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Commentary

COVID-19 highlights the policy barriers and complexities of postpartum sterilization

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ABSTRACT

Multiple barriers exist to sterilization in the postpartum period. One such barrier, the Medicaid Title XIX sterilization policy, requires publicly insured patients to complete a sterilization consent form at least 30 days prior to their scheduled procedure. While this policy was set in place in the 1970s to address the practice of coerced sterilization among marginalized women, it has served as a significant barrier to obtaining the procedure in the contemporary period. The COVID-19 pandemic has highlighted specific complexities surrounding postpartum sterilization and created additional barriers for women desiring this contraceptive method. Despite the time constraints to perform postpartum sterilization, some hospital administrators, elective officials, and state Medicaid offices deemed sterilization as "elective." Additionally, as the Center for Medicare and Medicaid Services (CMS) has revised telemedicine reimbursement and encouraged its increased use, it has provided no guidance for the sterilization consent form, use of oral consents, and change to the sterilization consent form expiration date. This leaves individual states to create policies and recommended procedures that may not be accepted or recognized by CMS. These barriers put significant strain on patients attempting to obtain postpartum sterilization, specifically for patients with lower incomes and women of color. CMS can support reproductive health for vulnerable populations by providing clear guidance to state Medicaid offices, extending the 180-day expiration of a sterilization consent form signed prior to the pandemic, and allowing for telemedicine oral consents with witnesses or electronic signatures.

Multiple barriers exist to accessing postpartum sterilization procedures including at the patient- and provider-level, within hospital settings, and at the policy level. The Medicaid Title XIX sterilization policy, mandates a sterilization consent form be signed at least 30 days prior to a sterilization procedure. This policy was enacted in 1974 in response to the unacceptable instances of coerced sterilization of marginalized women [2]. However, in several studies with clinical samples, as few as half of women on Medicaid who desire a postpartum sterilization actually have the procedure, and greater than 20% who do not obtain their desired postpartum sterilization will have a subsequent unintended pregnancy within the following year [3–7]. These unplanned and unintended pregnancies disproportionally impact low-income women of color, adding to the morbidity and mortality of this population [2,8].

These disparities in access to care and reproductive outcomes were widespread prior to the arrival of COVID-19 and it remains to be seen whether ongoing underlying disparities in health care will also be exacerbated during and due to the pandemic. Access to reproductive health care has only become more challenging during this pandemic with a recent survey estimating that up to 1/3 of women experienced pandemic-related delays or cancellations of sexual or reproductive health services [9]. In addition to the impact on individual patient health, unfulfilled sterilization requests are associated with significant public health impact and resultant costs to the health system [10].

Several specific barriers and complexities surrounding postpartum sterilization have been highlighted during the COVID-19 pandemic. First, sterilization, unlike other forms of contraception, requires the use of an operating room and personal protective equipment (PPE). Given the need to conserve PPE and minimize infectious exposure, the Centers for Medicare and Medicaid Services (CMS) recommended canceling or delaying elective proce-

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dures. However, the term "elective" was left up to interpretation by clinicians, hospitals, and even politicians. Although the American College of Obstetricians and Gynecologists (ACOG) has ample policy strongly stating that postpartum sterilization is urgent and not elective, many institutions and state Medicaid offices specified sterilization as "elective" and denied coverage for sterilization procedures completed during the peak of the pandemic [1,11]. While data of the prevalence of such restrictions and their long-term resultant impact are not yet available, individual state Medicaid restrictions as well as practice changes local to the authors and their institutions highlight the lack of prioritization of women's health and may lead to adverse outcomes.

Second, neither CMS nor individual state Medicaid agencies instituted any changes in sterilization consent form or process for reimbursement during the pandemic. For example, while telemedicine was encouraged by CMS to reduce exposure and comply with state shelter in place orders, no provision was made to transition from a hand-written signature on the sterilization consent form to allowance of oral consent or electronic signature to begin the 30-day waiting period. Through the Families First Coronavirus Response Act, states are also prohibited from ending a person's Medicaid coverage during this public health emergency; thus, potentially extending the timeframe a patient has insurance coverage for sterilization. However, there is lack of awareness of this among patients and providers and it is unclear when this provision will end [12]. CMS has also not issued specific guidance on whether or not the 180-day expiration date of the sterilization consent form will be adjusted so that those who were deferred from receiving a desired sterilization (due to consideration of sterilization as elective) can receive their procedure in a timely manner, without the need to fill out another sterilization consent form [12]. To our knowledge, one state (Missouri) is taking steps to extend the sterilization consent form validity past 180 days for those women who were unable to receive sterilization procedures due to the pandemic, but in the absence of CMS guidance on the matter, it is unclear if states have the authority to make these changes and whether such procedures will be reimbursed in part by federal dollars or need to be paid for exclusively with state-only funds [13]. As physician knowledge of sterilization consent form specifics, at baseline, is incomplete and demonstrates interstate and intrastate variation, the lack of clarity of changes in the process due to the pandemic will likely only exacerbate such misinformation and ultimately serve as an additional barrier to sterilization [14,15].

In a time when the United States (U.S.) is the only industrialized nation with a rising maternal mortality rate and a mortality rate three times higher in black women, can we deem women's health procedures such as sterilization truly elective [16]? Some will argue postpartum women have access to alternative methods of contraception, pregnancy is not inevitable, and therefore, women can wait for their sterilization procedure. However, this was true prior to the emergence of COVID-19, and yet women were at risk for unintended pregnancy. The U.S. health care system must pay special attention to the potential impact on already marginalized populations who faced disproportionate barriers prior to this global pandemic. As highlighted by the increasing complexity surrounding postpartum sterilization due to the pandemic, women's health is not a policy priority and women of color and low income consistently bear the brunt of the morbidity.

Prior to the COVID-19 pandemic, Massachusetts providers discovered widespread misinformation regarding policies and reimbursement beliefs surrounding the sterilization consent form and worked directly with their state Medicaid Office to provide online and clear guidance to complete the sterilization consent form [17]. This collaboration helped to clarify appropriate use of the sterilization consent form (i.e. preterm delivery, emergency abdominal surgery) and correct misconceptions surrounding the form. These guidelines will ultimately help to increase access to sterilization procedures for patients requesting the service. A similar approach could be done at individual state Medicaid offices and CMS to address misinformation and safeguard public health, especially during the COVID-19 pandemic and future public health emergencies. As the medical community has slowly begun to reopen office practices and increase surgical cases, will sterilization procedures be deemed a priority or will women be forced to wait longer and risk losing insurance coverage, having an unintended pregnancy, and suffering increased morbidity and mortality? CMS can support reproductive health for our most vulnerable populations by extending the 180-day form expiration, allowing for telemedicine oral consents or electronic signatures, and providing clear guidance to state Medicaid offices.

We urge policymakers to prioritize reproductive health outcomes and amend the sterilization consent form policy to facilitate access to care and not serve as a barrier. We also urge physicians, hospitals, and policymakers to prioritize potential adverse outcomes in women's health when evaluating risks and benefits of deferring and resuming surgical care. These small policy changes and personal advocacy efforts can help support women and their families at a critical time.

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