An innovative strategy to help reduce the rate of unintended short interval pregnancies (pregnancies that occur within 18 months of delivery) has been the introduction of immediate postpartum long-acting reversible contraception (IPP-LARC). IPP-LARC is the provision of either an implant or intrauterine device after delivery and in the hospital setting prior to inpatient discharge. This approach ensures access to the most effective reversible contraceptive options available. Implementing IPP-LARC also addresses the low rate of attendance at outpatient postpartum visits and lack of insurance coverage that Medicaid recipients often face in the postpartum period and thereby serves as an effective health equity strategy. Initially, some state Medicaid agencies offered this option, but with a payment model that included coverage within the global fixed delivery reimbursement. This payment model led to ongoing barriers to implementing IPP-LARC given hospital reluctances to cover the high upfront costs of LARC devices.\textsuperscript{1}

Since 2012, many state Medicaid agencies began providing separate reimbursement for inpatient LARC delivery. In their study, Steenland and colleagues\textsuperscript{1} set out to determine whether Medicaid payments for IPP-LARC have increased the availability and use of LARC across multiple states and hospital settings. Not surprisingly, they found such state funding was associated with increased LARC uptake among Medicaid recipients and, by proxy, for commercial insurance patients in states and specifically hospitals that offered IPP-LARC. These findings highlight the impact state agencies and policies have when they make provision of cost-effective methods a fiscal reality for clinicians and patients.

Importantly, while these findings are substantial and encouraging, the analysis by Steenland et al\textsuperscript{1} highlights ongoing barriers to full implementation of these policies.\textsuperscript{1} Notably, while substantial improvements occurred, they were mainly driven by a small proportion of hospitals that implemented IPP-LARC, after the policy only 10% of the hospitals provided more than 1% of birthing people with IPP-LARC. Factors associated with being an adopter of IPP-LARC included hospitals that have the highest level of obstetric care and those that are teaching hospitals. Factors associated with nonadoption of the policies included rural and Catholic hospitals. These findings highlight that the actualization of this policy across communities is low and uneven and that many birthing people continue to miss out on this key health strategy.\textsuperscript{1}

The association of high acuity obstetrical services and teaching hospitals as adopters is likely strongly correlated as many teaching hospitals offer higher level care. In a qualitative study examining facilitators and barriers to IPP-LARC implementation,\textsuperscript{2} the authors found that the adopters were often at teaching hospitals and efforts were attributed to faculty stakeholders who may be fellowship trained in Complex Family Planning and are committed to ensuring access to this policy. Many of these stakeholders may have allotted time to work on implementation using academic administrative time and/or with the backing of their leadership who sees this as a critical initiative given the high percentage of Medicaid births in their settings. However, the implementation of IPP-LARC protocols require substantial engagement with multiple stakeholders at the hospital level and competing clinical and administrative policies is often a barrier.\textsuperscript{2} It is unlikely that such faculty champions exist in non-academic settings or that when that they do that these individuals have the expertise, time, resources, or support they need to make IPP-LARC implementation a reality.

Greater attention is needed to help close these gaps in implementation as it is likely that disparities in care will grow at hospitals that have not implemented IPP-LARC compared with those
that have. The finding that rural hospitals are less likely to provide IPP-LARC is particularly problematic as such communities often face challenges to contraceptive access.\textsuperscript{3} Restricting access in a rural setting often means that there are no other community hospitals available to patients that are in close proximity, making state funding for IPP-LARC an impractical reality for rural patients. To improve IPP-LARC implementation, state funding agencies should include strategic maternal health initiatives that specifically include hospital incentives for IPP-LARC implementation and target rural settings. Investments should also be made to support collaborative and consultative support of stakeholders with expertise and experience with initiating IPP-LARC implementation.

Steenland and colleagues\textsuperscript{1} also found that none of the Catholic hospitals studied provided IPP-LARC. Notably, many Catholic hospitals exist in rural communities and serve as the sole community hospital.\textsuperscript{4} Catholic hospitals and health care facilities are expected to follow the Ethical and Religious Directives for Catholic Health Care Services, which restricts all forms of contraception on the basis that sex should be with the intention to procreate.\textsuperscript{4} Prior studies have highlighted that while workarounds sometimes exist in Catholic settings to allow for contraceptive access, this is usually more common for short-acting methods compared with LARC as short-acting methods are often obtained offsite and do not require hospital purchasing.\textsuperscript{4-6} Furthermore, workarounds often rely on the need to document a noncontraceptive indication, making the implementation of IPP-LARC purely for contraceptive access an impossibility.\textsuperscript{6} While state Medicaid agencies likely cannot overcome federal protections that allow religious institutions to restrict care, prior community responses to Catholic health care mergers and acquisitions have been impactful in blocking acquisitions or ensuring a certain level of reproductive care is maintained in contractual agreements. Raising awareness of the lack of availability of IPP-LARC at Catholic hospitals can help ensure that community members and other relevant stakeholders are fully informed about the impact Catholic affiliations can have on their care and their tax-payer dollars.

I commend and thank Steenland and colleagues\textsuperscript{1} for continuing to produce high quality evidence on the topic of IPP-LARC. The change from reimbursement as part of the global delivery fee to a separate reimbursement has been a critical step to improving IPP-LARC implementation. Questions that require additional work and research include to what extent these policies differentially affected patients (eg, patients from minoritized ethnic and racial groups compared with their White counterparts) and to what extent increasing access actualizes to lower rates of short-intended pregnancies across multiple states. Yet, regardless, we know from this study and virtually any other study on contraception initiatives that the more you provide contraceptive access, the more patients will gain contraception and that such efforts reduce unintended pregnancies. We must use the findings from this study to continue to move the needle forward and improve IPP-LARC implementation at the many hospitals that have not yet taken on this strategic health equity initiative. At a time when abortion access is no longer available in all states, we need more hospitals and state funding agencies to urgently respond with effective preventative health strategies like IPP-LARC now more than ever.

**ARTICLE INFORMATION**

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