures in Bayou Health, adding reimbursement for post-placental insertion prior to hospital discharge, and unbundling current procedural terminology delivery codes.

### **Maryland**

**Population (2015):** 6,006,401

**Total Number of Live Births (2014):** 73,921

**Number of Medicaid Covered Births (2010):** 25.9 percent

**Percent Number of Unintended Pregnancies (2010):** 71,000

**Medicaid Reimbursement Policy:** Effective September 2014, Maryland Medicaid changed their policy to reimburse for all LARC devices, including those placed immediately postpartum without preauthorization. Hospitals will now include the LARC invoice separately from the inpatient labor and delivery claim.

**State-Specific LARC Initiatives:** The Maryland Medicaid Program recognizes office visits and preventive visit codes as family planning services when billed in conjunction with a contraceptive management code. The program also has a family planning waiver program that provides benefits limited to contraceptive management.

### **Massachusetts**

**Population (2015):** 6,794,422

**Total Number of Live Births (2014):** 71,908

**Total Number of Unintended Pregnancies (2010):** 54,000

**Percent of Medicaid Covered Births (2010):** 26.8 percent

**State-Specific LARC Initiatives:** Since year one of the learning community, Massachusetts has had many successes, including engaging and mobilizing providers by raising the issue of LARC Medicaid reimbursement and encouraging collaboration among providers. There is significant investment by MassHealth (Massachusetts Medicaid) in studying the impact of postpartum LARC and alternative payment methodologies. Through focus groups with hospital administrators, Massachusetts found that providers were highly motivated to provide inpatient LARC devices and identified a number of inpatient insertion barriers.

### **Montana**

**Population (2015):** 1,032,949

**Total Number of Live Births (2014):** 12,432

**Total Number of Unintended Pregnancies (2010):** 7,000

**Percent of Medicaid Covered Births (2010):** 35.0 percent

**Medicaid Reimbursement Policy:** Effective January 2, 2015, Montana Medicaid unbundled the payment for LARC devices at time of delivery for prospective payment hospitals. The device and the insertion are billed on an outpatient claim, separate from delivery charges.

**State-Specific LARC Initiatives:** There are 30 birthing hospitals in Montana, 10 prospective payment hospitals, 17 rural critical access hospitals, one Indian Health Service hospital, and two birthing centers. In 2013, Medicaid reimbursed for 802 LARC devices.

### **New Mexico**

**Population (2015):** 2,085,109

**Total Number of Live Births (2014):** 26,052

**Total Number of Unintended Pregnancies (2010):** 22,000

**Percent of Medicaid Covered Births (2010):** 53.4 percent

**Medicaid Reimbursement Policy:** New Mexico's Medicaid coverage for postpartum LARC began in November 2013, with reimbursement for postpartum LARC insertion as an add-on payment to the global delivery fee.

**State-Specific LARC Initiatives:** Over the past year, New Mexico had success collaborating between the New Mexico Department of Health, the University of New Mexico, and Medicaid. The New Mexico

Department of Health recently embarked on their Delayed Parenthood Project which utilizes LARC to prevent teen pregnancy, focusing on 13 target areas with high teen birth rates.

### **Oklahoma**

**Population (2015):** 3,911,338

**Total Number of Live Births (2014):** 53,559

**Total Number of Unintended Pregnancies (2010):** 36,000

**Percent Number of Medicaid Covered Births (2010):** 64.0 percent

**Medicaid Reimbursement Policy:** On September 12, 2014, a new LARC policy went into effect so that immediate postpartum LARC is now separate from the bundled rate.

**State-Specific LARC Initiatives:** Oklahoma has a strong, collaborative public health system with strong public-private partnerships. In 2014, among SoonerCare (Oklahoma Medicaid) members, LARC usage was 8.45 percent for women 18 years and younger, 16.27 percent for women 19-24 years of age, and 14.72 percent for women 25 years and older. Until 2015, LARC was included in the bundle payment for pregnancy and birthing services. Providers advocated for a change, stating that inserting immediate postpartum LARC would be a great tool to reduce unintended and teen pregnancy.

### **South Carolina**

**Population (2015):** 4,896,146

**Total Number of Live Births (2014):** 57,627

**Total Number of Unintended Pregnancies (2010):** 42,000

**Percent of Medicaid Covered Births (2010):** 50.0 percent

**Medicaid Reimbursement Policy:** Medicaid coverage for postpartum LARC insertion began March 1, 2012, with reimbursement as an add-on payment to the global delivery fee.

**State-Specific LARC Initiatives:** The South Carolina Birth Outcomes Initiative (SCBOI) spearheaded efforts to implement widespread postpartum LARC access in hospitals across the state. As part of their work, they are working to address logistical challenges hospitals face with immediate postpartum LARC in in-patient settings, such as estimating proper stocking, storage, and inventory; obtaining patient consent; and changing provider practices. The group is also educating hospital staff, including lactation consultants, to provide information about LARC devices and clarify misperceptions related to expulsion rates and impact on breast milk production. In 2016, SCBOI, in collaboration with the Choose Well Initiative, developed The South Carolina Postpartum Toolkit, a resource for implementing LARC in the hospital postpartum setting using South Carolina's Medicaid payment policy.

### **Texas**

**Population (2015):** 27,469,114

**Total Number of Live Births (2014):** 399,766

**Total Number of Unintended Pregnancies (2010):** 298,000

**Percent of Medicaid Covered Births (2010):** 47.6 percent

**Medicaid Reimbursement Policy:** Effective January 1, 2016, hospitals may receive reimbursement for LARC devices in addition to DRG payment when a LARC device is inserted immediately postpartum. The hospital provider is required to submit an outpatient claim with the appropriate procedure code for the LARC device in addition to the inpatient claim for the delivery services. Hospital providers that also contract with the state-funded Family Planning Program may receive reimbursement for a LARC device inserted immediately postpartum for Emergency Medicaid clients.

**State-Specific LARC Initiatives:** Texas is in the process of creating protocols for immediate postpartum LARC for clinical providers. They have also established baseline data for immediate postpartum LARC implementation and will monitor the procedure's use moving forward.

## SUCSESSES

**The majority of states in the learning community have Medicaid policies for postpartum LARC.** Since year one of the learning community, Cohort I states have made progress in expanding access to LARC by continuing to support and sustain Medicaid policies in their state. All Cohort II states have Medicaid policies in place for LARC reimbursement. While policies vary from state to state in their structure and forms of reimbursement, they lay the foundation for widespread immediate postpartum LARC implementation.

**Provider training is being initiated.** States are working with their healthcare providers to offer training and tools they need to confidently insert LARC immediately postpartum. States have developed provider toolkits with up-to-date information on the use of LARC devices and how to appropriately bill for services. Some hospitals have initiated grand rounds focused on LARC placement education, connecting clinicians from different service locations. Furthermore the state launched the [South Carolina Postpartum LARC Toolkit](#), a collaborative effort between the Choose Well Initiative and SCBOI. The toolkit serves as a resource describing implementation of South Carolina's Medicaid policy on LARC services in the hospital postpartum setting.

**Enthusiasm and momentum to expand access to immediate postpartum LARC.** Both Cohort I and Cohort II states cited growing interest and investment among funders, providers, and consumers in expanding access to LARC in their state. There has been immense political will and support to improve maternal and infant outcomes in some states by increasing access to LARC for priority populations. Furthermore there has been an increase in demand and preference for LARC from consumers.

**Collaboration between Medicaid and public health agencies.** Cohort I states have seen numerous successes in collaborative partnerships and relationships in their state. State health agencies strengthened collaboration and cross sector partnerships with universities, Medicaid agencies, other government agencies, nongovernmental organizations, hospitals, and hospital associations. Collaboration is cited by almost all states in the learning community as a necessary component to drive expansion of LARC use and reimbursement. Cohort II states also mentioned ongoing partnerships in their states and the impact it has had on Medicaid policy change.

**Establishing evaluation measures and collection of data around LARC use.** While many states are still in the beginning phases of collecting data and evaluating their LARC programs, some have made strides in this area. States started developing evaluation plans and capturing Medicaid claims data to assess benefit uptake. LARC utilization is being incorporated into multiple state quality collaboratives, elevating LARC to a high level.

**Clinician champions.** All states in the learning community highlighted the importance of clinician champions. Often, these healthcare professionals serve as leaders in LARC expansion efforts. Clinicians are equipped to share information with peers and address misperceptions around immediate postpartum LARC.

## **CHALLENGES, BARRIERS, AND STRATEGIES TO ADDRESS THEM**

### **While Medicaid payment mechanisms are in place, policy implementation is still challenging.**

Effectuating Medicaid policies has been a persistent barrier since year one of the learning community. Clinicians and hospital administrative staff often do not have the information they need regarding Medicaid coverage availability or know how to access Medicaid coverage or receive reimbursement. Lack of consistency between Medicaid and commercial payer policies can also create barriers to use. To help communicate new and changing policies, states are working to develop outreach and communication materials for both physicians and consumers. Ongoing physician trainings and education is another strategy states are using to help mitigate persistent myths around LARC use. Strategies identified in year one are being implemented in year two, including in-person sessions and webinars to educate physicians and consumers on LARC. Lastly, states mentioned the importance of targeted outreach to religiously affiliated hospital systems, whose policies may not allow contraception.

**Confidentiality and informed consent.** States report ongoing concerns around confidentiality for inpatient LARC, as well as a need for standardized consent processes and protocols, especially for priority populations. Healthcare providers need guidance on when consent should occur to ensure informed consent is obtained appropriately for the postpartum setting. Furthermore, confidentiality is of high importance to adolescents, and providers must be knowledgeable about the laws addressing this in their states. States suggested that guidance related to confidentiality should be included in LARC protocols for both providers and consumers.

**Stocking and supplying LARC devices.** Another recurrent theme from year one was stocking and supply. Both Cohort I and Cohort II states reported challenges with stocking and supplying LARC devices. Offering LARC in an inpatient setting is significantly more expensive than in outpatient settings because LARC devices may not be covered under HRSA's 340B Drug Pricing program or are included in a bundled or capitated rate. Rural hospitals, in particular, cited difficulties in stocking LARC devices due to rising costs and budgetary constraints coupled with decreased patient load. Upfront costs and concerns about reimbursement continue to be a barrier for physician and pharmacy buy-in. Many states reported that providers were highly motivated to figure out how to provide inpatient LARC. Participants discussed stop-gap measures, such as white bagging, a method of stocking LARC devices in an outpatient clinic that directly charges the device to the individual patient's insurance instead of to the provider. These short-term solutions may give time for states to develop sustainable billing and reimbursement policies.

**Data collection.** A common challenge among both Cohort I and Cohort II states is collecting data, specifically around obtaining Medicaid claims data, to assess LARC uptake in their state. States stressed the need to analyze data around immediate postpartum LARC Medicaid payments. Furthermore, states want to begin to measure immediate postpartum LARC uptake and usage in hospitals.

**Provider/patient education.** Another challenge states cited was lack of provider or patient education on LARC. States want to develop educational materials for both patients and providers outlining the benefits of LARC devices while dispelling misperceptions.

**Engaging key stakeholders.** States emphasized the importance of clinician champions in increasing acceptance of and access to LARC. Many participants cited ongoing issues with identifying who the leaders and clinician champions are in their state. States are continuing to assess how to bring key stakeholders to the table, including the development of tools, educational materials, and data to build

the case for LARC. Participants discussed the importance of federal agencies and national organizations in providing support for immediate postpartum work in their states.

### **TECHNICAL ASSISTANCE NEEDS**

**Building the evidence base to support immediate postpartum LARC.** Participants were interested in how to engage in data collection and best practices to monitor impact and outcomes of LARC usage. In addition to collecting data, evaluating current LARC usage and uptake was cited by participants as important to continuing momentum. State teams requested different strategies for the effective use of data to drive utilization, study effects, and focus on areas of greater need. States requested tools to conduct cost analyses of LARC use and identified building the business case for expanding access to, and reimbursement of, LARC insertion and devices.

**Developing guidance on the creation of Medicaid policies.** Participants showed great interest in learning about other states' Medicaid policies and requested an assessment and comparison of these policies to better understand differences. States were particularly interested in what others had done around Medicaid state plan amendment (SPA) language and requested additional guidance on how to create similar language in their states.

**Financing options for LARC insertion and use.** State teams also requested help in identifying other sources of potential funding for LARC insertion and additional information around [white bagging and "buy and bill,"](#) a method where providers in outpatient clinics stock their own devices at their expense and bill Medicaid upon insertion.

**Creating educational and informational resources and tools to support LARC.** A collection of resources to address misperceptions and concerns by providers (expulsion rates, effects of hormonal implants on breastfeeding, etc.) and to inform consumers was a common technical assistance need among Cohort I and II states. Participants also requested tools to communicate new or changed policies. States identified specific resources to help implement LARC policies, raise awareness, and create best clinical practices including online toolkits for both clinical and community use, sample hospital protocols and Medicaid policies, provider training resources, FAQs for patients and providers to address controversial topics, and state stories of success and processes. Tools around messaging were also requested by states.

#### **Addressing implementation barriers with commercial payers.**

States recognize the need to expand payment policies beyond Medicaid, to increase access to LARC for all women. Participants wanted assistance with the best ways to approach and work with commercial payers.

**Maximizing peer-to-peer learning opportunities through the learning community.** Similar to year one, participants in the learning community were interested in learning opportunities outside of formal sessions, including requests for support in building connections between learning community state teams and obtaining contact information of participants.

### **NEXT STEPS**

Throughout the in-person meeting, participants identified next steps for state teams, ASTHO, and national partners. These steps are summarized below.

### **State Teams**

Through action-planning time, teams identified immediate and longer-term next steps to support advancing immediate postpartum LARC in their states.

**Continue to support provider training.** Some states are in the process of developing physician toolkits and other implementation tools. South Carolina's toolkit serves as a resource for many states.

**Create educational and outreach materials for providers and consumers.** Over the next year, many states will develop educational materials for providers and consumers on LARC. These materials will also serve to communicate new policies and procedures to clinicians.

**Explore additional funding opportunities and financing options.** Several states are pursuing additional private and state funding opportunities for LARC, including identifying 340B pricing options. One state wants to develop a process for immediate postpartum LARC reimbursement for women without a payer source.

**Continue to work on billing and coding for LARC.** Although most states have a Medicaid policy in place, many want to continue to identify barriers in their state around billing and coding. Furthermore, many participants cited the importance of better understanding commercial payer policies and reimbursement.

**Explore current and future data capacity.** Several states plan to explore and identify opportunities to expand data sources to make the case for immediate postpartum LARC. Specific data participants plan to explore include: IUD expulsion, insertion, and removal rates, and Medicaid claims data. Additional activities include developing a return on investment for LARC immediately postpartum and establishing data use agreements with care management organizations.

### **ASTHO and National Partners**

Based on the outcomes and technical assistance requests expressed during the in-person meeting, next steps for ASTHO and national partners include:

**Develop, collate, and disseminate resources.** In addition to disseminating findings from the learning community, ASTHO will continue to gather and populate its website with examples of policies, tools, protocols, and other resources to support implementing postpartum LARC policies. Other tools include media messaging and cost analysis and effectiveness tools.

**Connect with federal and national partners to build support at the national level.** ASTHO will continue to engage national partners, including the CDC, and explore ways in which additional support can be provided to the states. This includes sharing information and materials during learning community sessions, technical assistance calls, and emerging topic calls.

**Develop technical assistance plans.** ASTHO will continue to work with national partners and Cohort I and Cohort II states to develop meaningful technical assistance plans and begin implementation.

## **CONCLUSION**

Findings from the LARC learning community in-person meeting will inform the learning community's content and structure throughout the project. The learning community will meet virtually five times through June 2016. ASTHO and CDC will continue to work closely with the 13 state teams, as well as federal and national partners, to facilitate a meaningful, productive learning community that advances postpartum LARC initiatives in the participating states and identifies best practices and technical assistance needed to support other states. As part of the learning community, ASTHO hired a consultant to conduct key informant interviews with stakeholders in both Cohort I and Cohort II states. Topics covered in the interviews included the current status of their initiatives, challenges and barriers they are facing around LARC implementation, and additional technical assistance needs moving forward. This information will be used to inform the work and technical assistance needs of the learning community moving forward.

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- <sup>12</sup> Moniz MH, et al. "Characterization of Medicaid Policy for immediate Postpartum Contraception." *Contraception*. 2015. 92(6):523-31. Available at <http://www.ncbi.nlm.nih.gov/pubmed/26452327>. Accessed 4-1-2016.
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