NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

*The corresponding author has opted to make this information publicly available.

Personal or nonessential information may be redacted at the editor’s discretion.

Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-19-1339

Fulfillment of desired sterilization at time of cesarean section according to insurance status

Dear Dr. Arora:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Aug 29, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: This secondary analysis sought to better understand the rates of sterilization at cesarean section based on insurance status and determine whether the Medicaid sterilization form limited access for patients. The study was conducted with appropriate methodology and presents valuable information that is applicable both to clinicians and policymakers alike.

Generally speaking, the wording/grammar in some of the article could be improved upon for improved readability and clarity. Specific comments:

Line 37 - Provide the total number of patients included before breaking it down. I.e. "A total of XX participants were included, ..."

Line 41 - Remove "of" after "Sixty-four of women"

Line 55 - Reference 1, consider using a more up-to-date reference, i.e. Current Contraceptive Status Among Women Aged 15-49: United States, 2015-2017 NCHS Data Brief No. 327, December 2018

Line 109 - Note well that the Medicaid Sterilization form references a "premature" delivery, not specifically a "preterm" delivery. Many Medicaid offices/hospitals/providers have interpreted that to mean different cutoff dates/gestational ages. One could argue that a 38w delivery is premature for someone who was otherwise planning a 39w repeat c-section. It would be interesting to stratify your results to see if broadening the interpretation of that cutoff to gestational ages after 37w, would have allowed for more patient's to have had their sterilization procedure at the time of c-section.

Line 119-120 - Sentence starting with "Five records..." is poorly written, please rewrite for easier readability

Line 122 - Consider rewriting to "Differences in sterilization achievement at time of cesarean were compared..."

Line 124 - Add another 1-2 sentences describing/justifying use of LASSO. That is not a statistical analysis method that many clinicians will be familiar with.

Line 141 - Only include the total number of patients that you included in your analysis. It gets confusing when you reference 1331 women in one spot, then 478 in another. Stick with 478 and readers can look at the flowchart to see the overall numbers from the original study.

Line 159 - Remove "of" after "Sixty-four of women"
Reviewer #2: The purpose of this manuscript was "To evaluate whether women with Medicaid are less likely than their privately-insured counterparts to receive a desired sterilization procedure at the time of cesarean section." This was a secondary analysis of a retrospective, cohort study.

1. This study was conducted at a single, academic, urban, tertiary care teaching hospital. Were all of the subjects both private and insured seen by residents, fellows, faculty or physicians in private practice? Are those with private insurance more likely to be seen by physicians in private practice? Do they have a protocol for when to discuss contraception and complete the Medicaid form? How is the Medicaid form stored in their EMR? Does it have its own, highly visible tab? Is there an alert that triggers for the Medicaid form at a specific gestational age? The authors note that 66% of subjects had the "Medicaid form not valid." Was the form not valid because the patient decided very late in pregnancy or was sterilization/contraception discussed late in pregnancy (and hence the form was not filled out until too late in pregnancy)?

2. In Figure 1, the authors note that 352 subjects were excluded for lack of insurance. How many of the uninsured patients had a cesarean section? How many had sterilization performed if they had a cesarean section?

3. Why did the authors select the time frame of January 1, 2012 to December 31, 2014? Did they perform an 'a priori' sample size determination for the original study and base the time frame on number needed and the number of deliveries with sterilization done at their institution?

4. In this study the authors note "Of the 1331 women who desired sterilization in our initial study, 478 (36%) delivered via cesarean section." However in Table 1 of Reference #13 (original study) the number of subjects who desired postpartum sterilization was 1030 with Medicaid and 154 with Private insurance=1184. Please clarify difference. How many were primary or repeat cesarean sections? How many cesarean sections were scheduled and how many in labor?

5. Could the authors please expand their Materials and Method section to include the information about the contraceptive plan being a required field in their Discharge summary and that some erase it. Also could they include more information about training of the 4 researchers, how the data was extracted and validation, like they did in the Methodology section of reference #13.

6. The authors note "While ensuring sufficient time to make an informed decision is the purpose of the Medicaid waiting period, our study demonstrates that the harms outweigh the benefits." Could the authors expand on what specific harms their study demonstrates that outweigh the benefits of waiting to allow sufficient time to make an informed decision?

7. Have the authors considered submission to a contraceptive journal?

Reviewer #3: This is a secondary analysis of a single-center cohort at a tertiary care academic medical center in Ohio. The objective of the study was assess sterilization at the time of cesarean delivery and to evaluate whether women with Medicaid were less likely than privately-insured subjects to receive the desired sterilization procedure at the time of cesarean section. They adequately demonstrated that a statistically significant difference in rates of successful sterilization occurred with Medicaid patients receiving them less often. Perhaps what is most unique about this study was that it allowed to assess reasons for the sterilization procedure to not have been completed. Furthermore, they were able to determine pregnancy rates within a year for those patients who did not receive their desired sterilization, and all subsequent pregnancies occurred in the medicaid cohort.

One facet of the study (perhaps beyond the scope of this study) that would be interesting to look at would be what forms of birth control patients were using when they did not receive desired sterilization. Did some receive immediate post-
placental IUD or some form of contraception prior to discharge. The authors do point out that we should be astute clinicians and think of backup methods in patients who have a history of prior cesarean delivery (As this was shown to be barrier to completion of sterilization in some patients in this cohort) and perhaps we need to do a better job of counseling patients that this might be a possibility so picking a backup method is not a bad idea.

Perhaps more striking is that many subjects in this study had ample opportunity to complete the sterilization forms as they were seen at some point within 6 months of delivery. Singing of the form to make it valid at >30d is the biggest barrier. In a future study, or maybe even a comment, the authors might address why these forms were not signed at a prenatal care visit. Is it lack of time to discuss this adequately? Patient indecisiveness.

Overall - this study is very well done and furthers our understanding of a disparity between private and public insurance and would add a great deal to the literature already out there.

STATISTICAL EDITOR COMMENTS:
The Statistical Editor makes the following points that need to be addressed:

- lines 121, Tables: Need to enumerate all missing data and state how missing data were dealt with in the analysis phase.
- Table 3: Need to complete the referent group list. I presume the age is meant to be OR and aOR per year of age and GA at delivery is meant to be OR and aOR per week of GA. Need to specify which variables were included as adjustors in the final model.
- Tables 1, 2, 4: When the column total is < 100, should format the n(%) entries to nearest integer value for %.
- Flow chart, Fig 1: Should extend the diagram to include the subsets who had sterilization and who did not achieve sterilization in each cohort.

EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

- Why these dates? A lot of things could have changed in the intervening 5 year years regarding hospital processes, etc. Also, of these 8654 women, how many underwent cesarean birth?
- Please state how you determined the women's desire for sterilization prior to her delivery.
- In the form, please provide the denominator or those who desired sterilization for the 2 groups. I think that the denominator of the %'s you are giving on line 37 is the number in each group who desired sterilization but you never say that. What this sentence actually says is the 90% of women with private insurance who had a cs got sterilized. Clearly not true. Please edit.
- In the conclusion, you tell us us this is the most common reason why, but you don't give us how common other reasons for not receiving desired sterilization are. The abstract needs to stand alone--if your main conclusion is that these other factors (GA, Prenatal care, marital status) are at high risk of bias given the very small RR’s, then give us more information about the others reasons for non-completion. Why give % for non completion but RR for the other factors? (Please note that effect sizes (RR, OR) within the zone of potential bias should be noted as weak. Those effect sizes in the zone of potential interest should be emphasized. (Ref: False alarms and pseudo-epidemics. The limitations of observational epidemiology. Grimes DA, Schulz KF. Ob Gyn 2012;120:920-7)) This limitation (zone of potential bias) is true as well for your primary outcome--RR of 0.86 for the two groups.
- This conclusion starting w/ "This form..." is an over reach. Maybe its not the form, but the process of getting the form completed that is the barrier.
- And its local implementation. Your sentence starting on line 75 implies that it is a fact that the Medicaid
policy is a barrier to care. While I agree that it is likely such, by writing it the way you have, it does not seem to allow for the possibility that it is NOT a barrier to care. Please consider an edit.

- Again, concerns that the local process may be the issue, and not the Medical sterilization form itself should be considered. In the introduction, could you please state what the Medical sterilization policy is and may be a brief discussion of its history--how long has it been in place, note its a federal regulation and perhaps a line or two regarding its reason for being. You would need to shorten some of he rest of your introduction to keep your intro at about 1 page. Also, please describe the extant process for getting this form signed in your clinics. Clinic reminders? What EGA? Where was form kept? If EMR, is it scanned into record? IF paper, how was it made available in L&D?

- Please indicate local practice standards re: documenting contraceptive plans in the prenatal period (prior to delivery admission). Also, were these a mixture of paper and electronic prenatal records?

- Did you record whether the patient had a clinic visit 30 days or more prior to delivery?

- how did they differ?

- See note about this sentence in the abstract You never give us the N of women who delivered by Cesarean who desired sterilization.

- Please around line 147 tell us the n of how many women in each group desird but did not get the sterilization. This will make statements like the one here on line 159 easier to interpret. It looks like about 100 women were in this group (Desired, did not obtain) but make it easy on the reader.

- Then how did you figure it out for the other 45? I'm confused about how all of these numbers add up.

- On line 141 you give the total number with Cesarean delivery to be 478, but 306 +89+78+8=481. Please confirm the total number is 479 then account for the missing patients

- by "we encourage" do you mean, as a result of the findings of your study or do you mean that this was the stance regarding care in your clinic in the years of study?

- Does it demonstrate this? How do you know how many women benefited from having such a waiting period? You didn't study this.

- one cannot "extrapolate" specific documentation. Not sure what you mean by this.

- My understanding, which may be faulty, is that part of the reason for the 30 day period is to protect low income women from being pressured by providers into sterilization--which seems like a real risk given everything we are learning about biases against particularly black women within the health care system. In your conclusion, please expand a bit how to balance all of these opposing important issues: respecting the autonomy of women to make their own reproductive decisions while protecting them from inappropriate pressures.

- We prefer to avoid providing p values only unless that is the only appropriate test of significance. Where possible in the abstract AND the text, please provide an effect size (such as an OR or RR) and 95% CI's as well as the absolute numbers.

- please indicate what the BOLD represents.

- please make it clear here in the the 45 for whom it was not documented as reason that you determined this based on your inspection of the form. Should be clearer in the results section of the text as well.

2. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
   A. OPT-IN: Yes, please publish my point-by-point response letter.
   B. OPT-OUT: No, please do not publish my point-by-point response letter.

3. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.
4. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

5. Please submit a completed STROBE checklist with your revision.

Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

6. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

8. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

9. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

10. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

11. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

12. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size,
such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1").

13. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

14. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

15. Figure 1 may be resubmitted as-is with the revision.

16. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acz/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

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If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Aug 29, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/ong/login.asp?a=r). Please contact the publication office if you have any questions.
Reviewer #1: This secondary analysis sought to better understand the rates of sterilization at cesarean section based on insurance status and determine whether the Medicaid sterilization form limited access for patients. The study was conducted with appropriate methodology and presents valuable information that is applicable both to clinicians and policymakers alike.

Thank you for your time and thoughtful review.

Generally speaking, the wording/grammar in some of the article could be improved upon for improved readability and clarity. Specific comments:

Line 37 - Provide the total number of patients included before breaking it down. I.e. "A total of XX participants were included, ..."

This has been added.

Line 41 - Remove "of" after "Sixty-four of women"

This has been removed.

Line 55 - Reference 1, consider using a more up-to-date reference, i.e. Current Contraceptive Status Among Women Aged 15-49: United States, 2015-2017 NCHS Data Brief No. 327, December 2018

Thank you. This has been updated.

Line 109 - Note well that the Medicaid Sterilization form references a "premature" delivery, not specifically a "preterm" delivery. Many Medicaid offices/hospitals/providers have interpreted that to mean different cutoff dates/gestational ages. One could argue that a 38w delivery is premature for someone who was otherwise planning a 39w repeat c-section. It would be interesting to stratify your results to see if broadening the interpretation of that cutoff to gestational ages after 37w, would have allowed for more patient's to have had their sterilization procedure at the time of c-section.

Thank you for this interesting point. While we have reported this discrepancy on the part of providers in a prior study (https://www.ncbi.nlm.nih.gov/pubmed/28888588), we are unaware of any published reports of such variation on the part of Medicaid offices or hospitals (other than our own unpublished work from a third study). However, as we mention in the remainder of that paragraph, we followed the rules that are familiar to our clinicians, are our hospital’s policy, and are our understanding of the relevant state policy in Ohio.

However, while not clinically or policy-wise relevant in our study, out of curiosity, we did re-analyze the data given the reviewer’s comment. Eleven women in our cohort delivered at term but prior to 39 weeks. Of these women, only 2 additional women with Medicaid...
would have been able to be sterilized if the interpretation of the policy in Ohio were broader. Of course, 64 more would have been able to be sterilized if the waiting period did not exist, as it does not for privately-insured women.

Line 119-120 - Sentence starting with "Five records..." is poorly written, please rewrite for easier readability

We have edited for improved readability.

Line 122 - Consider rewriting to "Differences in sterilization achievement at time of cesarean were compared..."

This has been done.

Line 124 - Add another 1-2 sentences describing/justifying use of LASSO. That is not a statistical analysis method that many clinicians will be familiar with.

We have added additional information on LASSO. Thank you for this point.

Line 141 - Only include the total number of patients that you included in your analysis. It gets confusing when you reference 1331 women in one spot, then 478 in another. Stick with 478 and readers can look at the flowchart to see the overall numbers from the original study.

We have made this change.

Line 159 - Remove "of" after "Sixty-four of women"

Thank you for the close reading. We have made this change.

Line 170 - Add "the" after "of", so that it reads "4 of the cases..."

We have removed “of” so it reads “not able to be determined in 4 cases based on. . .” to ensure symmetry with our style throughout the remainder of the manuscript.

Lines 174-179 - Rewrite and clarify the sentences "Among women with Medicaid... (p values could not be calculated).", in particular the "who did not attended their postpartum visit" reads weird. I understand that you're saying women who did not have a tubal ligation attended their postpartum visit, but with first glance, I misunderstood and thought you were saying the percentage of women who didn't attend their postpartum visit.

We have edited to improve clarity.

Line 180 - Change "woman" to "women"
We have made this change. Thank you for the careful reading.

Line 182 - Include percentage with number 15

Thank you. We have added this percentage.

Line 241 - Remove the word "for"

This edit has been made.

Reviewer #2: The purpose of this manuscript was "To evaluate whether women with Medicaid are less likely than their privately-insured counterparts to receive a desired sterilization procedure at the time of cesarean section." This was a secondary analysis of a retrospective, cohort study.

Thank you for your time and thoughtful review.

1. This study was conducted at a single, academic, urban, tertiary care teaching hospital. Were all of the subjects both private and insured seen by residents, fellows, faculty or physicians in private practice? Are those with private insurance more likely to be seen by physicians in private practice? Do they have a protocol for when to discuss contraception and complete the Medicaid form? How is the Medicaid form stored in their EMR? Does it have its own, highly visible tab? Is there an alert that triggers for the Medicaid form at a specific gestational age? The authors note that 66% of subjects had the "Medicaid form not valid." Was the form not valid because the patient decided very late in pregnancy or was sterilization/contraception discussed late in pregnancy (and hence the form was not filled out until too late in pregnancy)?

Our hospital is a closed faculty group in academic practice. All patients (both privately- and Medicaid-insured) are seen by attendings in either their own clinics or in direct supervision of resident/fellows. Patients, regardless of insurance, are offered their choice of physician (whether in training or faculty). Those women with private insurance are more likely to be seen by faculty in their own clinics given referral patterns and patient self-selection. We do not have a protocol for when contraception and the Medicaid form are discussed in prenatal clinic. We have added a sentence into the Discussion discussing these limitations and its potential impact on external generalizability.

The Medicaid form is scanned in and stored in the EMR in the same tab as all other outside health records and consent forms. It does not have its own tab and there is no alert to sign the form. Of the 66% of women who did not have a valid Medicaid form, 68% had a visit within the timeframe that would have resulted in a valid form had the form been signed. This is mentioned in both the Results and stressed in the Discussion as a key take-away from this study. Ample opportunities to improve care exist. We thank the Reviewer for the suggestion for an informatics-based tool to remind clinicians to complete the form.
2. In Figure 1, the authors note that 352 subjects were excluded for lack of insurance. How many of the uninsured patients had a cesarean section? How many had sterilization performed if they had a cesarean section?

   Ninety-eight (27.8%) of the 352 uninsured patients had a cesarean section. Of these 98, 27 desired sterilization and 23 (85%) were completed.

3. Why did the authors select the time frame of January 1, 2012 to December 31, 2014? Did they perform an 'a priori' sample size determination for the original study and base the time frame on number needed and the number of deliveries with sterilization done at their institution?

   Yes, we had performed an a priori sample size calculation to determine the number of years of delivery records we would need to abstract for our primary study hypothesis as reported in Reference #13. We were adequately powered for that analysis – and as mentioned at the end of the Methods section of this manuscript, well-powered for this secondary analysis.

4. In this study the authors note "Of the 1331 women who desired sterilization in our initial study, 478 (36%) delivered via cesarean section." However in Table 1 of Reference #13 (original study) the number of subjects who desired postpartum sterilization was 1030 with Medicaid and 154 with Private insurance=1184. Please clarify difference. How many were primary or repeat cesarean sections? How many cesarean sections were scheduled and how many in labor?

   There were 1184 women who desired sterilization with either Medicaid or private insurance. The remaining 147 women (for a total of 1331) had either Medicare, Tricare/Champus, or were uninsured and were excluded from both the primary analysis and this secondary analysis as it was not relevant to the study hypothesis.

   We did not abstract the reason for the cesarean and timing in relation to labor.

5. Could the authors please expand their Materials and Method section to include the information about the contraceptive plan being a required field in their Discharge summary and that some erase it. Also could they include more information about training of the 4 researchers, how the data was extracted and validation, like they did in the Methodology section of reference #13.

   We have added both of these points to our Methods section.

6. The authors note "While ensuring sufficient time to make an informed decision is the purpose of the Medicaid waiting period, our study demonstrates that the harms outweigh the benefits." Could the authors expand on what specific harms their study demonstrates that outweigh the benefits of waiting to allow sufficient time to make an informed decision?

   We have elaborated on this sentence. What we meant was that women who desired sterilization were prevented from getting one (harm) and the benefit (ensuring informed consent) can be achieved in other ways without the form.
7. Have the authors considered submission to a contraceptive journal?

*Given the broad clinical relevance and policy implications, we feel our manuscript is best suited to a general ob-gyn journal.*

Reviewer #3: This is a secondary analysis of a single-center cohort at a tertiary care academic medical center in Ohio. The objective of the study was to assess sterilization at the time of cesarean delivery and to evaluate whether women with Medicaid were less likely than privately-insured subjects to receive the desired sterilization procedure at the time of cesarean section. They adequately demonstrated that a statistically significant difference in rates of successful sterilization occurred with Medicaid patients receiving them less often. Perhaps what is most unique about this study was that it allowed to assess reasons for the sterilization procedure to not have been completed. Furthermore, they were able to determine pregnancy rates within a year for those patients who did not receive their desired sterilization, and all subsequent pregnancies occurred in the Medicaid cohort.

One facet of the study (perhaps beyond the scope of this study) that would be interesting to look at would be what forms of birth control patients were using when they did not receive desired sterilization. Did some receive immediate post-placental IUD or some form of contraception prior to discharge. The authors do point out that we should be astute clinicians and think of backup methods in patients who have a history of prior cesarean delivery (As this was shown to be a barrier to completion of sterilization in some patients in this cohort) and perhaps we need to do a better job of counseling patients that this might be a possibility so picking a backup method is not a bad idea.

*Postplacental IUD was not available at our hospital during the study timeframe (or any other hospital in the region). We did report in a separate secondary analysis on the provision of bridge contraception to interval sterilization (or lack thereof) ([https://www.ncbi.nlm.nih.gov/pubmed/30095782](https://www.ncbi.nlm.nih.gov/pubmed/30095782)). However, given your question, we did return to the data to see what was prescribed prior to discharge in those who did not receive sterilization at the time of cesarean. Of the 89 women with Medicaid who were not sterilized, 7 received Depo-Provera, 2 received progestin-only pill prescriptions, 1 received a prescription for the combined oral contraceptive pill. 5 planned on an interval IUD and the remainder planned on interval sterilization. Of the 8 privately insured women who were not sterilized at time of cesarean, 1 received Depo-Provera and the remainder planned on interval sterilization.*

*As the data are complex and not immediately related to this study hypothesis, we have not included it in this manuscript, though as you reference, we have briefly discussed alternative contraceptive plans in the Discussion as a major clinical take-home point.*

Perhaps more striking is that many subjects in this study had ample opportunity to complete the sterilization forms as they were seen at some point within 6 months of delivery. Singing of the form to make it valid at >30d is the biggest barrier. In a future study, or maybe even a comment,
the authors might address why these forms were not signed at a prenatal care visit. Is it lack of
time to discuss this adequately? Patient indecisiveness.

Given the study methodology of relying only on chart documentation, we are unable to
determine the reason the forms were not signed given the (as you point out), the
opportunity in terms of office visits prior to delivery. Based on our clinical practice, we
assume much of this is due to physicians not inquiring regarding contraception due to a
lack of time or priority given to contraception as well as patient indecisiveness. However,
we do not have any empiric evidence of this from this study (or from the literature).

Overall - this study is very well done and furthers our understanding of a disparity between
private and public insurance and would add a great deal to the literature already out there.

Thank you for your time and thoughtful review.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 121, Tables: Need to enumerate all missing data and state how missing data were dealt with
in the analysis phase.

Thank you for this important point. We have added missingness to Table 1. The Methods
section has the enumerated information regarding missingness (“We were missing data
in five (1.0%) records for the variable of adequacy of prenatal care, 13 (2.7%) records
for marital status, and 26 (5.4%) records for education level. Complete data were
available for 437 (91.4%) records.”). However, we did not previously discuss how we
dealt with this missing data for our LASSO and so have added a sentence in the Methods
section discussing imputation.

Table 3: Need to complete the referent group list. I presume the age is meant to be OR
and aOR per year of age and GA at delivery is meant to be OR and aOR per week of
GA. Need to specify which variables were included as adjustors in the final model.

Thank you for this point. We have made these changes and included these two referents.
We have edited the footnote to the table that mentions that all variables shown were
included in the final model for increased clarity.

Tables 1, 2, 4: When the column total is < 100, should format the n(%) entries to nearest integer
value for %.

This has been accomplished.

Flow chart, Fig 1: Should extend the diagram to include the subsets who had sterilization and
who did not achieve sterilization in each cohort.
This has been done.

EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor’s specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

***The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - rzung@greenjournal.org.***

- Why these dates? Alot of things could have changed in the intervening 5 year years regarding hospital processes, etc. Also, of these 8654 women, how many underwent cesarean birth?

  \[
  \text{This is a secondary analysis of a database abstracted in 2016-2017. The study period (3 years) was chosen based on a sample size calculation for the outcome of interest of the primary study hypothesis.}
  \]

  \[
  \text{We have added the number and percent of cesareans in the overall study cohort to the abstract. It is also shown in Figure 1.}
  \]

- please state how you determined the women's desire for sterilization prior to her delivery.

  \[
  \text{We have added this additional information in the Methods section.}
  \]

- In the form, please provide the denominator or those who desired sterilization for the 2 groups. I think that the denominator of the %’s you are giving on line 37 is the number in each group who desired sterilization but you never say that. What this sentence actually says is the 90% of women with private insurance who had a cs got sterilized. Clearly not true. Please edit.

  \[
  \text{Thank you for catching this. This has been revised for clarity and to include the denominators.}
  \]

- In the conclusion, you tell us us this is the most common reason why, but you don't give us how common other reasons for not receiving desired sterilization are. The abstract needs to stand alone--if your main conclusion is that these other factors (GA, Prenatal care, marital status) are at high risk of bias given the very small RR's, then give us more information about the others reasons for non-completion. Why give % for non completion but RR for the other factors? (Please note that effect sizes (RR, OR) within the zone of potential bias should be noted as weak. Those effect sizes in the zone of potential interest should be emphasized. (Ref: False alarms and}
pseudo-epidemics. The limitations of observational epidemiology. Grimes DA, Schulz KF. Ob Gyn 2012;120:920-7)) This limitation (zone of potential bias) is true as well for your primary outcome--RR of 0.86 for the two groups.

- This conclusion starting w/ "This form..." is an over reach. Maybe its not the form, but the process of getting the form completed that is the barrier.

  We have rewritten the sentence to reflect this ambiguity.

- and its local implementation. Your sentence starting on line 75 implies that it is a fact that the Medicaid policy is a barrier to care. While I agree that it is likely such, by writing it the way you have, it does not seem to allow for the possibility that it is NOT a barrier to care. Please consider an edit.

  We have changed to address the ambiguity around this

- Again, concerns that the local process may be the issue, and not the Medical sterilization form itself should be considered. In the introduction, could you please state what the Medical sterilization policy is and may be a brief discussion of its history--how long has it been in place, note its a federal regulation and perhaps a line or two regarding its reason for being. You would need to shorten some of he rest of your introduction to keep your intro at about 1 page.

  We have added language regarding the history, impetus, and federal nature of the policy to the Introduction. We have attempted to keep this addition succinct (one sentence) in order to keep the Introduction brief.

- Also, please describe the extant process for getting this form signed in your clinics. Clinic reminders? What EGA? Where was form kept? If EMR, is it scanned into record? IF paper, how was it made available in L&D?

  We have added this additional information to the Methods section.

- Please indicate local practice standards re: documenting contraceptive plans in the prenatal period (prior to delivery admission). Also, were these a mixture of paper and electronic prenatal records?

  We have added this additional information to the Methods section.

- Did you record whether the patient had a clinic visit 30 days or more prior to delivery?
Of the 66% of women who did not have a valid Medicaid form, 68% had a visit within the timeframe that would have resulted in a valid form had the form been signed. This is mentioned in the Results

- how did they differ?

Further analyses were not done comparing those who had (vs did not have) a visit within the aforementioned timeframe. We are happy to include a new Table comparing these two populations, if desired, but did not do so at this time due to concerns regarding brevity.

- See note about this sentence in the abstract You never give us the N of women who delivered by Cesarean who desired sterilization.

We have added this to the Results section.

- Please around line 147 tell us the n of how many women in each group desired but did not get the sterilization. This will make statements like the one here on line 159 easier to interpret. It looks like about 100 women were in this group (Desired, did not obtain) but make it easy on the reader.

We have added this to the Results section.

- Then how did you figure it out for the other 45? I'm confused about how all of these numbers add up.

We have added additional clarification in the Methods, Results, and Discussion sections regarding this question.

- On line 141 you give the total number with Cesarean delivery to be 478, but 306+89+78+8=481. Please confirm the total number is 479 then account for the missing patients

These numbers have been corrected. Thank you for catching this.

- by "we encourage" do you mean, as a result of the findings of your study or do you mean that this was the stance regarding care in your clinic in the years of study?

This portion of the Discussion has been reworded, hopefully affording greater clarity.

- Does it demonstrate this? How do you know how many women benefited from having such a waiting period? You didn't study this.

This portion of the Discussion has been reworded.

- one cannot "extrapolate" specific documentation. Not sure what you mean by this.
We have added additional clarification regarding women for whom inspection of the form was required

- My understanding, which may be faulty, is that part of the reason for the 30 day period is to protect low income women from being pressured by providers into sterilization—which seems like a real risk given everything we are learning about biases against particularly black women within the health care system. In your conclusion, please expand a bit how to balance all of these opposing important issues: respecting the autonomy of women to make their own reproductive decisions while protecting them from inappropriate pressures.

Our understanding of the policy mirrors yours and we share your concern regarding the presence of both overt racism and implicit bias impacting the care of women of color.

We have added language acknowledged the importance of maintaining a measure to prevent coercion and the paradoxical nature of the form both preventing women from being sterilized unwillingly and preventing women from being sterilized when they want to.

- We prefer to avoid providing p values only unless that is the only appropriate test of significance. Where possible in the abstract AND the text, please provide an effect size (such as an OR or RR) and 95% CI’s as well as the absolute numbers.

p-values are removed from the abstract and text and are only shown in the 2 tables with demographic characteristics.

- please indicate what the BOLD represents.

This has been added to the description of the table.

- please make it clear here in the the 45 for whom it was not documented as reason that you determined this based on your inspection of the form. Should be clearer in the results section of the text as well.

A further explanation was included in the Methods and Results sections of the text as well as added to the Table.

2. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
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3. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

Acknowledged.

4. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

The lead author (Dr. Morris) confirms that this manuscript is an honest, accurate, and transparent account of the study being reported, that no important aspects of the study have been omitted, and that any discrepancies from the study as planned have been explained.

5. Please submit a completed STROBE checklist with your revision.

Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are
available at [http://ong.editorialmanager.com](http://ong.editorialmanager.com). In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

*This has been done.*

6. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at [https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize](https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize). If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

*This has been done.*

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

*We are within these limits.*

8. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal’s electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

*We have no acknowledgements.*

9. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not
contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

_We have checked the abstract carefully._

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

_We are at 298 words._

10. Only standard abbreviations and acronyms are allowed. A selected list is available online at [http://edmgr.ovid.com/ong/accounts/abbreviations.pdf](http://edmgr.ovid.com/ong/accounts/abbreviations.pdf). Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

_We have checked our abbreviations and acronyms._

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_We have removed the virgule throughout. We do not use and/or,_

12. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

_We present effect sizes throughout. P-values are only presented in the demographics tables._

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

_N/A._

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%_)

_We have done this._

13. Please review the journal's Table Checklist to make sure that your tables conform to journal
This has been done.

14. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

This has been done.

15. Figure 1 may be resubmitted as-is with the revision.

This has been done.

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