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Increasing Access to Contraception: Examining Barriers and Facilitators of Long-Acting Reversible Contraception

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Abstract

Objective(s): To identify barriers and facilitators related to reimbursement processes, device acquisition costs, stocking, and supply of long-acting reversible contraception (LARC) from 27 jurisdictions (26 states/1 territory) participating in the Increasing Access to Contraception Learning Community from 2016 to 2018.

Materials and Methods: A descriptive study using qualitative data collected through 27 semistructured key informant interviews was conducted during the final year of the learning community among all jurisdictional teams. Excerpts were extracted and coded by theme, then summarized as barriers or facilitators using implementation science methods.

Results: Most jurisdictions (89%) identified barriers to reimbursement processes, device acquisition, stocking, and supply of LARC devices, and 85% of jurisdictions identified facilitators

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Authors' Contributions

C.D.K. conceptualized the study (lead), validated findings (lead), and drafted portions of the full article (lead). H.P.P. conceptualized the study (lead), developed the methodology (lead), conducted the analysis (lead), and drafted portions of the full article (lead). C.L.D. curated the data (equal), provided software analysis (equal), reviewed the methodology (supporting), and reviewed and edited the full article (equal). C.E. curated the data (equal), provided software analysis (equal), and reviewed and edited the full article (supporting). L.R. reviewed the methodology (equal) and reviewed and edited the full article (equal). E.P. provided resources for study investigation and data collection (lead) and reviewed and edited the full article (supporting). S.A. provided resources for study investigation and data collection (equal) and reviewed and edited the full article (supporting). A.V. conceptualized the study (supporting), curated the data (lead), provided software analysis (equal), and reviewed and edited the full article (supporting). S.C. provided subject matter expertise (equal) and reviewed and edited the full article (equal).

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for these domains. Payment methodology challenges and lack of billing and coding processes were identified as the most common barriers to reimbursement processes. Device acquisition cost challenges and lack of delivery facility protocols for billing were the most common barriers to device acquisition, stocking, and supply of LARC. The most common facilitator of reimbursement processes was expanded payment methodology options, whereas supplemental funding for acquisition costs and protocol development were identified as the most common facilitators of device acquisition, stocking, and supply.

Conclusion: Revised payment methodologies and broader health systems changes including additional funding sources and protocols for billing, stocking, and supply were used by learning community jurisdictions to address identified barriers. The learning community framework offers a forum for information exchange, peer-to-peer learning, and sharing of best practices to support jurisdictions in addressing identified barriers and facilitators affecting contraception access.

Keywords

long-acting reversible contraception; LARC; state strategies; payment reform; device acquisition costs; stocking and supply; reimbursement

Introduction

LONG-ACTING REVERSIBLE CONTRACEPTION (LARC; implants and intrauterine devices [IUD]) is safe and highly effective (<1% failure rate),[1-4] requires one clinical visit for long-term use,[5] and has high satisfaction[6] and continuation rates.[7] The Affordable Care Act requires many insurers to provide, without cost sharing, all Food and Drug Administration (FDA)-approved contraceptive methods, including LARC.[8] Decreased out-of-pocket patient costs are associated with increased use of LARC.[9,10]

Recent survey data (2017–2019) indicate LARC is used by 10.4% of reproductive-aged women in the United States (defined as women aged 15–49 years).[11] Among women with ongoing or potential need for contraceptive services of ages 18–49 years, LARC use ranges from 6.9% to 36.1% by state.[12] Variation in LARC use is impacted by barriers to access including reliance on social networks in contraceptive decision making, personal autonomy in contraceptive choice, and systems-related barriers.[13,14]

Systems-related barriers to LARC access may include provider or clinic cost reimbursement for the device and associated contraceptive services (*i.e.,* screening for pregnancy intention, patient-centered counseling, insertion fees, device removal/replacement, and device reinsertion).[15] In addition, high acquisition and stocking costs of devices in health care facilities affect access to LARC, limiting availability to patients (*i.e.,* high costs of devices and device expiration may impact the number purchased by a clinic or facility).[15]

Other identified barriers are the preapproval requirements or step therapy by insurers limiting same-day LARC insertion (*i.e.,* payor protocols or authorization for LARC procedures before the appointment or requirements for a patient to first try and fail another contraceptive method before authorizing LARC).[15] Such barriers may require multiple health care visits for receipt of LARC.[15]

To address these barriers, in 2016, the Centers for Medicare and Medicaid Services published an informational bulletin describing state payment strategies and policy guidance to optimize access and use of LARC.[16] Strategies such as raising reimbursement rates to ensure providers offer the full range of contraceptive options and services including LARC, and removing logistical and administrative barriers (*e.g.,* acquisition and stocking costs, limiting disposal fees, and billing changes to allow for same-day office visits and insertion while removing preauthorization requirements) were described.[16]

In response to identified barriers, the Association of State and Territorial Health Officials (ASTHO), in collaboration with the Centers for Disease Control and Prevention (CDC), the Centers for Medicaid and CHIP Services (CMCS), and the Office of Population Affairs (OPA), convened the Increasing Access to Contraception Learning Community (referred to as "IAC LC") of 26 states and 1 territory (referred to as "jurisdictions") to increase access to contraception including LARC.[17]

The IAC LC, from 2016 to 2018, consisted of jurisdictional teams led by state health officials or designees, state Medicaid medical directors, maternal and child health directors, family planning directors, and clinical champions, and offered virtual learning sessions, intensive technical assistance, and peer-to-peer sharing.[18,19] Resources were developed and catalogued by ASTHO to support participating jurisdictions and included tools such as summaries of payment strategies for LARC, a modifier-25 code for billing same-day LARC, and trainings for provider counseling and billing codes for LARC insertion.[17]

A process evaluation of the IAC LC, conducted in 2018, concluded that the learning community model of developing goals and strategies to address identified barriers was effective for most jurisdictional teams.[19] The majority of teams (85%) reported virtual learning sessions enabled work to progress, and 63% of jurisdictional teams reported peer-to-peer (*i.e.,* jurisdiction-to-jurisdiction) and expert-to-peer interaction supported connectedness and sharing of resources to address reimbursement challenges, logistical, stocking, and other administrative barriers to increasing access to LARC.[19]

Our most recent study, an assessment of IAC LC jurisdictional teams 1 year after the close of the IAC LC, indicated 87% of jurisdictions were sustaining efforts to support goals aimed at increasing contraception access.[18] However, though both studies summarized the IAC LC framework and jurisdictional team progress, neither study defined common barriers or facilitators to increasing access to LARC—foundational to developing effective sustainable strategies for implementing reimbursement processes, decreasing device acquisition costs, or increasing device stocking and supply.

To inform the final year of the IAC LC, jurisdictional teams were interviewed to provide qualitative information on implementation of strategies and activities focused on increasing access to contraception, using an implementation science framework.[20] The information provided by the jurisdictions offered perspectives of state and territorial health officials and other state leaders, adding to the growing literature on administrative barriers and facilitators affecting the availability of LARC.[21-26] The purpose of this analysis is to describe the barriers and facilitators identified by jurisdictional teams for the LARC reimbursement

process, device acquisition, stocking, and supply. Qualitative excerpts offer further context for identified barriers and facilitators.

Materials and Methods

The IAC LC, described in detail elsewhere,[17-19] included jurisdictional teams that developed annual action plans consisting of goals, strategies, and activities to implement systems changes to improve access to contraception. States were selected for participation in the IAC LC through solicitation by ASTHO. ASTHO requested all interested jurisdictions submit a letter of interest with a commitment for participation by the state or jurisdictional health official and other state health department leaders and practicing family planning or obstetric clinical champions as described earlier.

Twenty-six states (Alabama, Alaska, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Texas, Washington, and Wyoming) and one territory (Commonwealth of the Northern Mariana Islands) participated in the IAC LC.

The IAC LC was evaluated using an implementation science framework measuring developed strategies and outcomes to standardize complex evidence-based public health programs into practice.[18] Our prior studies tested the usefulness of implementation science in evaluation of the IAC LC,[25] summarized the use of the learning community itself as an implementation strategy,[26] and assessed the sustainability of IAC LC goals.[18] For this study, we focus on understanding the development of implementation strategies. Proctor defines an implementation strategy as a method or technique used to support programs or practices.[20]

An implementation strategy should identify and define who implements the strategy and specifies the target, time frame, and outcome of the strategy. To fully develop an implementation strategy, barriers and facilitators affecting both the implemented program and population receiving the program services are identified. Our study reports the barriers and facilitators identified by jurisdictional teams implementing strategies to improve access to LARC, with a specific focus on reimbursement processes, device acquisition, stocking, and supply.

Semistructured qualitative interviews were conducted by teleconference to better understand jurisdictional team experiences in identifying goals and activities.[18] The interview guide and the qualitative interviews were developed by the University of Illinois at Chicago (UIC), a part of the ASTHO evaluation team (C.L.D., C.E., A.V.). Other study coauthors reviewed the interview guide and provided subject matter feedback to further refine questions (C.D.K., E.P., S.A., S.C.).

Two to three interviewers conducted one hour to one and a half hour interviews in the final year of the IAC LC (2018) with two or more members of each jurisdictional team per scheduled group call. The team members participating in the final interviews varied by jurisdiction but met requirements to participate in the IAC LC as described above. The questions in the interview guide were grouped by IAC LC domain as described elsewhere[18];

in brief, the nine domains were provider awareness and training; reimbursement and financial sustainability; informed consent and ethical considerations; logistical, stocking, and administrative barriers; consumer awareness; stakeholder partnerships; service locations; data, monitoring, and evaluation; and specific populations.

The questions were designed to solicit detailed information on jurisdictional team implementation strategies including barriers and facilitators. Recordings of the interviews were transcribed for coding of excerpts by three ASTHO evaluation team members (C.L.D., C.E., A.V.). Transcripts were divided among the evaluation team members, and a coding dictionary was developed based on the interview guide and domains identified for the IAC LC. During the coding process, additional *in vivo* codes were developed from the interview responses, then refined through constant comparison.[27]

Additional to the broader IAC LC domains described above, data on the two specific domains of interest for this study were coded:(1) reimbursement processes (*i.e.,* a subdomain of the reimbursement and financial sustainability domain) and (2) device acquisition, stocking, and supply (*i.e.,* a subdomain of the logistical, stocking, and administrative barriers domain). Additional evaluation and interview processes have been described elsewhere.[18]

Codes specific to this study's domains were aggregated into the following themes and reported in data tables by groupings defined as barriers to the following: (1) reimbursement process and (2) device acquisition, stocking, and supply, and facilitators of the following: (3) reimbursement process and (4) device acquisition, stocking, and supply. Deidentified excerpts within themes were coded by one study author (H.P.P.), reviewed by another study author (C.D.K.), and discrepancies were discussed and resolved through consensus.

Barrier and facilitator summaries were developed and defined by the same study authors independently, reviewed then compared, and differences were resolved through consensus. Validation checks were completed by coauthors when summaries were aggregated by theme.

Descriptive counts and percentages of the number of jurisdictions identifying barriers or facilitators by theme were counted, summarized, and reported. Directly transcribed interview excerpts identified during the coding process were used to offer further contextual interpretation of reported findings by defining and describing issues, barriers, and facilitators within themes. Qualitative extracts were coded using Dedoose, a qualitative mixed-methods web-based software application,[28] and aggregated themes were developed in Microsoft Excel 365 (2022) during development of final data tables for the article. The project received an exemption from the institutional review board at UIC and was determined nonresearch public health practice by the CDC.

Results

Most jurisdictions participating in the IAC LC (89%; 24 of 27) described either a barrier to the reimbursement process or device acquisition, stocking, and supply (Table 1). The remaining 11% of jurisdictions did not identify any barriers. Of those 24 jurisdictions, payment methodology challenges of prior authorization requirements or billing mechanisms was the most common barrier to the reimbursement process, identified by 13 jurisdictions

(54%), followed by lack of billing and coding processes for payment among 9 jurisdictions (38%).

Acquisition cost challenges was the most common barrier for device acquisition, stocking, and supply, identified by 17 of the 24 jurisdictions (71%), whereas lack of delivery facility protocols for immediate postpartum LARC was the second most identified barrier by 8 jurisdictions (33%).

Similarly, many jurisdictions (85%; 23 of 27) identified a facilitator of reimbursement or device acquisition, stocking, and supply (Table 1) with the remaining 15% of jurisdictions identifying no facilitators. Of those 23 jurisdictions, for reimbursement processes, expanded payment methodology options for removing requirements or cost offsets was the most identified facilitator among 8 jurisdictions (35%), whereas supplemental funding for acquisition costs was the most identified facilitator for device acquisition, stocking, and supply among 15 jurisdictions (65%), followed by facility protocol development for purchasing and supply processes in 9 jurisdictions (39%).

Barriers to the reimbursement process

Payment methodology challenges of prior authorization requirements or billing mechanisms was a barrier described by many jurisdictions (Table 2). Mechanisms of reimbursement, including prior authorization for purchasing devices, changes in billing rates or complex reimbursement policies with multiple payors, and the process for requesting Medicaid plan amendments were qualitatively reported. For example, one jurisdiction (#8) described a barrier as:

> The cost of the device is still within the…rate that is provided to health centers, and so that's not able to be billed out separately. And so, it's one, they're reimbursed at one rate for the insertion of the device, so that covers provider time, all infrastructure, supplies, and the device itself. So, it's cost-prohibitive in that respect, as well. Only if the patient is covered under [an insurer] are they able to bill…and so that's a barrier.

Among jurisdictions identifying issues with the lack of billing and coding processes, not having adequate training, knowledge, or facility protocols on how to bill or code was another frequently identified barrier to reimbursement. As described by a jurisdiction (#5):

> They don't know how to bill for immediate postpartum LARC and they don't know how to do it without prior authorization. They don't know how to do it without same-day billing. I mean we hear…I just heard another person say, well, they can't send them to clinics because they won't get their postpartum visit paid for if they put the LARC on the same day.

Barriers to device acquisition, stocking, and supply

Barriers for device acquisition, stocking, and supply were commonly described as acquisition cost challenges. Keeping a stock of LARC devices in the hospital or clinic could become costly for some facilities, impacted by patient demand, cost recovery, purchasing

restrictions, upfront purchase requirements, and inventory management. One jurisdiction (#9) stated the barrier as:

> I think the biggest challenge that we hear over and over again, on the normal process, is just being able to stock LARC and having them available for same-day insertion, if that's the patient's desire. I think that's probably an ongoing question/concern that we hear. Some folks really liked the pharmacy benefit and medical benefit and it worked well for them. But folks who really want to stock—to have a stock on hand for same day insertion, I would say that's the biggest, the biggest challenge that we hear. Just because of the upfront cost for LARC.

Facilitators of the reimbursement process

The most common facilitator of reimbursement described by jurisdictions was expanded payment methodology options for removing requirements or cost offsets (Table 3). Removing prior authorization requirements, standardizing billing, and unbundling of LARC costs from the global obstetric fee for those who choose immediate postpartum LARC helped expand services and allow for more timely reimbursement in hospitals and clinics. One jurisdiction (#22) described it as:

> Now that the regulations have changed to allow unbundling of the LARC devices and their insertion from the global OB fee, I feel like that was a huge barrier taken down to allow efforts now to expand that more broadly.

Facilitators of device acquisition, stocking, and supply

Supplemental funding for acquisition costs was recognized across most jurisdictions as a facilitator of device acquisition, stocking, and supply. Jurisdictions expanded services by leveraging federal or jurisdictional grant funding, and receiving donations from private, for-profit, and nonprofit foundations or anonymous donors. One jurisdiction (#6) described it as:

> Looking at non-traditional places that we've not normally looked to for funds, they've always been mainly through grants. And so looking at foundations and other non-profits that would be interested in this work is something new. So the [de-identified] Foundation is one of our first to really look at how they might be able to support us in this work.

The second most frequently acknowledged facilitator was protocol development for purchasing and supply including device acquisition and stocking. Implementing purchase, stocking, and billing protocols improved provision of LARC in hospitals and clinics. One jurisdiction (#19) reported it as:

> There's program guidance in the program manual for the expectations of how they'll order and stock the contraception that's supplied by the program. And we do work with the pharmacy. The program works closely with the state pharmacy to manage spending for contraceptive purchases and to monitor district needs versus their orders.

Discussion

Most jurisdictions participating in the IAC LC identified barriers and facilitators related to reimbursement process, acquisition costs, stocking, or supply of LARC. The most common barriers for reimbursement processes were payment methodology challenges of prior authorization or billing mechanisms and lack of billing and coding processes. The most common barriers for device acquisition, stocking, and supply included device acquisition cost challenges and lack of delivery facility protocols. The facilitator commonly identified for reimbursement processes was expanded payment methodology to remove requirements or offset costs. The facilitators identified for device acquisition, stocking, and supply were supplemental funding and protocol development.

State teams previously identified the IAC LC as a useful forum to address barriers and promote facilitators.[18,19] The IAC LC required consistent and diverse jurisdictional team composition including practicing clinical champions, public health leaders, state-level payors, and program staff supporting implementation of strategies to address a wide range of barriers to contraceptive access within jurisdictions. [17-19,26,29] Collaborative partnerships developed by jurisdictional team members can provide resource sharing, development of achievable goals, and support sustainable systems changes that can impact access to services.[19,26]

Similarly, clinical champions are identified key influencers within jurisdictional health systems advocating for additional training, protocol development, and revisions to reimbursement systems at both the individual clinic or facility level and the jurisdictional agency level.[30] The IAC LC supported active peer-to-peer knowledge transfer, networking, and exchange between jurisdictions, suggesting sharing of information on successful strategies provided information for jurisdictional teams to consider when developing action plans and goals.[19,31]

Studies have demonstrated that providers in health systems are central to addressing reimbursement processes, stocking, and supply barriers in the provision of LARC.[32-34] Judge-Golden et al. conclude that approximately half of providers in one health care system were unable to offer LARC at annual patient visits due to barriers such as scheduling and billing challenges, inadequate time for patient counseling, and limited availability of LARC stock.[32] A study of providers in Los Angeles identifies comparable barriers.[33]

Similarly, barriers to provision of LARC in smaller rural Federally Qualified Health Centers (FQHCs) require referral to larger FQHCs or scheduling of follow-up appointments, limiting on-site access for people residing in these areas.[34] Our findings emphasize the role of providers in identifying barriers to accessing LARC including prior authorization requirements, coverage-related restrictions, inventory challenges, and purchasing limitations.

Opportunities to address such barriers at the health systems level include quality improvement initiatives to improve reimbursement processes, increasing access to LARC immediately postpartum, led by state Perinatal Quality Collaboratives (PQCs)—networks of providers that implement health system-specific initiatives.[35] For example, Tennessee and Florida PQCs report improvements in reimbursement processes for immediate postpartum

LARC insertion through coordination of payors and providers, and revision of billing codes.[36,37]

Likewise, providers have developed guidance for clinics and health systems—the Bixby Center for Global and Reproductive Health offers a publicly available *Intrauterine Devices & Implants: A Guide to Reimbursement*—outlining strategies to address revision of reimbursement practices, and to support changes in purchasing, stocking, and inventory maintenance of devices at the health system and provider levels.[38] Our findings underscore the need for such resources to be implemented and disseminated in clinical practice in a variety of settings from the delivery facility to health care clinics.

Individual jurisdictions have implemented changes to Medicaid reimbursement processes for LARC. Vela et al. identified nine states representing diverse populations and geographic regions in the United States to describe state Medicaid payment policy innovation.[39] Though all state policies in the study provided coverage for LARC, variation in state policies was noted in provider reimbursement for insertion fees, patient counseling for LARC removal, or follow-up.[39]

State innovations to enhance access include policies to increase device reimbursement, options for pharmacies to bill Medicaid programs directly rather than clinics seeking reimbursement to decrease the upfront device costs,[39] using reduced pricing programs such as the 340B drug pricing program,[40] and increasing provider awareness and training for use of billing codes.[39] Billing and coding processes for payment and improved billing mechanisms were barriers most often reported for reimbursement in our study. Training of providers on billing, coding, and claims submissions; standardizing reimbursement processes; and offsetting costs were facilitators utilized by jurisdictions participating in the IAC LC to improve access to LARC.

CDC clinical guidance for contraception[2,41,42] and clinical membership organization committee opinions[5] can also contribute to equitable access to contraception. Recommendations and guidance from clinical membership organizations support implementation of best clinical practices to address barriers while supporting patient autonomy.[43] Previous research suggests that clinical or provider champions and clinical change agents with the knowledge and experience to move evidence to practice[44] are central to identifying gaps and implementing systems changes such as protocols for billing and reimbursement for immediate postpartum LARC separate from the global obstetric fee.[29,30]

Similarly, recent research suggests that using a patient-centered respectful care focus when offering contraceptive options is a part of equitable quality care and includes increasing availability of LARC same day, during routine medical visits.[45] Developed by clinical or provider champions, a proposed reproductive and sexual health equity framework embodies recognition of marginalized populations, historical trauma, and equal access to services[46]—principal components of patient-centered care and contraceptive choice.

Engaging clinical or provider champions to lead quality improvement initiatives to address patient counseling, including device removal and follow-up identified as reimbursement

barriers in this study, could support contraceptive choice and increase access to the full range of contraceptive options including LARC.

To fully measure implementation strategies, Proctor notes the complexity of description, operational definition, and measurement.[20] An operational definition includes identifying discrete components of the strategy including barriers and/or facilitators experienced by those who enact those strategies.[20] The information reported by the IAC LC state team members provides foundational information for further strategy development, including rapid-cycle quality improvement initiatives led by PQCs, gaps in existing reimbursement policies, revisions of protocols for purchasing and supply of devices, and leveraging of clinical champions.

Though clinical champions play a critical role in removing barriers to LARC while facilitating LARC access, implementing strategies for systems changes requires support from state health department leaders, payors, device manufacturers, program staff, and hospital administrators. Future studies can incorporate these findings into the measurement of implementation strategy effectiveness.

Several limitations exist for our study. First, results represent jurisdictions that participated in the IAC LC, and may not be generalizable to the entire United States or territories, although the IAC LC did include jurisdictions with varying public health structures from all regions across the country. Second, we interviewed each jurisdictional team as a group and that may have influenced responses of individual team members. Third, our findings are reported by IAC LC teams that do not include patients and, therefore, may not include all barriers or facilitators to LARC as encountered by those who choose it.

Regardless of these limitations, our findings provide a summary of barriers and facilitators affecting reimbursement processes, device acquisition, stocking, and supply of LARC identified by jurisdictions implementing systems changes to improve access to contraception.

Conclusions

Barriers identified in our study affecting LARC reimbursement processes, device acquisition, stocking, and supply may be addressed by leveraging facilitators such as expanded payment methodologies; additional funding; leveraging clinical champions; and protocols for device purchasing, stocking, and billing. Though the IAC LC offered a forum for information sharing and peer-to-peer learning, continued statewide efforts to implement quality improvement initiatives and leverage clinical champions can contribute to the evidence for systems changes that support increased availability of LARC.

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Table 1.

Affecting the Reimbursement Process, Device Acquisition, Stocking, and Supply of Long-Acting Reversible Contraception
urisdictions Participating in the Increasing Access to Contraception Learning Community, 2018[a]

Barriers by domain							Facilitators by domain							
...bursement process themes			Device acquisition, stocking, and supply themes				Reimbursement process themes				Device acquisition, stocking, and supply themes			
...ayment ...hodology ...allenges ...f prior ...orization ...irements ... billing ...chanisms	Coverage related restrictions for removal or reinsertion	Policy amendment limitations	Lack of inventory	Service site limitations	Acquisition cost challenges	Lack of delivery facility protocols for immediate postpartum LARC	Coordination of providers and payors on billing and coding	Provider training on administrative processes for billing or coding	Policy amendment implementation	Expanded payment methodology options for removing requirements or cost offsets	Protocol development for purchasing and supply	Supply chain process improvements	Supplemental funding for acquisition costs	Cost savings programs for device purchases
X											X		X	
	X	X			X								X	
X		X				X							X	
		X			X		X							
X		X			X	X				X			X	X
X					X			X		X	X		X	
	X	X	X	X	X									X
X		X						X		X				
X					X	X	X						X	
	X				X				X			X	X	X
					X								X	
X					X						X			
X					X									
					X				X				X	
											X			X
					X	X	X	X		X			X	X
						X								
											X			X
	X				X		X				X		X	
X	X			X	X		X		X	X			X	X
					X						X		X	

Barriers by domain							Facilitators by domain							
Reimbursement process themes			Device acquisition, stocking, and supply themes				Reimbursement process themes				Device acquisition, stocking, and supply themes			
ayment hodology allenges f prior horization uirements billing chanisms	Coverage-related restrictions for removal or reinsertion	Policy amendment limitations	Lack of inventory	Service site limitations	Acquisition cost challenges	Lack of delivery facility protocols for immediate postpartum LARC	Coordination of providers and payors on billing and coding	Provider training on administrative processes for billing or coding	Policy amendment implementation	Expanded payment methodology options for removing requirements or cost offsets	Protocol development for purchasing and supply	Supply chain process improvements	Supplemental funding for acquisition costs	Cost savings programs for device purchases
X		X				X	X	X		X				
			X								X		X	
X					X									
X		X			X	X				X	X		X	
X						X				X				
13	**5**	**8**	**2**	**2**	**17**	**8**	**6**	**4**	**3**	**8**	**9**	**1**	**15**	**7**

the following in alphabetical order: Alabama, Alaska, California, Colorado, Commonwealth of the Northern Mariana Islands, Connecticut, Delaware, Georgia, Florida, ouisiana, Maryland, Massachusetts, Mississippi, Montana, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Texas, Washington, West Virginia, and

ception.

Table 2.

AGGREGATE REPORTED BARRIERS TO THE REIMBURSEMENT PROCESS, DEVICE ACQUISITION, STOCKING, AND SUPPLY OF LONG-ACTING REVERSIBLE CONTRACEPTION IDENTIFIED BY THE INCREASING ACCESS TO CONTRACEPTION LEARNING COMMUNITY PARTICIPATING JURISDICTIONS, 2018

Themes	Reported barriers to the reimbursement process
Lack of Billing and Coding Processes for Payment	Jurisdictions identified a need to provide within clinic or facility training on the billing and coding process including removing prior authorization requirements, implementing protocols for quality improvement, and working with the device manufacturer for reimbursement.
Payment Methodology Challenges of Prior Authorization Requirements or Billing Mechanisms	Prior authorization requirements impact reimbursement for clinic and facility purchase of LARC devices limiting stock and availability. Mechanism of reimbursement including inpatient and outpatient billing, changes in billing rates, bundled rates, multiple payors, and complex or unclear jurisdictional-specific Medicaid policies present challenges to offering LARC. The process for requesting plan amendment changes from jurisdictional-specific Medicaid programs to carve out eligible patient groups limits individual or smaller clinics from using benefits available to larger health systems.
Coverage-Related Restrictions for Removal or Reinsertion	Reimbursement for LARC devices is affected by restrictions on coverage-related requirements for the removal or reinsertion of a device when not medically indicated, when prior authorizations are needed, or when a patient has a preference for early removal.
Policy Amendment Limitations	Limits in administrative support inhibit the development of new or amendment of existing jurisdictional policies for reimbursement of LARC.
	Reported barriers to device acquisition, stocking, and supply
Lack of Inventory	Clinics may not keep LARC inventory on site requiring a return patient visit, limiting opportunities for providers to offer same-day insertion for people who choose LARC.
Service Site Limitations	Delivery facilities with religious affiliation may lack mechanisms for stocking and supply including ability to purchase, provider preference, and policies within those facilities.
Acquisition Cost Challenges	Facilities and clinics may limit allocation of funding to stock devices due limited demand (*e.g.,* rural areas with smaller populations of people who choose LARC) or concerns over device expiration before placement. Delivery facilities may not stock LARC devices as hospital administrations perceive challenges in cost recovery, long-term financial viability, and revenue generation. The cost of devices limits the allocation of resources for clinic and facility upfront purchase, and the eligibility requirements for jurisdictional-specific 340B programs are applicable to a subset of the patient population resulting in disparate availability. Procurement of devices is limited due to inventory management challenges and variability of patient method selection. Inconsistent and variable funding for the purchase of devices limits sustainable availability for all people who choose LARC.
Lack of Delivery Facility Protocols for Immediate Postpartum LARC	Provision of immediate postpartum LARC in delivery facilities requires protocols for purchasing and stocking of various brands of devices for use before expiration, support of the hospital pharmacy to stock and restock devices, and addressing logistical issues such as device availability in the labor and delivery unit and insertion guidelines or procedures for providers postdelivery.

LARC, long-acting reversible contraception.

Table 3.

AGGREGATE REPORTED FACILITATORS OF THE REIMBURSEMENT PROCESS, DEVICE ACQUISITION, STOCKING, AND SUPPLY OF LONG-ACTING REVERSIBLE CONTRACEPTION IDENTIFIED BY THE INCREASING ACCESS TO CONTRACEPTION LEARNING COMMUNITY PARTICIPATING JURISDICTIONS, 2018

Themes	Reported facilitators of the reimbursement process
Coordination of Providers and Payors on Billing and Coding	Collaboration and coordination among stakeholders including clinics, delivery facilities, and providers improve billing and reimbursement processes by rapid dissemination of jurisdictional-specific Medicaid billing and policy changes, communicating with insurance companies, and providing support to advance policy in jurisdictions.
Provider Training on Administrative Processes for Billing or Coding	Training providers on reimbursement billing, coding, and submission of claims improves billing efficiency and timeliness of the payment process.
Policy Amendment Implementation	Changes in jurisdictional-specific Medicaid policy language, such as removing limitations on LARC removal and replacement, expanding sites that are eligible to provide LARC placement and devices, and broadening family planning services have reduced barriers in reimbursement.
Expanded Payment Methodology Options for Removing Requirements or Cost Offsets	Clinics and facilities have implemented programs with insurers to remove prior authorization requirements to pay for devices and standardized the billing process for all clinics within a jurisdiction. Options to bill outside of the global obstetric fee or receive reimbursements to offset costs for immediate postpartum placement increases accessibility to services in delivery facilities.
	Reported facilitators of device acquisition, stocking, and supply
Protocol Development for Purchasing and Supply	LARC supply is increased when hospitals and clinics develop and implement purchasing, stocking, and billing protocols.
Supply Chain Process Improvements	Reducing the interval between LARC supply orders in jurisdictional-specific Medicaid policy language has reduced barriers to supply.
Supplemental Funding for Acquisition Costs	Federal or jurisdictional grants have provided funding to jurisdictional programs, clinics, and facilities to reduce barriers to obtaining personnel, training, and device supply. Private, for-profit, and nonprofit foundations and anonymous donors have been instrumental in reducing barriers to stocking and supply by providing funding resources to clinics and facilities.
Cost Savings Programs for Device Purchases	Clinics and facilities have used funding from existing government programs and public insurance such as Title X, block grants, and CHIP to purchase supply of devices. Having access to jurisdictional-specific 340B pricing options and defined population or pricing carve-outs allows FQHCs, county clinics, and some delivery facilities to adequately stock LARC.

CHIP, The Children's Health Insurance Program; FQHCs, Federally Qualified Health Centers; LARC, long-acting reversible contraception.