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Review of Publicly Available State Policies for Long-Acting Reversible Contraception Device Reimbursement

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Abstract

Background: Provider challenges to accessing long-acting reversible contraception (LARC) include level of reimbursement for LARC device acquisition and cost to stock. State-level LARC device reimbursement policies that cover a greater proportion of the cost of the LARC device and enable providers to purchase LARC upfront may improve contraceptive access.

Materials and Methods: To summarize state-level policies that include language on LARC device reimbursement in the outpatient setting, we conducted a systematic, web-based review among all 50 states of publicly available LARC device reimbursement policies that include coverage of LARC devices as a medical or pharmacy benefit, the use of the 340B Drug Pricing Program to purchase LARC devices, and separate payment for LARC devices outside of the Medicaid Prospective Payment System (PPS) payment rate for Federally Qualified Health Centers or Rural Health Clinics.

Results: Forty-two percent (21/50) of states with publicly available state-level policies included language on LARC device reimbursement. Among the states, 24% (5/21) had coverage policies as a medical benefit, 33% (7/21) as a pharmacy benefit, and 19% (4/21) as both a medical benefit and pharmacy benefit; 38% (8/21) used the 340B Program to purchase LARC devices; and 62% (13/21) indicated separate payment for LARC devices outside of the Medicaid PPS payment rate.

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Conclusion: State-level policies for LARC device reimbursement vary, highlighting differences in reimbursement strategies across the U.S. Future research could explore how the implementation of these payment methods may impact LARC device reimbursement and whether increased reimbursement may improve access to the full range of contraceptive methods.

Keywords

long-acting reversible contraception; LARC device reimbursement; state-level LARC reimbursement policy

Introduction

Increasing access to quality contraceptive care, including client-centered contraceptive counseling and the full range of contraceptive methods,[1] expands contraceptive options for women of reproductive age,[2–4] supports method choice,[5] and reduces unintended pregnancy.[6,7] Long-acting reversible contraception (LARC) methods, including intrauterine devices and contraceptive implants, are safe and effective,[8,9] have a failure rate of less than 1%, require one-time insertion,[10] and can yield cost savings for the health care system.[11,12] However, barriers exist to accessing LARC in the outpatient setting, including administrative barriers (*i.e.,* level of reimbursement for LARC devices) and logistical barriers (*i.e.,* acquisition and stocking costs for LARC devices).[8,13–20] Same-day initiation protocols for contraception can reduce women being lost to follow-up and placed at increased risk of an unintended pregnancy.[13,21]

Health insurance coverage is a key factor to increase contraceptive use for women at risk of unintended pregnancy. Women of reproductive age with health insurance coverage have higher rates of contraceptive use and higher rates of using the most or moderately effective methods compared with those without health insurance coverage.[22]

The Affordable Care Act (ACA) requires many group and individual health plans and Medicaid plans to provide in-network coverage for certain preventive services without patient cost sharing, including contraceptive counseling and at least one form of contraception within each of the 18 Food and Drug Administration (FDA)-approved methods of contraception for women.[23,24] The ACA's federal contraceptive coverage requirements for group and individual health plans have expanded contraceptive coverage without cost sharing to most privately insured women with group and individual health plans.[25–27]

However, insurance companies may still use reasonable medical management techniques (*e.g.,* practices that promote the most cost-efficient and effective drug and procedure options while allowing the insurer to control expenditures and use comparable drug brands) for each of the FDA-approved methods for women by the FDA.[28] In addition, states have several options for covering family planning services through Medicaid for individuals who are not otherwise eligible for comprehensive Medicaid (*e.g.,* include in its State Plan Amendment an optional "family planning eligibility group" established under the ACA, use a Medicaid section 1115 waiver to develop demonstration projects for increased contraceptive coverage).[29]

Furthermore, multiple state Medicaid agencies and Medicaid Managed Care Organization (MCO) health plans have implemented payment strategies and used policy guidance[19,30,31] for LARC device reimbursement to improve patient and provider awareness by reimbursing for patient education and counseling,[32] improve LARC use by reimbursing for the actual cost of the contraceptive method or services,[8,9,16,18] and provide clear guidance on billing and reimbursement to ensure providers receive appropriate payment.[18–20,33]

Coverage policies that reimburse LARC devices in the outpatient setting through a medical or pharmacy benefit can address acquisition and stocking costs, as well as support same-day initiation.[20,29] As a medical benefit, LARC devices can be made available through same-day access because providers can purchase the device before insertion and then bill for the device postinsertion.[20,29] However, in practice, practitioners report that the high cost of stocking LARC devices upfront may include the risk of absorbing the cost of unused devices.[20,29] When states have coverage policies that reimburse LARC devices as a pharmacy benefit, providers order the device from a specialty pharmacy, for a specific patient, and the health plan is billed for the LARC device and dispensing fee to deliver the LARC device to the provider; the provider then bills for insertion of the device.[29,30]

The pharmacy benefit decreases the burden on the provider by allowing providers to order LARC devices from the pharmacy and not assume the high upfront costs.[18] However, unless the pharmacy is on-site, this approach requires a return visit by the patient once the provider receives the device from the pharmacy.[20,29] If the device is not inserted, some pharmacies may allow providers to return unopened LARC devices without bearing the cost.[20,29] If the device cannot be returned to the pharmacy, there may be a financial burden to the provider.[20,29] Some states have coverage policies that reimburse LARC devices as a pharmacy benefit and a medical benefit, thereby leaving the choice of device acquisition to the provider.[20,29]

The 340B Drug Pricing Program (340B Program) is a federal program, created by section 340B of the Public Health Service Act (42 U.S.C. § 256b) and administered by the Health Resources and Services Administration (HRSA). The 340B Program requires pharmaceutical manufacturers to sell drugs for outpatient use to eligible “covered entities” (*i.e.,* safety-net providers and others identified in the law) at a discount as a condition of a manufacturers’ products being covered by Medicaid.[34]

Some states, however, have “carved out” the pharmacy benefit for Medicaid MCO enrollees, which means providers cannot use 340B drugs for those patients.[20,29,34,35] Covered entities eligible to participate in the 340B Program include safety net providers that serve a significantly disproportionate number of low-income and uninsured patients and recipients of specific federal grants from HRSA, the Centers for Disease Control and Prevention (CDC), the Office of Population Affairs, and the Indian Health Service (IHS).[34]

An eligible safety net provider may purchase the LARC device at a discounted rate and may be reimbursed separately for a dispensing or procedure fee, depending on state Medicaid policy.[34,36] However, some states may not permit safety net providers to use drugs and devices purchased through the 340B Program for Medicaid patients to avoid duplicate

discount billing when state Medicaid agencies instead opt to bill manufacturers for a rebate under the Medicaid rebate program for covered drugs dispensed to Medicaid enrollees.[34,37] In these states, if the LARC device is not purchased through the 340B Program, Medicaid pays the lesser of the cost actually occurred or the amount listed on the Medicaid fee schedule.[34,37]

Lastly, the Prospective Payment System (PPS) is a method of reimbursement in which Medicaid payment is made based on a predetermined, fixed amount that is specific to Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs).[38,39] The FQHC and RHC Medicaid PPS payment rates are based on a PPS base rate and annual state adjustments using the Medicare Economic Index, a measure of medical practice cost inflation, and any changes in scope of services included in the encounter rate.[40]

Given the high cost of LARC devices, providers may be unable or reluctant to purchase and bill for LARC when reimbursement for the device is embedded in the per-visit rate.[20] Some states allow separate payment for the LARC device outside of the PPS payment rate for FQHCs or RHCs.[29,41] In states that allow separate payment for LARC devices in the outpatient setting, the Center for Medicaid & CHIP Services (CMCS) approved reimbursement to FQHCs or RHCs for the per-visit rate, including LARC insertion, and a separate reimbursement for the LARC device.[19,20,38,39]

This review will focus on state-level LARC device reimbursement policies in the outpatient setting that may improve contraceptive access by addressing acquisition and stocking costs. Addressing these barriers may enable same-day access. The objective of this review is to summarize state-level policies that include language on LARC device reimbursement using abstracted information from publicly available documents. Specifically, this review assesses LARC device reimbursement policies that include the following components: coverage of an LARC device as a medical or pharmacy benefit, the use of the 340B Drug Pricing Program to purchase LARC devices, and separate payment for the LARC device outside of the Medicaid PPS payment rate for FQHCs or RHCs.

Materials and Methods

Study design and data collection process

A systematic, web-based review of information about states' LARC-related reimbursement policies in outpatient settings was conducted from October 2017 to May 2018 among all 50 states. Using search engine sources that did not charge for access and did not include databases available behind a paywall (*i.e.,* Google), available documents, including state law or state statutes and regulations, provider bulletins, state reports, toolkits, and other state health or other health agency published documents were identified for data abstraction. Documents that did not address a state policy that was inclusive of or specific to LARC were excluded. This review addressed state-level, LARC-related policies with specific language on LARC device reimbursement.

The data collection process is described elsewhere.[42] In brief, a systematic search was conducted by two abstractors that used search terms agreed upon by study authors to search

separately and simultaneously by state, independently cross-referenced the search findings of the other by completing double-data entry of source information, and then reconciled any differences between findings.

Study authors (O.R.S., J.F.H., and K.U.) further validated the abstracted information by randomly selecting then contacting nine state Health Department and Medicaid programs to confirm the accuracy of the extracted policy information. Study authors (O.R.S, K.U., and L.R.) reconciled any discrepancies in policy information abstraction to ensure consistency in the search strategy, data entry, data coding, and variable definitions. Abstracted information included (1) policy source, (2) verbatim text of the policy, (3) summary of the policy text, and (4) date policy was enacted, adopted, or implemented, if available.

Data summary process and definitions

All documents addressing states' policies on LARC device reimbursement in the outpatient setting were abstracted for in-depth review. Information summarized included (1) publicly available policy for payment of LARC device, (2) policy source, and (3) the type of LARC device reimbursement methods identified in policy.

All available state documents were identified, and study authors examined and abstracted all summary information from the data sources. Discrepancies were reconciled among study authors (O.R.S., K.U., and L.R.) to ensure consistency in the search strategy, data entry, data coding, and variable definitions. Documents authored by the state or an agency with the authority to establish reimbursement policies within the state that referred to or detailed LARC device reimbursement were categorized as "publicly available." States with indirect reference to a policy (*i.e.,* a policy document from a state and authored by an entity without authority to create reimbursement policies) were categorized as an "indirect reference."

States with a policy source described in a state document that cites a state source for reimbursement that was publicly unavailable for review or no policy sources that referenced LARC device reimbursement were categorized as "not publicly available." Both indirect reference and not publicly available policies were excluded from the analysis.

Among states with publicly available policies, policy information was further classified into four variables based on whether a state's LARC device reimbursement included the following components: (1) medical benefit, (2) pharmacy benefit, (3) use of LARC devices purchased through the 340B program for Medicaid enrollees, and (4) separate reimbursement from the PPS encounter rate for FQHCs and RHCs. For each state, based on the publicly available information collected, the study authors determined whether the state's policy included one or more of the LARC device reimbursement components being studied, a reimbursement mechanism not included in this study, or both.

Statistical methods

Descriptive statistics were used to analyze the abstracted information. Counts and percentages were calculated for identified policies for LARC device reimbursement by a state. This study was determined to be public health practice and, therefore, did not require the Institutional Review Board approval at CDC or the University of Illinois Chicago.

Results

Among the 50 states, 42% (21/50) had publicly available statewide policies that referred to LARC device reimbursement in outpatient settings (Table 1). Among states with policy language on LARC device reimbursement, reimbursement language was included in these types of policies: 90% (19/21) identified Medicaid, 5% (1/21) Medicaid and non-Medicaid state regulation or statute, and 5% (1/21) Other (*i.e.,* policies specific to non-Medicaid insurers, including private insurance companies or bulletins targeting the insurance marketplace for private individual or small-group purchasers) (Table 1).

However, among the 21 states with publicly available policies for LARC device reimbursement, 5% (1/21) did not have policy language specific to the LARC device reimbursement policy components of this review. Specifically, one state did have policy language that included IUD and implant insertion and removal reimbursement but did not have specific language for LARC device reimbursement (Table 2).

Coverage of LARC device through medical or pharmacy benefit

Specific to the policy components of this analysis, 21 states had reimbursement policies; 24% (5/21) indicated coverage of LARC devices as a medical benefit, 33% (7/21) as a pharmacy benefit, and 19% (4/21) as both (Table 2).

Dispensing of LARC device purchased through 340B Program to Medicaid enrollees

Eight states (38%; 8/21) indicated use of the 340B Program by an eligible safety net provider to purchase LARC devices to dispense to Medicaid enrollees, with one state allowing eligible 340B safety net providers an option to opt-out of the 340B Program for Medicaid enrollees, thereby enabling the state to claim rebates for those drugs through the Medicaid Drug Rebate Program (Table 2).

Reimbursement for LARC device through separate payment outside of the PPS

Thirteen states (62%; 13/21) indicated separate payment for the LARC device outside of the PPS payment rate for FQHCs or RHCs (Table 2).

Discussion

Research has shown that given the cost, providers may have difficulty purchasing and stocking LARC, which may be a barrier to patient access.[20] Previous studies have shown that LARC reimbursement rates as well as acquisition and stocking costs can result in barriers to LARC access.[18]

This review highlights the variation in publicly available state-level policies that relate to four categories of LARC reimbursement. Twenty-one states (42%; 21/50) have publicly available policies that include language on LARC device reimbursement and among these states, 90% (19/21) have reimbursement policies specific to the components of this review. Our results indicate that inclusion of these components in state-level policies for LARC device reimbursement varies, highlighting differences in reimbursement strategies used for LARC services across the United States. To provide further interpretation and context to

the unique circumstances of each state system, while highlighting the variability of policy language, relevant examples from a few different state policies are provided.

For states with coverage policies that reimburse LARC devices as a medical benefit and a pharmacy benefit, providers can choose the acquisition and reimbursement method, which may facilitate a providers' ability to stock LARC devices to support same-day insertion. For example, Texas Medicaid and Healthy Texas Women providers can use the medical benefit or the pharmacy benefit; however, Family Planning Program providers can only use the medical benefit method.[43]

Previous research reports that when patients are required to return for a second visit for LARC insertion, up to 50% of clients will not return for the LARC insertion visit.[21] CDC's evidence-based contraceptive guidance recommends providing immediate access to contraceptive methods at the same visit if a woman is not pregnant and there is no medical reason to require clients to return for a follow-up visit.[5,44,45] When providers have LARC devices on-site, they can offer patients same-day initiation and can improve contraception access.[13,21,46]

States that have LARC device reimbursement policies specific to the purchase of LARC devices through the 340B Program allow eligible safety net providers to reduce the costs associated with purchasing and stocking LARC devices.[34] For example, in 2014, the Iowa Department of Human Services allowed any eligible provider using the 340B Program to fill prescriptions for Medicaid patients with LARC devices acquired through the 340B Program and bill Medicaid their actual acquisition cost plus the dispensing fee.[47] If the LARC device is not purchased through the 340B Program, the LARC device is billed in accordance with existing state Medicaid reimbursement methodologies, allowing rebates to be collected by the state.[47]

Prior research has also shown that state policy permitting eligible providers' use of the 340B Program to purchase LARC devices can improve LARC access through the cost savings realized directly by the eligible provider.[18] However, the actual cost savings will depend on the level of reimbursement received from Medicaid.[35] Eligible entities that use the 340B Program have to adhere to state and program requirements that include informing the state Medicaid agency that they are dispensing 340B drugs to Medicaid beneficiaries, having a system in place to prevent duplicate discounts, and not using contract pharmacies to dispense to fee-for-service Medicaid beneficiaries unless an arrangement to prevent duplicate discounts has been agreed upon with the State Medicaid agency.[35]

Previous research has shown that states' reimbursement rates for the cost of the LARC device can impact the financial viability of safety net providers, such as FQHCs and RHCs, and improve patient access to care.[20,41] The literature has also demonstrated that states that have LARC device reimbursement policies to separate payment for the LARC device outside of the Medicaid PPS payment rate for FQHCs or RHCs can improve LARC access by increasing the level of reimbursement for LARC devices.[16,20,29] For example, the New Mexico Human Services Department unbundled LARC devices from FQHC, RHC, hospital-based RHC, and IHS FQHC encounter rates so that LARC devices can be reimbursed

separately in addition to the encounter rate as the “encounter rate is not sufficient to cover the cost of the [LARC device].”[48,49]

Within states, barriers to implement reimbursement strategies often include provider or provider systems state-level reimbursement mechanisms and provider education and training on the provision of quality contraceptive services. Multiple state Medicaid plans have increased access to the full range of reversible contraception by implementing payment strategies and providing policy guidance to address these barriers.[19,31] Many individual and group health plans, as required by ACA, have increased contraceptive coverage without cost sharing.[26] To ensure the ACA’s federal standards for contraceptive coverage are fully implemented, ongoing patient and provider education and continued oversight at the state and federal levels are essential.[26] Furthermore, providers can put into practice evidence-based quality contraceptive services.[5,44,45]

Previous research reported considerations for providers to address barriers to access, including provide patient-centered contraceptive counseling so that the contraceptive method is what they need and want[50]; counsel pregnant women about all forms of contraception they can use postpartum to make an informed decision[51,52]; help patients understand the full range of contraceptive methods that their health insurance covers[13]; provide same-day contraception services to reduce losing patients to follow-up and risk of an unintended pregnancy[13,21,46]; maintain their education and technical skills to deliver high-quality contraceptive care, including training in LARC insertion, removal, and management[44,45]; and support provider champions seeking to implement reimbursement policies by sharing evidence-based guidance with other providers.[53–55]

In addition to LARC device reimbursement in the outpatient setting, state-level policies for immediate postpartum LARC device insertion and reimbursement for removal and reinsertion of LARC can further support improved contraception access. As part of the broader systematic review of publicly available state-level information on LARC, separate analyses on reimbursement policies for immediate postpartum LARC and LARC removal and reinsertion also reported variations in state-based policies. Medicaid reimbursement policies for immediate postpartum LARC services more often include the cost of the device than provider reimbursement and less often offer reimbursement for provider insertion fees, highlighting a significant systems barrier to contraceptive access for women who choose LARC immediately postpartum.[42]

Policies that include reimbursement for LARC removal or reinsertion most often include LARC removal and more often include reinsertion, highlighting barriers to access LARC removal and reinsertion.[56] Barriers to removal may inhibit use of LARC if women lack assurance that removal will be an option or if they perceive resistance from providers when they raise the possibility of removal.[57] State-level reimbursement policies can provide the foundation for development of a broader system for LARC reimbursement and support increased access for women who choose LARC methods and ensure women can discontinue their LARC method at any time.

The findings in this review are subject to several limitations. First, LARC device reimbursement policies may be provided through a state-level policy without reference to the specific language or components used in our search strategy, potentially impacting the number of policies identified. Second, because our review was limited to publicly available policies, we may not have captured nonpublic or unpublished policies, including group and individual health plan policies or additional state laws accessible only on a proprietary legal database. Third, almost all state-level LARC device reimbursement policies were specific to state Medicaid programs, limiting generalizability of LARC device reimbursement policies to Medicaid policies and potentially masking a significant proportion of health systems and payors that have LARC device reimbursement policies in the outpatient setting.

Fourth, given few publicly available policies for group and individual plans were accessible in our review, we were not able to assess state-level laws or regulations and the use of innovative LARC device reimbursement strategies among group and individual plans and insurance companies. Fifth, we did not include policy review for the District of Columbia or any U.S. territories or freely associated states. Finally, since the data collection was limited to the 2017 to 2018 time frame, some state-level policies may have been developed, amended, or repealed following the review time frame and not captured in the review. Furthermore, although these policies included strategies specific to reimbursement of LARC devices, we did not evaluate if these polices fully covered cost of procuring LARC devices.

Conclusion

State-level policies for LARC device reimbursement in outpatient settings vary, highlighting differences in reimbursement strategies. This review provides a summary of publicly available state-level policies that include language on LARC device reimbursement specific to coverage of the LARC device as a medical or pharmacy benefit, the use of the 340B Program to purchase LARC devices for use by Medicaid enrollees, and separate payment for the LARC device outside of the PPS payment rate for FQHCs or RHCs. While variations are noted, existing policies provide guidance for facilities and providers on LARC device reimbursement and many states are actively implementing payment strategies to address implementation challenges.

The literature suggests that these types of policies may increase reimbursement levels for LARC devices, reducing acquisition and stocking costs that can impede same-day initiation that may improve access and subsequent LARC utilization.[18,20,29] Future research is needed to better understand the policy impact on costs and benefits to providers and patients, explore how the implementation of these payment methods may improve LARC device reimbursement, how adequate reimbursement may improve equitable access to the full range of contraceptive methods, including LARC, and specifically which policies best support expanded contraceptive options for women.

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Table 1.

States with Publicly Available Policy for Long-Acting Reversible Contraception Device Reimbursement in Outpatient Settings by Policy Source (n = 50 States)

	Policy characteristics	
State	**Publicly available policy**	**Policy source[a]**
Alabama	—[b]	—
Alaska	—	—
Arizona	—	—
Arkansas	—	—
California	Yes[c]	Medicaid
Colorado	Yes	Medicaid
Connecticut	—	—
Delaware	Yes	Medicaid, State Regulation
Florida	—	—
Georgia	Yes	Medicaid
Hawaii	—	—
Idaho	Yes	Medicaid
Illinois	Yes	Medicaid
Indiana	—	—
Iowa	Yes	Medicaid
Kansas	Yes	Medicaid
Kentucky	—	—
Louisiana	Yes	Medicaid
Maine	—	—
Maryland	Yes	Medicaid
Massachusetts	—	—
Michigan	—	—
Minnesota	—	—
Mississippi	Yes	Medicaid
Missouri	Yes	Medicaid

State	Policy characteristics	
	Publicly available policy	Policy source[a]
Montana	—	—
Nebraska	—	—
Nevada	Yes	Medicaid
New Hampshire	—	—
New Jersey	Yes	Other[d]
New Mexico	Yes	Medicaid
New York	Yes	Medicaid
North Carolina	Yes	Medicaid
North Dakota	—	—
Ohio	—	—
Oklahoma	—	—
Oregon	—	—
Pennsylvania	—	—
Rhode Island	—	—
South Carolina	Yes	Medicaid
South Dakota	—	—
Tennessee	—	—
Texas	Yes	Medicaid
Utah	—	—
Vermont	—	—
Virginia	—	—
Washington	Yes	Medicaid
West Virginia	—	—
Wisconsin	—	—
Wyoming	Yes	Medicaid

[a]Policy includes state Medicaid plan documents (*i.e.,* State Plan Amendment, 1115 family planning waiver) and state regulation or statute.

[b]—Indicates states with “Indirectly Referenced” or “Not Publicly Available” sources. The term “Indirectly Referenced” describes states with a policy document from a state and authored by an entity without authority to create reimbursement policies. The term “Not Publicly Available” describes states with a policy source described in a state document that cites a state source for reimbursement that is publicly unavailable for review or no policy sources that referenced LARC device reimbursement.

[c] A "Yes" specified a policy source that indicated the state policy did include language on LARC device reimbursement.

[d] The term "Other" can include policies specific to non-Medicaid insurers, including private insurance companies or bulletins targeting the insurance marketplace for private individual or small-group purchasers.

LARC, long-acting reversible contraception.

Table 2.

Long-Acting Reversible Contraception Device Reimbursement Policies by State, (n = 21 States)

	LARC device reimbursement policy component			
State	**Medical benefit[a]**	**Pharmacy benefit[b]**	**340B Drug pricing program[c]**	**PPS[d]**
California	__[e]	—	Yes	—
Colorado	—	—	Yes	Yes
Delaware	—	—	—	Yes
Georgia	—	—	—	Yes
Idaho	—	—	Yes	Yes
Illinois	—	—	Yes	Yes
Iowa	—	—	Yes[f]	Yes
Kansas	—	—	—	Yes
Louisiana	—	Yes	—	Yes
Maryland	—	—	—	Yes
Mississippi	Yes	—	—	—
Missouri	Yes	Yes	—	Yes
New Jersey	—	Yes	—	—
New Mexico	—	—	—	Yes
New York	—	—	—	Yes
North Carolina	—	—	Yes	—
South Carolina	Yes	Yes	—	—
Texas	Yes	Yes	Yes	Yes
Washington	Yes	Yes	Yes	—
Wyoming	—	Yes	—	—

Among the 50 states, 21 had statewide policies that referred to LARC device reimbursement. However, among the 21 states with publicly available policies for LARC device reimbursement, 20 states had policy language specific to the LARC device reimbursement policy components of this review. One state (Nevada) had policy language that included IUD and implant insertion and removal reimbursement but did not have specific language for LARC device reimbursement.

[a]The LARC device can be ordered and purchased by the provider before insertion. The LARC device is then billed for reimbursement postinsertion.

[b]The LARC device can be ordered by the provider from a specialty pharmacy, for a specific patient. The health plan is billed by the pharmacy for the LARC device and dispensing fee to deliver the LARC device to the provider. The provider bills for insertion or implantation.

[c] The LARC device can be purchased by an eligible safety net provider at a set and discounted rate for eligible patients. Providers may be reimbursed separately for a dispensing or procedure fee, depending on state Medicaid policy.

[d] The LARC device can be reimbursed separately from the PPS encounter rate specifically for Federally Qualified Health Centers and Rural Health Centers.

[e] —Indicates "Not Specified."

[f] Eligible 340B safety net providers in the state are given an option to opt out of using the 340B Drug Pricing Program for devices dispensed to Medicaid enrollees, thereby allowing the state to claim a rebate through the Medicaid Drug Rebate Program.

LARC, long-acting reversible contraception; PPS, Prospective Payment System.