



# The Role of Medicaid Policy in Reducing Racial Disparities in Maternal Mortality and Other Maternal Health Outcomes: A Literature Review Series

## *Issue 3: Postpartum Long-Acting Reversible Contraception*

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**Health policy researchers from the American Institutes for Research** conducted a literature review focused on three Medicaid coverage policies—prenatal and postpartum home visiting, freestanding birth centers, and postpartum long-acting reversible contraception—to offer insight into how Medicaid and other programs can leverage policies to advance maternal health equity. This brief summarizes literature review findings that concern postpartum long-acting reversible contraception (LARC).

Literature review findings on Medicaid coverage of prenatal and postpartum home visiting and freestanding birth centers can be found [here](#). Support for this work was provided by the [AIR Equity Initiative](#). The authors thank Talia Fish, Naba Husain, and Karen Ghelman for their research support.

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## Introduction

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Medicaid plays a key role in providing maternity-related services for pregnant people, paying for slightly less than half of all births nationwide and nearly two thirds of births to Black, Native, and Hispanic parents. Recognizing the importance of Medicaid in advancing health equity, the Biden-Harris administration released the White House Blueprint for Addressing the Maternal Health Crisis in 2022,<sup>1</sup> outlining specific actions that the federal government will take to improve maternal health and address disparities. To encourage state-level adoption of policies to help improve maternal health outcomes, the Center for Medicare and Medicaid Innovation has announced a new decade-long Transforming Maternal Health Model to support state Medicaid agencies in the development of a whole-person approach to pregnancy, childbirth, and postpartum care.<sup>2</sup>

LARC's effectiveness in preventing short-interval pregnancies and increasing the time between pregnancies may help reduce the rates of maternal morbidity and mortality.

One of the key components of improving maternal health outcomes is increasing access to and use of effective methods of contraception. Access to contraception grants many women greater reproductive and bodily autonomy, which can positively impact overall health and well-being. Long-acting reversible contraception (LARC), considered the most effective form of contraception, comes in the form of intrauterine devices and contraceptive implants, according to the Centers for Disease Control and Prevention (CDC).<sup>3</sup> Short-interval pregnancies, defined as pregnancies separated by an interval less than 18 months, are associated with several adverse outcomes for both the mother and child. These include preterm

birth, low birth weight, and preeclampsia.<sup>4</sup> While LARC is effective at helping to reduce these outcomes, racial disparities exist in access to and use of LARC. To address these challenges, policy recommendations include training providers on ways to offer culturally sensitive care, requiring providers to offer contraception counseling during prenatal visits, educating providers and consumers on LARC and Medicaid reimbursement and coverage options, and covering the cost of LARC removal. This brief

- ◆ examines the evidence on the effectiveness of LARC in reducing short-interval pregnancies, maternal mortality, and other maternal health outcomes for racial minorities;
- ◆ explores stigma, challenges, and unintended consequences for equity-focused implementation of LARC; and
- ◆ offers LARC policy and program considerations for Medicaid and other decision-makers.

## Literature Review Methodology

To examine the evidence on the effectiveness of the policies to reduce racial disparities in maternal health outcomes, we iteratively defined a list of search terms and inclusion/exclusion criteria for each of the three policies (including manuscripts published between 2017 and 2022<sup>5</sup> on studies conducted in the United States) and searched a variety of databases and search engines to find applicable published manuscripts. To explore the literature on challenges and promising practices, we expanded our search to include gray literature, such as briefs and reports. We reviewed each article for relevancy to the goals of the literature review. We extracted data from each relevant article using a data extraction protocol and used the data to create a summary of findings.

## Medicaid Coverage of Long-Acting Reversible Contraception

The Center for Medicaid and CHIP Services (CMCS) introduced the Maternal and Infant Health Initiative (MIHI) in July 2014 in an effort to improve maternal and infant health outcomes by increasing the number of postpartum visits, improving the content of visits, and increasing access to and use of effective methods of contraception.<sup>6</sup> Given that LARC is the most effective form of contraception,<sup>3</sup> states have been adopting policies that increase access to and use of LARC, especially for their Medicaid populations. Of the 45 states, plus the District of Columbia, that have adopted LARC policies and

Long-acting reversible contraceptives include copper IUDs, hormonal IUDs, and hormonal contraceptive implants (effective for 10, 5, and 3 years, respectively).



reimbursement approaches, South Carolina is regarded as the pioneer in the area of Medicaid LARC reimbursement policies.

In 2012, the South Carolina Department of Health and Human Services (SCDHHS) unbundled the costs of immediate postpartum LARC insertion from the costs of childbirth through the South Carolina Birth Outcomes Initiative (SCBOI). As the first state to implement an immediate postpartum payment for LARC separate from the labor and delivery payment, South Carolina provided an example of how to optimize reimbursement for LARC that other states could follow.<sup>6</sup>

For instance, states such as Illinois now leverage the 340B program for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to cover LARC device reimbursements.<sup>6</sup> Additionally, CMCS identified the following categories of payment strategies used by state Medicaid agencies:

1. Provide timely, patient-centered comprehensive coverage for the provision of contraceptive services (e.g., contraception counseling and insertion, removal, replacement, or reinsertion of LARC or other contraceptive devices) for women of child-bearing age.
2. Raise payment rates to providers for LARC or other contraceptive devices in order to ensure that providers offer the full range of contraceptive methods.
3. Reimburse for immediate postpartum insertion of LARC by unbundling payment for LARC from other labor and delivery services.
4. Remove logistical barriers for supply management of LARC devices (e.g., by addressing supply chain, acquisition, stocking cost, and disposal cost issues).
5. Remove administrative barriers for provision of LARC (e.g., by allowing for billing office visits and LARC procedures on the same day and removing preauthorization requirements).<sup>6</sup>

## Evidence on the Effectiveness of LARC in Improving Maternal Health Outcomes

In our review of LARC and its ability to improve maternal health outcomes, we identified two research categories that effectiveness studies tended to focus on: (a) policies and programs that increase LARC access and utilization and (b) the ability of LARC to prevent pregnancy. Three studies, detailed below, provide insights on how LARC-targeted policies and programs can impact individuals and potentially improve maternal health outcomes. Each of the referenced articles categorized LARC's impact on pregnancy as either prevention of short-interval pregnancies or increased time between pregnancies.

The first study<sup>7</sup> examined the relationship between postpartum contraception and interpregnancy intervals in adolescents aged 10–24. The primary outcome examined was the initiation of postpartum contraception 3 months after birth; the secondary outcome was time to repeat birth within 33 months. The study concluded that LARC was more effective at increasing time between pregnancies than non-LARC and non-contraceptive methods. LARC users

There is limited research on the direct impact that Medicaid-funded LARC reimbursements have on maternal health outcomes.

experienced a median of 790 days between births ( $p < .001$ ); non-LARC users, a median of 659 days; and women using no form of contraception, a median of 624 days.



The second study<sup>8</sup> investigated how South Carolina’s Medicaid policy change in 2012 allowing payment unbundling for LARC impacted utilization and repeat pregnancy within a short interval. The study found that overall LARC utilization increased following South Carolina’s policy change, but there were differences across different groups of women. Those with inadequate prenatal care (defined as fewer than seven visits) and with high-risk pregnancies were more likely to obtain immediate postpartum LARC than women with adequate prenatal care and medically normal pregnancies. Women living in urban areas were more likely to receive LARC than women living in rural areas. Overall, the study determined that, for the participants, postpartum LARC utilization lowered the chance of a repeat pregnancy within 18 months of birth.

The third and final study<sup>9</sup> conducted a retrospective chart review to determine the change in immediate postpartum LARC utilization before and after Ohio unbundled payment for inpatient postpartum LARC and mandated universal access to inpatient postpartum LARC. The study found that in the 2 years following the policy change LARC utilization increased significantly and immediate postpartum LARC lowered the risk of short-interval pregnancy.

All three studies highlight the importance of access to contraceptive methods like LARC as a way for women to exercise reproductive autonomy.

## Equity-Focused Implementation of LARC: Harmful Implications, Barriers to Care, and Promising Practices

While much of the research on LARC policies and programs can be used to improve maternal health outcomes, especially for Medicaid populations, the research shows that these same policies and programs have unintended consequences. One cannot discuss the potential benefits of LARC without also acknowledging the history of racism in reproductive health for women of color. Forced sterilization and LARC have been used as modes of “population control against Black, Indigenous, and People of Color into the twenty-first century.”<sup>10</sup> In particular, a few of the studies from our research call attention to the disparities in access to and use of LARC among certain racial and ethnic groups.



### Potentially Harmful Implications

In investigating policies designed to increase access to and use of postpartum LARC, it is critical to consider the history of discriminatory targeting of certain sociodemographic groups. One study<sup>11</sup> examined 2014 Medicaid claims data from 17 states to identify factors that influence postpartum contraception in the Medicaid population.<sup>12</sup> The study

identified social determinants of health and geographic factors that were associated with LARC utilization. For instance, the study found that adolescents aged 15–20 experienced an increased likelihood of LARC usage and that Black women were significantly more likely to receive LARC in the 3-days postpartum than White women. The study described its social vulnerability findings in the following way:

*Of great interest is the finding from this study that a woman's residing in the most vulnerable counties was significantly associated with provision of both LARC and MMEC. However, variable associations were observed between the CDC's themes of social vulnerability, LARC provision and MMEC uptake. For example, women residing in the most vulnerable counties in terms of housing and transportation had greater odds of LARC provision, whereas those living in counties with vulnerable socioeconomic status (which includes living below poverty, unemployment, low income, no high school diploma) had fewer odds of LARC provision. Similarly, women living in the most vulnerable counties in terms of socioeconomic status, household composition and disability status (age 65 years or older or 17 years or younger, older than age 5 with a disability, or single parent households) had higher odds of MMEC uptake in the 60-day postpartum period, whereas those residing in the most vulnerable counties in terms of minority status and language as well as housing and transportation had lower odds of MMEC uptake.<sup>11</sup>*

Compared to White women, Hispanic and non-Hispanic Black women are more likely to report feeling pressured to choose LARC over other contraceptive care.<sup>1</sup>

A second study<sup>13</sup> analyzed billing records at Grady Health System in Atlanta, Georgia, to determine the impact of the 2014 Medicaid reimbursement policy on LARC uptake in a large Atlanta hospital with a sizable Medicaid population. The study found that reimbursement for LARC insertion significantly contributed to increased LARC utilization (which climbed from a postpartum LARC placement rate of 2.6% to 16.8%). The results varied significantly among racial and ethnic groups: Before the reimbursement policy, 65.4% of women who received inpatient postpartum LARC were Black and 15.4% were Hispanic; after the policy implementation, 90.9% of women who received inpatient postpartum LARC were Black, and 4.9% were Hispanic.

In addition, one unintended consequence of postpartum LARC access and utilization is the coercion and pressure that women feel to choose LARC as their contraception of choice. A qualitative study<sup>14</sup> on South Carolina's immediate postpartum LARC counseling with women enrolled in Medicaid revealed dissatisfaction. Some women reported feeling coerced into LARC insertion. Some felt that they did not receive enough information or that the information was delivered at the wrong time (e.g., during labor and/or when they already had a non-LARC postpartum contraceptive plan). Furthermore, the study found that three out of 10 women who received immediate postpartum LARC as a result of the counseling encountered financial, logistical, or physical barriers when they tried to have the LARC removed.

## Other Barriers and Considerations

For many women who want access to postpartum LARC, particularly women of color and women in rural areas, barriers exist. Social and structural determinants of health, such as financial instability, limited education, food insecurity, and lack of access to housing and transportation exacerbate barriers to accessing LARC.<sup>10</sup> Women living in rural and medically underserved areas lack access to LARC services, which prevents



them from obtaining LARC counseling and insertion. Additionally, misinformation on the efficacy, safety, and availability of LARC has led to low levels of LARC utilization, specifically among adolescents.<sup>15</sup>

## Promising Practices

Our research uncovered a few promising practices for increasing LARC utilization by women of color. First, person-centered and culturally sensitive care can reduce perceived coercion reported by women and can thus increase utilization. Comprehensive contraception counseling, which includes counseling women on their contraception options prior to labor, can empower them to make educated decisions regarding their reproductive health and reduce feelings of coercion immediately postpartum. In order to train providers on culturally sensitive care, research suggests partnering with women’s health champions and community-based organizations in local areas.<sup>10</sup>

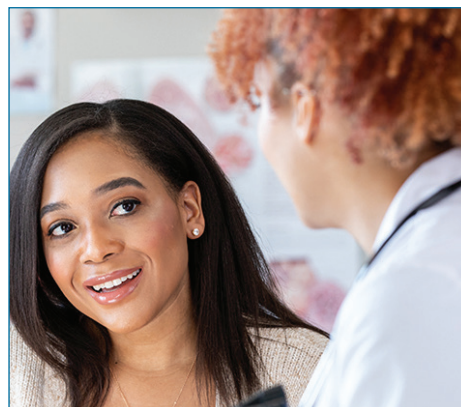
Because 55% of Medicaid recipients do not attend their 6-week postpartum visit, the introduction of postpartum contraception options should take place prior to the start of labor.<sup>14</sup>

Additionally, ensuring that clinicians, pharmacies, lactation consultants, and billing and administration departments build multidisciplinary support and understand their role in educating patients about LARC and combating misinformation, monitoring utilization, and leveraging Medicaid reimbursement offerings will help to increase LARC utilization.

## Policy and Program Considerations

Our research emphasizes the potential for LARC to prevent short-interval pregnancies and help to reduce the rates of maternal morbidity and mortality when culturally sensitive care is employed. As state Medicaid agencies focus on expanding the scope of LARC policy to create and offer more equitable reproductive health services, it is important to consider how trauma, race, education, and culture influence contraception preferences. In particular, federal and state Medicaid policymakers and program administrators should consider

- ◆ implementing **learning collaboratives** as a tool for states working to increase immediate postpartum LARC utilization and remove barriers to care;<sup>16</sup>
- ◆ requiring providers to offer **contraception counseling during prenatal visits** so that women feel informed and empowered instead of coerced and pressured about their contraception options immediately postpartum;
- ◆ educating providers and consumers on **LARC and Medicaid reimbursement and coverage options** to increase LARC utilization;
- ◆ training primary care providers on **LARC procedures** to increase access for women living in rural areas with limited access to women’s health specialists;<sup>17</sup>



- ◆ covering the **costs of LARC removal**, as research indicates that individuals can experience barriers to removal of LARC if Medicaid insurance is lost; and
- ◆ training providers on ways to offer **culturally sensitive reproductive care** and investing in a **diverse reproductive care workforce**.

## Endnotes

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