

Policy Brief:

Medicaid Coverage for Immediate Postpartum LARC

The intrauterine device (IUD) and contraceptive implant, known as long-acting reversible contraception (LARC), are highly effective contraceptive methods that are safe for most women, including adolescents. LARC can be offered immediately postpartum (the period following childbirth and prior to hospital discharge) as a safe, effective option for postpartum contraception.

Postpartum contraception is usually offered and provided during the 6-week postpartum visit. However, approximately 10-40 percent of women do not return for this visit and are at risk for subsequent unintended, short-interval pregnancy. For those who do return, nearly 60 percent may have resumed intercourse and could already be at risk for another pregnancy. Adolescents are at higher risk for a rapid repeat pregnancy, with estimates of 12-49 percent of postpartum adolescents experiencing a pregnancy within one year of delivery. Unintended and short-interval pregnancies can result in a higher risk of preterm birth and worsened neonatal outcomes.¹

Immediate postpartum LARC has the potential to reduce unintended and short-interval pregnancy. However, more widespread adoption of immediate postpartum LARC has been hampered by systems barriers, such as the inability to obtain reimbursement for LARC devices and services provided immediately postpartum. Obstetrician-gynecologists and other obstetric care providers should incorporate immediate postpartum LARC into their practices, counsel patients appropriately about advantages and risks, and advocate for institutional and payment policy changes to support provision.¹ For patients who want to initiate LARC prior to leaving the hospital, such policies can provide patient-centered care and improve health.

Immediate Postpartum LARC Is Safe and Effective^{1,2}

- Two immediate postpartum LARC options exist: IUDs and the contraceptive implant
- LARC is highly effective at preventing pregnancy (failure rate <1%)
- LARC can be inserted safely immediately following a vaginal or cesarean delivery
- LARC methods are safe for postpartum women and women who are breastfeeding

Immediate Postpartum LARC Can Bolster Health Outcomes

- Immediate postpartum LARC has the potential to reduce unintended and short-interval pregnancy^{1,2}
- Short-interval pregnancies (having another pregnancy within 1 year of delivery) are most often unintended and are an independent risk factor for preterm delivery and adverse neonatal outcomes^{1,2}
- Short interpregnancy intervals have also been associated with maternal mortality, maternal anemia, difficulty managing chronic medical conditions, and uterine rupture following cesarean delivery^{3,4,5}

Immediate Postpartum LARC Is Cost-Effective

- In one Oregon hospital, immediate postpartum placement of IUDs in women covered by Emergency Medicaid was estimated to save \$3.00 for every \$1.00 spent.⁶
- Immediate postpartum contraceptive implant placement in adolescents was found to be cost-effective in Colorado. For every \$1.00 spent on immediate postpartum placement, \$0.79, \$3.54, and \$6.50 would be saved at 12, 24, and 36 months. A cost analysis revealed savings of \$2.5 million over 2 years for every 1,000 women covered by Medicaid.⁷
- Accounting for the medical costs of the resulting unintended pregnancy, insertion of a contraceptive implant immediately postpartum is expected to save \$1,263 per patient compared with insertion at the postpartum visit.⁸

Current Medicaid Policy for Immediate Postpartum LARC

- Most states have published guidance regarding reimbursement for LARC initiation prior to hospital discharge, separate from the hospital payment for delivery.
 - The ACOG LARC Program [maintains a list](#) of final or proposed state guidance regarding Medicaid reimbursement.⁹
- States use a variety of different strategies to implement reimbursement through Medicaid.
 - The [Kaiser Family Foundation](#) and [CMS](#) both have resources describing reimbursement mechanisms in different states.^{10,11}
 - For example, South Carolina became the first state to implement Medicaid reimbursement policies for coverage of both the LARC device and the insertion procedure at the time of delivery through use of a supplemental billing code (J code with family planning modifier).

ACOG Recommendations for Immediate Postpartum LARC¹

- Optimally, patients should be counseled prenatally about the option of immediate postpartum LARC. Counseling should include advantages, risks of IUD expulsion, contraindications, and alternatives to allow for informed decision-making.
- Immediate postpartum LARC should be offered as an effective option for postpartum contraception; there are few contraindications to postpartum IUDs and implants. Ob-gyns and other obstetric care providers should counsel patients about the convenience and effectiveness of immediate postpartum LARC, as well as the benefits of reducing unintended pregnancy and lengthening interpregnancy intervals.
- Ob-gyns and other obstetric care providers should incorporate immediate postpartum LARC into their practices and advocate for institutional and payment policy changes to support provision.

Contact the [ACOG LARC Program Help Desk](#) for assistance & visit www.pcainitiative.acog.org for more information.

This resource was last updated on May 26, 2020, please visit the LARC Program website at <https://www.acog.org/programs/long-acting-reversible-contraception-larc> for more information.

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¹ Immediate postpartum long-acting reversible contraception. Committee Opinion No. 670. American College of Obstetricians & Gynecologists. August 2016.

² Long-Acting Reversible Contraception: Implants and Intrauterine Devices. Practice Bulletin No. 186. American College of Obstetricians & Gynecologists. November 2017.

³ Shachar BZ, Lyell DJ. Interpregnancy Interval and Obstetrical Complications. *Obstet Gynecol Surv.* 2012;67:584-96.

⁴ Conde-Agudelo A, Rosas-Bermudez A, Castaño F, Norton MH. Effects of birth spacing on maternal, perinatal, infant, and child health: a systematic review of causal mechanisms. *Stud Fam Plan* 2012;43:93-114.

⁵ Gemmill A, Duberstein Lindberg L. Short Interpregnancy Intervals in the United States. *Obstet Gynecol.* 2013;122: 64-71

⁶ Rodriguez MI, Caughey AB, Edelman A et al. Cost-benefit analysis of state- and hospital-funded postpartum intrauterine contraception at a university hospital for recent immigrants to the United States. *Contraception*, 2010;(81): 304-308.

⁷ Han L, Teal SB, Sheeder J, Tocce K. Preventing repeat pregnancy in adolescents: is immediate postpartum insertion of the contraceptive implant cost effective? *Am J Obstet Gynecol* 2014;211(1):24.e1-7.

⁸ Garipey A, Duffy J, Xu X. Cost-effectiveness of immediate compared with delayed postpartum etonogestrel implant insertion. *Obstet Gynecol*; 2015(126)1:47-55.

⁹ <http://www.acog.org/IPPLARCMedicaid>

¹⁰ <http://www.kff.org/womens-health-policy/state-indicator/medicaid-coverage-of-intrauterine-devices-iuds-implants-and-reimbursement-policy/>

¹¹ <https://www.medicare.gov/federal-policy-guidance/downloads/cib040816.pdf>