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Title: Coverage and Billing of Postpartum LARC Services

Introduced by: Miriam Rienstra Bareman for the Medical Student Section

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Referred to: Reference Committee A

House Action: **APPROVED**

Whereas, long-acting reversible contraceptives (LARCs) provide long-term, reliable, and highly efficacious prevention of unintended pregnancy with a range of options including hormonal and non-hormonal intra-uterine devices (IUDs) or subdermal hormonal implants^{1,2,3,4,5}, and

Whereas, roughly 45 percent of pregnancies in the USA are unintended, 35 percent of subsequent pregnancies occur within 18 months status post-live birth, and short-interval pregnancies pose significant risk factors including prematurity, low birth weight, and small for gestational age^{5,6,7,8}, and

Whereas, numerous national organizations support immediate postpartum LARC placement as safe and highly efficacious (<1 percent failure rate), because of its effectiveness in reducing unintended, short-interval pregnancies, eliminating patient loss to follow up, and cost-effectiveness^{2,3,4,9,10,11,12,13,14,15}, and

Whereas, LARCs are an increasingly popular option for birth control with usage increasing from 5.8 percent in 2002 to 15 percent of women in 2015 having used a LARC as their birth control option because of their top-tier efficacy, safety, long-term effect, ease of use, and rapid return of fertility^{1,2,3}, and

Whereas, in contrast, in Michigan only 6.7 percent (2008) of women were using a LARC as a postpartum form of contraception, suggesting barriers to access, and

Whereas, roughly 65 percent of women desire a postpartum LARC but are unable to receive it, and 71 percent cited the need to attend a follow-up appointment as the major barrier^{11,18,19}, and

Whereas, the total cost of a LARC ranges from \$400-1300 but the cost for a publicly funded unintended pregnancy is \$8,798, and in Michigan 61.5 percent of publicly funded births are unintended, resulting in \$282 million in annual public expenditure²⁰, and

Whereas, immediate postpartum LARCs are a cost-effective strategy for preventing expensive and high-risk unintended and short-interval pregnancies, with models showing that immediate postpartum placement prevents 88 unintended pregnancies per 1,000 women over a two-year time period and results in a cost savings of \$282,540 and a gain of 10 quality-adjusted life years (QALYs)^{12,13,14}, and

Whereas, a majority of Medicaid programs and private insurers currently pay for all labor- or delivery-related services under a global fee classified under a single diagnosis-related group (DRG)

54 code which does not currently allow for billing and reimbursement for a postpartum LARC
55 placement²¹, and

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57 Whereas, the inability for providers to bill separately for immediate postpartum LARCs de-
58 incentivizes hospitals to promote the service or provide patient education regarding LARCs, which
59 prevents patients from access to a much-needed service^{16,21}, and

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61 Whereas, while Michigan Medicaid prohibits separate billing for immediate postpartum LARC
62 placement, it does allow for separate billing of postpartum sterilization¹⁷, and

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64 Whereas, although 34 states have approved Medicaid reimbursement for immediate
65 postpartum LARCs in a hospital setting, as of April 2016, Michigan was not among those who had
66 approved separate billing or increased bundled billing for such¹⁷, and

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68 Whereas, the American Medical Association recognizes through its policies the efficacy of
69 immediate postpartum LARC placement as a cost-effective and safe method of reducing unintended
70 pregnancies, and supports coverage by Medicare, Medicaid, and private insurance²²; therefore be it

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72 RESOLVED: That MSMS supports current American Medical Association policy H-75.984
73 pertaining to the efficacy of postpartum long-acting reversible contraceptives placement and the
74 need to increase availability and coverage; and be it further

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76 RESOLVED: That MSMS continue to advocate for the coverage of immediate postpartum long-
77 acting reversible contraception devices and placement by public and private insurers; and be it further

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79 RESOLVED: That MSMS advocate that long-acting reversible contraceptives devices and
80 placement be billed and paid separately from the obstetrical global delivery fee.

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83 WAYS AND MEANS COMMITTEE FISCAL NOTE: NONE

Relevant MSMS Policy:

Medical Liability Coverage for Medicaid Obstetrical Care

MSMS supports a plan for the Michigan Department of Community Health to assume responsibility for all medical liability for obstetrical care for the Medicaid population. (Prior to 1990) – Edited 1998, 2005

Preventive Services

Preventive health services such as physical examinations, well-baby visits, necessary immunizations and family planning services should be included in the Medicaid program. (Prior to 1990) – Edited 1998

Relevant AMA Policy:

Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984

1. Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee.

2. Our AMA encourages relevant specialty organizations to provide training for physicians regarding (a) patients who are eligible for immediate postpartum long-acting reversible contraception, and (b) immediate postpartum long-acting reversible contraception placement protocols and procedures.

Requirements or Incentives by Government for the Use of Long-Acting Contraceptives H-75.991

(1) Involuntary use of long-acting contraceptives because of child abuse raises serious questions about a person's fundamental right to refuse medical treatment, to be free of cruel and unusual punishment, and to procreate. The state's compelling interest in protecting children from abuse may be served by less intrusive means than imposing contraception on parents who have committed child abuse. The needs of children may be better met by providing close supervision of the parents, appropriate treatment and social services, and foster placement care when necessary. There is not sufficient evidence to demonstrate that long-acting contraceptives are an effective social response to the problem of child abuse. Before long-acting contraceptives could be considered as a response to individual cases of child abuse, the issue would need to be addressed by society broadly. Society must be careful about taking shortcuts to save resources when constitutional rights are involved.

(2) Serious questions are raised by plea bargains, or negotiations with child welfare authorities, that result in the use of long-acting contraceptives. Such agreements are made in inherently coercive environments that lack procedural safeguards. In addition, cultural and other biases may influence decisions by the state to seek the use of a long-acting contraceptive.

(3) If welfare or other government benefits were based on the use of long-acting contraceptive agents, individuals would be required to assume a potentially serious health risk before receiving their benefits. Government benefits should not be made contingent on the acceptance of a health risk.

(4) Individuals should not be denied access to effective contraception because of their indigence. Use of long-acting contraceptives should be covered by Medicaid and other health insurance programs, both public and private.

(5) Long-acting contraceptives may be medically contraindicated. Assessing the health risks of long-acting contraceptives is substantially outside the purview of courts and legislatures.

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² Espey E, Hofler L. Long-Acting Reversible Contraception : Implants and Intrauterine Devices. *ACOG Pract Bull*. 2017;130(121):251-269. <https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins---Gynecology/Public/pb186.pdf?dmc=1&ts=20171103T1741365924>.

³ Diedrich JT, Zhao Q, Madden T, Secura GM, Peipert JF. Three-year continuation of reversible contraception. *Am J Obstet Gynecol*. 2015;213(5):662.e1-662.e8. doi:10.1016/j.ajog.2015.08.001.

⁴ Randel A. Guidelines for the Use of Long-Acting Reversible Contraceptives. *Am Fam Physician*. 2012;85(4):403-404.

⁵ Finer LB, Zolna MR. Declines in Unintended Pregnancy in the United States, 2008–2011. *N Engl J Med*. 2016;374(9):843-852. doi:10.1056/NEJMsa1506575.

⁶ Gemmill A, Lindberg LD. Short interpregnancy intervals in the United States. *Obstet Gynecol*. 2013;122(1):64-71. doi:10.1097/AOG.0b013e3182955e58.

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