Provider/External Stakeholders Questions
Revisions to the 1E-7 Family Planning Services Policy

Comments from the NC Pediatric Society
January 29, 2021

1. What is important to your constituents/colleagues regarding this policy?

Thank you for the opportunity to comment on the Family Planning Services Policy 1E-7. The North Carolina Pediatric Society is in support of this policy revision to extend Medicaid coverage from a 3-month supply to 12 months’ supply of contraceptive pills. Allowing NC Medicaid participants to fill a 12 month supply of oral contraceptive prescription at one time is just good public health practice. We also urge allowing a 13 rather than 12 month supply so that women wishing to be on continuous rather than cyclic oral contraceptives (those who wish to skip the withdrawal bleed for medical or personal reasons) would also be able to get a full year of continuous contraception.

This would allow women to take charge of their reproductive health, decreases the risk of missed doses and the potential for unintended pregnancies if women cannot get to the pharmacy in time. Consistent use of contraception is the most effective method of preventing pregnancy and birth spacing promotes healthier birth outcomes. Allowing women to get a year’s prescription for contraceptives at one time removes some of the financial and logistical barriers to continuous usage of contraceptives. This is of particular concern for low- and middle-income women who may have unpredictable work hours, face difficulty accessing transportation, or other barriers.

Short inter-pregnancy intervals have been associated with adverse neonatal outcomes, including low birth weight and prematurity. ACOG reports that as many as 40% of women do not return for the 6 week postpartum visit; attendance rates are even lower in limited resource areas, further contributing to health disparities. Unplanned pregnancies and close birth spacing can increase the likelihood of premature births, future pregnancy obstetric complications, decreased attention to current babies with whatever consequences that may have on development, increased emotional and financial strain on parents (with all of their potential consequences, e.g. postpartum depression, increased risk of depression, increased risk of IPV).
Unfortunately, coverage expires at the end of the month in which the 60th day falls, postpartum. Statewide, attendance of postpartum visits is around 40% or less. This is clearly a key opportunity to address chronic health issues and contraception. Family Planning Medicaid has almost the same financial eligibility as Medicaid for Pregnant Women, so it is key to provide access both for individuals who did not get care in the window in which they still had postpartum Medicaid coverage, or low-income individuals not meeting other Medicaid eligibility requirements. As all the caveats above indicate that this group of women face many barriers in accessing care. So, in one visit, to be able to prescribe a full year of contraception at a time when they have coverage would enhance access and reduce barriers to care. In short, extending Medicaid coverage for postpartum women from 3 months’ to 12 or 13 months’ supply reduces the chances that women would have a gap in birth control use.

2. Would you recommend any unit or other limitations to the service?

   No, there are no further recommended units or limitations to this service.

3. If this service should be limited to certain diagnoses, please include your recommendations with evidence to support the diagnoses that you have recommended.

   Prescription should be at the medical discretion of the provider based on individual patient situations.

4. Is there any additional evidence in medical literature on the procedure that you would like to present?

   A Massachusetts study looked at the impact of health care reform on low-income women accessing reproductive health services. This study reported that concentrated efforts are needed to make sure that health services are available and accessible to populations who many times “fall through the cracks of health care reform”. 1 In addition to mitigating barriers, of great concern is the maternal mortality rate that in on the rise in the US, along with the stark racial disparities in maternal mortality: Black women are three to four times more likely to die from a pregnancy-related complication than non-Hispanic white women, and American Indian/Alaska Native women are two and a half times more likely to die from a pregnancy-related complication than non-Hispanic white women. North Carolina ranks 30th in the country in terms of maternal mortality rates, according to the Centers for Disease Control and Prevention (CDC). To the extent that a year prescription can help lengthen birth spacing and improve birth outcomes, this policy change might help address these gaps.

   North Carolina has the opportunity to follow the lead of many other states, such as California, where a one-time script for a 12 month supply of contraceptive pills has been allowed for Medicaid participants since 2017. 2 Annual dispensing of contraceptive pills allows for consistent, reliable access to birth control which reduces the incidence of unintended pregnancies by 30 percent and increases contraception continuation rates. 3


5. What additional criteria would you include in the policy to define the service and identify community standards of practice?

We reiterate further positive step forward would be allowing a 13 rather than 12 month supply so that women wishing to be on continuous rather than cyclic oral contraceptives (those who wish to skip the withdrawal bleed for medical or personal reasons) would also be able to get a full year of continuous contraception.

The re-enrollment/other paperwork should be done at birth in hospital, not with undue burdens on a new mother.

The exclusion of dental and mental health coverage in this policy is concerning. Poor dental hygiene is common in pregnant women and carries significant risk for baby. Also, considering that FP Medicaid persists for several weeks postpartum, it appears that behavioral health should be included in coverage to address postpartum depression which can have significant impact on baby. Hep B coverage should also be included and clearly stated within the coverage for STD screening.