TOOLKIT

Expanding Access to Contraceptive Methods for FQHC Patients in Mississippi

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Health Management Associates

Introduction

State Medicaid programs are the largest single source of funding for Federally Qualified Health Center (FQHC) services, and they have a number of policy and payment levers at their disposal to promote comprehensive access to contraceptive methods, including long-acting reversible contraceptives (LARCs). The goal of this toolkit is to support Mississippi efforts to enhance access in FQHC settings by highlighting some of the reimbursement and policy options that can be leveraged, as well as identifying barriers and potential strategies.

FQHCs are community-based health care providers that deliver comprehensive, culturally competent, high-quality primary health care services, as well as integrated access to pharmacy, mental health, and oral health services. FQHCs deliver care to the most vulnerable individuals and families and provide services regardless of patients' ability to pay, through use of a sliding fee scale. FQHCs are required to provide obstetrics, gynecology, and voluntary family planning services to their patients, as well as share current evidence-based recommendations, training, and other resources to support high-quality primary health care services in these areas.

Converge is a Mississippi-based nonprofit that believes all people should have access to quality, affordable family planning care.

Converge is collaborating with FQHCs in Mississippi to help increase their knowledge of Medicaid policies related to family planning, with a specific focus on barriers related to LARCs. Until a recent Medicaid policy change, FQHCs were unable to receive any reimbursement from Medicaid for LARC devices, which resulted in a significant financial burden to clinics. Converge is also partnering with reproductive justice leaders in the state to ensure that patient autonomy and access to the full range of contraceptive care are centered in their work. To take advantage of a recently passed Medicaid State Plan Amendment improving reimbursement options for LARCs, Converge formed and convened a statewide advisory group to educate FQHCs. One product of this effort is this toolkit on how to overcome potential logistical and systems barriers. In addition to this toolkit, Converge commissioned focus groups of women about their experiences receiving family planning care in Mississippi. This toolkit will:

- Provide an overview of LARC-related policies that affect FQHCs and Medicaid Managed Care Organizations.
- Specifically address reimbursement challenges related to stocking and billing, as well as provide recommendations and considerations for overcoming these barriers in Mississippi.
- Discuss other barriers to providing LARCs in the FQHC setting and potential avenues to address them.

This toolkit is intended to help support a thorough, ongoing process that involves analysis of the state's current landscape, an assessment of potential solutions, and engagement of local stakeholders to support progress that is underway in Mississippi. This engagement and collaboration will continue to be necessary to address nuanced challenges that require sustained partnerships to overcome. In general, the toolkit is designed to support the larger public health goals of removing all barriers to reproductive autonomy, including ensuring that every person has ready access to their contraceptive method of choice. While this toolkit is intended to be a practical resource and support for decision making, it is not exhaustive and does not capture all of the nuanced policy and reimbursement issues that may exist at the state level. Nor does it describe all possible decision points or courses of action. We also do not attempt to quantify the results of specific policy and reimbursement options, as the impact will vary depending on many factors.

Role of LARCs in Comprehensive Family Planning Services

As health care providers and state Medicaid programs seek to meet their communities' family planning needs, they increasingly recognize the importance of access to a comprehensive range of contraceptive options, including LARC. Even though LARC utilization has increased in recent years, it is still relatively low in the United States despite their safety, effectiveness, and high rates of patient satisfaction.[i] Studies show that the overall percentage of U.S. female contraception users of childbearing age who use LARCs has grown. By 2014, just over 14% of women using a contraceptive relied on a LARC (just under 12% used an IUD, and just under 3% used an implant), up from 2% in 2002 to 6% in 2007 and 9% in 2009. [ii, iii] However, women with Medicaid coverage have been one of the few groups that did not see recent increases in utilization. While increased utilization is not in itself an appropriate goal, the disparate rates suggest a potential access gap. Between 2009 and 2012, use of LARCs among Medicaid-covered women remained fairly flat at 11.0% (compared with 11.5% in 2009), whereas prevalence of LARC use among women with private insurance and "other" coverage[iv] increased to 11.1% (up from 7.1%) and 14.0% (up from 8.0%), respectively.[v,vi] Compared with other countries, the prevalence of IUD use among married or in-union women in the United States is below the global average (5.1% in the United States compared with 13.7% worldwide).[vii] All FQHC patients should be able to access the full range of birth control options, regardless of their payer source.

Medicaid Policy and Coverage Barriers

Medicaid family planning coverage varies from state to state, and although most states cover LARCs in some way, broad underlying Medicaid coverage issues exist in many states that limit access to and utilization of LARCs.[viii,ix] Depending on the state, patients and providers may face challenges such as restrictive utilization management requirements (including restrictions on coverage for removals) or lack of same-day access for device insertion. In an effort to address barriers, a June 2016 letter to State Health Officials from the Centers for Medicare and Medicaid Services (CMS) encouraged states to cover all FDA-identified contraceptives (including LARC) under their state plan and indicated that one pathway to do this is to align their state plan with their Alternative Benefit Plan (ABP) coverage for these services.[x] **Since there is a 90% federal match for family planning services and supplies, the cost to states of covering LARCs can be relatively low.**[xi]

The State Health Official letter also clarified several key Medicaid coverage issues that are often cited as barriers to accessing LARC, stating that:

- States and managed care plans **cannot require step therapy** for family planning (i.e., cannot require that a particular contraception method be used first) or impose policies that restrict a change in method.
- States and managed care plans should not adopt practices or policies that delay provision of a preferred contraception method or impose medically inappropriate **quantity limits** (such as allowing only one LARC insertion every five years, even in cases where an earlier LARC was expelled or removed).
- The only allowable **prior authorization** criteria is the determination that the contraception method is medically necessary and appropriate for the individual.
- LARC reimbursement to providers **must include insertion, removal, and the device itself** (although these may be billed and paid separately).
- Family planning services and supplies, including contraceptives and pharmaceuticals, must be provided to the patient **without cost sharing**. [xii]

Links to the State Health Official letter and other CMS guidance can be found in Appendix B.

FQHC Policies Shaping LARC Access

Depending on their state's LARC coverage and reimbursement policies under Medicaid, FQHCs may face specific incentives or disincentives to providing LARCs because of the state's unique payment structure, which can lead to LARCs being excluded as an option for many patients. Pursuant to federal law, FQHCs are paid for Medicaid services via a Prospective Payment System (PPS) rate or an approved Alternative Payment Methodology (APM). The PPS rate is an all-inclusive, cost-based encounter rate, which includes a face-to-face visit with a provider and any services provided incident to that visit (e.g., lab services). [xiii] The PPS per-visit rate is calculated based on reasonable and allowable costs for FQHC services, as documented during a baseline period. The rate is inflated annually by the Medicare Economic Index (MEI) and when an FQHC experiences a change in the type or intensity of services that results in a meaningful change in cost per visit over time.

If a state elects to utilize an Alternative Payment Methodology (APM), the APM must pay providers at least what they would have been paid under the PPS, and providers must voluntarily elect to be reimbursed under the APM rather than the PPS. The PPS per-visit rate is calculated based on what is considered a reasonable cost for such services, as documented during a baseline period, with adjustments.

For FQHCs, the PPS rate is an important factor for states to consider in seeking to improve LARC uptake. How the PPS rate is structured, what costs are carved out of the rate, and whether the rate is enough to cover LARC costs can impact the ability and willingness of FQHCs to offer LARC. To briefly define the terminology used in this toolkit, LARC "costs" may refer to: (1) the cost of providing LARC-related services and/or (2) device costs. Providing LARC-related services, including device insertion and removal, under the PPS visit rate may pose challenges for some FQHCs if their rate does not account for a longer or more complex visit that may be necessary for LARC procedures. However, it is cost of the device—which typically ranges from $50 to $500 under 340B [xiv]—that often

represents the most significant financial barrier. For this reason, the options presented below focus primarily on device reimbursement.

Following is a discussion of state options to reimburse FQHCs for LARC device costs, both included in and separate from PPS rates.

LARC Device Reimbursement Under the PPS Rate

States frequently include Medicaid-covered LARC devices as part of the FQHC PPS encounter rate, meaning that FQHCs cannot bill separately for them. This can present an obstacle for FQHCs since the encounter rates, depending on how they are structured, are frequently not sufficient to cover the high cost of the device. Although PPS rates are based on FQHCs' reasonable and allowable costs, rates in many states are based on FQHC costs from the baseline period of FY 1999-FY 2000 [xv] when LARC utilization was much less prevalent. States are required to have processes in place to adjust individual FQHCs' PPS rates based on an increase (or decrease) in the scope of services provided by the FQHC, such as adding a new service or a change in the intensity of services. In states with LARC covered under the PPS rate, FQHCs would typically need to appeal to the state for a rate adjustment to account for any addition or increase in LARC device costs or if they are beginning to offer LARCs for the first time. In order to enhance access under this methodology, states would need to provide a clear and simple pathway to allow FQHCs to request and obtain a higher encounter rate for providing LARC and to ensure that the rate covers the device and other LARC-associated costs. When deciding whether to include LARC devices as part of the PPS rate, states should consider how they would capture these device costs as part of an all-inclusive encounter rate, the potential administrative burden imposed on FQHCs to submit a rate adjustment request, and the burden on the state itself to process these requests. In aggregate, unless the increase in LARC provision is large and represents a significant cost relative to other services the FQHC provides, the change may not ultimately result in a meaningful increase in the FQHC's overall cost per visit and may not justify the FQHC going through the process.

PPS Rate as a Barrier to Same-Day LARC Access

The significant acquisition, stocking, and disposal costs associated with LARC devices contribute to same-day access issues. Because upfront stocking of LARC devices is expensive and because it can be challenging for states to adjust the PPS rates to fully account for increases in LARC provision, bundling LARC device costs into the PPS rate is generally viewed as less likely to support LARC provision than carving it out of the PPS rate or other innovative approaches.

Reproductive Health and LARC Access in Mississippi

Despite the presence of family planning services for women provided by FQHCs, the Title X Program administered by the Mississippi State Department of Health, and the Medicaid state family planning waiver that provides coverage for family planning services to some low-income people, many Mississippi residents continue to face an overall lack of access to reproductive health services. The overall high rate of uninsurance (12%[xvi]) and rural nature of much of the state, as well as associated overall health care access challenges, funding constraints, provider supply, and lack of provider capacity specific to reproductive health services all contribute to limited access. A recent study identified wait times for reproductive health services and lack of LARC availability as significant issues in Mississippi across provider and insurance coverage types. The longest wait time across provider types were for IUDs, at 29 days. Health departments had the longest wait times to provide a reproductive health care appointment, with 82 days being the maximum wait time and 30 days being the average wait time, suggesting that health department capacity is inadequate to meet demand for these services. The maximum wait time at FQHCs was shorter, at 34 days, and the average wait time was 8 days. FQHCs and other community-based clinics were more likely to offer wanted services than hospitals, but across provider types, the strongest predictor of not being able to book an appointment at all was asking for an IUD or emergency contraception. [xvii] In Mississippi, LARC use at Title X clinics is the lowest in the nation among young people, with fewer than 1% of young women age 15 to 19 years in Mississippi seeking contraceptive services at Title X service sites in 2013, further suggesting a lack of availability of these methods. [xviii]

FQHCs serve a critical purpose in providing primary care to people all over Mississippi, including to Medicaid enrollees and the uninsured. Their role as trusted primary care homes based in and serving the needs of their local communities makes them a crucial access point for reproductive health care. FQHCs are required to provide voluntary family planning services, including "appropriate counseling on available reproductive options consistent with Federal, state, local laws and regulations. These services may include management/treatment and procedures for a patient's chosen method, e.g., vasectomy, tubal ligation, placement of long-acting reversible contraception (LARC) (IUDs and implants)."[xix]

However, the exact services offered at each FQHC clinic site may vary, and funding constraints, reimbursement policies, provider capacity, and other factors potentially limit patient access to the full range of family planning methods that Medicaid covers.

Policies Addressing Access to LARCs in Mississippi FQHCs.

Mississippi FQHC Payment for LARCs

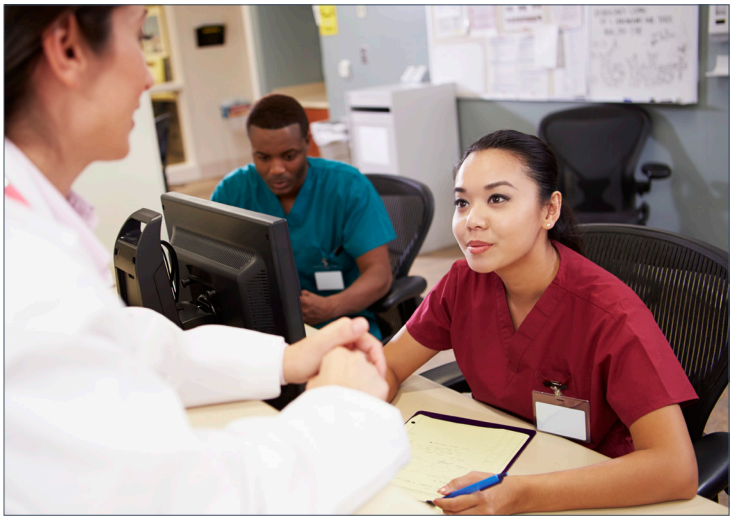
Historically, although Medicaid family planning benefits are comprehensive, Mississippi Medicaid did not reimburse FQHCs for LARCs outside the encounter rate, which resulted in significant barriers to accessing LARCs. In addition, Mississippi's PPS rate is still based on cost data from the year 2000[xx], and reopening this process would pose major political and policy challenges. To address this issue broadly for physician-administered drugs and devices, including LARCs, the Mississippi Division of Medicaid has made recent policy changes that support separate reimbursement for them for multiple provider types, including FQHCs. In October 2018, the Centers for Medicare and Medicaid Services (CMS) approved two State Plan Amendments enabling FQHCs and Rural Health Clinics (RHCs) in Mississippi to bill under the pharmacy benefit for certain physician-administered drugs, including LARCs. These SPAs were made retroactively effective July 1, 2018. For a guide to billing codes for LARCs, please see Appendix A.

These policy changes are a first step toward addressing barriers to access to a comprehensive set of contraceptive options in FQHCs.

Table 1. Recent Mississippi State Plan Amendments Affecting LARC Reimbursement

Setting/Population	State Plan Amendment
FQHCs	State Plan Amendment 18-0012: [xxi] Federally Qualified Health Center (FQHC) Physician Administered Drugs (PADs) was approved to "allow the Division of Medicaid to reimburse an FQHC the encounter rate for the administration of certain categories of physician administered drugs (PADs), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the FQHC encounter rate, effective July 1, 2018."
RHCs	State Plan Amendment 18-0013 [xxii]: Rural Health Clinic (RHC) Physician Administered Drugs (PADs) allows the Division of Medicaid to "allow RHC's to receive reimbursement outside of the encounter rate for the administration, insertion and removal of physician administered drugs that are reimbursed through the pharmacy benefit, effective July 1, 2018."
Note: A third State Plan Amendment, 18-0011 [xxiii]: Physician Administered Drugs (PADs), issued in February 2019, allows the Division of Medicaid to reimburse for certain PADs as either a medical or pharmacy claim for non-FQHC and non-RHC providers, in order to improve beneficiary access. It is not included here because FQHCs are the focus of this toolkit.	

Mississippi Medicaid Managed Care Environment

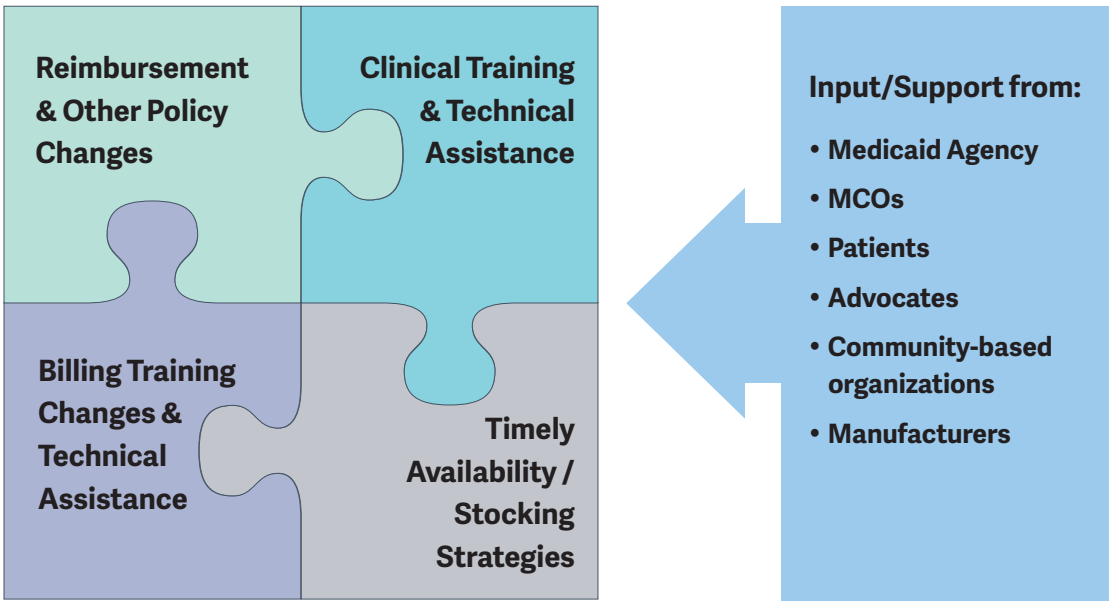


Total Medicaid enrollment in Mississippi was 437,875 in 2018, with about 69% of Medicaid beneficiaries enrolled in a managed care plan as part of the Coordinated Access Network (MississippiCAN) Medicaid managed care program. The remainder are in fee-for-service Medicaid. Total Medicaid expenditures were $5.3 billion in 2018, with about 49.9% of spending through managed care and the rest through fee-for-service. Two Medicaid managed care plans dominate enrollment as of April 2019 - Centene and United each hold nearly half of the market share, with the remaining ten percent enrolled in Molina. Mississippi awarded the current contracts to Magnolia Health (Centene), Molina Healthcare, and UnitedHealthcare starting in July 2018. Magnolia Health and UnitedHealthcare were incumbents with history in the state's managed care program.

In addition, CMS approved the first ever 10-year 1115 Medicaid waiver extension to Mississippi in December 2017, which among other things established that Mississippi will continue to provide family planning services for people ages 13 through 44 who are not enrolled in Medicaid, Medicare, or the Children's Health Insurance Program (CHIP) with income of up to 194% of the federal poverty level.[xxiv]

Potential Strategies

Figure 1. Strategies and Key Steps to Increase LARC Availability in FQHCs



Following is a description of state options to reimburse FQHCs for LARC device costs, both included in and separate from PPS rates.

Reimbursement Strategies

LARC Carve Out/Unbundling from FQHC and RHC PPS

Carving out the cost of LARC devices from the FQHC PPS rate is generally the recommended option to ensure adequate reimbursement, particularly in states where an FQHC is unlikely to meet the threshold for a change in scope PPS rate adjustment or in states where there are caps or other limitations on rates.

There is considerable variability across states in the extent to which the cost of certain services or devices are carved out of the PPS rate and billed independently. A substantial number of states have now carved payment for LARC devices out of the PPS per-visit rate, using a State Plan Amendment. Reimbursement for LARCs in these states typically is set at one of three levels: 1) the 340B acquisition cost, 2) for devices purchased outside that program, the lower of the provider's charges, or 3) the rate on the Medicaid provider fee schedule. Table 2 illustrates recent examples of state carve-out language, in addition to the Mississippi policies summarized in Table 1 above.

Medicaid Managed Care Organization Strategies

Nationally, Medicaid managed care organizations (MCOs) take widely varying approaches to promoting access to the full range of contraceptive options, and to LARCs specifically, though states have opportunities to encourage MCOs to support access. Federal law requires FQHCs that participate in managed care networks to be paid at least the PPS rate (directly by plans or through an added wrap-around payment by the state), and MCOs must pay FQHCs at least what they pay other providers for the same services.[xl] Otherwise, MCOs have considerable flexibility in how they reimburse FQHCs. CMS noted in its 2016 LARC bulletin that the states taking the most proactive approaches to increasing LARC access through Medicaid policy have MCO contract requirements intended to promote it.[xli] For example, Illinois' external quality review organization (EQRO) "developed a family planning readiness review tool and reviews the plans' family planning policies and procedures…the MCO

Table 2. State Plan Amendment and Other Key LARC Carve-Out Policies

State	SPA/Policy Language
Colorado carved out LARCs from the RHC PPS rate in 2015.	SPA language: "Effective April 1, 2015, the Department of Health Care Policy and Financing will reimburse Long Acting Reversible Contraception (LARC) separate from the Rural Health Clinic per visit rate. Reimbursement will be the lower of: 340B acquisition costs; Submitted charges; or fee schedule for LARC as determined by the Department of Health Care Policy and Financing. Rural Health Clinics will be paid using the Medicaid fee schedule posted at https://www.colorado.gov/hcpf/provider-rates-fee-schedule and last updated July 1, 2014." [xxv]
Delaware carved out LARCs from the FQHC PPS rate in 2017.	SPA language: "For services provided on or after January 2, 2017 the cost of long-acting reversible contraceptives (LARCs) will be based on actual acquisition cost (AAC). The FQHC must submit a separate claim to be reimbursed for the AAC of a LARC." [xxvi]
Georgia carved out LARCs from the PPS rate for FQHCs and RHCs in 2015.	Georgia used the following SPA language for both FQHCs and RHCs: "Effective for dates of services on or after May 15, 2015, FQHCs may elect to receive reimbursement for Long Acting Reversible Contraceptives (LARCs) (specifically intrauterine devices and single rod implantable devices) for contraceptive purposes. Reimbursement for the LARCs shall be made in accordance with the following: • To the extent that the LARCs were purchased under the 340B Drug Pricing Program, the FQHC/RHC must bill the actual acquisition cost for the device. • Reimbursement shall be made at the FQHC/RHC's actual 340B acquisition cost for LARCs purchased through the 340B program. For LARCs not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or the rate on the Department's practitioner fee schedule, whichever is applicable. • Reimbursement is separate from any encounter payment the FQHC/RHC may receive for LARCs." [xxvii]
Idaho carved out LARC devices from the FQHC and RHC PPS rate in 2016. Insertions will be paid at the PPS rate.	Idaho used the following SPA language for both FQHCs and RHCs: "Effective 07/01/16, reimbursement for Long Acting Reversible Contraception (LARC) shall be separate from the FQHC/RHC PPS rate. In addition to payment at the PPS rate for the insertion of the device(s), RHCs will be eligible for payment for cost of the device(s) for claims with dates on or after 07/01/16 to be paid at the 340b acquisition cost. For device(s) not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or the rate on the fee schedule posted at: http://www.healthandwelfare.idaho.gov." [xxviii]

State	SPA/Policy Language
Illinois **has taken a number of steps including a PPS carve-out for FQHCs and RHCs, and an additional $35 incentive payment for 340B providers that use LARCs, as highlighted in a CMS bulletin.** [xxix]	Illinois used the following SPA language for both FQHCs and RHCs: "FQHC/RHC Long Acting Reversible Contraceptives (LARC). Effective for dates of service on or after October 13, 2012, FQHCs and RHCs, as described in subsection (2)(a), may elect to receive reimbursement for LARCs (specifically intrauterine devices and single rod implantable devices) for contraceptive purposes. [xxix] Reimbursement for LARCs shall be made in accordance with the following: To the extent that the LARC was purchased under the 340B Drug Pricing Program, the FQHC or RHC must bill the actual acquisition cost for the device. Reimbursement shall be made at the FQHC or RHC's actual 340B acquisition cost for LARCs purchased through the 340B program. For LARCs not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or the rate on the Department's practitioner fee schedule, whichever is applicable. Reimbursement is separate from any encounter payment the FQHC or RHC may receive for LARCs. Additional Dispensing Fees to Providers: Effective July 2014, HFS increased the dispensing fee add-on payment to $35 for providers who dispense highly-effective contraceptives through the 340B federal drug pricing program. In order to receive the additional fee, providers must identify 340B purchased drugs by reporting modifier "UD" in conjunction with the appropriate procedure code and actual acquisition cost for the birth control method on the claim form."
Kansas **carved out LARC devices from the FQHC and RHC PPS rate in 2018.**	Kansas used the following SPA language for both FQHCs and RHCs: "Effective February 27, 2018, LARCs insertion and removal visits will be paid at the FQHC/RHC PPS encounter rate. The devices will be reimbursed as outlined in Attachment 4.19-B #12.a. Page 1.1, item number 6. (under FFS)" [xxxi, xxxii]
Louisiana carved out LARCs from the RHC and FQHC PPS rate in 2019 as outlined in the Healthy Louisiana Health Plan Advisory. [xxxiii]	Louisiana used the following SPA language for both FQHCs and RHCs: "Effective for dates of service on or after January 1, 2019. RHCs/FQHCs shall be reimbursed a separate payment outside of the PPS rate, accordingly, for long-acting reversible contraceptives (LARCs). This alternate methodology will include the PPS rate, plus reimbursement for the device. Reimbursement for LARCs shall be the lesser of, the rate on file or the actual acquisition cost, for entities participating in the 340B program. RHCs/FQHCs eligible for 340B pricing must bill Medicaid at their 340B actual acquisition cost for reimbursement." [xxxiv, xxxv]
Maryland began reimbursing FQHCs for a visit and the acquisition costs of LARCs in 2013, detailing payment rates for copper and hormonal IUDs and the contraceptive implant.	CMS summarized the state's policy as follows: [xxxvi] "FQHCs are reimbursed for an office visit and the acquisition cost for one (1) of the three (3) covered LARC devices. Practitioners receive reimbursement for one of the three devices, as indicated by their respective J code: • J7300 • J7302 • J7307"[xxxvii] The policy memo listing 2013 payment rates is available at https://mmcp.dhmh.maryland.gov/Documents/PT%2022-13%20FQHC%20Transmittal%20No.%201.pdf

State	SPA/Policy Language
Montana carved out LARCs from the FQHC and RHC PPS rate in 2017.	Montana used the following SPA language for both FQHCs and RHCs: "Effective July 1, 2017, FQHCs/RHCs are eligible for an add-on reimbursement for LARCs. Reimbursement shall be separate from the RHC PPS rate and will be equal to the actually acquisition cost (AAC)."[xxxviii]
New York carved out LARCs from the PPS rate for FQHCs and RHCs in 2016.	SPA language: "For services provided on and after April 1, 2016, the cost of long acting reversible contraceptives (LARC) will be separated from the PPS reimbursement. Reimbursement for LARC will be based on actual acquisition cost. The facility must submit a separate claim to be reimbursed for the actual acquisition cost of the LARC device."[xxxix]

contract was revised to include language that provider policies/protocols shall not present barriers that delay or prevent access, such as prior authorizations or step therapy failure requirements; and that clients should receive education and counseling on all FDA-approved birth control methods from most effective to least effective, and have the option to choose the preferred birth control method that is most appropriate for them."[xlii]

However, inclusion of these requirements in state MCO contracts is not prevalent, and measures that prioritize LARC usage over other methods run the risk of incentivizing providers to pressure patients to use a particular method. In addition, relatively frequent movement of enrollees in and out of coverage and among Medicaid plans may contribute to a lack of focus from plans on ensuring that enrollees who are interested in contraception are able to access it. Few states currently maximize managed care payment and policy opportunities to expand comprehensive access to contraceptive methods. Performance measures in reproductive health can and should prioritize patient experience and access to all methods. Not only is this an ethical imperative, but more patient-centered counseling and interaction with providers about contraceptive options has been shown to improve access to patients' preferred methods, and support more use of the most effective methods and longer continued use of the chosen method.[xliii]

While states can powerfully shape incentives and priorities for health plans, MCOs can also take steps individually or collaboratively to support access to contraception even when state contracts do not mandate it. The table below lists several options that MCOs could consider pursuing, in partnership with providers, including FQHCs, to serve as a starting point for brainstorming and discussion of potential approaches. (Also see the discussion earlier in this paper of utilization management provisions that CMS has indicated are **not** permissible.)

Figure 2. Medicaid Managed Care Policy Approaches to Increase LARC Access

- Enhanced payment for education/counseling in addition to FQHC encounter
- Pay-for-performance quality metrics specific to reproductive health and not based on utilization of any specific method
- Policies and/or pilot programs to promote comprehensive access to reproductive care
- Support provider training and technical assistance
- Explore potential industry partnerships to address stocking issues
- Consult stakeholders to identify, address needs & gaps

All these approaches require strong clinical leadership and buy-in at multiple levels of health plan management. Provider champions — for example, an influential provider or association—can be critical partners to pilot a new approach.[xliv] For example, a large, multi-state Medicaid managed care organization in Washington, D.C., developed a "Care Cart" that contained LARCs and related supplies, to be placed in FQHCs. The health plan purchased the devices to stock the cart in advance and for restocking, ensuring that an immediate supply of LARCs was always on-hand.[xlv]

Other State-Driven Potential Payment Strategies

Alternative Payment Methodologies: State Medicaid programs can use APMs either in place of or alongside the PPS rate, as long as they ensure that FQHCs are still paid at least the amount they would have received under PPS and as long as the FQHC receiving the APM agrees to it. A state seeking to enhance LARC access at FQHCs could design an APM that incorporates family planning incentives and/or performance metrics as part of a broader payment methodology.

Family planning waivers: Family planning waivers are a standard tool for states to support access to family planning services for people outside traditional Medicaid eligibility, and states can reexamine the scope and impact of their waivers for potential enhancements at renewal and as they identify access challenges or other priorities.

1115(a) demonstration waivers: States could purchase a batch of LARC devices (e.g., a month's worth of devices, leveraging the 90% federal match) and furnish them to Medicaid providers who offer LARC, without cost to the provider. The provider would not bill the state for the devices used, just for services such as insertion and removal, and the state would replenish the provider's LARC supply once it is depleted. CMS in its recent State Health Official Letter expressed interest in exploring section 1115(a) demonstration authorities to ensure that providers who furnish covered medical assistance for eligible individuals have access to an inventory of LARC devices. CMS stated that it will consider "other state ideas like this, related to all types of family planning services, subject to the regular process for review, approval, and evaluation of section 1115(a) demonstrations."

90% federal match for family planning services: States should ensure that they obtain the enhanced match for family planning services, including those provided through MCOs.

Operational Strategies

Billing and Coding

Accurate billing and coding for LARC counseling visits and insertions is essential to ensure rapid and accurate reimbursement for the visit. An understanding of reimbursement policies, coding, and billing must be shared across clinical, administrative, and management staff at FQHCs. Incorrect coding of a visit can lead to denied claims, which further limits the financial capabilities of a clinic to invest in keeping more LARC devices in stock. See Appendix A for specific billing codes.

Proper and adequate documentation in a patient's medical record is also essential to support each billing code if the provider is to receive reimbursement from a payer (public or private). Medicaid enrollees must not be billed cost-sharing (co-payments or coinsurance) for family planning services and supplies.

Provider Education

Provider education is a critical component of ensuring access to reproductive health services that meet patients' needs, including for contraception broadly and LARCs in particular.[xlvi] LARC methods require specific training, including on an ongoing basis as new devices are developed. Increasing the number and types of providers trained on LARCs can support providers in offering LARC methods to women who want them and make more providers available to do insertions and removals. Some providers still are not trained on LARC insertion and removal and/or do not offer LARCs as a method for their patients, even if the patient wishes to have a LARC. Provider training also increases FQHC capacity to effectively use vetted tools for counseling that could be adopted more widely by FQHCs if staff were trained and ready to do LARC insertion.

State Supports for Operational Challenges

States can support FQHCs in navigating LARC-related operational challenges in a number of ways. At minimum, states can provide clear and straightforward guidance to providers on Medicaid cost reporting, billing and coding guidance, and policy clarifications related to LARC, as necessary, to ensure that FQHCs understand the state's coverage provisions and know how to get reimbursed for LARC and LARC-related services.[xlvii] States may also consider convening provider learning collaboratives that include clinical, billing, and management staff, offering technical assistance on LARC provision and reimbursement, and encouraging and disseminating information about LARC clinical training opportunities.[xlviii] In addition to guidance, training, and technical assistance, States also have various options available to help with up-front device costs. This could be done by directly supplying devices, using Title X funds to support purchase of devices, or working with manufacturers or a third-party entity to supply an inventory of LARCs to providers.

Strategies to Support Timely Availability

As mentioned throughout this toolkit, LARC devices have high up-front costs. Additionally, in some states (though not Mississippi), FQHCs are not permitted to bill Medicaid for more than one encounter on the same day.[xlix] FQHCs and other clinic sites that see a predominantly lower-income population, including a substantial number of Medicaid enrollees and uninsured, are reluctant to bear the cost of ordering a supply of LARC devices to keep onsite for same-day insertions. More often, a clinic will order the LARC device specifically for the patient or have it ordered through the pharmacy benefit, and the patient will return to the clinic for the insertion of the device at a later date. This allows a site to bill the patient's insurance (either public or private) or assist the patient with paying for it individually, but the need to order the device creates a delay. The patient may not return for the insertion visit, for a multitude of reasons. One study found that 45.6%—nearly half—of women did not return for the second visit [l], leaving them at higher risk for an unintended pregnancy and without access to their contraceptive method of choice.

The financial burden of purchasing and maintaining a stock of LARC devices for same-day insertion is commonly cited as a barrier for providers. A state's decision about whether to cover LARCs under the Medicaid pharmacy benefit or under the medical benefit plays a key role in this issue, as it determines how the devices are obtained and who pays for them.

In states that cover LARCs through their pharmacy benefit, the process typically involves the pharmacy billing the state Medicaid program for the LARC and dispensing fees. The pharmacy then delivers the LARC to the provider and the provider bills for insertion or implantation. In this scenario, the woman must see the provider twice, first to get the LARC prescription and then to get it inserted. If the woman does not return for insertion, providers generally are not permitted to return unused LARCs to the pharmacy, which results in an unnecessary financial loss for the state and ultimately means that the patient does not get access to the method she chose.

In states that cover LARCs through their Medicaid medical benefit, providers are more able to stock the devices in-house, eliminating the need for the patient to come back for a second visit and reducing potential waste from unused LARCs. However, there is a high upfront cost to stocking LARCs,[li] which contributes to FQHCs and other providers being unable or unwilling to stock an adequate number of devices for same-day insertions.[lii]

Several strategies exist to address the issue of timely availability of LARCs, including when LARCs are billed through the pharmacy benefit.

Encourage stocking of LARCs

Problems related to stocking LARCs can limit access to this method of contraception to a greater degree than for other contraceptive methods and can preclude access at some providers.

Manufacturer Arrangements: States or health plans can establish arrangements with LARC manufacturers to stock providers with the devices and also allow

them to be returned if unused, shifting the payment incentives associated with LARCs. One example of this is a pilot program in Illinois with two manufacturers to stock physician offices with these devices without charging an upfront cost to the providers. This allows providers to have a stock of LARC devices on-hand so that if the patient decides she wants to use this type of contraception, it can be inserted immediately and she does not need to return for a second visit.[liii] Another manufacturer offers a low-cost device when FQHCs purchase through the 340B program (note that 340B drugs can be used for Medicaid enrollees only if they are "carved in" by the FQHC)[liv].

Same Day Billing: States should also ensure that clinics are allowed to bill for an office visit and LARC procedure (device insertion) that occur on the same day, if necessary.

Automated Stocking: A variety of technological supports exist to address stocking challenges, including automated dispensing systems that support decentralized medication management for a comprehensive range of contraceptive methods. The XpeDose system made by STELLAR Rx, for example, adjudicates pharmacy claims and dispenses devices at the point of service, avoiding the need for multiple visits. This system is able to stock the full range of birth control methods. These systems can be used in FQHCs or RHCs to ensure same-day availability of a variety of contraceptive methods.

Specialty Pharmacy

Use of a specialty pharmacy is one option for increasing rapid availability of LARCs in some settings. Specifically, for outpatient utilization of LARCs (including within FQHCs), in states where LARC can be billed through the pharmacy benefit, specialty pharmacies can bill Medicaid for the LARC on behalf of a provider and ship it to the provider overnight for insertion (or use this approach with a different method of stocking). While this does not enable same-day availability, unlike advance-stocking approaches, it can reduce waiting time between the first appointment and the second appointment to insert the LARC. Specialty pharmacies are more likely to have LARCs in stock than the average neighborhood pharmacy, but FQHCs can also build relationships with their local pharmacies to identify ways to meet demand for LARCs, such as communicating about stocking options to speed up access.

Recommendations and Considerations

Mississippi's recent policy changes to reimburse administration of physician-administered drugs outside the PPS rate create opportunities for FQHCs and RHCs to expand access to the full range of contraceptive options, and in particular to start to address some of the barriers to offering LARC. In order to implement them, FQHCs and RHCs need clear guidance on billing from the state, as well as support to train providers on LARC insertion. In addition, the use of automated dispensing systems holds promise to address stocking challenges.

The recent policy changes also create an opportunity for FQHCs, the state Medicaid program, advocates, health plans, community-based organizations, and other stakeholders to identify and discuss remaining barriers and challenges to contraceptive access on an ongoing basis, as well as how best to provide reproductive health services that center and support patient autonomy.

Conclusion

Mississippi is on a path to addressing barriers to access to comprehensive family planning services for Medicaid enrollees in FQHCs, RHCs, and more broadly. Addressing barriers and ensuring that patients' needs are being met is an ongoing process that requires collaboration and feedback to address the nuances of state, regional, and local environments. State resources, research and evaluation support, provider capacity, and philanthropic and community-based resources will need to be brought to bear to support operational changes that providers need to make to continue moving forward and to understand the impact of the changes. Policymaking is an ongoing process in which communication and feedback are critical.

Appendices

Appendix A: At-a-Glance Medicaid Billing Codes for LARC

Long Acting Reversible Contraceptives Covered by Mississippi Medicaid		
Drug Name	**NDC**	**Effective Date**
Kyleena 19.5mg	50419042401	7/1/2018
Liletta 52 mg System	00023585801	7/1/2018
	52544003554	7/1/2018
Mirena	50419042101	7/1/2018
	50419042301	7/1/2018
Nexplanon 68 mg Implant	00052433001	7/1/2018
Paragard T 380-A IUD	51285020401	7/1/2018
Paragard T 380-A IUD	59365512801	9/1/2018
Skyla 1 kit 14mcg/24hr	50419042201	7/1/2018

Billing Directions:

- CADD drugs will not count toward monthly prescription drug limits applicable to covered outpatient drugs.
- Prescribers should identify drugs to be billed to a beneficiary's pharmacy benefit (via POS claim) by notating on the prescription that the drug will be administered in an outpatient setting, such as a physician's office.
- The pharmacy provider should enter a value of '11'(Office) in NCPDP Field 307-C7 (Place of Service) to identify that the CADD drug will be administered in a clinician setting and as the mechanism whereby the pharmacy claims processing system will not count the claim toward the prescription monthly limit. The pharmacy provider should ensure that the CADD drug is routed directly to the prescriber's office.
- The prescriber should not seek duplicative reimbursement for the drug or drug delivery system on a medical claim. If appropriate, administration or related procedure codes may be submitted on the claim of the provider rendering the applicable service involving the drug or drug delivery system.

Source: Mississippi Division of Medicaid Fee Schedules, updated July 2018. Please note that the electronic version of this toolkit may be updated as new information becomes available from the Mississippi Division of Medicaid.

ICD-10 CM Diagnosis Codes Cost of encounter/visit
Z30.017 Encounter for initial prescription of other contraceptives (implant)
Z30.46 For checking, reinsertion, or removal of the implant
Z30.014 Encounter for initial prescription of intrauterine contraceptive device.
Z30.430 Encounter for insertion of intrauterine contraceptive device
Z30.431 Encounter for routine checking of intrauterine contraceptive device
Z30.432 Encounter for removal of intrauterine contraceptive device
Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device
Other IUD-related codes: T83.31 Breakdown (mechanical) of intrauterine contraceptive device T83.32 Displacement of intrauterine contraceptive device T83.39 Other mechanical complication of intrauterine contraceptive device Modifiers: A – initial encounter; D – subsequent encounter; S – sequela

FQHC encounter codes:	
HCPCS Codes: • T1015 – clinic visit/encounter • G0466 - – FQHC visit, new patient • G0467 – FQHC visit, established patient • G0468 – FQHC visit, IPPE or AWV	CPT codes: • 99201 - 99205 Office/outpatient visit new patient • 99212 - 99215 Office/outpatient visit established patient • Modifier: FP
Place of service code: 50 (FQHC); 72 (rural health clinic)	

CPT Procedure Codes Cost of insertion/removal	J Codes Cost of Device/Supplies
11981 Insertion, non-biodegradable drug delivery implant; modifier 53 (discontinued) 11982 Removal, non-biodegradable drug delivery implant 11983 Removal with reinsertion, non-biodegradable drug delivery implant 58300 Insertion of IUD; potential modifiers: 22 (difficult insertion); 51 (same day removal/reinsertion); 53 (discontinued procedure) 58301 Removal of IUD Other procedure codes: 992XX E/M based on either on key components or time spent counseling; modifier: 25 (significant, separately identifiable E/M service on same day as procedure); 33 (preventive service) 11702 Lidocaine 81025 Pregnancy test 76857 Ultrasound, pelvic 76830 Ultrasound, transvaginal	**J7307** Ethonogestrel Implant, 68 mg, 3-year duration (Nexplanon®) **J7296** Levonorgestrel-releasing intrauterine contraceptive system, 19.5 mg 5-year duration (Kyleena®) **J7297** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3-year duration (Liletta®) **J7298** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5-year duration (Mirena®) **J7300** Intrauterine copper contraceptive (Paragard® T-380A) **J7301** Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg (Skyla®)

Appendix B: Additional Resources

General LARC

American College of Obstetricians and Gynecologists, "Long-Acting Reversible Contraception Program," https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-ReversibleContraception
ACOG provides extensive information about clinical and administrative aspects of LARCs, including resources for provider education, billing and coding, and policy guidance for states considering changes to Medicaid policy affecting access to family planning services.

Gavin, Loretta, et al. "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs." April 25, 2014. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm
This report established LARCs as being among the most effective options for family planning, including for nulliparous women. The report provides recommendations developed collaboratively by CDC and the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS). The recommendations outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services.

National Women's Health Network (NWHN) and SisterSong: National Women of Color Reproductive Justice Collective, Joint Statement of Principles on LARCs, https://www.nwhn.org/nwhn-joins-statement-principles-larcs/
This statement details principles established by SisterSong and NWHN to guide clinicians, professional associations, providers, public health agencies, funders, and others in the provision of LARCs: "Our guiding principles are that we strongly support the inclusion of LARCs as part of a well-balanced mix of options, but we reject efforts to direct women toward any particular method. Only affordable coverage of all options — and a comprehensive, medically accurate, and culturally competent discussion of them — will ensure treatment of the whole human being and truly meet the health and life needs of every woman."

University of California San Francisco, Person-Centered Reproductive Health Program, https://fcm.ucsf.edu/person-centered-reproductive-health-program

The Person-Centered Reproductive Health Program engages in activities designed to develop, evaluate, and disseminate innovative family planning interventions, as well as research to deepen understanding of women's preferences and experiences around contraception, driven by listening to what women want in contraception and contraceptive care to best meet their reproductive needs and ensure their reproductive autonomy.

Coding Guidance

"2018 Update: Coding for the Contraceptive Implant and IUDs," ACOG, May 9, 2018. https://www.acog.org/-/media/Departments/LARC/Coding-Guide-2018FINAL.pdf?dmc=1&ts=20190612T2206239327

"Coding Guidelines for Contraceptives," UpstreamUSA, October 1, 2015. http://www.upstream.org/wp-content/uploads/2015/11/Upstream-Contraceptive-CodingGuide_111215_1115A.pdf
This guide focuses on the specific codes that should be used for different contraceptive methods, not specific to LARCs. It does provide guidelines for contraceptive coding in general and explains the different types of codes and when/how the codes should be used and provides some sample scenarios to give examples of how certain encounters should be coded and documented.

"Intrauterine Devices & Implants: A Guide to Reimbursement," University of California San Francisco, Last updated April 2016. http://larcprogram.ucsf.edu/
The UCSF LARC Reimbursement Guide, which is regularly updated on the website, provides clinicians and administrators with tools and guidance for billing and getting reimbursed for LARCs. It also provides assistance to assist clinics with addressing challenges around stocking, provider education, and other barriers.

LARC and Medicaid

Vikki Wachino, "Medicaid Family Planning Services and Supplies." SHO #16-008, Center for Medicare and Medicaid Services, June 14, 2016. https://www.medicaid.gov/federal-policyguidance/downloads/sho16008.pdf
This CMS letter to State Health Officials clarifies pervious guidance on the delivery of family planning services and supplies to all Medicaid beneficiaries.

Vikki Wachino, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," CMCS Informational Bulletin, Center for Medicare and Medicaid Services, April 8, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf
This CMS Informational Bulletin describes various states' approaches for increasing access and uptake of LARCs under the Medicaid program.

Other Federal Programs

Multiple federal agencies work on contraception issues and other issues related to improving maternal and child health and wellbeing. In 2014, CMS launched a Maternal and Infant Health Initiative. In addition to CMS, there is the Title X program overseen by the Office of Population Affairs and the Centers for Disease Control and Prevention's (CDC) Winnable Battles, which include a focus on teen pregnancy. Information about maternal and infant health and contraception is available from the CDC's Division of Reproductive Health as well as from the Health Resources and Services Administration's (HRSA's) Maternal and Child Health Bureau (MCHB). Links and further information are available here: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-ofcare/contraception.html

Endnotes

[i] Guttmacher Institute news release. "Use of Long-Acting Reversible Contraceptive Methods Continues to Increase in the United States." October 8, 2015. https://www.guttmacher.org/news-release/2015/use-long-actingreversible-contraceptive-methods-continues-increase-united-states

[ii] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008 and 2014, Contraception, 2018, 97(1):14–21, doi:j.contraception.2017.10.003.

[iii] Kavanaugh, Megan, et al. "Changes in Use of Long-Acting Reversible Contraceptive Methods Among U.S.

[iv] Women, 2009–2012." Obstetrics & Gynecology, Vol. 126, No. 5, November 2015.

https://medweb.nch.org/INTERMED/Data/ComponentFiles/1362/11_ABOG_January%202016.pdf

Other coverage in the study refers to Medicare, military health care, or other forms of government health care (not including Indian Health Service).

[v] Kavanaugh, et al, 2012.

[vi] The CDC National Health Statistics Report show slightly different percentages for LARC use among the different insurance coverage groups for 2011-2013. That data can be found in Daniels, et al: http://www.cdc.gov/nchs/data/nhsr/nhsr086.pdf

[vii] United Nations 2015 estimates show that contraceptive prevalence among married or in-union women (age 1549) globally was 13.7% for use of IUDs (compared with 5.1% in the U.S.), and 0.7% for use of implants (1.0% in the U.S.). (Source: United Nations Department of Economic and Social Affairs, Population Division, "Trends in Contraceptive Use Worldwide, 2015." http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Repor t.pdf

[viii] Intrauterine Devices & Implants: A Guide to Reimbursement. University of California, San Francisco. http://larcprogram.ucsf.edu/medicaid

[ix] Walls J, Gifford K, Ranji U, and Salganicoff A, *Medicaid Coverage of Family Planning Benefits: Results from a State Survey*, Kaiser Family Foundation, September 15, 2016. https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey-reversible-contraception/

[x]Alternative Benefit Plans (ABP), which cover states' optional Affordable Care Act Medicaid expansion population as well as other groups in certain states, must cover at least one form of contraception within each method approved by the U.S. Food and Drug Administration (FDA)—including LARC. Traditional Medicaid state plan benefits packages are not required to cover all FDA-identified contraceptive methods for beneficiaries, although CMS recommends that they do. (Source: Wachino, Vikki. "Medicaid Family Planning Services and Supplies." SHO #16-008, Center for Medicare and Medicaid Services, June 14, 2016. https://www.medicaid.gov/federal-policyguidance/downloads/sho16008.pdf

[xi] Ranji, Usha et al. "Medicaid and Family Planning: Background and Implications of the ACA." Kaiser Family Foundation, February 3, 2016. http://kff.org/report-section/medicaid-and-family-planning-medicaid-familyplanning-policy/

[xii] Wachino, SHO #16-008, 2016.

[xiii] Certain services can be "carved out" of the PPS and paid for separately. Additionally, a state may use a single rate for all FQHC services (e.g., medical, dental, behavioral) or multiple rates based on the costs of each specific service type.

[xiv] The $50 IUD, Liletta, is much less expensive than other LARC devices on the market (which range from $250 to $500) but is not appropriate for all women.

[xv] Under the Medicare and Medicaid Benefits Improvement and Protection Act (BIPA) of 2000, the initial Medicaid PPS base rate for an FQHC in 2001 was set based on its costs for the prior two fiscal years. States were required to pay FQHCs 100% of their average reasonable and allowable costs during FY1999 and FY2000, adjusted to account for any increase (or decrease) in the scope of services furnished in FY2001 by the FQHC. These costs were then divided by the average number of encounters to derive a per encounter payment for the FQHC.

[xvi] Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey, 2008-2017.

[xvii] Claire Kimberly, Ashley Peterson, Angelique Walker, and Kari White. Obstacles Women Face to Receive Reproductive Health Services: A Secret Shopper Method in Mississippi, *Med Rep Case Stud* 2018, Vol 3(3): 167 DOI: 10.4172/2572-5130.1000167.

[xviii] Centers for Disease Control and Prevention. 2015. "Vital Signs: Trends in Use of Long-Acting Reversible Contraception Among Teens Aged 15–19 Years Seeking Contraceptive Services—United States, 2005–2013." Morbidity and Mortality Weekly Report 64(13): 363-369. Accessed November 13, 2015. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6413a6.htm?s_cid=mm6413a6_w

[xix] https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/scope/form5aservicedescriptors.pdf

[xx] See Mississippi Administrative Code Part 211 at https://medicaid.ms.gov/wp-content/uploads/2013/12/Admin-Code-Part-211.pdf

[xxi] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MS/MS-18-0012.pdf

[xxii] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MS/MS-18-0013.pdf

[xxiii] https://www.medicaid.gov/State-resource-center/Medicaid-State-

Plan-Amendments/Downloads/MS/MS-18-0011.pdf

[xxiv] HMA Information Services analysis.

[xxv] Colorado SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-15-0002.pdf

[xxvi] Delaware SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/DE/DE-17-003.pdf

[xxvii] Georgia SPA: https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/15-001%20FQHC_RHC%20%20Reimbursement%20for%20purchase%20of%20LARCs.pdf

[xxviii] Idaho SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ID/ID-16-0005.pdf

[xxix] Wachino, CMCS Informational Bulletin, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf

[xxx] Illinois SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IL/IL-14-0027.pdf

[xxxi] Kansas FQHC SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/KS/KS-18-002.pdf

[xxxii] Kansas RHC SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/KS/KS-18-001.pdf

[xxxiii] Healthy Louisiana Health Plan Advisory 18-17, November 1, 2018. http://ldh.la.gov/assets/docs/BayouHealth/HealthPlanAdvisories/2018/HPA18-17.pdf

[xxxiv] Louisiana RHC SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/LA/LA-18-0014.pdf

[xxxv] Louisiana FQHC SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/LA/LA-18-0013.pdf

[xxxvi] Maryland indicated that it did not use a SPA to carve LARC out from the PPS, however no further information was available. CMS indicated that SPAs are currently the expected approach for states seeking to carve LARCs out of the PPS.

[xxxvii] Wachino, CMCS Informational Bulletin, 2016.

[xxxviii] Montana SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-17-0001.pdf

[xxxix] New York SPA: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NY/NY-16-0028.pdf

[xl] §§ 1902(bb)(5) and 1903(m)(2)(A)(ix) of the Public Health Service Act.

[xli] Wachino, CMCS Informational Bulletin, 2016.

[xlii] Wachino, CMCS Informational Bulletin, 2016.

[xliii] Dehlendorf, C., Henderson, J., Vittinghoff, E., Grumbach, K., Levy, K., Schmittdiel, J., Lee, J., Schillinger, D., & Steinauer, J. (2016). Association of the quality of interpersonal care during family planning counseling with contraceptive use. American Journal of Obstetrics and Gynecology, 215(1), A1-A16.

[xliv] A variety of approaches, including the use of 1115 waivers, are discussed in Rosenbaum, Sara, et al. "Using Payment Reform Strategies to Strengthen Family Planning Services at Community Health Centers." Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Research Brief #38. January 7, 2015.

[xlv] Caroline Rosenzweig, Laurie Sobel, Alina Salganicoff, Jennifer E. Moore, and Ashley A. Hernandez Gray. *Medicaid Managed Care and the Provision of Family Planning Services*, Kaiser Family Foundation, April 2017. http://files.kff.org/attachment/Report-Medicaid-Managed-Care-and-the-Provision-of-Family-Planning-Services

[xlvi] See, e.g., Okoroh, Ekwutosi M et al. Policy change is not enough: engaging provider champions on immediate postpartum contraception. American journal of obstetrics and gynecology vol. 218,6 (2018): 590.e1-590.e7. doi:10.1016/j.ajog.2018.03.007

[xlvii] For instance, see The Texas LARC Toolkit: https://www.hhsc.state.tx.us/WomensHealth/Documents/texas-larctoolkit.pdf

[xlviii] Examples of LARC clinical training resources and opportunities can be found here: https://www.acog.org//media/Departments/LARC/20160219TrainingResource.pdf?la=en

[xlix] National Association of Community Health Centers, "Medicaid Reimbursement for Multiple Same-Day Encounters: Florida's Experience." Issue Brief #7, October 2012. http://nachc.org/wpcontent/uploads/2015/11/Medicaid-Same-Day-Visits-FINAL.pdf

[l] Bergin, A., Tristan, S., Terplan, M., Gilliam, M. L., & Whitaker, A. K. (2012). A missed opportunity for care: Two-visit IUD insertion protocols inhibit placement. Contraception, 86(6), 694-697. DOI: 10.1016/j.contraception.2012.05.011. https://uic.pure.elsevier.com/en/publications/a-missed-opportunity-forcare-two-visit-iud-insertion-protocols-i

[li] FQHCs qualify for 340B pricing, a federal drug pricing program that establishes a price ceiling for pharmaceutical companies to charge qualified entities. As such, the 340B costs for LARC devices range from $250 to $500 for the implant and the Mirena, Skyla, and Paragard IUDs; the Liletta IUD has a 340B price of $50.

[lii] Wachino, SHO #16-008, 2016.

[liii] Wachino, CMCS Informational Bulletin, 2016.

[liv] For more information on the complex interaction between Medicaid and the 340B program, see the National Association of Community Health Centers (NACHC) 340B Manual for Health Centers at http://www.nachc.org/wp-content/uploads/2018/09/Medicaid-chapter-from-NACHC-340B-Manual.pdf

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