# State Story

**South Carolina Increases Access to LARCs Immediately Postpartum to Reduce Unintended Pregnancy**

*The South Carolina Department of Health and Human Services is leading efforts to reduce unintended pregnancies by increasing access to long-acting reversible contraception, particularly in the hospital immediately after birth.*

Unintended pregnancy continues to be a major health problem in the United States. Mistimed, unplanned, or unwanted pregnancies are associated with an increased risk of poor maternal and infant outcomes, including delayed access to prenatal care, preterm birth, and negative physical and mental health effects for mother and child.[i,ii,iii] According to the American College of Obstetricians and Gynecologists (ACOG), high unintended pregnancy rates in the United States may be in part the result of relatively low use of long-acting reversible contraception (LARCs).[iv]

- Approximately 50 percent of pregnancies in the United States are unintended. This rate has not changed significantly in 20 years.
- The rate of unintended pregnancy in 2001 was substantially above average among women aged 18-24 who were unmarried (particularly cohabiting), low-income, had not completed high school, or were in a minority group.

LARCs are safe and highly effective methods of contraception that require no user intervention, work over long periods of time, and can be reversed. LARCs include intrauterine devices (IUDs) and hormone contraceptive implants that prevent ovulation. They can be inserted at any time during a woman's menstrual cycle, as well as immediately postpartum[v] in a hospital inpatient setting. Inserting LARCs immediately post-delivery has several benefits, including fewer appointments for the mother, which increases convenience and reduces no shows. ACOG recommends LARC methods be offered as first-line contraceptive methods and encouraged as options for most women. However, a number of barriers exist to increased LARC use, including lack of healthcare provider knowledge or skills, low patient awareness, and high upfront costs because many insurance plans do not cover LARC devices and insertion.[vi]

South Carolina was the first state in the nation to change its Medicaid reimbursement policy to cover LARC. Medicaid covers 57 percent of all births in the state, primarily through its five managed care organizations (MCOs).

Additionally, the South Carolina Birth Outcomes Initiative (SCBOI) was formed in 2011 and is housed at the South Carolina Department of Health and Human Services (SCDHHS). SCBOI is a collaborative that brings together more than 100 stakeholders to improve the health outcomes for newborns in the Medicaid program and also throughout the state's population. Its key partners include the South Carolina Hospital Association, Blue Cross and Blue Shield of South Carolina, OB/GYN/MFMs, nurses, South Carolina Department Health & Environmental Control (SCDHEC), and March of Dimes. SCBOI is divided into six workgroups that meet monthly to work on different topic areas, and are led by a vision team of leaders from key partner organizations.


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In 2011, SCBOI heard from OB/GYN partners that many women at high-risk for unintended pregnancy never showed up for their six-week postpartum check-up, which is an ideal time to discuss family planning and insert a LARC. In fact, no show rates among this population have been estimated as high as 55 percent, and these women often did not come back for an office visit until they were pregnant again, often unintentionally. Stakeholders believed that inserting LARC devices immediately postpartum, while women were still in the hospital after giving birth, would be a good option and solution. Consequently, the SCBOI decided to focus on supporting LARC insertion immediately postpartum.

**Steps Taken**

- After receiving approval from the state Medicaid agency, the reimbursement policy was changed to fully cover LARC devices and insertion procedures in hospital and inpatient settings. Specifically, the policy allowed providers to bill for the insertion procedure and hospitals to bill for the cost of the IUD or implant device. This allows for both the delivery and all costs associated with LARCs to be reimbursed, promoting a cost-effective, preventive health practice that has the potential to result in Medicaid savings.[vii] SCDHHS also ensured that the cost of the LARC device and insertion procedure was covered in the capitated rate for all Medicaid managed care plans in the state.
- SCDHHS issued a bulletin in January 2012 communicating the new reimbursement. The policy went into effect in March 2012.
- One year after the policy went into effect, SCDHHS was notified by one of the largest birthing hospitals in that they were not receiving reimbursement for LARCs inpatient. They discovered that the Medicaid electronic claims system had not been updated to align with the new policy. SCDHHS worked with internal IT staff to update the system, as well as with hospital claims staff to better educate them on how to bill correctly for the new service. SCDHHS also issued a clarification bulletin in August 2013 with additional details about how to bill for LARC insertion inpatient. All claims for inpatient LARC insertion dating back to the policy's enactment were paid. SCDHHS continues to offer resources and assistance to help with billing and claims.
- The largest private payer in the state, BlueCross BlueShield South Carolina (BCBSSC), also adopted the Medicaid policy for their covered members reimbursing for the device outside the Diagnosis Related Group (DRG).[1]
- BCBSSC's Medical Director, who sits on the SCBOI Vision Team, was a key supporter, which resulted in also applying the policy to members of the Public Employee Benefit Authority, the insurance benefit carrier for state employees.
- SCDHHS provides information and updates about the policy and utilization of LARCs at SCBOI meetings. Physician champions from SCBOI continue to share information about policy implementation at their own hospitals. In addition, SCDHHS works with hospitals to discuss how to best support continued educational efforts on claims issues through their SCBOI team.
- Hospitals have faced a number of logistical challenges to implementing systematic postpartum LARC insertion, including estimating proper stocking, storage and inventory, and changing provider practices. Nursing staff—particularly labor and delivery nurses—and administrative

[1] 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."[1]

staff were key champions to addressing logistical issues and bringing all members of the care team on board.
    - Some hospitals created tackle boxes or go-to boxes that included the equipment and supplies needed for LARC insertion that could be quickly retrieved, at any time, in both the labor and delivery area and on surgical floors.
    - Hospital staff coordinate with pharmacy staff to properly stock, store, and inventory LARC devices.
    - In one hospital, an OB/GYN champion worked with nursing supervisors and physicians on four different floors to develop and implement protocols and training for inserting the progesterone implant Nexplanon.
- SCDHHS and SCBOI partners focused on training for providers, key care team members, and stakeholders to increase knowledge about postpartum LARC insertion and address provider concerns. Through funding from the South Carolina Campaign to Prevent Teen Pregnancy, SCDHEC staff provided training and technical assistance to providers and staff in one community hospital, including lactation consultants, to educate them about LARCs and clear up misperceptions.
- Many providers believed certain myths about LARC insertion, including that LARCs have very high expulsion rates immediately postpartum and that progesterone-only LARCs negatively impact breastmilk production. Other providers did not support LARC insertion immediately postpartum in general, or did not know how to insert an IUD in specific postpartum situations (for example, after a C-section).
- There have been five SCBOI annual symposiums where LARC's were highlighted in breakout sessions. The Third Annual SCBOI Symposium in November 2014 featured LARC breakout workshops that were attended by 350 participants. Partners also hosted a SCBOI webinar (slides here) in March 2015.
- In addition to inpatient utilization efforts, SCBOI and SCDHHS developed another mechanism for outpatient LARC billing to reduce provider barriers. The process, known as white bagging, entails payers (e.g., Medicaid) purchasing drugs or devices through a specialty pharmacy, which then ships them to the provider for administration to a patient. Through 2015, pharmacy benefit accounts for 30 percent of overall LARC purchases.
- As a next step, SCBOI, the Choose Well initiative, and physician champions developed a comprehensive postpartum LARC toolkit, released in November 2015. The toolkit includes modules on prenatal family planning counseling, standardizing the consent process, and adolescents' unique needs.
- On behalf of SCDHHS, for the past two years SCBOI has had access to the SimCOACH, a fully-equipped mobile simulation training center, which has enabled SCBOI to visit all 44 birthing hospitals to demonstrate maternal and child delivery training as well as insertion of hormonal implants.

**Results**

- SCBOI received very positive feedback from physicians and patients. Individual OB/GYNs say LARCs are wildly popular with their patients because of the convenience of receiving a LARC immediately after delivery. In three of the largest birthing hospitals, their rate of inpatient insertions is approximately 30 percent.

- As of May 2016, LARC insertions have increased significantly. Seventeen percent of Medicaid patients who give birth choose to have a LARC device inserted immediately postpartum.
- SCDHHS and SCBOI continue to work collaboratively to analyze additional data on LARC utilization and the impact of the inpatient policy on quality health measures.

**Lessons Learned**

- **Partnerships are key**. Identify local physician champions who will advocate for immediate postpartum LARC with hospital administrators. Other key hospital partners include labor and delivery staff, pharmacy, and hospital claims department staff. These partners must be part of the conversation early on to help avoid logistical pitfalls. The more effective and efficient those partnerships are from the beginning, the easier full implementation will be. In addition, it is important to collaborate with other stakeholders to target populations at high risk for repeat births such as teen moms.
- **Working closely with payers and hospital billing staff is critical**. Medicaid systems and claims staff must be at the table from day one. It is also important to keep MCOs informed throughout the policy change process so they are prepared to launch their updated claims systems when Medicaid releases their provider bulletin. It is equally important to offer ongoing informational calls and opportunities for Q&A sessions with hospital billing managers before, during, and after policy implementation. Finally, in South Carolina it was critical to clarify and confirm MCO contract language obligations for recording inpatient DRGs.
- **Listening to provider cost concerns.** In South Carolina, the LARC device is subject to a state sales tax under law. This ranged from $45-$60 per device. Inpatient and outpatient providers routinely stated that this was cost prohibitive to their continued LARC prescribing. As a result, in July 2016, SCDHHS increased the reimbursement based on an 8 percent tax for all devices. Blue Cross Blue Shield follows SCDHHS's reimbursement rate, which replicates the coverage for the device for providers treating private insurance holders.
- **Demand for LARCs is high.** Once women receive accurate information about LARCs, they tend to be very receptive to having one. One hospital's high volume of Nexplanon insertions and apparent low removal rate illustrates how well they are being received.
- **Debunking myths is critical to achieve buy-in**. Many different stakeholders—including patients, nurses, physicians, and other hospital staff—have misconceptions about LARCs that must be addressed to achieve broad buy-in. In addition, many stakeholders either aren't aware of LARCs or the demand for them. In particular, it is important to anticipate and be prepared to answer questions about whether IUD expulsion rates are higher with postpartum insertion.

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