



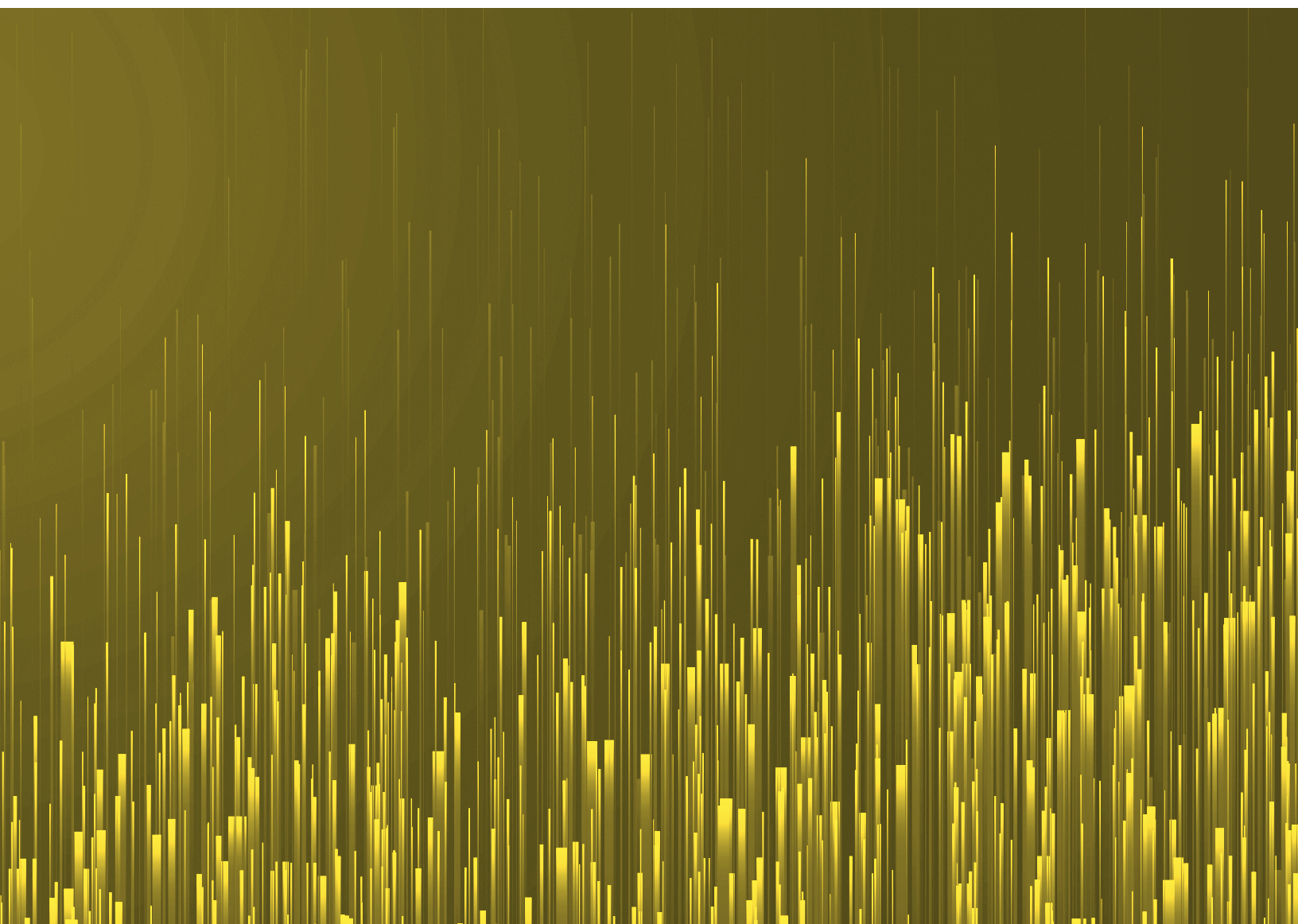
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# POLICY BRIEF

Medicaid Reimbursement Policy Options for  
Expanding Access to Long-Acting Reversible  
Contraception at Federally Qualified Health Centers

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## Introduction and Summary

Contraceptive choice, access, and affordability are core determinants of an individual's economic and personal health. Access to contraceptives has improved women's rates of enrollment and graduation from higher education, contributed to significant increases in women's participation in the workforce, and is connected to increased wages.<sup>1</sup> While the availability of new Food and Drug Administration (FDA)-approved contraceptives increased access, the risk for reproductive coercion — and specifically, the risk that state or medical actors would incentivize the use of certain types of contraceptives to control the bodies of women of color — also increased. These intersecting complexities differentiate contraceptives from other types of health care, necessitating nuanced approaches to the financing and delivery of sexual and reproductive health care that is centered around equity, meaningful access, and choice.<sup>2</sup>

Systemic racism and a history of unjust policies have been at the heart of inequitable health outcomes for women — particularly for those who rely most heavily on safety net programs. The development of any equity-based health care policies must center the needs, access, and agency of individuals of color and other marginalized groups. As providers of comprehensive primary and preventive care to medically underserved populations across the U.S., federally qualified health centers (FQHCs) play a critical role in meeting the sexual and reproductive health needs of underserved populations, including many low-income patients of color. Due to systemic challenges to the delivery of safety net services, FQHCs face a range of challenges related to the provision of certain types of sexual and reproductive health care services, including the delivery of Long-Acting Reversible Contraceptives (LARCs) as part of delivery of the full range of contraceptive methods and services.

Instead of being reimbursed based on the specific costs of services rendered, FQHCs receive “bundled” payments for each qualifying visit or “encounter” under the Medicaid Prospective Payment System (PPS). While each FQHC's PPS reimbursement rate is ostensibly derived from the cost of services for a generalized population, these payment rates often fall short of covering the costs associated with purchasing and stocking LARCs or providing related services. These financial challenges impact the ability of FQHCs to provide a full range of contraceptive methods by making LARC purchasing and stocking prohibitive to many health centers. To address these issues, some have sought to “unbundle” or carve out Medicaid reimbursement for LARC devices from the FQHC PPS reimbursement for the encounter or service. As highlighted above, contraceptive access and choice are central to an individual's physical and financial health. Systems which prohibit the ability of safety net providers to purchase and stock certain types of contraceptive methods can perpetuate disparities in access for communities that rely on these services.

One option that stakeholders should consider to address barriers to stocking a full range of contraceptive methods at FQHCs is to reexamine LARC reimbursement policies in fee-for-service Medicaid programs. This should include looking to states that have separated or “unbundled” Medicaid reimbursement for LARC devices from the FQHC PPS rate. Pursuing this policy — alongside other actions that address barriers to LARC services in FQHCs and with consideration of the best practices gleaned from past implementation efforts — would expand the contraceptive options available to low-income individuals. Additionally, adoption of this policy would work towards achieving broader equity and access goals, help providers meet clinical guidelines for providing quality family planning services, and advance state budgetary goals. The recommendations herein comprise part of a broader agenda to improve access to counseling and services on the full range of contraceptive options for individuals with low incomes. These recommendations must be coupled with robust protections against reproductive coercion by providers that experience new incentives to dispense certain contraceptives.

## Discussion

### IMPORTANCE OF ACCESS TO THE FULL RANGE OF CONTRACEPTIVE METHODS, INCLUDING LARCS

**Importance of Contraceptive Access, Including LARCs.** Access to appropriate sexual and reproductive health care is a fundamental component of health and overall well-being. Comprehensive family planning care, including access to the full range of contraceptive methods, is critical for individuals to achieve their sexual health and reproductive goals. Moreover, such care is continually linked to positive outcomes for women in postsecondary education and employment; earning

power; mental health and happiness; and the well-being of children.<sup>3</sup> The U.S. Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs' (OPA) Quality Family Planning Guidelines instruct providers to offer counseling and services for a full range of contraceptives as part of a patient-centered approach to family planning service delivery.<sup>4</sup> Yet, despite the past 20 years of innovation in contraceptive technology, expanded access to coverage and preventive care under the Affordable Care Act (ACA), and efforts to enhance provider training to provide reproductive health services, there is still persistent unmet need for family planning services. There are personal and provider-based barriers to LARC access in addition to policy barriers at both the state and federal levels.

**TABLE 1—BARRIERS PREVENTING ACCESS TO LARCS**

TYPE OF BARRIER	BARRIER	EXPLANATION
Personal	Misconceptions among patients	Patients may be unaware of the effectiveness and safety of LARCs or have concerns about the risks associated with LARCs. <sup>5</sup>
	Financial limitations	For patients who lack adequate insurance coverage for LARCs, paying out-of-pocket may be prohibitively expensive and interfere with patient choice. <sup>6</sup>
	Personal and cultural concerns	Socioeconomic or cultural health-related pressures, including past trauma, may reduce openness to LARCs. <sup>7</sup>
	Historical legacy	The dark, often racist, history of reproductive coercion in the U.S. contributes to suspicion of LARCs in some communities. <sup>8</sup>
Provider	Lack of training for providers	A lack of training and knowledge among providers, especially regarding the safety and efficacy of IUDs, pose challenges to wider adoption of LARCs. <sup>9</sup>
	Requiring second visits for insertion	Some providers, often because LARCs are not stocked in advance, require separate appointments for counseling and placement which can decrease patient uptake because a significant proportion of patients do not return for a second visit. <sup>10</sup>
	No reasonable geographic access	An estimated 19 million women of reproductive age live in "contraceptive deserts" and lack access to publicly funded contraceptive services. <sup>11</sup>
State	Refused Medicaid Expansion	Twelve states have refused to expand eligibility for Medicaid, <sup>12</sup> leaving many without a source of contraceptive coverage.
	Absence of family planning-only Medicaid program	About half of states have not implemented waivers or state plan amendments (SPAs) to grant family planning coverage to low-income women ineligible for Medicaid.
	Medicaid reimbursement and payment	Medicaid programs and managed care organizations may inadequately reimburse or pay for LARC-related services.
	Requiring parental consent or notification	State laws in 19 jurisdictions restrict the legal ability to independently access contraception for some women under 18 years of age, often requiring parental consent, notification, or both. <sup>13</sup>

**TABLE 1—BARRIERS PREVENTING ACCESS TO LARCS (CONTINUED)**

Federal	Exemptions from contraceptive coverage	Federal regulations affirmed by the Supreme Court allow employers and health plans with “religious or moral objections” to deny coverage for contraception without penalty. <sup>14</sup>
	Political interference in federal funding	Restrictive administrative policy surrounding eligibility for Title X funding effectively barred specialized family planning providers from receiving federal funds, jeopardizing access for 1.6 million women. <sup>15</sup>
	Lack of alignment in federal definitions of family planning	Inconsistencies in the statutorily defined service requirements in federally funded programs that provide access to family planning services result in patients receiving less comprehensive care at some clinics. <sup>16</sup>

**Protecting Choice in Contraceptive Access.** As providers and policymakers seek to meet sexual and reproductive health needs through access to a comprehensive range of contraceptive methods, including LARCs, it is important to acknowledge the historical and ongoing risk of coercion. For example, reversible contraceptive methods were used towards coercive ends in the 1990s, when some state legislatures attempted to pass legislation that would incentivize or mandate LARC placement among women receiving public assistance.<sup>17</sup> Enhancing an individual’s ability to select for themselves the best contraceptive method must be central to any policy decision regarding LARC access, not increased utilization of LARCs. This need to protect individuals’ freedom of choice is reflected in federal Medicaid statute and in the ACA, which provides that enrollees must be “free from coercion and mental pressure and free to choose the method of family planning to be used.”<sup>18</sup>

**Impact of COVID-19 on Contraceptive Use and Access.** Logistical and economic barriers related to the COVID-19 pandemic exacerbated existing inequities through their disproportionate effects on women with low incomes, LGBTQ+ people, and women of color. Persistent high unemployment among these groups has, in turn, led to losses in employer-sponsored health coverage, including coverage for contraceptive services and supplies.<sup>19</sup> In a 2020 Guttmacher Institute study, one-in-three

respondents reported experiencing delays or cancellations of sexual and reproductive health care appointments or facing issues receiving contraception because of the pandemic. The same study showed that over one-in-four respondents are worried about affording or obtaining contraceptive care; half of these respondents reported considering a longer acting contraceptive method, such as a LARC. Each of these responses were more pronounced among Black and Hispanic women, as well as for lesbian and bisexual women.<sup>20</sup> Later in the pandemic, provider surveys indicated a robust adoption of telehealth services for contraceptive counseling, though over half of providers surveyed referred patients for in-person visits less than 25 percent of the time.<sup>21</sup>

## **FQHCs AND THEIR ROLE IN PROVIDING FAMILY PLANNING SERVICES**

**Overview of Federally Qualified Health Centers (FQHCs).** The federal Health Center Program, established under Section 330 of the Public Health Service Act and administered by the Health Resources and Services Administration (HRSA), makes grants to eligible organizations for the purpose of providing a wide range of primary care services for medically underserved populations in the U.S.<sup>22</sup> Recipients of Section 330 funds, known as FQHCs, must adhere to multiple service requirements outlined in federal statute and regulation.

For example, FQHCs must offer comprehensive primary care services; serve patients regardless of their ability to pay; offer care on a sliding fee scale; maintain a governing board, a majority of which is composed of patients; and meet other standards designed to enable underserved communities to access quality care.

Today, FQHCs serve more than 29 million people nationwide across 1,400 networks with more than 11,000 service delivery sites.<sup>23</sup> In recent years, the size of the patient population served by FQHCs has grown significantly. Between 2000 and 2018, the total number of patients served by FQHCs grew by an estimated 196 percent, or 18.8 million additional patients.<sup>24</sup> This increase is due, in part, to coverage expansion and investment in the safety net achieved under the ACA. The network of FQHCs funded under Section 330 has successfully established critical access points for primary and preventive care in low-income and underserved communities.

**Providing Family Planning at FQHCs.** FQHCs play an increasingly important role in providing family planning services, especially for uninsured or underinsured women, or women with low incomes. In 2013, FQHCs served nearly 5.8 million women of reproductive age nationwide.<sup>25</sup> In 2015, FQHCs served 30 percent of all female patients who obtained contraceptive care at a publicly funded family planning center — approximately 2 million patients in total.<sup>26</sup>

Individual FQHCs vary considerably in the scope and quality of family planning services they deliver. Although virtually all FQHCs provide contraception, many do not provide all methods of contraception. There is a need to improve the ability of FQHCs to provide individuals the option for all methods of contraception. For example, many do not provide LARC services on-site — in one study, only 52 percent of FQHCs reported dispensing both IUDs and implants.<sup>27</sup> For those that do furnish on-site access to LARC services, evidence suggests that many FQHCs require at least two patient visits for the prescription and placement of the product.<sup>28</sup>

**Financing Family Planning at FQHCs.** The family planning care that low-income women access at FQHC sites is financed by a variety of means. As safety net providers, FQHCs rely heavily on federal funding streams to support the provision of care. In addition to health center funding provided under Section 330, which may be used to cover the cost of providing allowable services to medically underserved patients, some providers receive additional federal dollars from the Title X family planning program — the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Title X funding is provided as a grant in advance of service delivery and is flexible compared to reimbursement received following the provisions of health care services, which could facilitate available funding to stock contraceptive methods. By virtue of Title X's service requirements — including the statutory requirement that grantees offer a "broad range"<sup>29</sup> of family planning methods and services — FQHCs that receive Title X funding are likely to be more experienced in the delivery of sexual and reproductive health care, including offering a wider range of contraceptive methods, than are FQHCs outside of the program.<sup>30</sup> However, administrative policies initiated in 2018 that restricted eligibility for Title X funding effectively barred specialized reproductive health providers from receiving federal funds, jeopardizing access for 1.6 million women.<sup>31</sup> These regulations dramatically impacted patient access to Title X health centers. As part of rebuilding the Title X program — as was initiated by more recent administrative action<sup>32</sup> — it is important to equip FQHCs with all available tools to provide patients with a range of options.

In addition to these federal funding streams, FQHCs may have access to other state and local grants that also support the provision of reproductive health care. Additionally, because they receive Section 330 funds, FQHCs are eligible to enroll in the 340B Drug Pricing Program, which entitles them to purchase prescription drugs and devices from manufacturers at a discount and is sometimes helpful for FQHCs purchasing comparatively expensive products such as LARCs.<sup>33</sup>



FQHCs also rely on reimbursement by third-party payers, including government health programs such as Medicaid, to finance family planning services. By far, the largest source of reimbursement for care provided at FQHCs is Medicaid.<sup>34</sup> Medicaid comprises 43 percent of FQHCs' total revenue according to latest reporting, while the health centers see 1-in-6 Medicaid beneficiaries.<sup>35</sup> And across all provider types, including FQHCs, Medicaid pays for 75 percent of publicly funded family planning services provided in the United States.<sup>36</sup>

Medicaid's large role in family planning is attributable, at least in part, to changes in the program that have permitted states to expand family planning coverage.<sup>37</sup> For example, the ACA amended the Social Security Act to establish the Medicaid Family Planning State Option — an optional family planning eligibility group for otherwise Medicaid-ineligible individuals — that states could make permanent through a state plan amendment (SPA).<sup>38</sup> While full-benefit Medicaid-eligible individuals receive a wide array of care under other Medicaid coverage categories, individuals in this optional eligibility group are covered only for family planning services and family planning related services. In most states that have adopted a family planning option, an individual's eligibility for family planning-only coverage is determined solely by income (e.g., postpartum women with incomes at 200 percent of the federal poverty level).<sup>39</sup> Seventeen states have exercised the option to expand access to family planning services through a SPA and nine others expanded access through a Section 1115 family planning waiver, for a total of 26 states.<sup>40</sup>

## MEDICAID PAYMENT POLICY AND BARRIERS TO LARC ACCESS AT FQHCs

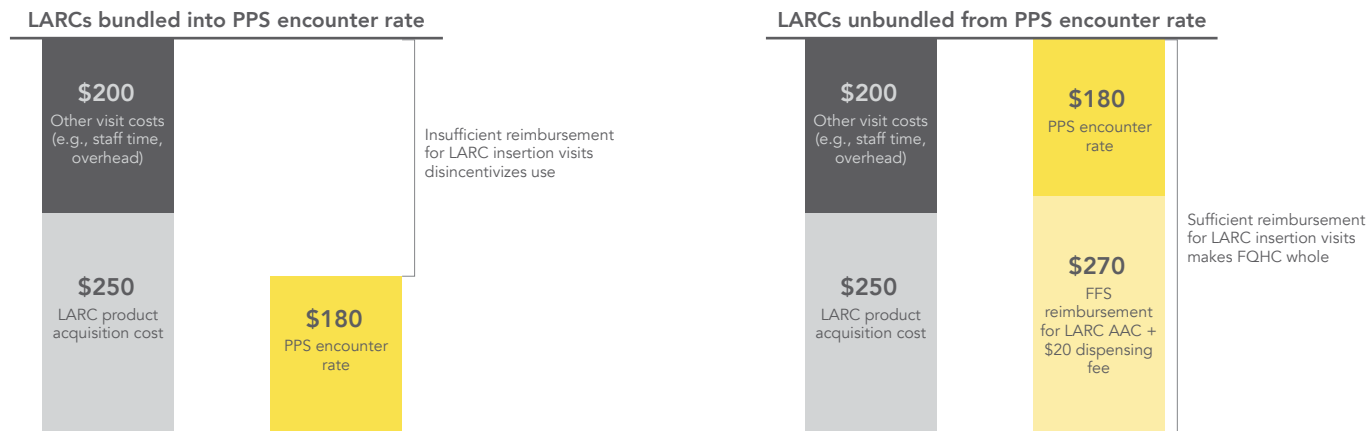
**Medicaid Payment for FQHC Services.** FQHCs meet women where they live and are uniquely positioned to

offer women counseling and services related to the full range of contraceptive methods including LARCs, despite a range of cost and education related barriers. These challenges range from inadequate clinical training and provider shortages to logistical and reimbursement-related challenges to providing LARC-related services — including the high cost of stocking LARC devices, issues with billing and coding, and navigating 340B program requirements.<sup>41</sup>

One substantial barrier, and the focus of this paper, is Medicaid reimbursement policy for LARC services provided by FQHCs. Medicaid pays FQHCs on a per-visit basis through the Prospective Payment System (PPS), which reimburses not based on the costs of the individual services rendered, but instead provides a single, bundled payment rate for each qualifying patient visit or encounter.<sup>42</sup> As FQHCs serve patients regardless of ability to pay and because many services FQHCs offer are not reimbursable by the traditional fee-for-service (FFS) Medicaid payment model, PPS was created to ensure stable, predictable funding for FQHCs as they serve their communities.<sup>43</sup> However, while PPS was calculated based on each FQHC's historical costs, it has neither kept pace with the rising cost of healthcare nor accounted adequately for complex services, covering just 80 percent of a center's costs on average.<sup>44</sup>

**Impact of Bundling LARC Device Reimbursement in the FQHC PPS Rate.** While the FQHC encounter rate under Medicaid is viewed as a successful model for financing and ensuring the quality of general primary care services at FQHCs, the PPS rate formula often does not appropriately account for the costs of providing services that entail more staff time or other expenses. This includes services and devices provided in a typical LARC visit. Because the PPS bundled rate often fails to offset the costs associated with providing LARCs to patients, FQHCs may be deterred from offering these methods of contraception to women.

**FIGURE 1—EXAMPLE REIMBURSEMENT COMPARISON: FQHC PPS ENCOUNTER RATE VS. LARC COSTS UNBUNDLED FROM PPS ENCOUNTER RATE**



Numbers provided in Figure 1 are illustrative in nature and should not be cited as official costs.

## STATE EFFORTS TO “UNBUNDLE” LARC DEVICE REIMBURSEMENT FROM THE FQHC PPS RATE

**State “Unbundling” Efforts.** Challenges associated with the FQHC PPS rate have led state policymakers to adopt alternative payment methodologies for FQHC Medicaid payment. This includes changes to state Medicaid programs that are aimed at separating out and appropriately reimbursing FQHCs for services and devices related to providing LARCs. To date, 12 states have used a Medicaid

state plan amendment (SPA) or another similar mechanism to directly carve reimbursement for a LARC device out of the FQHC PPS rate as a medical benefit.

We use a case study on Georgia’s experience using a SPA to unbundle the cost of LARC devices for FFS Medicaid patients at FQHCs to highlight the promise and challenge of this policy option. A more fulsome analysis of Georgia’s experience with unbundling LARC devices from Medicaid PPS at FQHCs is available from Health Management Associates.<sup>45</sup>

**FIGURE 2—FACTORS INFLUENCING LARC ACCESS AT FQHCs**

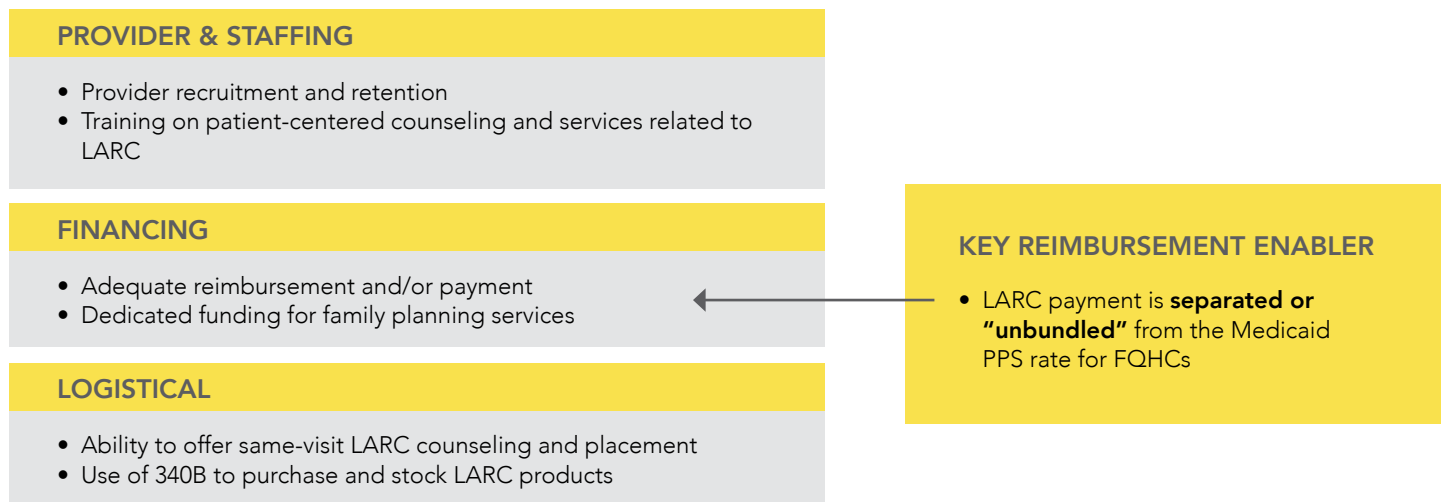
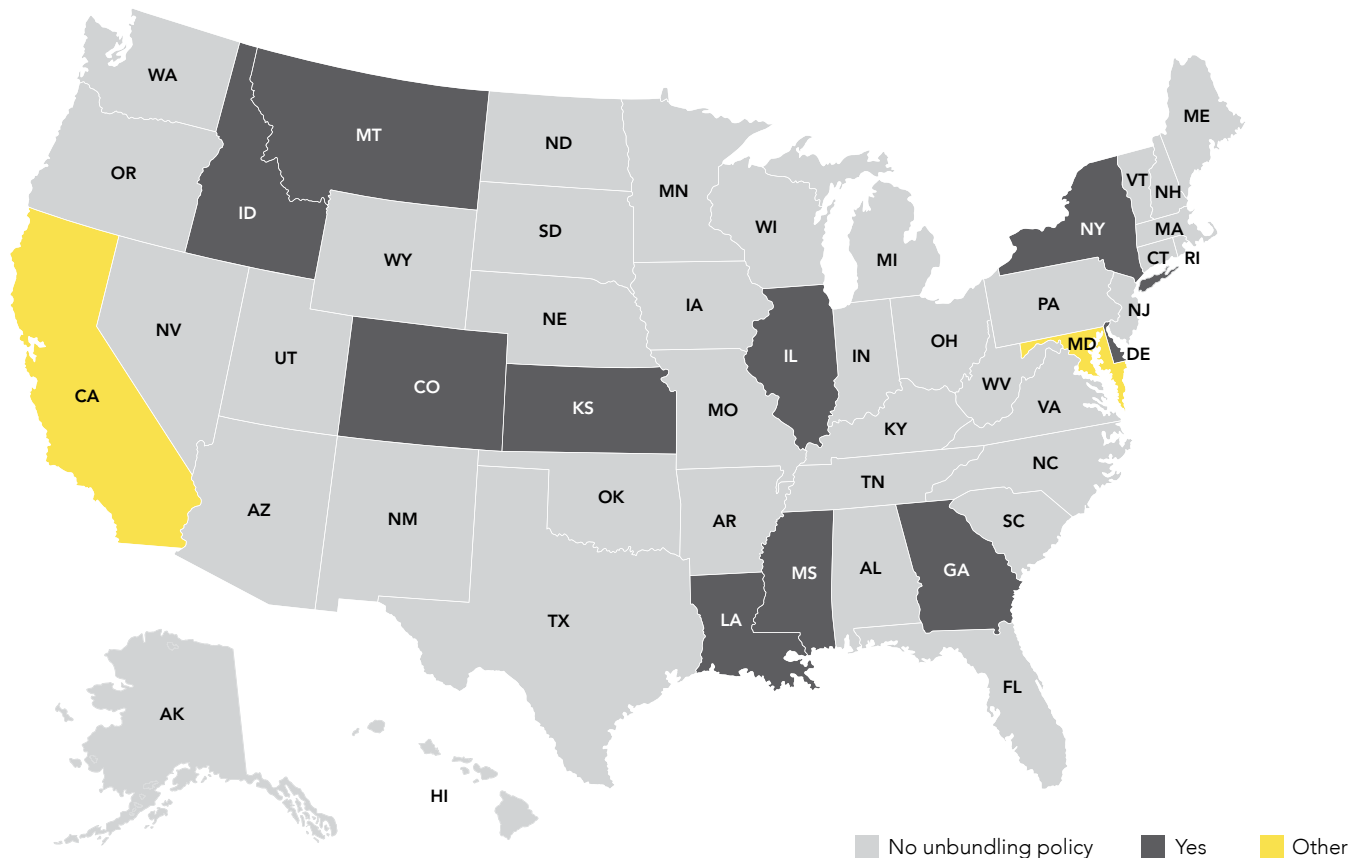


FIGURE 3—MEDICAID FFS STATE LARC UNBUNDLING IN FQHCS



*"Other" indicates that the state allows for payment of LARC devices outside of FQHC PPS through another state level policy or program.*

**Georgia Case Study.** In 2010, 60 percent of all pregnancies in Georgia (119,000) were unintended.<sup>46</sup> Unintended or closely spaced pregnancies can have negative health and economic consequences for women and their families.<sup>47</sup> To address these outcomes, the Georgia Medicaid program, following consultation with obstetricians in the state, advocated for a policy that established FFS Medicaid reimbursement of facility, provider, and ultrasound costs for the placement of LARC devices immediately postpartum which saw implementation in 2011.<sup>48</sup>

With involvement of the Georgia Primary Care Association (PCA), Georgia submitted and received approval for a SPA that expanded the unbundling of reimbursement for

LARC devices from the PPS at FQHCs and rural health clinics (RHCs) within FFS Medicaid in 2014. In May 2015, FQHCs and RHCs began to bill and be reimbursed for the actual acquisition cost of LARCs purchased under the 340B Program in addition to the encounter rate payment.<sup>49</sup>

In Georgia, the unbundling policy change may be contributing to improvement on the outcomes that Georgia Medicaid sought to address, as well as on contraceptive access and availability. Data from the Georgia Pregnancy Risk Assessment Monitoring System (PRAMS) in 2017 shows that unintended pregnancies were down from 2010 to 43.3 percent.<sup>50</sup>

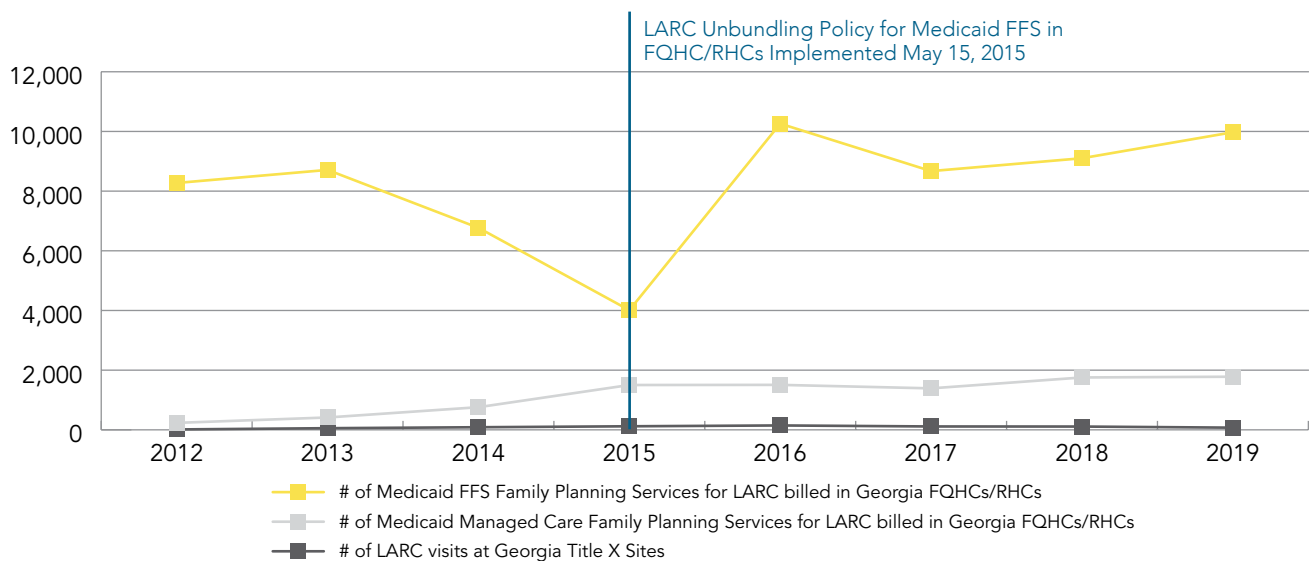


Claims data for Georgia Medicaid FFS shows that following the unbundling policy change, LARC encounters in FQHCs and RHCs increased as a proportion of all services through 2018. While not the population the policy was designed to improve access for, LARC utilization at FQHCs and RHCs increased by 98 percent in 2015 among women enrolled in Medicaid Managed Care (which covers 85 percent of Georgia's total Medicaid population), establishing a new baseline utilization volume at that level. For FFS patients, LARC utilization increased by 36.8 percent in 2015 and 23.5 percent in 2016, with an overall LARC utilization increase from 1.2 percent to 1.7 percent in 2018 for Medicaid-enrolled women of reproductive age receiving services at FQHCs/RHCs. In sum, available data suggests that negative health outcomes have decreased, while utilization and availability of LARCs has modestly increased at FQHCs — even benefitting women who are enrolled in managed Medicaid.

A confounding factor in the claims data that may have reduced the impact of unbundling on Medicaid-funded LARC utilization is the transition of Title X grantee status from the Georgia Department of Public Health to The Family Health Centers of Georgia, Inc. (FHCGA), an FQHC network, in 2014.

Comparing LARC utilization at Title X sites to Medicaid FFS and Managed Care family planning services, a significant and sustained increase in Title X utilization is observed in 2016 in contrast with comparatively meager utilization in Medicaid. The simultaneous implementation of the transition of grantee status and the unbundling policy is likely a key factor, in addition to Georgia's Title X program establishing a LARC purchasing pool. This purchasing pool allowed FQHCs to fund the advance purchase of LARCs to help providers address stocking challenges. Access to LARC-specific training for Title X providers likely played a role as well.

**FIGURE 4—LARC VISITS PER YEAR IN GEORGIA FQHC/RHCS BY MEDICAID FFS AND MEDICAID MANAGED CARE VS. TITLE X-FUNDED LARC VISITS PER YEAR**



Source: Georgia Department of Community Health Claims Data (Medicaid) and HHS OPA Family Planning Annual Report Data (Title X)

Georgia's experience provides several lessons that could enhance implementation and increase the potential that the policy achieves its goals:

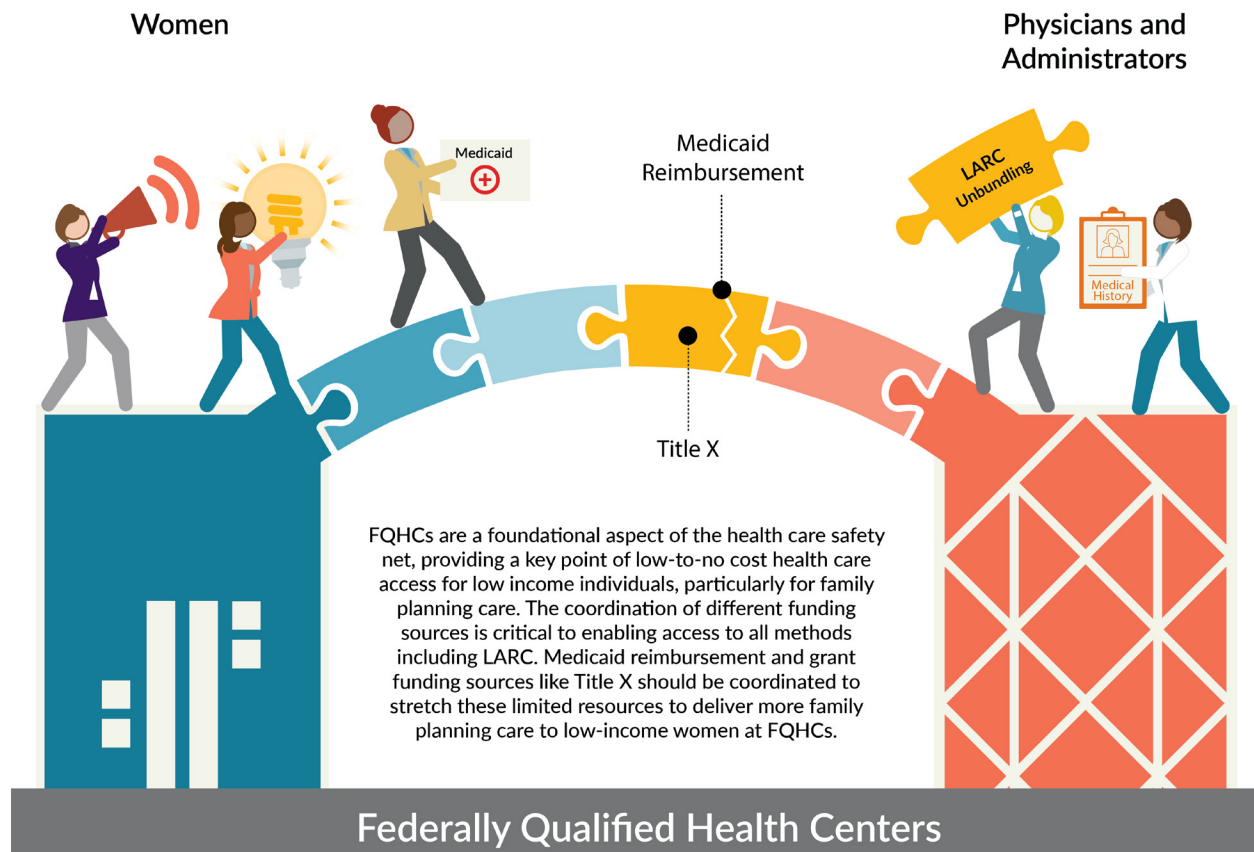
- **Staff Training and Education.** Communication about the unbundling policy change targeted to providers was limited to an update in a monthly provider bulletin. Key informants interviewed for the case study suggest that, in the absence of a more robust dissemination effort, providers and clinic staff had limited awareness or understanding of the new policy. Additionally, informants indicate that while a series of training sessions tailored to clinic-specific needs helped FQHC and RHC providers develop expertise, frequent staff turnover contributed to recurrent gaps in expertise. Continuous training and advance stocking of LARC devices could enable more successful retention of LARC-related training and skills for providers. Billing professionals received notice regarding billing protocols associated with the policy change, but FQHCs with small staff or experiencing turnover may also benefit from ongoing training on billing and other administrative functions.
- **Complexity of Family Planning Funding Sources.** As noted, another potential influence of lower-than-expected Medicaid billing was the transition of Georgia's Title X grant from the Department of Public Health to FHCGA in 2014.<sup>51</sup> Generally, Title X funding can be used for a variety of infrastructure, training, and family planning services. Title X-funded family planning services are generally for individuals not eligible for Medicaid, as well as for some services that are not included in a state's Medicaid benefit. Due to the overlap in covered services, as well as ambiguities related to obtaining third-party payment for Title X-eligible patients, some providers may have leveraged the flexibility of Title X grant funds, viewing those funds as easier to use than billing Medicaid for LARCs. Informants also cite stocking LARCs as a challenge, particularly for FQHCs that were previously unaccustomed to offering the service. The establishment of a purchasing pool for LARCs helped address this issue but may have led to disproportionate LARC services

being billed to Title X instead of Medicaid in FQHCs. Clarifying guidance from federal agencies may benefit providers' understanding of the hierarchy and eligibility requirements related to funding from Medicaid and the Title X program. Furthermore, states should include technical assistance as a key component of the policy implementation process.

- **Policy Champions and Stakeholder Engagement.** State-based groups — the Obstetrics and Gynecology (OB/GYN) Society of Georgia, Georgia Department of Public Health, Georgia PCA, and FHCGA — as well as the Association of State and Territorial Health Officials (ASTHO) were key supporters of LARC reimbursement reform in Georgia. The OB/GYN Society of Georgia, in particular, provided important political and technical support to Georgia Medicaid as they performed budget and policy analyses. Strong, sustained support from policy champions and key stakeholders through the policy development and implementation phases is essential to maximizing the participation of the providers who implement the policy in the field.
- **Community Characteristics.** In interviews, informants in Georgia repeatedly cited the axiom "if you know one FQHC, you know one FQHC." Indeed, comparing two clinics — even when their patient populations appear similar — may expose differences in clinics' staff culture, culture of the surrounding patient community, leadership's willingness to embrace policy change, administrative capacity, training regimes, financial condition, and more. More broadly, cultural beliefs about LARCs may impact utilization following policy change, and population characteristics — like those beliefs — may differ between managed Medicaid, FFS Medicaid, and other coverage groups. Policy champions should consider such dynamics to maximize the potential impact of the policy change on contraceptive access.

Despite the apparent impact of the unbundling policy in Georgia, its implementation provides several lessons that, if considered in future efforts at such reforms, could increase clinic participation and the likelihood that the access goals of the policy are met.

FIGURE 5—COORDINATION OF FUNDING SOURCES AT FQHCs



## Recommendation and Policy Options

### STATES SHOULD CONSIDER UNBUNDLING MEDICAID REIMBURSEMENT FOR LARC DEVICES PROVIDED BY FQHCs

Medicaid programs should follow the lead of those states that have successfully unbundled reimbursement for FQHC-provided LARC devices, which has proved a cost-effective way to bolster the service offerings of FQHCs and expand the choice of contraceptive methods available to individuals, in line with CDC and OPA Quality

Family Planning guidelines. Several approaches are available to achieve these ends, each of which can be attained by gaining approval from the Centers for Medicare and Medicaid Services (CMS) to reimburse FQHCs for the cost of LARC devices independent of the FQHC PPS rate. Under such scenarios, the ordinary encounter rate would still cover LARC-associated services such as counseling, placement, and removal.

Although state Medicaid programs can cover LARC devices as a medical benefit, pharmacy benefit, or both, reimbursement as a medical benefit is preferred because it facilitates purchase and stocking of LARC devices and enables same-visit insertion availability. Research shows that almost half of women who choose IUDs do not return

for insertion, suggesting that two-visit protocols create barriers to a woman's ability to have an IUD placed.<sup>52</sup> Under the medical benefit, providers can purchase and stock LARC devices that they then keep on hand, only billing Medicaid for the device after placement. Alternatively, states could choose to reimburse LARC devices separately from the FQHC PPS rate as a pharmacy benefit. Under this approach, providers order the device from a specialty pharmacy for a specific patient. Note that obtaining LARC devices for patients through a pharmacy benefit — i.e., through a specialty pharmacy — does not allow for same-visit placement.<sup>53</sup>

Regardless of whether LARC devices are covered under the medical or pharmacy benefit, we recommend two related mechanisms that are available to states and FQHCs to gain CMS approval for this type of change. We also discuss a third option which, though technically viable, we do not recommend states pursue for the purposes outlined above.

1. Pursue a Medicaid **state plan amendment (SPA)** that allows FQHCs to unbundle reimbursement of the LARC device from the PPS rate as a medical benefit; or
2. Use an FQHC **alternative payment methodology (APM)** as defined in statute, either in place of or alongside the PPS rate, that incorporates family planning incentives and/or performance metrics as part of a broader payment methodology.

**State Plan Amendment.** States can pursue a Medicaid SPA to carve out payment for LARC devices from the FQHC PPS rate. Under federal Medicaid law, states can choose to submit SPAs to request approval of operational and policy changes to their Medicaid programs — including certain changes to provider payment methodologies.<sup>54</sup> States that have already used SPAs to unbundle LARC device reimbursement for FQHCs share some commonalities in their approach. For example, these states typically set reimbursement for LARC devices at the lower of two charges: either the provider's actual charges or in accordance with the provider fee schedule. Also, states using SPAs for this purpose often direct FQHCs to bill state Medicaid programs

at actual acquisition cost for LARC devices purchased under the 340B Program. The language necessary to advance a SPA in state legislatures can be simple — draft legislative text can be found in the appendix.

**FQHC Alternative Payment Methodology (APM).** In cases where a state and an FQHC (or group of FQHCs) agree to deviate from the prescribed FQHC PPS rate, federal law prescribes a unique process for creation and approval of such changes for FQHCs.<sup>55</sup> We recommend this route to improve reimbursement for LARC devices and services. An APM may be used if it pays no less than the per-visit PPS rate, and if both the state and all affected FQHCs agree to the change.<sup>56</sup> As a part of this approach, states may also “rebase” FQHC PPS rates to reflect changes in services they provide and the cost of providing those services. Since altering the FQHC PPS rate requires changing a state's Medicaid plan, APMs are typically implemented through the submission and approval of SPAs. Examples of states that have addressed payment for FQHC-provided LARC devices using APMs include Arizona and Oregon.

**Note:** Another option available to states looking to make changes to LARC reimbursement at FQHCs is to formally waive FQHC PPS rate payment requirements for FQHCs offering LARC devices as part of a Medicaid Section 1115 demonstration waiver. Under Section 1115 of the Social Security Act, CMS has the power to grant waivers to a wide range of Medicaid requirements to carry out demonstration projects.<sup>57</sup> However, because such a change to LARC device reimbursement at FQHCs is both possible and preceded via the aforementioned two options (i.e., SPAs and the FQHC APM) — and despite waivers' use for expanding family planning coverage for low-income women in other care settings — use of an 1115 waiver is not recommended to achieve this outcome for LARC reimbursement for FQHCs. In addition to being time-limited and vulnerable to political shifts at the state and federal level, 1115 waivers carry additional requirements such as cost neutrality and opportunity for community input. The issuance of an 1115 waiver would also effectively remove the statutory safeguard for FQHCs' floor for reimbursement, in addition to removing state FQHCs from

the process of approving the change (when compared to the FQHC APM). To be clear, if such a route were pursued by a state as a strategy to unbundle LARC reimbursement from the FQHC PPS rate, it would likely be opposed by that state's FQHCs, given the precedent it would set and given the other options available. To our knowledge, no state has yet pursued this option for LARC reimbursement.

## UNBUNDLING POLICIES SERVE PUBLIC HEALTH AND BUDGETARY GOALS

The principles of noncoercion and protecting women's autonomy are critical to efforts to expand contraceptive access that includes LARCs. Any policies that alter incentives for LARCs must be coupled with a commitment — from stakeholders and in design — to offer patients the full range of FDA-approved methods and be grounded in those principles. Pursuing the policy options described above to unbundle reimbursement for LARC devices from the FQHC PPS rate can also serve several important public health and budgetary goals:

- **Enabling FQHCs to Better Meet Nationally Recognized Family Planning Guidelines.** One of the most significant barriers to the ability of FQHCs to offer LARCs to their patients is the financial burden to clinics of purchasing and stocking LARC devices. Inadequate reimbursement for LARC devices contributes to this issue. Providing more adequate reimbursement for LARC devices would ease this barrier, thus enabling more FQHCs to offer LARC services as a part of the wider set of family planning methods and services they offer to patients. This is consistent with the recommendations of the CDC and OPA, whose Quality Family Planning Guidelines instruct family planning providers to counsel on and provide access to the full range of FDA-approved contraceptive methods, including LARCs, using a patient-centered approach.<sup>58</sup>
- **Addressing Unmet Need for Contraception Among Low-Income Women.** Women with low

incomes face significant challenges in obtaining the contraceptive methods of their choosing. In 2019, Medicaid is estimated to have covered only 40 percent of low-income women.<sup>59</sup> An estimated 19 million women of reproductive age are in need of publicly funded contraception and lack reasonable access in their county to a health center that offers the full range of contraceptive methods.<sup>60</sup> This gap in access has likely been exacerbated by past federal actions that eliminated funding to certain providers of Title X-funded family planning services, impacting roughly 1.6 million patients.<sup>61</sup> Unbundling LARC device reimbursement from the FQHC PPS rate helps to enable FQHCs to provide women seeking care at FQHCs the full range of contraceptive methods. Making these devices more widely available via FQHCs — an important source of care for many low-income women of reproductive age — could help address the unmet need for publicly funded family planning services in the U.S.

- **Reducing Costs Within State Medicaid Programs.** Increasing access to the full range of contraceptive methods including LARCs for safety-net providers aligns with the fiscal goals of state Medicaid programs. According to a 2016 study by the Guttmacher Institute, every dollar invested in publicly funded contraceptive care saves \$4.83 in Medicaid expenditures.<sup>62</sup> With respect to LARCs specifically, studies indicate that even when LARCs are not used for their indicated duration they become cost-saving relative to short-acting contraceptive methods within three years of use.<sup>63</sup> A South Carolina initiative to carve-out LARC device reimbursement from the bundled Medicaid payment hospitals receive for delivery saved \$1.7 million from January 2012 to May 2016.<sup>64</sup> Adjusting Medicaid reimbursement to FQHCs that provide LARC devices and services is an effective method of reducing the costs of providing family planning care, which is especially salient as many states grapple with the budgetary strain resulting from the COVID-19 pandemic and its economic consequences.<sup>65</sup>



## STRATEGIC CONSIDERATIONS FOR ENGAGING STATE MEDICAID LEADERS ON LARC UNBUNDLING POLICY

A number of strategic considerations will be helpful in persuading key decision makers — including state Medicaid officials — to explore approaches to unbundle Medicaid reimbursement for LARC devices provided by FQHCs.

- **Documenting Existing LARC Reimbursement Policies.** Before recommending changes, the existing policy regarding Medicaid reimbursement for LARC services in the FQHC setting should be reviewed. This includes whether LARCs are covered under the program's medical benefit, pharmacy benefit, or both. This information can be found in the state's plan for Medicaid, any state plan amendments, and any applicable waivers. Together these documents specify the nature and scope of the Medicaid program. Generally, these and other documents are made available online.
- **Establishing Need for Publicly Funded Family Planning.** State-level data showing the need for publicly funded family planning services among non-managed care Medicaid enrollees is a critical tool in advocacy. For example, policymakers and administrators will benefit from understanding the number of Medicaid enrollees who are individuals of reproductive age (15-49) within the state, the number of individuals of reproductive age who received care at FQHC sites, and the number of contraceptive patients/visits at FQHC sites. Need for LARC-related services may be estimated by multiplying the proportion of Title X clients that continued or adopted a LARC method in their last visit in the state's Region by the number of Medicaid enrollees that are women of reproductive age in the state. Such data could also enhance understanding around health disparities and reveal opportunities to design equity-centered policy solutions. Data sources include the state Medicaid agency, HRSA's Uniform Data System, and the

national Family Planning Annual Report (FPAR) issued annually by the Office of Population Affairs.

- **Demonstrating Economic Impacts.** Increased utilization of highly effective forms of contraception, including LARCs, yields cost-savings to state Medicaid programs. State Medicaid officials and policymakers will be highly interested in the budgetary impact of expansions in LARC access. The Association of State and Territorial Health Officials (ASTHO) provides an interactive tool for state Medicaid officials and public health practitioners that may be useful for assessing the potential economic impact of increased utilization of LARC methods among Medicaid enrollees.<sup>66</sup> In order to analyze the economic impacts of this policy, the state may have to identify several key pieces of information, including the number of Medicaid enrollees who are women of reproductive age; the total number of births for Medicaid-covered women; the total gross prenatal, labor, and delivery costs for births to Medicaid-covered women; the percentage of unintended pregnancies for Medicaid-covered women, and the number of Medicaid-covered women of reproductive age seen in FQHCs.
- **Building and Maintaining Key Relationships.** Stakeholders who are likely to be influential in LARC reimbursement policy include Medicaid directors and other agency officials, governors, and non-governmental partners. Non-governmental stakeholders may include medical societies, providers and their respective membership organizations, hospital groups, consumer advocacy groups, and managed care plans. Partnerships with state legislators, especially those serving on committees of jurisdiction responsible for overseeing state Medicaid programs, may be another avenue for partnership on LARC access issues. Where this policy change is enacted, these same stakeholders will be important allies and thought partners during implementation — which Georgia's experience shows is critical to achieving and maximizing of policy goals.



## STATES SHOULD CONSIDER OTHER POLICY CHANGES TO IMPROVE EQUITABLE ACCESS TO LARCS FOR MEDICAID ENROLLEES

The impact of the above policy options would be limited to the FFS Medicaid population. In recent decades, state Medicaid programs have gradually shifted away from the traditional FFS Medicaid system toward managed models of delivering care. Today, most individuals of reproductive age enrolled in Medicaid are enrolled in managed care arrangements through Managed Care Organizations (MCOs).<sup>67</sup> Thus, while improvements in LARC access for FFS Medicaid enrollees are an important first step and could serve as a model for further reform, states should also revisit Medicaid MCO contract requirements intended to promote access to LARCs. States are increasingly requiring or encouraging MCOs to use value-based payment models, including APMs, to improve quality and reduce costs. As described above, APMs could enable LARC reimbursement that is adequate for FQHCs and incorporate family planning incentives or performance metrics as part of a broader payment methodology aimed at improving the delivery of care and maximizing patient autonomy.

The case study summarized above highlights the difficulties that FQHCs continue to face in stocking LARC devices, even in the presence of unbundling policies. Bulk purchasing arrangements or other purchase pooling strategies (such as those used in Georgia) to enable consistent LARC stocking would further bolster predictability for FQHCs that provide LARCs and the women that choose the method.

Moreover, policymakers and advocates should view the recommendations advanced in this brief as part of a broader agenda to improve equitable access to counseling and services on the full range of FDA-approved contraceptive methods. Inadequate Medicaid reimbursement for LARC devices is only one of several barriers that present challenges for safety-net health centers like FQHCs as they address patients' contraceptive needs. Other policy changes at the state and federal levels that are likely to further minimize barriers to LARC availability at FQHCs include:

- Increasing access to clinical training and technical assistance on topics related to family planning services,
- Increasing funding and availability of grant programs and uptake of evidence-based clinical guidelines supporting family planning,
- Collecting and analyzing data on family planning care provided at FQHC sites,
- Reforming state scope-of-practice and licensing laws to address shortfalls in trained providers,
- Expanding training opportunities on systemic racism, ethics, and cultural competency in family planning, and
- Enhancing collaboration, training, and sharing of best practices across providers, billing professionals, and administrators.<sup>68</sup>

## Conclusion

Low-income women covered by Medicaid should have access to the full range of FDA-approved contraceptive methods and services, including counseling and services related to LARCs — and the freedom to make reproductive decisions for themselves free of coercion. Although FQHCs are ideally positioned to offer women counseling and services related to the full range of

contraceptive methods including LARCs, Medicaid reimbursement policy for FQHCs poses a major barrier to providing those services, as it fails to cover the full cost of purchasing LARC devices and providing LARC services.

Through ongoing collaboration with providers and other stakeholders during both policy design and implementation, policymakers and advocates can work to address this issue by unbundling or carving out reimbursement for LARC devices from the FQHC PPS

rate. This recommendation should be part of a broader policy agenda to improve access to counseling and services on the full range of contraceptive methods for women with low incomes irrespective of the clinic at which they seek care.

## Appendix

### APPENDIX A — DRAFT LARC UNBUNDLING SPA LANGUAGE

Effective for dates of services on or after **[EFFECTIVE DATE]**, FQHCs/RHCs may elect to receive reimbursement for Long-Acting Reversible Contraceptives (LARCs) (specifically intrauterine devices and single rod implantable devices) separate from any encounter payment the FQHC/RHC may receive for the insertion of the LARC. Reimbursement for LARCs shall be made in accordance with the following:

- I. 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.
- II. Reimbursement shall be made at the FQHC/RHC's actual 340B acquisition cost for LARCs purchased through the 340B program.
- III. 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.
- IV. Additional Dispensing Fees to Providers: Effective **[DATE]**, **[MEDICAID AGENCY]** 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.

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**Waxman**



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