



# New Jersey Reproductive Health *Access* Project

## *Provider Access Commitment Toolkit*

## About the New Jersey Health Care Quality Institute

The New Jersey Health Care Quality Institute (**Quality Institute**) ([njhcqi.org](http://njhcqi.org)) is a multi-stakeholder non-profit organization that was founded in 1997. Our mission is to improve the safety, quality, and affordability of health care for **everyone**. To support healthy communities and individuals, we believe that health care should be:

1. Safe and of high quality;
2. Accessible and affordable;
3. Equitable, respecting individual dignity; and,
4. Transparent, to promote accountability and quality improvement.

For more than two decades, the Quality Institute has informed our research and policy work with the front-line experiences of our diverse membership of providers, purchasers, health plans, associations, consumer groups, and health care companies. The Quality Institute's Board of Directors and Leadership Council, a multi-stakeholder group representing organizations involved in service delivery or payment, provides additional expertise in guiding our work. Our evidence-based collaboration has built the Quality Institute's solid reputation, which allows us to maintain strong communication with state policy makers in the legislature and within the executive branch at both the state and federal level. This project is a part of the Quality Institute's growing portfolio of work to increase access to quality reproductive health services across the state, including contraceptive and perinatal care.

*\*The contents of this toolkit were largely finalized before the COVID-19 pandemic. While processes for health care delivery may change as a result of this public health emergency, the main priorities, best practices, and information provided in this toolkit remain relevant.*

## Acknowledgments

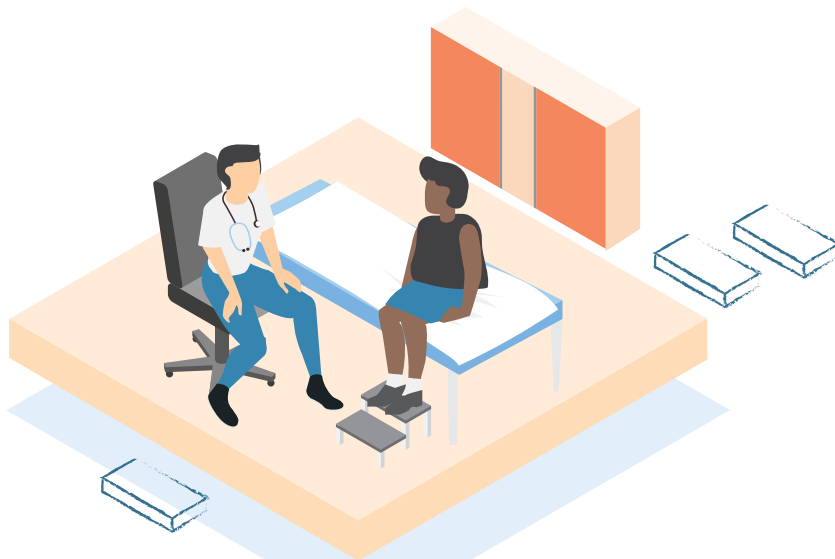
The Quality Institute would like to acknowledge the staff and partners that contributed to the development of this toolkit, as well as related activities to advance access to reproductive health services in New Jersey. Linda Schwimmer, Brittany Stapelfeld Lee, and Kate Shamszad devoted substantial time and resources into understanding both the barriers to accessible and high-quality reproductive health care in New Jersey, as well as strategies to improve outcomes for these services through enhanced provider education. Additionally, the content of this toolkit was created with great assistance from Dr. Barbara Levy and Linda Locke, who both served as consultants on this project. Patricia Kelmar was also instrumental in collecting and analyzing research about barriers to care that provided the foundation for this resource through past work with the Quality Institute. The individuals from the state agencies, community-based organizations, health systems, and other key stakeholders who comprised the NJ-RHAP Steering Committee also contributed greatly to the completion of this toolkit. *A full list of the Steering Committee members is available at the end of this toolkit.* Additionally, the Quality Institute thanks The Nicholson Foundation for their support on previous projects that advanced overall understanding about the landscape of reproductive health services in the state.

Finally, this work would not have been possible without the generous support of Arnold Ventures ([arnoldventures.org](http://arnoldventures.org)). The Quality Institute thanks them for their investments in our mutual goal of advancing access to quality and comprehensive reproductive health services in New Jersey and nationally.

*\*The views expressed are solely those of the authors.*

# Table of Contents

<b>About the New Jersey Health Care Quality Institute</b>	<b>2</b>
<b>Acknowledgments</b>	<b>2</b>
<b>Section 1: Overview and Purpose</b>	<b>4</b>
1a. New Jersey Reproductive Health Access Project	4
1b. NJ-RHAP Provider Access Commitment Toolkit	4
1c. Reproductive Health: Contraceptive Services, LARC, and Beyond	6
1d. Foreword from Reproductive Justice Contributor - Linda Sloan Locke	6
1e. Overview of Contraceptive Services in New Jersey	8
1f. Patient and Provider Barriers	8
<b>Section 2: Providing Comprehensive, High-Quality, and Accessible Services</b>	<b>10</b>
2a. Fundamentals of Service Delivery	10
2b. Contraceptive Methods	11
2c. Reproductive Coercion	11
2d. Contraceptive Counseling	13
2e. Barriers to Contraceptive Counseling	15
<b>Section 3: Reproductive Health Providers</b>	<b>17</b>
3a. Who's Who: Providers of Reproductive Health	17
3b. Provider Training and Education Opportunities	18
3c. Supporting New Providers to Deliver Comprehensive Services and Reducing Barriers to LARC	20
3d. Myths vs. Facts	21
<b>Section 4: Understanding the New Jersey Coverage Landscape</b>	<b>23</b>
4a. Federal and State Policies	24
4b. Types of Coverage Available in New Jersey	24
<b>Section 5: Reimbursement for Contraceptive Services</b>	<b>27</b>
5a. Overview	27
5b. Billing, Coding, Reimbursement	28
5c. Common Coding Scenarios	29
<b>Section 6: Purchasing, Stocking, and Storing LARC</b>	<b>33</b>
6a. Unpacking the Supply Chain of LARC	33
6b. Stocking and Storing LARC in Provider Offices	34
<b>Section 7: Increasing Access in the Office and the Community</b>	<b>36</b>
7a. Office Protocols to Increase Access	36
7b. Improving Access in the Community	38
<b>Section 8: Looking Forward</b>	<b>40</b>
<b>Key Resources</b>	<b>41</b>
<b>NJ-RHAP PACT Resources</b>	<b>42</b>
<b>NJ-RHAP Steering Committee</b>	<b>42</b>
<b>Endnotes</b>	<b>43</b>



# Overview and Purpose

## 1a. New Jersey Reproductive Health Access Project

The New Jersey Reproductive Health Access Project (NJ-RHAP) is a project run by the New Jersey Health Care Quality Institute (Quality Institute) with support from Arnold Ventures.

NJ-RHAP is a statewide initiative created to empower New Jersey patients, their providers, and payers, to identify the reproductive health services that are best for themselves and their families and to expand access to the full range of contraceptive options available.

NJ-RHAP seeks to identify and improve state laws, regulations, and contracts while increasing providers' understanding of key policies that impact service delivery for reproductive health services, specifically contraceptive services.

The goal of NJ-RHAP is to educate providers, reduce the policy and payment system barriers that prevent individuals from accessing the contraceptive method(s) they most desire, and to promote policy change that supports patient-centered reproductive health care.

## 1b. NJ-RHAP Provider Access Commitment Toolkit

The primary goal of this toolkit (the NJ-RHAP PACT) is to provide a comprehensive resource for providers on the policies, procedures, and best practices for the provision of reproductive health services in New Jersey. This toolkit provides strategies to improve access to care and includes clarification and guidance to increase providers' understanding of the complex systems and policies that impact their work. The toolkit contains resources and stand-alone documents to support providers and to implement process improvement activities needed to operationalize these recommendations and further enhance patient experiences and outcomes.

*\*Individuals seeking reproductive health care, specifically services aimed at preventing pregnancy, do not identify solely as women. This toolkit avoids the use of gender-specific terminology whenever possible and promotes interactions that are inclusive of a range of gender identities and sexual orientations.*

## > Key Questions

### WHO ARE “PROVIDERS”?

The clinicians who typically come to mind when discussing reproductive health are not the only professionals who play an important role in ensuring the quality and accessibility of services. The full care team, including staff who answer office phones, schedule appointments, and check patients in when they arrive, operations staff who participate in billing, coding and insurance verifications, as well as the leadership at these health systems that can make decisions on core office policy and procedures, are all instrumental in this effort. **In this toolkit, when we refer to “providers”, we use that term to be inclusive of these professionals and others who may not be mentioned above.**

### WHY PROVIDER EDUCATION?

Understanding, accessing, and providing quality reproductive health services is extremely challenging. In New Jersey, providers of reproductive health services must act within the confines of a significant number of federal and state laws, policies, regulations, programs, contracts, and payers. This can make it challenging for providers to understand what is permissible and reimbursable for each patient at any given time. Research on access to comprehensive reproductive health care identifies significant clinician and patient reported barriers around education, accessibility, capacity, and knowledge of services.<sup>1</sup> **In addition to empowering individuals with education and tackling systemic policy barriers to care, we must also equip the provider workforce with the information and tools needed to help them implement high-quality services to ensure the best outcomes and experiences for populations seeking services across the state.**

### WHAT IS A “LARC”?

LARC stands for long-acting reversible contraception.

LARCs provide continuous contraceptive coverage over a period from 3-12 years depending on the product. There are two types of LARCs:

- An implant placed under the skin containing etonorgestrel, a progestin hormone, which is effective for 3 years, and
- Intrauterine devices/systems (IUDs) that are placed in the uterus.
  - There are several types of IUDs available, most of which deliver levonorgestrel, a progestin hormone, in various doses.
  - There is also a non-hormonal copper-containing IUD, which is effective for the longest period, up to 12 years.

Implants and IUDs require insertion and removal by a qualified health care professional. They can be removed at any time, after which a patient will shortly return to their baseline fertility.<sup>2</sup>

## 1c. Reproductive Health: Contraceptive Services, LARC, and Beyond

A significant portion of this toolkit discusses opportunities to advance access to contraceptive services, with many of the examples and data points focused on long-acting reversible contraception (LARC). The focus of this content was driven by research, data, and discussions with stakeholders that identified these services as the most complex for providers and their patients to access. As this toolkit was designed to address the expressed concerns of the provider community, our content mirrors that focus on contraception, and on LARC

specifically. However, it is imperative to note that reproductive health care extends far beyond contraceptive services and LARC. There are significant areas to advance quality and access in the field of reproductive health care beyond this scope. This toolkit is a part of that ongoing work. The Quality Institute is committed to continuing to engage with our partners and support efforts across the state to improve access to all reproductive health services.

## 1d. Foreword from Reproductive Justice Contributor — Linda Sloan Locke, CNM, MPH, LSW, FACNM

*About Linda: A midwife for over forty years, Linda Sloan Locke has a career-long commitment, not only to midwifery and women's health, but also to health disparities, the intersection of health and mental health, and social justice. She obtained her Bachelor of Science in Nursing and Master of Public Health from the University of Michigan. She completed her midwifery education at SUNY Downstate and her Master of Social Work, with a certificate in Violence Against Women and Children, from Rutgers University. Her midwifery experience includes: Chief of Midwifery at a large tertiary care center, clinical practice at Planned Parenthood, Federally Qualified Health Centers (FQHCs), as well as community hospital and private midwifery practice. As a social worker, she has been an in-home therapist with a focus on adolescents. In her role as Reproductive Justice Contributor on this project, Linda leveraged her clinical knowledge and first-hand experience about the barriers that providers and patients face in receiving care to advance the use of a reproductive justice lens while increasing access to services.*

My own experiences as a health care provider for over forty years, combined with my experience as a Black woman, have informed my perspective on the importance of prioritizing reproductive justice in this work. From my early career experiences as a clinic director at a family planning clinic, as

a midwifery student at a tertiary care hospital in Brooklyn, and through a wide variety of experiences in clinical practice in both community and tertiary level hospitals, family planning clinics, FQHCs, and domestic and sexual violence programs, I have witnessed the inequities in care for those in marginalized communities. In every setting and at every level, from system leadership down to individual providers, stereotypes about certain people, preconceived ideas, and both explicit and implicit biases add additional layers of oppression and obstacles for people seeking services. This is especially true for those who are Black, brown, native, poor, immigrant, or gender non-conforming. These experiences have shaped my commitment to ensuring that a social justice lens is used to inform health care delivery and that reproductive justice is made a priority in this work.

Reproductive justice, a concept defined in 1994 by SisterSong ([sistersong.net](http://sistersong.net)), is the human right for people to maintain personal bodily autonomy, to have children or not have children, and to parent those children in safe and sustainable communities.<sup>3</sup>

Rooted in the human rights framework of the World Health Organization and the United Nations, which identifies reproductive health as a human right, the concept seeks to center and address these issues of bodily autonomy, access and decision making,

and combines the concepts of reproductive rights with social justice.<sup>3</sup>

There has been a long history of **reproductive injustice** in the United States, especially toward people of color (Black, brown and indigenous) and other marginalized people (incarcerated, low-income, teens, and persons with disabilities). In the area of reproductive health, in family planning, and contraception services specifically, there is a particularly troubling history of injustice and coercion. As recently as the 1990s, documentation shows practices of sterilization without consent and coercion with financial or other incentives (such as reduced prison sentences, or as a requirement for receiving welfare) to have LARC inserted. These efforts were often supported or funded by federal or state governments. Even today, while these more blatant policies have been eliminated, coercion remains in the form of inadequate information given to women about sterilization, policies such as the family cap, and programs providing cash incentives for sterilization.<sup>4</sup>

It is, therefore, crucial that reproductive justice is considered at every level of intervention to assure health equity and prevent similar injustices from occurring. While our goal in this project is to reduce or eliminate barriers to reproductive health and increase access to patient-centered care, it is also essential to avoid what has been called “LARC Zeal”. It is important that our efforts remain centered around providing people with equal access and education to the full range of contraception options

and not steering them towards any particular method.

“LARC Zeal” has been described by the National Women’s Health Network as institutional or provider enthusiasm for LARCs to the exclusion of other methods, which runs the risk of hampering an individual’s ability to decide what methods are best for their unique circumstances and can heighten the possibility of coercion.<sup>5</sup>

At all levels of policy development, implementation, and service delivery, prioritizing reproductive justice means evaluating policies to assure they are grounded in evidence, support individual rights and avoid coercion through processes that promote shared decision-making and patient-centered care planning. It means avoiding policies which, though well-meaning, may have negative unintended consequences. Utilizing best practices and resources provided in this toolkit can assist providers, health systems, and state and federal organizations in putting patient knowledge and access at the forefront of reproductive health service delivery, both in New Jersey and nationally.

As we utilize a reproductive justice lens throughout this work, we will move toward achieving our goals of improved reproductive health care access, and the broader goal of having a positive impact on the people in New Jersey.

— Linda Sloan Locke, CNM, MPH, LSW, FACNM

## > *NJ-RHAP PACT Resource*



For more information on reproductive justice and LARCs, review the “NWHN-SisterSong Joint Statement of Principles on LARCs” available at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).



## 1e. Overview of Contraceptive Services in New Jersey

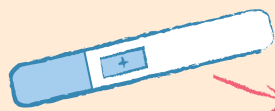
The need for improvement in the quality and accessibility of reproductive health services in New Jersey, specifically education efforts and access to contraceptive services, is clearly articulated through the data for unintended pregnancy and contraceptive utilization provided below.

However, it is critical to point out that in New Jersey and nationally, reproductive health services are often regarded as ancillary to other medical needs and frequently prioritized only when linked to outcomes that are typically viewed as socially “unfavorable”, such as teen pregnancy or a high

number of pregnancies for low-income populations. To reduce stigma and increase access, high-quality and accessible reproductive health care must be promoted as the necessary medical services that they are.

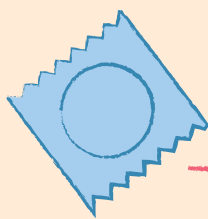
With that in mind, we provide the statistics below as tangible examples of specific areas where the state can see improved outcomes in the provision of reproductive health services, specifically contraceptive care.

### > Key Data



- While the rates of unintended pregnancy nationally and in New Jersey have decreased over the past few years, 25.3% of births in the state are unintended.<sup>6</sup>

- As of November 2022, 430,230 women in need in New Jersey live in contraceptive deserts..<sup>7</sup>

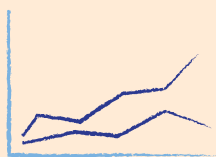


- 2017 data from Guttmacher indicated that 72.1% of New Jersey women (age 18-49) who were at risk of an unplanned pregnancy were using some form of contraceptive.<sup>8</sup>

➤ **27% of these women were using the least effective contraceptives, while 17.8% were using only moderately effective contraceptives.<sup>8</sup>**

- New Jersey is ranked 7 out of 50 for the highest number of teen birth rates and 18 out of 50 for highest number of teen pregnancies.<sup>1</sup>

➤ Wide variation for teen birth rates exists by both race and county. Teen births for racial/ethnic groups in New Jersey range from 1 to 8 per 1,000.<sup>1</sup>



## 1f. Patient and Provider Barriers<sup>1</sup>

In addition to the quantitative data above, information about the barriers that providers and their patients face for these services is critical to inform interventions that are aimed at increasing access to care.

Throughout this toolkit, we explore strategies to address these barriers and improve access to services. Examples of these barriers, which were identified through the Quality Institute’s previous research on this topic, include:



## PATIENT BARRIERS

- **Financial Access:** Costs of contraception, which can vary based on an individual's insurance and the type of contraception, can be a significant barrier to care. The availability of publicly funded contraceptive services is an important measure of access. Counties in New Jersey with the greatest percentage of women in need of contraceptive assistance are Union, Hudson, Bergen, Essex and Passaic. Some of these same counties have the lowest prevalence of contraceptive use in the state, as evidenced by Medicaid data.
- **Mistrust and Informed Consent:** Patient mistrust of healthcare systems may stand in the way of reproductive health and contraceptive access. The history of past abuses of marginalized communities, including procedures such as sterilization done without adequate consent, and coercion towards certain birth control methods, as well as their own past experiences or those from friends may drive these concerns. Patients may also fear that their desires and wishes will not be listened to, such as provider resistance to removal of a reversible contraceptive device.
- **Fear of Side Effects:** Patients may avoid some contraceptives if they are not sure that they will receive the proper provider support and interventions that may be needed to address potential side effects.
- **Language and Cultural Challenges:** Language barriers pose significant challenges, in addition to cultural barriers, which can become evident when discussing contraceptives. Special attention is needed when communicating with certain populations, such as adolescents, clients with disabilities, non-English speaking clients, and those from diverse cultural backgrounds.
- **Confidentiality of Services:** While a minor's right to privacy to obtain contraceptives is upheld at the federal level, some

misconceptions about how confidentiality of services is maintained raises concerns for providers and patients. Title X regulations allow providers to maintain confidentiality for teens with no parental intervention. But confidentiality policies, especially pertaining to minors, vary across New Jersey commercial insurance handbooks. Lack of confidentiality, and lack of transparency about related policies, may hinder access to family planning services and contraceptive options.\*

## PROVIDER BARRIERS<sup>1</sup>

- **Availability of Contraceptives of Choice:** Some methods of contraception are more challenging for providers to make available for their patients – such as LARCs. This is due to a variety of reasons. For example, the requirements imposed on some facilities to meet regulations to be considered a sterile environment for insertion. Additionally, because LARCs require a significant up-front cost, most providers do not store an inventory, which means patients must return for a second visit after the LARC has been ordered and received for insertion.
- **Preauthorization:** Conversations with stakeholders indicate that patients and providers lack clarity about the need for preauthorization for certain contraceptives such as LARCs. Even the mere perception of a need for preauthorization is a stumbling block to convenient and timely access for both the provider and the patient.
- **Provider Knowledge and Skills:** Some providers carry misconceptions relating to LARC risk or are unaware of the newer options for birth control. If providers are not confident in their skills to safely insert LARCs, they are less likely to offer these methods in their offices. If they do offer LARCs during counseling, they may recommend patients go to a clinic that has more experience, which would require the patient to set up another appointment to receive their chosen method of contraception.



# Providing Comprehensive, High-Quality, and Accessible Care

## 2a. Fundamentals of Service Delivery

When providers consider what it means to deliver reproductive health services to patients, usually clinical aspects of care come to mind. However, where and how services are made available, how people find out about services, how services are paid for, and providing care in a patient-centered manner are equally important components of care delivery.

Reproductive health is an important part of all health care, not something that exists only within the walls of a provider office specifically designated for “women’s health care”. Providers who serve patients of all populations, and in all types of facilities, should consider the role they play in providing high-quality and accessible reproductive health services.

Core components of comprehensive reproductive health care include, but are not limited to:

- Family-planning counseling, information, education, and services, including access

to the full range of safe and effective contraceptive methods

- Education and services for prenatal care, safe delivery and post-natal care, including breast-feeding and infant care
- Prevention and appropriate treatment of infertility
- Counseling, education, and provision of abortion services, including the provision of safe abortion services and care after the procedure
- Prevention and treatment of reproductive tract infections, sexually transmitted diseases, breast and cervical cancer screenings, and other reproductive health conditions
- Information, education, and counseling, as appropriate, on human sexuality, reproductive health, and parenting<sup>9</sup>

While not all facilities will be able to provide a comprehensive range of services, providers are obligated to understand fundamental components of care and to be able to reflect on gaps in knowledge or capacity and make appropriate process decisions to address those deficits.

Identifying the strengths and limitations of an office or health system and working to establish streamlined care for their patient population is essential, whether that is providing counseling and making a referral for services, providing counseling and delivering select services with referrals for others, or providing the full range of services to their patients.

## 2b. Contraceptive Methods

There are many different contraceptive methods available to patients today that vary in complexity of use, cost, side effects, and effectiveness. These factors all play a role in the patient's decision of which method to choose.

Options for contraception include:

- Most effective: Sterilization (not reversible), IUDs, implants
- Moderately effective: Injectables, patches, rings, diaphragms, and oral contraceptives
- Least effective: Internal/external condoms, sponges, spermicides, fertility-awareness methods, withdrawal<sup>10</sup>

While it is important to explain the effectiveness of each method for preventing pregnancy, the best method of contraception is the one that meets the needs of an individual and is used appropriately.

Therefore, comprehensive patient-centered counseling for contraception will help the patient choose the best method for their situation.

A 2016 national study of women in family planning and abortion clinics identified characteristics of contraceptive methods which were “extremely important” to them.<sup>11</sup>

- Of 23 total items, the method's effectiveness at preventing pregnancy was the item that most (89%) women said was “extremely important.”
- The next most important characteristics were if the method is easy to get (81%), affordable (81%), and easy to use (80%).
- Many women also considered other characteristics, such as a method's potential side effects, non-contraceptive benefits as well as partner preferences and peer experiences.

Providers should consider these factors and utilize them to facilitate productive conversations with patients when engaging in comprehensive contraceptive counseling.

## 2c. Reproductive Coercion

When identifying best practices for comprehensive contraceptive counseling, providers must be sensitive and aware of factors that can contribute to reproductive coercion. In addition to provider and system driven interventions that might interfere

with an individual's ability to maintain control over decisions about their own reproductive health, coercion from intimate partners or other friends and family members can also occur.

## > Key Question



### What is Reproductive Coercion?

Reproductive coercion is a type of domestic abuse that includes explicit behaviors to promote pregnancy that is unwanted, interfering with contraception, and pregnancy coercion, including threats of abandonment if pregnancy does not occur. The abuses can be physical or psychological and do not only come from a male partner. In some cultural circles, extended family, especially older female relatives, control reproductive decision-making. As many as 1 in 4 women who present at a sexual health clinic report having experienced this type of abuse.<sup>12</sup> Younger individuals, as well as racial minorities, are particularly at risk for reproductive coercion. Almost 1 in 8 females who sought care from a school health center experienced recent reproductive coercion<sup>13</sup>

### EXAMPLES OF REPRODUCTIVE COERCION

- Partners who cajole that sex feels better without a condom, or who secretly remove a condom during sex
- Partners who lie that they have had a vasectomy
- Partners who promise to withdraw before ejaculation and do not
- Partners who pierce condoms or other barrier methods
- The forceful removal, destruction, or hiding of contraceptive methods
- Forcing an individual to have an abortion

### PROVIDER ROLES IN ADDRESSING REPRODUCTIVE COERCION

Providers should be especially suspicious that coercion may be happening when partners/family members accompany patients to every visit and refuse to leave the room to permit private conversations. It is important for all patients, including minors, to be seen alone by their provider for at least a portion of their visit to facilitate safe and productive conversations that may help identify the presence of reproductive coercion. This policy should be promoted and consistently adhered to in all office environments.

Providers should screen patients for signs of reproductive coercion, educate patients on the topic, and counsel about harm-reduction strategies if needed.

Recommended screening questions include:

- Has your partner or others in your life ever forced you to do something sexually that you did not want to do or refused your request to use contraception?
- Has your partner or others ever tried to get you pregnant when you did not want to be pregnant?
- Are you worried your partner or others will hurt you if you do not do what they want with the pregnancy?
- Does your partner or others in your life support your decision about when or if you want to become pregnant?

In some cases, providers knowingly or unknowingly may be acting as perpetrators of reproductive coercion. For example, a provider or system may recommend sterilization to low-income populations or those with limited mental capacity. To avoid reproductive coercion, providers must prioritize patient education and patient choice, avoid language or counseling that steers an individual to a method of contraception based on internal bias, and continuously

assess practices and policies that can threaten the bodily autonomy of all populations. State policies that provide financial incentives for certain contraceptive methods, such as LARCs, can also be interpreted as coercive, and while decreasing access barriers to all

forms of contraception is important, the promotion of individual empowerment and decision-making authority over one's own reproductive health should always take precedence.

## 2d. Contraceptive Counseling

Providing patient centered comprehensive and culturally sensitive counseling about contraceptive options is essential to improving access to quality services and promoting bodily autonomy for all populations.

It is important to provide contraceptive counseling throughout the lifespan, with attention to particularly critical periods such as pregnancy and postpartum. As individuals' lives and needs change, continued

counseling is needed to ensure that the most appropriate contraception is accessible for that stage in life. The best contraception method is the one that the individual will use, so it is important to acknowledge changing needs and priorities of each patient throughout their life.

Shared decision-making models are fundamental to the provision of all medical care, but especially contraceptive counseling.

### > Key Question



#### What is Shared Decision-Making in Reproductive Health?

**“The process of shared decision-making (SDM) requires clinicians to set aside their personal biases or preferences for care, offer balanced information about all treatment options, and help patients navigate that information to arrive at their own decisions. All reproductive health decision-making takes place within the power dynamics and social structures of patients’ lives, including the history of reproductive coercion, forced sterilization, and bias between patients and providers. Using a shared decision-making model in reproductive health is a patient-centered step toward addressing that social context.”**

— Innovating Education in Reproductive Health: Changing the Conversation: Shared Decision-Making in Reproductive Health<sup>14</sup>

Additional components of comprehensive contraceptive counseling include:

- **Patient-centered care**, which places the individual's health needs, quality of life concerns, and desired health outcomes at the forefront of care and respects the patient's viewpoints and preferences.
- Patient-centered care promotes active listening on the part of providers as a tool

to promote true collaboration and shared decision-making and uses language that is most appropriate for the patient.

- **Cultural humility**, which includes a respectful and humble attitude towards persons of other cultures, as well as self-reflection and recognition of power imbalances.
- **Trauma-informed care**, which recognizes that any person may be a survivor of trauma.

- Key principles of trauma-informed care include: provider recognition of the prevalence of trauma and its impact, understanding of a survivor's need to be respected, connected and fully informed

in a safe environment, and care delivery that is centered in collaboration and provides the patient with opportunities for empowerment, and resists re-traumatization.

## > Key Quote



**“Traumatic life events are widespread and encompass exposure to a variety of interpersonal violence scenarios, including sexual assault. The trauma experienced by individuals can have lasting adverse effects on their functioning and mental, physical, social, and emotional wellbeing. The trauma informed approach to care uses a framework that acknowledges the effect of trauma, recognizes signs and symptoms of trauma, responds by integrating knowledge about trauma into practices, and seeks to resist re-traumatization. The key principles of trauma informed care include ensuring physical and emotional safety, maximizing trustworthiness, prioritizing individual choice and control, empowering individuals, and encouraging peer support. This framework is particularly relevant to provision of care to sexual assault survivors and can help optimize the patient–provider relationship, improve health outcomes, and reduce long lasting burdens of trauma.”**

— American College of Obstetricians and Gynecologists (ACOG) Committee Opinion, Number 777 March 2019<sup>15</sup>

Utilizing these principles will enable the provider to focus on individual autonomy, preferences, and needs to ensure a counseling interaction which is most appropriate and effective. *Links to effective counseling models are available in the resources section of this toolkit (p.41).*

Providing culturally competent contraceptive services includes considering the experiences and needs of individuals across gender and sexuality spectrums. Heterocentric views (those that favor binary gender identity and opposite sex relationships) are deeply embedded in reproductive health services, including emphasis on “women’s care” for certain reproductive health services that may not be inclusive of experiences of transgender individuals. Providers should avoid making assumptions about an individual’s identity and behaviors and establish relationships with patients that includes using preferred pronouns and asking non-leading questions. Offices should identify opportunities to increase representation

and diversity both for racial and ethnic minorities and also for gender and sexuality within their staff and within educational and marketing materials. Additional resources that can be used to promote culturally informed and comprehensive care for these populations are available at the end of this toolkit.

## A NOTE ABOUT PRENATAL CARE

Pregnancy is a particularly important time for counseling about the use of contraception after delivery. Prenatal care visits offer an opportunity for ongoing discussion and exposure to comprehensive materials that can aid patients in their decisions for post-partum contraception. If considering sterilization, patients on Medicaid will need to know the requirements for coverage and will need to sign a consent at least 30 days before delivery, making these proactive discussions a necessary component of prenatal care.<sup>16</sup> Additionally, if patients are interested in having a LARC inserted post-partum, those conversations



should also happen during prenatal visits to identify the most appropriate time to initiate that method. Because there are so many priorities during prenatal visits, practices may find it most helpful to have materials available for their pregnant patients

that provide accessible and comprehensive information about contraceptive options. Those materials can be provided to patients at one visit with the discussion held at a subsequent visit once reviewed by the patient.

## 2e. Barriers to Contraceptive Counseling

Patient and provider discomfort, misunderstandings, or differences related to cultural beliefs, and system level policies can prevent effective counseling from occurring and in turn result in poor quality and accessibility of reproductive health services.

### **KNOWLEDGE GAPS/INACCURATE BELIEFS (PATIENT AND PROVIDER)**

Patients' lack of knowledge, misperceptions, and concerns about the safety of contraceptive methods, such as unfounded concerns that oral contraceptives are linked to major health problems or that IUDs carry a high risk of infection, are major barriers to contraceptive use. Health care providers may also have knowledge deficits that can hamper their ability to offer appropriate contraceptive methods to their patients, such as uncertainty about the risks and benefits of different contraceptives and gaps in knowledge about appropriate medical eligibility and contraindications.

- Educational materials that are evidence-based, unbiased, culturally informed, and provide detailed yet understandable information about contraceptive methods can be helpful in addressing knowledge gaps and misconceptions for both patients and providers.

### **PRIVILEGE**

Providers have inherent privilege bestowed upon them by their profession, and certain clinicians also enjoy privilege afforded them by their gender, race, ethnicity or economic status. Privilege can affect the way clinicians “package” the information they share with patients and impacts the intersection of client interactions with systems of care. Providers may

make assumptions based on a patient's age, race, or ethnicity about which methods to present first or emphasize while giving contraceptive information.

- Instead, providers can begin the interaction by asking the patient what is most important to them when selecting a method, and then proceed by giving the patient information about all methods, which can support shared decision-making about which method is best for each individual patient.

### **CULTURAL/RELIGIOUS BELIEFS (PATIENT AND PROVIDER)**

Belief systems may impact a patient's willingness to accept certain methods, or a provider's willingness to offer them. Also, clinicians practicing in religiously affiliated health systems or other sites may have limitations placed on their ability to offer contraceptive counseling and care.

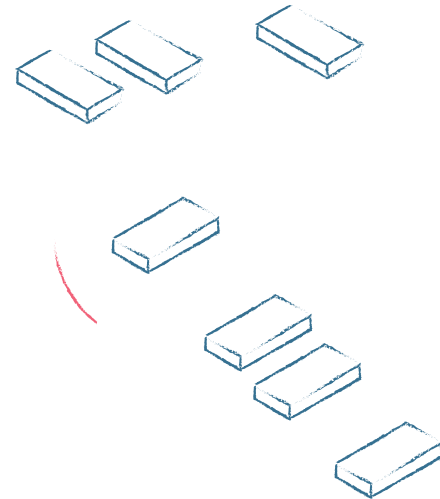
- Providers can employ active listening to better understand patients' cultural and religious beliefs about which contraceptive methods they are familiar with and interested in. From that, they can use affirmative statements to acknowledge and respect those beliefs and assist the patient in understanding all options available to them and help them select a method that they are comfortable with. If a provider's place of employment prevents them from offering the full range of reproductive health services, they should educate themselves on appropriate referrals to ensure their patients can receive comprehensive services.

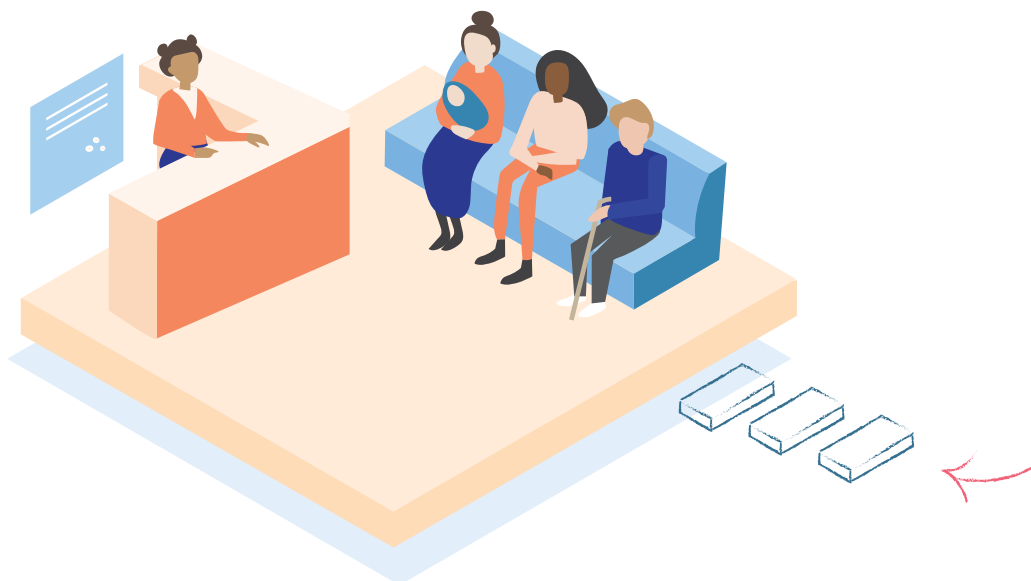


## SYSTEMS ISSUES

Scheduling models that promote shorter visits may negatively impact clinicians' ability to offer comprehensive counseling due to time constraints and competing priorities. Support from health system leadership is crucial to ensure quality and comprehensive care is not compromised due to scheduling limitations.

- Clinicians can provide administrators with evidence that supports quality contraceptive counseling as an effective and necessary step in the provision of reproductive health care and open a dialogue about the role of the practice in establishing systems that support provision of these services. The use of team-based care, using a variety of types of clinicians to provide cost-efficient and effective care, and growing the use of telehealth can also provide flexibility for both patients and providers.
- During the COVID-19 pandemic, telehealth for many health care services was established a standard of care, and paid for by insurance including Medicaid. Telehealth can be used to provide patient counseling and discussion regarding contraceptive choice, eliminating the need for an in-person office visit.





# Reproductive Health Providers

## 3a. Who's Who: Providers of Reproductive Health

Typically, patients, administrators, insurers, and clinicians themselves often think of the primary providers of reproductive health services as obstetricians and gynecologists (OB/GYNs). Although these clinicians are delivering a significant portion of services, individuals can receive care in a variety of places and from a diverse set of providers.

Clinical providers of reproductive health care may include:

- OB/GYNs
- Certified Nurse-Midwives and Certified Midwives
- Primary Care Physicians, including Family Physicians, Internists, and Pediatricians
- Advanced Practice Clinicians, including Women's Health Nurse Practitioners (NPs/APNs), Family Practice NPs, Adult NPs, Pediatric NPs, and Physician Assistants
- Additional clinical providers, including nurses, pharmacists, lactation consultants, health educators, school nurses, community health workers, and medical assistants

Pediatricians or other providers who primarily see younger patients should be educated about best practices for reproductive health services and implement strategies to increase knowledge and access around contraception. Young people specifically may feel increased levels of fear, stigma, or embarrassment around seeking these services. A provider's knowledge of the unique needs of this patient population, as well as their approach and bedside manner, can not only improve the patient's experience but can also be the foundation for empowering sexual and reproductive health moving forward. Educational materials tailored to teens and young adults can be especially helpful.

## > Resource



**Sex, Etc. ([sexetc.org](http://sexetc.org))** is a Rutgers University-based website and magazine, featuring medically accurate sexual health information created by teens for teens with the support of sex education experts. Provider offices can subscribe to the Sex, Etc. magazine as a valuable resource to have in their waiting rooms or exam rooms.

Providers whose work may focus less on reproductive health can still be faced with questions about an individual's contraceptive choices or other related services. They must be able to deliver quality care and answers to these patients or, when necessary, refer to a provider who can do so. Often, other medical conditions for which individuals see

a provider for can impact their decision around contraceptive use. If a provider does not have the appropriate knowledge, resources, and comfort to address reproductive health within the context of disease management, a patient may be at risk for less-than-optimal reproductive care.

## \* Example



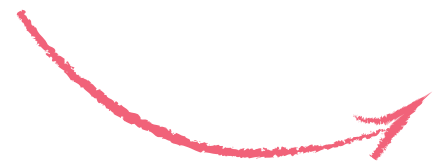
**A.D., a 37-year-old patient, presents to a primary care provider for an annual visit not related to her contraceptive method.**

**A.D. is currently using estrogen/progestin pills for contraception and is a nonsmoker but has gained 15 pounds in the past year and now presents with primary hypertension. The provider advises discontinuation of the oral contraceptives due to increased risks for individuals with hypertension. Failure to provide this patient with options for other methods of reliable contraception could put them at risk for an unplanned pregnancy, potentially resulting in a high-risk pregnancy due to their age, obesity, and hypertension. In addition to advising A.D. to stop taking the oral contraceptives, the provider should use a shared decision-making model to discuss the patient's family planning needs and provide education about other options to meet the patient's health care needs.**

## 3b. Provider Training and Education Opportunities

Training and continuing education opportunities afford practitioners the ability to expand their scope of practice, improve their ability to fully counsel patients, stay up to date on current best practices, and make the best and most appropriate referrals.

The following information provides some recommended training resources for clinicians and administrative staff who interact with individuals seeking reproductive health services.



## ONLINE AND IN-PERSON EDUCATION

### Innovating Education in Reproductive Health

[innovating-education.org](https://innovating-education.org)

- Generates, curates, and disseminates free curricula and learning tools about sexual and reproductive health to transform health professionals' education.
- Includes video instructional featuring different LARC insertion and removal scenarios and information on contraceptive services across the gender spectrum.

### National Clinical Training Center for Family Planning (NCTCFP)

[ctcfp.org](https://ctcfp.org)

- Trains and supports clinical family planning Nurse Practitioners, Certified Nurse Midwives, Physicians, and Physician Assistants through competency-based modules with a focus on providers within Title X and other public health clinics.
- Offers webinars, podcasts, and calendar of training opportunities.

### Healthknowledge

[healthknowledge.org](https://healthknowledge.org)

- Online learning portal that offers a wide variety of courses to improve health care delivery, including a reproductive health section with content on contraception, cultural competence, and the intersection of reproductive health with infectious disease and behavioral health.

### Beyond the Pill

[beyondthepill.ucsf.edu/new-online-training](https://beyondthepill.ucsf.edu/new-online-training)

- Free online training about contraceptive methods and strategies to increase access to services.

### Reproductive Health Access Project

[reproductiveaccess.org](https://reproductiveaccess.org)

- Expansive resource database for providers,

practice management staff, and patients about reproductive health services, including contraceptive care.

- Provides LARC training for primary care clinicians through their Hands-On Reproductive Health Training (HART) Center, for providers interested in integrating IUD and contraceptive implants into their clinical practice.

### Postpartum Contraceptive Access Initiative (PCAI)

[pcainitiative.acog.org](https://pcainitiative.acog.org)

- Resources to support providers in offering the full range of contraceptive methods to patients after delivery through comprehensive individualized trainings.

## LARC TRAININGS

The provider facing websites for various LARC devices contain helpful information around utilization, ordering of devices, and patient and office materials. Trainings for specific devices may also be available through partnerships at professional conferences or through professional organizations.

ACOG's "The LARC Program" ([www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception](https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception)) provides resources on LARC including clinical guidance, educational materials, a LARC help desk, and billing and coding support.

### Nexplanon

[merckconnect.com/nexplanon/professional-resources](https://merckconnect.com/nexplanon/professional-resources)

- Resources for trainings, ordering information, and patient and provider resources.

### Kyleena

[hcp.kyleena-us.com](https://hcp.kyleena-us.com)

- Insertion/removal videos, requests for in-person trainings, ordering information and additional resources.

**Mirena**

<https://www.mirenahcp.com/insertion-and-removal>

- Insertion/removal videos, requests for in-person trainings, ordering information and additional resources.

**Skyla**

[labeling.bayerhealthcare.com/html/products/pi/Skyla\\_PI.pdf](https://labeling.bayerhealthcare.com/html/products/pi/Skyla_PI.pdf)

- Information about clinical best practices for use.

**Liletta**

<https://www.lilettahcp.com/resources>

- Video and documents on placement and reimbursement, as well as a request portal for live insertion demonstrations and downloadable resources for purchasing/reimbursement related processes.

**Paragard**

[hcp.paragard.com/placement-removal/placement-removal-videos](https://hcp.paragard.com/placement-removal/placement-removal-videos)

- Placement and removal videos, training guides, and requests for placement training kits.

### 3c. Supporting New Providers to Deliver Comprehensive Services and Reducing Barriers to LARC

*Guest Contributor: Dr. Taru Sinha is the Director of Women's Health at CentraState Family Medicine Residency Program and Assistant Professor at Rutgers Robert Wood Johnson Medical School in the Department of Family Medicine and Community Health. She is leading the Maternity Safety Initiative at the Visiting Nurse Association of Central Jersey Community Health Center and has been passionately involved in training and teaching family medicine residents for over 20 years.*

In New Jersey, LARC is primarily administered at OB/GYN offices, family planning, or women's health clinics. Care around LARCs is largely managed directly by OB/GYNs or is provided with OB/GYN supervision or consultation with other providers. Increasing the number of providers and/or facilities that have clinicians who are trained and comfortable with LARC insertion and removal would directly expand access to the full range of contraceptive options.

While the educational components needed to train medical residents on these services is robust throughout the state, opportunities to support new providers in maintaining and growing their skillset and comfort with the administrative components of LARC management is lacking.

For example, family medicine residents throughout the state are well-trained in the insertion and removal of LARC as it is an integral component of their core curriculum. Most residents express confidence in their ability as well as an active desire to perform these procedures post-residency. However, surveys of new licensees from the New Jersey Academy of Family Physicians (NJAFP) and the Accreditation Council for Graduate Medical Education (ACGME), report that few family physicians continue to provide these services.<sup>17</sup> Additionally, national research found that 49% of patient respondents reported the lack of trained primary care providers as a barrier to accessing LARC.<sup>18</sup>

Anecdotal evidence, collected through conversations with practicing faculty, suggests three potential reasons for these barriers and potential solutions:

- Most family medicine graduates join practices in which **there is no ongoing culture of LARC administration**. In addition, the practice may not have a relationship with an OB/GYN office to which new licensees could refer patients, should there be any complications. If new providers are given opportunities to remain confident in the skills they gained in their residencies, the number of qualified clinicians who can provide these services will increase across the state.
- New graduates are **inadequately informed about billing, coding, and reimbursement issues** around LARC. Misunderstanding about these administrative components of service delivery can prevent new graduates from discussing this option with patients and make them hesitant to suggest changes to a practice that does not typically provide these services. CME activities, either through the NJAFP or within their residencies, can help increase education on this topic and promote accurate and efficient billing and coding practices that maximize reimbursement.
- Most outpatient primary care practices do not stock or store LARCs. Consequently, same-day access to LARC is unavailable to their patients. New licensees should be offered practical guidance to work with practice management, pharmaceutical companies, and insurers to address any financial or operational concerns around “buy and bill” models.

With appropriate administrative support, education, and clinical guidance, newly trained primary care providers can be key players in efforts to reduce barriers to accessing comprehensive contraceptive services, including LARC.

— Dr. Taru Sinha

### 3d. Myths vs. Facts

Clinician misconceptions about elements of reproductive health care can result in failure to appropriately counsel and provide comprehensive services to patients. Additionally, patients often have false beliefs about contraception. Combined, these misconceptions and myths can be obstacles to service delivery and hinder access to comprehensive and high-quality care.

#### **X Myth**

Providers may hold outdated beliefs and misconceptions about appropriate candidates for certain contraceptive methods. For example, the belief that IUDs may not be suitable for adolescents or those who have never given birth due to increased expulsion rates, concerns of higher risk of sexually transmitted infections (STIs) or pelvic inflammatory disease (PID), or concerns of increased risk of subsequent infertility or ectopic pregnancy.

#### **✓ Fact**

ACOG, as well as other major professional and governmental agencies, indicate no restrictions are needed for IUD use for these populations and that the advantages of the methods outweigh any risks.<sup>19</sup> ACOG reports that adolescent expulsion rates are comparable to other populations, that both adolescents and those who have never given birth have high continuation rates and that there is no evidence of increased infertility.<sup>19</sup> Both ACOG and the American Academy of Pediatrics (AAP) recommend IUDs as suitable for adolescents. Utilizing information found in several sources may assist providers in updating their knowledge base and increasing comfort in this area.



## **X Myth**

Misconceptions or narrow viewpoints about which patients need contraceptive counseling can exclude persons who do in fact need counseling or other related services. For example, a provider may assume that older individuals, persons in same-sex relationships, those who do not report current sexual activity, or individuals with physical/cognitive disabilities do not need contraceptive counseling. This means they may not provide the full spectrum of care, including patient education, which could be a necessary component of their reproductive health care.



## **✓ Fact**

It is essential that all persons receive reproductive health care and contraceptive counseling. Those not sexually active at the time of their visit may become so before their next annual appointment. Older individuals may have needs that have changed over time or may have misconceptions about their ability to become pregnant. Additionally, individuals with disabilities should be screened for and provided with comprehensive reproductive health services.<sup>20</sup> Individuals primarily engaged in same-sex encounters may still have contraceptive needs.<sup>21</sup> When a provider's approach to service delivery is based on a general assumption about a population, rather than on the individual patient, they place their patients at risk for unintended pregnancy or other poor reproductive health outcomes.

## **X Myth**

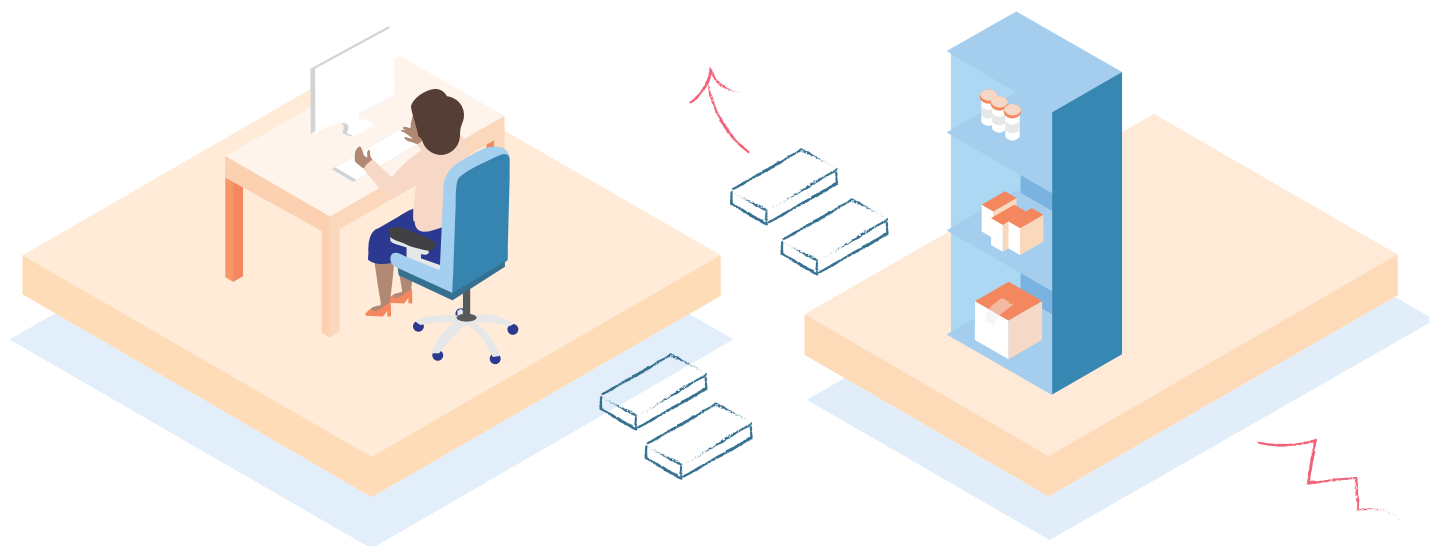
Inaccurate beliefs about requirements for the safe initiation of contraception and provider follow-up create additional barriers to care for patients. These include: limiting IUD insertion or initiation of other methods based on a patient's menstrual cycle, requirement for a gynecological exam with STI screening prior to contraceptive initiation, the need for provider surveillance for side effects that restricts providing a prescription for a full year of a contraceptive method, and reluctance for initiation of contraception immediately post-abortion due to perceived increased risk.



## **✓ Fact**

ACOG and U.S. Medical Eligibility Criteria (MEC) support method initiation at any time during the menstrual cycle as long as pregnancy can be reasonably excluded.<sup>22, 23</sup> Rates of PID are the same with STI screening prior to IUD insertion as compared with day-of-procedure screening with treatment after insertion when needed.<sup>24</sup> Additionally, ACOG, and other provider organizations, endorse over-the-counter access to hormonal contraception without age restrictions with no need for pelvic exam, STI screening, or provider surveillance.<sup>25</sup>





# Understanding the New Jersey Coverage Landscape

Providers cannot be expected to know the specific details of coverage for contraceptive services for every insurer across the state at any given time, as these details frequently change. However being familiar with the fundamentals of contraceptive coverage and factors that could increase access or reimbursement for these services is an essential part of empowerment for providers and their patients. Coverage parameters, patient cost sharing, and brands of contraceptives covered are specific to each health plan but may also be dictated by state and federal regulations.

Individuals who do not have access to health insurance due to cost, employment, or immigration status can still receive free or low-cost reproductive health services through a variety of state, federal, and private programs.

## > NJ-RHAP PACT Resource



Providers should use the NJ-RHAP PACT Tools “10 Steps to Verify Coverage for Contraceptive Services” and “Reproductive Health Services for Uninsured and Underinsured Individuals in New Jersey” to appropriately confirm coverage for contraceptive services for each patient and connect them with additional resources for coverage or discounted services if needed. These tools are available at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).

## Section 4a: Federal and State Policies

### FEDERALLY MANDATED BENEFITS

Regulations established in the wake of the Affordable Care Act (ACA), require health plans and insurers that offer group or individual health insurance policies to include female contraception in the list of preventive services to be provided without patient co-payment.<sup>26</sup> These plans must cover, in-network and without a copayment, at least one form of contraception within each of the 18 FDA identified methods, including:

- Barrier methods, like diaphragms and sponges
- Hormonal methods, like birth control pills and vaginal rings
- Implanted devices, like intrauterine devices (IUDs)
- Emergency contraception, like Plan B® and Ella®
- Sterilization procedures
- Patient education and counseling<sup>26</sup>

Under this mandate, health plans are permitted to use formularies, prior authorization, or other benefit design strategies within a given category of contraception that could promote accessibility of one form of that contraceptive method over another within the same category (such as coverage for one brand of IUD and not another), but cannot structure their benefits to favor one method over another (such as providing coverage for oral contraceptives but not injectable contraceptives).<sup>26</sup>

*\*Currently, federal regulations exempt certain employers (such as religiously affiliated hospitals or schools) from this mandate if complying with it goes against their religious or moral beliefs. For-profit organizations and religiously affiliated nonprofits with religious objections to providing contraceptives can receive an “accommodation”, which means they are not required by the federal government to “contract, arrange, pay, or refer for contraceptive coverage”. However, health insurance companies that provide coverage to employers who receive an accommodation to this mandate, are required to provide and manage coverage for contraceptive services. This does not occur for plans provided by an exempt employer.<sup>27</sup>*

### STATE MANDATED BENEFITS

In addition to the federal regulations, New Jersey law also requires health plans sold in the state to cover a set of mandated health benefits. Among those mandated benefits for coverage in New Jersey are prescription female contraceptives, which includes but is not limited to, birth control pills, implanted devices, and diaphragms, at no cost to the patient.<sup>28</sup>

State law also requires plans to provide coverage for prescription contraceptives (such as birth control pills) dispensed at one time for up to a 12-month period in accordance with New Jersey P.L. 2021, C.376.<sup>29</sup>

### 4b. Types of Coverage Available in New Jersey

In New Jersey, individuals can have health care coverage through the state’s Medicaid program, the individual Marketplace, or through their (or a family member’s) employer. Plans offered through employers in New Jersey can be part of the fully insured market or be a self-insured/ERISA plan. In a self-insured plan, the employer assumes the financial risk for health care costs for covered employees. State laws do not regulate self-insured plans.

- Plans that are “fully-insured”, which include those available on the individual Marketplace, the Individual Health Coverage (IHC) program, and the Small Employer Health (SEH) market, are required to comply with *both* the federal and state mandates for coverage of contraceptives unless they met the requirements for a religious exemption or accommodation. Therefore, these plans

are required to provide coverage, at no cost to the patient, for a minimum of one form of contraception within each of the 18 FDA identified categories.

- Plans that are “self-funded”, also known as “ERISA” plans, are typically provided by larger employers. These plans are exempt from state-mandated benefits but may be subject to federal requirements, such as the contraceptive mandate in the ACA. Coverage details for these plans are only available to enrollees. Therefore, providers must work with the patient and their plan to understand coverage parameters for contraceptive services. Individuals who have insurance through the State Health Benefits Program (SHBP) have coverage that is considered self-funded. However, they are subject to certain State-mandated benefits, including those around coverage for contraceptive services.

## MEDICAID

Individuals may be eligible for the state’s Medicaid program based on a variety of factors such as income, household size, and health status. Family planning is a mandatory benefit under federal Medicaid regulations. However, as there is no formal definition of the term “family planning,” discretion is given to the states to define the specific services and supplies that are included in the program.<sup>30</sup>

Based on state regulations, family planning services in New Jersey’s Medicaid program include:

- Medical history and physical examination (including pelvic and breast)
- All FDA-approved contraceptives including condoms
- Pregnancy testing
- Family planning counseling
- Genetic counseling
- Sterilization for men or women
- HPV immunizations
- HIV and STD screenings<sup>31</sup>

\*<https://njfamilycare.dhs.state.nj.us/njspcp.aspx#:~:text=The%20New%20Jersey%20Supplemental%20Prenatal,visits%20or%20labor%20and%20delivery.>

Regulations further ensure that family planning services and supplies are a covered benefit, including condoms, contraceptive devices, contraceptive supplies, diaphragms, contraceptive injections, and family planning supplies, such as pregnancy test kits. Birth control implants are also

a covered product.<sup>32</sup> Prescription contraceptives (such as birth control pills) may be dispensed at one time for up to a 12-month period.

Preauthorization is prohibited for family planning services under the Medicaid State Plan,<sup>33</sup> therefore there are no prior authorization requirements for individuals to receive contraceptive services through New Jersey Medicaid.<sup>34</sup>

Individuals may receive Medicaid services through a fee-for-service model, with no other insurer coordinating care, or through a Managed Care Organization (MCO) that administers the benefits

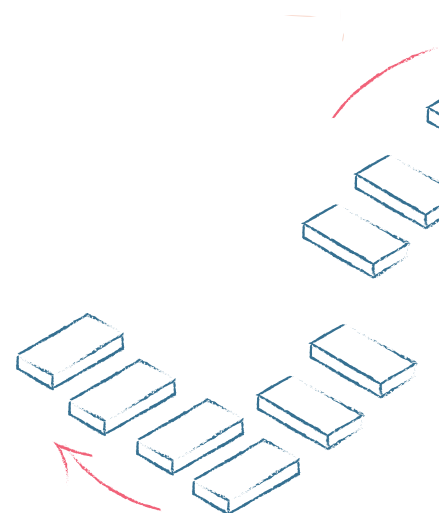
Additionally, New Jersey Medicaid launched the **Plan First Program** in 2019. Plan First is a limited benefit program offered through the State’s Medicaid program which provides family planning services. The Plan First Program provides coverage and services for eligible individuals, including birth control and family planning counseling. To be eligible for Plan First, individuals must be between 139%-205% Federal Poverty Level (FPL), New Jersey residents, U.S. citizens or Qualified Immigrants, and not currently pregnant or sterile. *Plan First does not provide minimum essential health care coverage, such as physicals, and does not count as coverage for New Jersey’s mandate for coverage.*<sup>35</sup> The New Jersey Supplemental Prenatal and Contraceptive Program (NJSPCP) is run by NJ FamilyCare. NJSPCP is a limited-benefit program. It provides prenatal and family planning services, including contraceptive care, to women who are undocumented. It does not provide complete healthcare coverage, such as hospital visits or labor and delivery.\*

Information about what type of plan an individual has can help guide conversations with insurers about what benefits are covered and equip providers with necessary information needed to ensure they can provide the most robust set of contraceptive services to patients with limited out of pocket expenses. The type of plan a patient has, such as a plan through the SHBP or a Medicaid MCO, may be listed on the patient’s health insurance card or may be information the patient

themselves can provide. However, providers should still take all steps to verify coverage of services and inform patients of cost-sharing in advance of providing the service.

## **NJ STATE FAMILY PLANNING FUNDING AND TITLE X**

The New Jersey Department of Health provides significant funding to New Jersey's statewide family planning project, and the federal government also provides funding for reproductive health services through Title X. Title X is the only federal grant program dedicated solely to providing low-income families and uninsured individuals with family planning and related preventive health services. Its overall purpose is to promote positive birth outcomes and healthy families by allowing individuals to decide the number and spacing of their children. In New Jersey, 10 agencies that supported nearly 50 health centers received state and federal family planning funding in 2019.<sup>37</sup> To find the closest family planning clinic, visit the NJ Family Planning League website ([njfpl.org](http://njfpl.org)).





# Reimbursement for Contraceptive Services

## 5a. Overview

Although the ACA significantly expanded access to contraceptive services, barriers related to coverage and cost still exist. Additionally, patients may not have coverage at the time of their visit or may not want to utilize their insurance for a variety of reasons related to privacy, stigma and fear.

Despite these complexities, providers should have efficient systems in place to verify coverage and communicate with all necessary parties, including insurers and manufacturers, to streamline access to services for each patient.

## > Resource



**The National Women's Law Center has a nationwide hotline, CoverHer ([nwlc.org/coverher](https://www.nwlc.org/coverher)), that provides guidance on insurance company barriers to contraceptive services (1-866-745-5487).**

Individuals who have insurance plans that are exempt from the coverage requirement for contraceptive services outlined by the ACA will likely incur both a co-pay and some additional cost for reproductive health services. In high deductible plans, the patient may be responsible for the entire cost of the visit and their chosen method of contraception depending on their health care expenditures during the calendar year. LARC has a higher up-front cost than other forms of contraception, which can further exacerbate patient hesitancy to utilize these methods.

It is advisable for practices to verify coverage before visits. Some payers provide on-line verification; however, it is important to be able to accurately assess eligibility for coverage for the date of service. Knowledgeable staff and standardized procedures around verifying coverage for contraception and contraceptive related services help prevent patients from receiving unexpected medical bills and the office from providing care that might not be reimbursed. In addition, provider offices should be aware of services available for uninsured or underinsured

populations so that they can receive care regardless of their ability to pay.

When provider offices are equipped with information needed to be appropriately

reimbursed for services, they will have more available funds to invest into things like technology advancements or sliding scale services for low-income patients.

## 5b. Billing, Coding, Reimbursement

In addition to verifying coverage, correct coding and billing are essential for practices to optimize reimbursement for services. Successful practices engage physicians and other professionals in code selection for each encounter.

Simply stated, CPT codes describe “what” was done during a patient visit and ICD-10 codes describe the “why”.

Payer software links the CPT and ICD-10 codes to screen for medical necessity and appropriateness. Using unspecified codes or the same codes for every encounter are “red flags” for payers and will likely result in denials of payment and costly audits. By taking necessary steps to code accurately for reproductive health services, specifically contraceptive management, appropriate and timely payment can occur, and improper billing and coding techniques can be phased out.

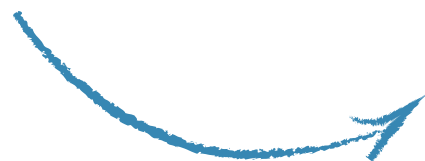
Billing and coding errors may occur when clinicians rely on coders or other staff members to assign codes based on the medical record, without the benefit of having been part of the patient interaction. Clinician engagement in understanding and utilizing proper coding can increase practice revenue, reduce administrative burden and protect patients from denied coverage.

Contraceptive services are frequently provided in conjunction with other services such as annual wellness visits or visits for specific health concerns. Payers generally have policies that deny payment for more than one service during an encounter unless the additional service is “significant and separately identifiable”. It is common for payers to “bundle” payments and they will only reimburse for what they consider the most appropriate CPT code based on the “why” – the ICD-10 code attached to that visit. Modifiers can be used to bypass the payer “bundle” and to describe a significant additional service that was performed.

### > *NJ-RHAP PACT Resource*



For more information, consult the “Billing and Coding Guide for Contraceptive Services” available at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).



## 5c: Common Coding Scenarios

### EVALUATION AND MANAGEMENT (E/M) SERVICES WITH CONTRACEPTIVE COUNSELING

*J.L., a 44-year-old hypertensive patient is seen for evaluation and management of abnormal uterine bleeding. A relevant history and physical examination are performed, and a differential diagnosis is established. Labs and imaging are ordered and options for management reviewed. The patient discloses that they are recently divorced and soon may be in a new sexual relationship. They didn't think they could become pregnant at 44. An additional 15 minutes is spent discussing contraceptive options and STI prevention.*

#### CORRECT CODING FOR THIS VISIT

*Note: For 2020, the total time of the encounter may be used to choose a level of E/M service if >50% of the encounter is counseling.*

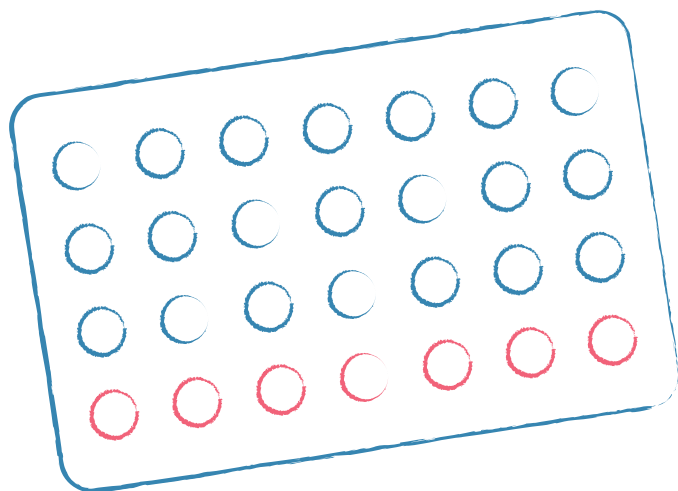
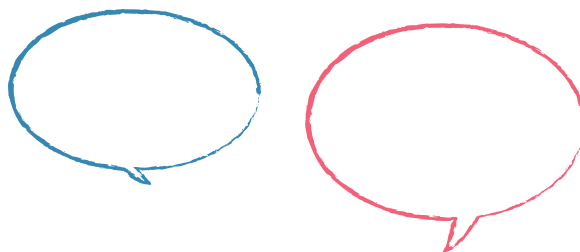
- **992XX** for the E/M service.
- **DO NOT REPORT 99401** (Preventive Medicine Counseling and/or risk factor reduction interventions provided to an individual (separate procedure) approximately 15 minutes) since this is designed a "separate procedure" which means it will be bundled into any other service by payers.

### CONTRACEPTIVE COUNSELING

*K.S., a 35-year-old patient with chronic hypertension, diabetes, and obesity comes in requesting birth control pills. The patient's medical co-morbidities preclude safe prescription of combined oral contraceptives and considerable time is spent providing counseling about options for safe and effective birth control.*

#### CORRECT CODING FOR THIS VISIT

- Codes **99401-99404** are reported when the entire encounter is for preventive medicine (contraceptive and/or STI counseling).
- The coding is based on the time spent with the patient face-to-face.
- The diagnosis code is **Z30.09** (encounter for other general contraception counseling).





## INITIATION OF INJECTABLE CONTRACEPTIVE

*T.K. is a 37-year-old patient who has been on combined oral contraceptives since the birth of their last child 5 years ago. T.K. is overweight, has type 2 diabetes and has recently been diagnosed with hypertension. T.K.'s primary care physician took them off oral contraceptives with a referral to an OB/GYN (your office) for counseling regarding contraceptive options. Comprehensive counseling is provided including all non-estrogenic options. 30 minutes is spent counseling and providing tools for shared decision-making. T.K. decides to proceed with an injection of Depo-Provera during this visit as their chosen method of contraception.*

### CORRECT CODING FOR THIS VISIT

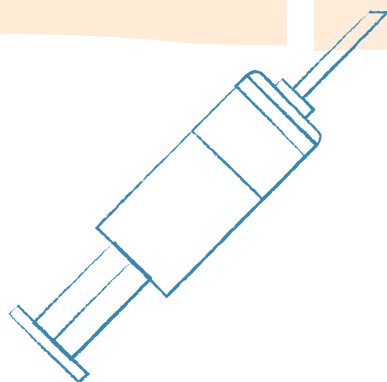
- **99402:** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
  - **81025:** Urine pregnancy test (if indicated)
  - **Z32.02:** Negative pregnancy test
  - **96372:** Therapeutic, prophylactic, or diagnostic injection
  - **J1050:** Depo Provera 1mg (150 Units)
  - **Z30.013:** Encounter for prescription of injectable contraception
- Modifiers are not necessary when coding for injections, tests or medications along with a counseling or evaluation and management service.

## PREVENTATIVE VISIT WITH PRESCRIPTION OF ORAL CONTRACEPTION

*A.S. is a 27-year-old established patient coming in for an annual examination and to discuss birth control options. A.S. is sexually active and does not want to become pregnant. A.S. smokes one pack of cigarettes daily, has a BMI of 28, and is generally sedentary. In the visit, A.S. and the provider discuss lifestyle modification, smoking cessation, healthy diet and review goals for contraception and perform an age-appropriate examination. After discussion, the patient decides to try low dose oral contraceptives. You provide a prescription for 12 months of pills and educate about follow-up care if there are any issues with the medication.*

### CORRECT CODING FOR THIS VISIT

- **99395:** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, age 18-39
  - **Z01.419:** Encounter for gynecological examination (general) (routine) without abnormal findings
  - **Z30.011:** Encounter for initial prescription of oral contraceptive pills
- You do not code separately for the smoking cessation counseling, contraceptive counseling and other age-appropriate screening or counseling since these are all bundled into the preventive medicine service.



## REMOVAL AND REINSERTION OF AN IUD

*N.G., a 32-year old patient, had a 52 mg, 5-year duration levonorgestrel IUD inserted five years ago and desires removal of the IUD and insertion of a new one. Minimal counseling is required as the patient had no problems with the IUD over the last few years. After vital signs are documented, the IUD is removed without difficulty and a new 52 mg, 5-year duration levonorgestrel IUD is inserted.*

### CORRECT CODING FOR THIS VISIT

- **58301** (removal)
- **58300-51** (insertion)
- **J7298** (levonorgestrel-releasing intrauterine contraceptive system [Mirena®], 52 mg [5-year duration]) for the device.

*Note: Practices will need to know the relative value units (RVUs) assigned to each code. Convention is that the first procedure is paid at 100% and the second at 50% to account for the overlap in work (for example vital signs are taken only once, the same room, exam paper, speculum, and equipment are used). RVUs for common OB/GYN procedures are available on ACOG's website: Medicare Relative Value Units and Payment Indicators for 2020*

- **Modifier 51** (multiple procedures) is added to the lesser valued procedure.
  - IUD insertion (**58300**) is allocated 2.28 total RVUs in 2019 and IUD removal (**58301**) has 2.70 RVUs.
  - Therefore, the modifier **-51** is applied to the insertion code.
- No E/M services code is reported since the brief discussion and taking of vital signs is not considered a significant service.
- **Z30.433** (removal and reinsertion of IUD) is reported for the diagnosis.

To avoid claim denials, providers should check with payers to determine if they reimburse for both removal and reinsertion at the same encounter, and how to bill appropriately to ensure payment.

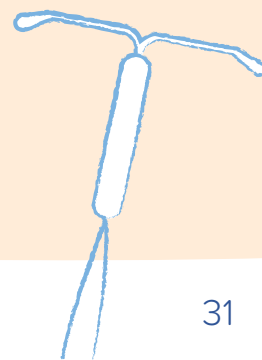
## IUD INSERTION AFTER A PROCEDURE

*G.Z., a 27-year old patient, presented with heavy bleeding at 9 weeks gestation and by limited ultrasound was found to have a non-viable pregnancy. The physician recommended uterine evacuation in the office. The patient requested placement of a copper IUD during the same encounter. The physician spent a total of 25 minutes counseling the patient about the miscarriage and contraceptive choices.*

### CORRECT CODING FOR THIS VISIT

- **99214-25** to report the evaluation and management service provided at the time of the procedures, which was significant and separately identifiable. (Documentation MUST identify those issues discussed with the patient.)
- **76817** (transvaginal ultrasound)
- **59812** (incomplete abortion completed surgically) (9.37 total RVUs)
- **58300-51** (IUD insertion) (2.28 total RVUs)
- **J7300** (intrauterine copper contraceptive [Paragard®] [10-year duration]) is reported for the IUD supply.
- The ICD-10 codes **O03.39** (spontaneous abortion with other specified complications, incomplete) and **Z30.430** (insertion of IUD) are the diagnosis codes.

If the miscarriage was complete (requiring no surgical intervention), the following coding would be appropriate: An E/M service with a modifier **25** (significant, separately identifiable E/M service), plus **58300** for the IUD insertion and **J7300** for the IUD.



## MISSING STRINGS

*K.M., a 22-year old patient, complains about being unable to feel the IUD strings for a device that was placed last year. Correct coding will depend on the level of services required to manage this patient.*

### CORRECT CODING FOR THIS VISIT

- If, on examination, the provider is able to tease the strings from the cervix:
  - A low-level evaluation and management (E/M) service – **99213**.
  - **Z30.431** (routine checking of IUD) as the diagnosis code.
- If the physician is unable to find the strings, provides a limited ultrasound examination, and documents appropriate intrauterine location of the IUD.
  - A low-level E/M service (**99212-3**) plus the limited ultrasound, **76857**
    - ▶ No modifier is needed to report an imaging study in conjunction with E/M services.
  - Diagnosis code **T83.32XA** (displacement of IUD, initial encounter) should be used to justify the need for ultrasound.

## UNSUCCESSFUL REMOVAL OR PLACEMENT OF AN IUD

*S.P., a 37-year old patient, comes in requesting IUD placement. S.P. has a history of 3 previous cesarean births. Access to the uterine cavity is challenging due to scarring, and after multiple attempts at IUD placement, the procedure is abandoned due to patient discomfort.*

### CORRECT CODING FOR THIS VISIT

For attempted removal or placement of an IUD which is unsuccessful in the office encounter, modifier **-53** may be added to the CPT code for the attempted procedure. The record should document the difficulty encountered, for example, cervical stenosis or pain.

- **58300-53** plus the appropriate J code for the IUD device for an aborted insertion
- **58301-53** for an aborted removal.
- **N88.2** may be used for cervical stenosis or stricture.



## Purchasing, Stocking, and Storing LARC

Patients face significant access barriers for LARC that are the result of the high cost of these devices and the need to return for multiple visits to receive the contraceptive method they desire. Providers and health systems should be informed about different purchasing options, strategies to mitigate financial risk and steps to take to increase access for their patients.

### 6a. Unpacking the Supply Chain of LARC

In New Jersey, a provider will purchase LARC through a “Buy and Bill” model or through a process referred to as “white bagging.”

- In a “Buy and Bill” model, a provider or office purchases devices from manufacturers to have on hand. After a device is inserted, the practice seeks reimbursement for the device from the insurer and/or patient. This practice allows for same-day access to LARC, as a patient does not have to return to the office due to lack of stock at the time of their initial visit, but requires up-front purchasing by the practice which can raise concerns about cash flow and potential costs of unused devices.
- “White Bagging” is a process available through some health plans in which a provider or office orders the devices through a specialty pharmacy after it is prescribed to the patient. In other words, a device is ordered for a specific patient and the pharmacy bills the insurer for the cost of the device. This process takes time and patients must return for a follow-up appointment to receive their LARC.

Regardless of the process used to obtain a device and whether same-day access to a form of contraception is available, providers should educate patients about all of their options and use a shared decision-making approach to help the patient make a choice that is best for them.

### > NJ-RHAP PACT Resource



To learn more about LARC purchasing and stocking, review the “LARC ‘Buy and Bill’ Model: Key Points and Considerations” available at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).

## 6b. Stocking and Storing LARC in Provider Offices

### \* *Important note*



Care is optimized when an individual can receive their contraceptive of choice at the time of the initial visit. There are systems and steps that practices can implement to make this feasible without facing undue risk for the cost of devices or delays in seeing other patients in the office.

**Anticipatory management:** Working with the entire staff in the office to uncover barriers to providing LARC at the initial office visit will help to engage each member of the team to resolve problems in their area and work together to serve patients.

Provider offices may be hesitant to purchase LARC devices upfront and to seek reimbursement for the devices from patients and their insurance carrier after insertion due to the upfront costs and perceived financial risks associated with the “buy and bill” model. Even provider offices that are interested and willing to use this model report occasional difficulty with processes required by finance departments/staff and with finding the space needed to store devices. Despite some of these challenges, having an appropriate stock of LARC devices available in an office can address many barriers to accessing this form of contraception, and significantly reduces the likelihood that an individual does not return for the repeat visit needed to place a LARC once it has been ordered by the office.

When provider offices implement a system of upfront purchasing of the device, the adherence to systems that efficiently verify coverage and obtain any necessary authorization for LARC insertion is especially important, as these processes can

ensure the practice will receive insurance or patient reimbursement for the device they purchased from the manufacturer.

### PROJECTING LARC STOCKING NEEDS

Understanding past utilization of LARCs is a fundamental component of purchasing the correct number and type of LARC to keep in stock for a practice. Some manufacturers will provide a volume discount for purchasing multiple units, so understanding where and when multiple units can be purchased upfront can result in savings for the provider office. To better understand their stocking needs, practices should query their billing software to determine how many IUD and implant insertions, by device type, are typically performed in a month, quarter and year. In doing these projections, provider offices should consider expiration dates of devices to ensure that they are not purchasing more than can be used over the shelf-life of the product. As few as 5-10 encounters within a quarter may meet the bulk purchasing amount needed to obtain a manufacturer discount. Sales representatives from LARC manufacturers can assist in determining stocking needs and can work with your office to develop an affordable purchasing plan.

### > *NJ-RHAP PACT Resource*



For more information about how to move towards same-day access, review the “5 Steps for Increasing Same-Day Access to LARC” tool available at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).

## Before, During, and After: Best Practices to Ensure Reimbursement and Positive Outcomes for LARC Insertions



### APPOINTMENT SCHEDULING (BEFORE)

- Train front office staff to collect all relevant insurance information at the time of initial appointment scheduling
- Verify insurance coverage prior to the office visit
- Provide patient with links to online counseling materials
- Pre-authorize LARC (if necessary) and document payer guidance regarding correct coding and billing
- Ask patient if they have had difficulty with exams or procedures in the past (survivors of intimate partner violence, sexual assault or previous difficult medical procedures may need more time in the office)
- Schedule other shorter appointments between contraceptive counseling and placement of LARC to maximize provider's time to see other patients while patient receiving LARC reads forms and is prepared for procedure



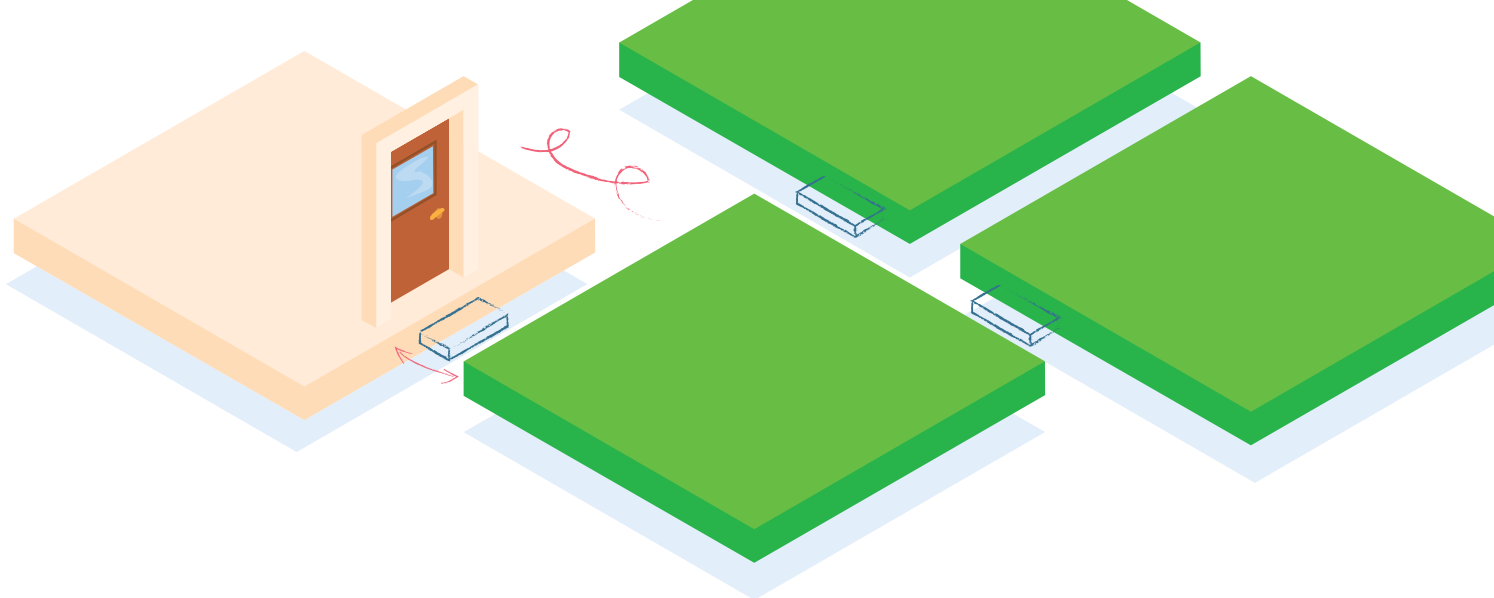
### DAY OF VISIT (DURING)

- Copy front and back of insurance card – re-verify coverage (especially if it is early in the month/year)
- Explain to the patient their responsibility for any costs and collect payment if necessary
- Provide written materials and links to tools prior to encounter with the provider for patient to review
- Provide form or provide a place on intake paperwork for patient to write questions they have for the provider
- Create a safe, non-threatening environment for discussion of contraceptive options (ensure patient has time alone with the provider - without other family members or partner)
- Review informational/ counseling materials while patient is still clothed to make them more comfortable asking questions
- Obtain signed consent



### DAY OF VISIT (AFTER)

- Follow practice procedures for documenting the visit, billing, and coding for services appropriately
- Inform patient of potential side effects and when/how to contact the office to discuss concerns
- Establish system to remind patients during annual visits and/or through secure communication platforms when it is time to remove/replace LARC



# Increasing Access in the Office and the Community

## 7a. Office Protocols to Increase Access

All professionals engaged in a patient's reproductive health care play an important role in ensuring access to high-quality services. Business decisions around the purchasing and stocking of contraceptives made by leadership at health systems and the execution of many of these best practices and policies by front-desk staff can greatly impact patient experience and health outcomes. It is crucial that all professionals are supported in understanding the part they play in efforts to increase access to services and supporting patient-centered care.

### HEALTH SYSTEM LEADERSHIP

Leaders within health systems can support clinicians and office staff by subsidizing training programs that increase provider competency and comfort with different reproductive health services. They can also make investments in office technology and initiate stocking practices which support increased access to services and identify opportunities for providers to have additional time with patients when necessary to ensure that contraceptive counseling is provided with a patient-centered approach.

#### IDEA

Review strategic goals for the system and discuss how these goals align or deviate from strategies needed to improve access to care. Consider establishing metrics that can measure success for these goals. Solicit feedback from staff routinely, to identify problems and work together on solutions.





## PRACTICE MANAGEMENT

Those who oversee the day to day operations, staffing, and structure of an office have a significant impact on the culture of the organization, the success of various initiatives, and the general patient experience and satisfaction with care. Professionals, such as office managers, can serve as check points to ensure that best practices are operationalized sustainably, new staff are trained appropriately, and bad habits are addressed promptly. Practice management staff can help promote best practices to increase access to care through on-going staff training opportunities and informative materials in waiting rooms and patient rooms.

## OFFICE STAFF

A patient can have multiple interactions with office staff before they see a clinician. Individuals who answer the phones, schedule appointments, greet patients, and provide essential office duties are often the first, second, and third points of contact patients have when seeking care. From the first call to schedule an appointment, the intake process on arrival, and everything during and after the visit, the office staff generate the “culture” and experience a patient will have in accessing contraceptive services. Front office personnel can significantly influence a patient’s willingness to disclose what services they might be seeking when scheduling an appointment, as well as their likelihood to return for any necessary follow-up appointments. The input of front office staff in developing operational tools and processes to support an office, as well as support provided to them by leadership to implement best practices and learn more about clinical components of their work, can make a significant difference in patient satisfaction.

### IDEA

Review the patient experience from the time they make an appointment through all stages of care provided at the office – brainstorm all potential barriers to care a patient may face. Work with appropriate staff to identify patient-centered solutions to each barrier. Office management staff can also better understand these barriers through establishment or increased utilization of patient satisfaction surveys. Check with patients to see if the office is getting it right and continue to adjust to meet their individual needs.

### IDEA

Post checklists of office protocols developed to increase access (such as questions each patient should be asked when scheduling appointments) at front-desk computers and phones to serve as a visual reminder for staff. Include information about the importance of word choice and leading versus non-leading questions in this document and provide opportunity for staff to practice these techniques through role-play exercises. Incorporate staff into the development and ongoing assessment of these tools to ensure they are a helpful resource for existing and new members of the team.

## > NJ-RHAP PACT Resource



For a worksheet to support front-desk staff in these best practices, fill out the “Priority Setting Worksheet for Front Desk Staff” available at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).

## 7b. Improving Access in the Community

### > Key Quote



**“Birth control, as a core component of family planning, is one of the most important public health success stories of our generation.”<sup>40</sup>**

— American Public Health Association Executive Director, Georges Benjamin, MD.

Communities, providers and organizations must work together to prioritize community engagement in their efforts to increase access to high-quality reproductive health care. When providers and organizations engage beyond their typical environment and more within their community, they can develop a true partnership, create greater trust, improve patient satisfaction, and increase effective organizational decision-making that reflects community needs.

Community engagement can range from information-gathering conversations to more formal focus groups with community members. Maintaining substantive, ongoing relationships is essential in building trust and being responsive to changing needs and priorities.

Respect and understanding for the role and value of community engagement are pertinent to all reproductive health providers, particularly those who serve marginalized or underprivileged populations.

### **COMMUNITY ENGAGEMENT WITHIN CLINICAL SETTINGS:**

Communities of color and other marginalized groups have significant history with reproductive coercion that contributes to community skepticism and distrust regarding reproductive health initiatives and inaccurate beliefs about certain contraceptive methods. Acknowledgement of this history and of the clinician’s privilege, addressing issues around implicit bias, and ensuring that programs have maximum transparency are essential for community acceptance and to repair these vital relationships. Any community engagement surrounding reproductive health services, specifically contraception, should always be centered in the promotion of bodily autonomy.

Examples of community engagement include:

- Community membership on boards of directors, community, or consumer advisory boards
- Outreach to community leaders and organizations for input on new or ongoing initiatives
- Partnerships with community organizations on mutual efforts or support for their existing work
- Engaging community members in program implementation whenever possible
- Focus groups and community forums that prioritize authentic listening models
- Community participation in the development and distribution of educational materials

*\*Note: Authentic community engagement is much more than extending an invitation to participate in an event or sit on a board. Program organizers must work to create space for diverse viewpoints and promote active engagement with community members who are willing to participate in these activities. They also must move beyond listening to active response and incorporation of issues/ideas raised by the community*

Information about reproductive health care including all methods of contraception, as well as information about pregnancy spacing and preconception health, is essential for all people seeking reproductive health care as well as those seeking primary care or specialty services. Information available within clinical settings or through services open to the public is not only beneficial to patients, but also any friends or family members who accompany them to their appointments or who they might share information with after leaving the office.

Examples include:

- Written materials or brochures in waiting areas and in each exam room
- Information about clinic, practice, or hospital websites
- Employing a system which sends information via text or email to patients when an appointment is approaching
- Tailored materials to give to patients at critical moments in care, such as discharge after childbirth
- Support groups open to the community, which are held at a clinical site
- Donation tables in offices, which allows patients and community members to access donated items such as household goods, non-perishable foods, diapers, etc.

All educational materials should be culturally appropriate (variety of races, ethnicities, and multi-lingual), and not hetero-centric (inclusive of a variety of gender and sexual identities). Community members can be a valuable resource in providing feedback on proposed materials.

## EDUCATION IN NON-CLINICAL SETTINGS

Expanding the availability of reliable reproductive health education outside of a clinical setting is important in reinforcing information provided at appointments as well as to reach individuals who do not seek reproductive or other types of preventive care. These efforts also increase the likelihood that individuals will be more engaged and informed about their options for care and could help them be less vulnerable to reproductive coercion. Professionals, such as Community Health Workers, can be instrumental in community-based education efforts. They can use their connection with the specified population to inform the structure of the outreach and be a friendly face that community members recognize and feel comfortable with during the engagement.

Possible locations for this type of work, which often includes distribution of culturally competent educational materials and potential on-site screening and counseling, might include:

- Breastfeeding support groups or other groups focused on pregnancy and new parents
- Domestic and Sexual Violence agencies
- Hair and nail salons
- Child Care agencies and Head Start programs
- Libraries
- Street Fairs and Health Fairs
- Places of worship

### > *NJ-RHAP PACT Resource*



To guide your efforts for community engagement use the “Community Engagement Planning Worksheet” resource available at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).



## Looking Forward

Providers across the state need to be informed about current policies related to the provision of reproductive health services and opportunities to increase access both through office protocol and through their engagement with patients. Support for these efforts is fundamental in moving towards more robust access to high-quality services as well as for the promotion of education and bodily autonomy for patients.

Improvements in coverage of services as well as consumer education efforts will not maximize access for patients in New Jersey if providers do not have the information and tools necessary to deliver accessible and high-quality care. We must continue to increase education and resources available on this topic for a variety of populations while also utilizing more macro-level interventions to further improve the landscape of comprehensive reproductive health services in New Jersey.

Our state has made positive strides in this effort through policy change related to the payment for LARCs immediately post-partum and with the launch of the state plan amendment to extend eligibility for family planning services. It is important that the state, health systems, payers, providers, and community-based organizations continue to prioritize this work to identify future areas for policy improvement. This should be done with an awareness of the complex operational considerations needed to maximize the positive impact these changes can have on patients and with reproductive justice at the center of all efforts.

The Quality Institute will continue to work with our partners throughout the state and nationally to advance policy and programmatic changes that will increase the accessibility and quality of reproductive health services across New Jersey.

### > NJ-RHAP PACT Resource



**What's next? Take the "NJ-RHAP PACT Pledge" to document your commitment to improving access to reproductive health care.** Access the pledge at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).

## > Key Resources

For hyperlinks to all key resources listed here, please visit the electronic version of this toolkit at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).

### New Jersey Specific Resources

- [New Jersey Family Planning League: Find a Health Center Tool](#)
- [New Jersey Medicaid: Plan First Program](#)
- [New Jersey Medicaid Provider Newsletters:](#)
- [NJ FamilyCare \(NJFC\) Coverage of Long-Acting Reversible Contraceptive \(LARC\) Devices \(October 2018\)](#)
- [Introduction to Plan First \(September 2019\)](#)
- [New Jersey Medicaid Rate Information](#)

### Counseling Models

- [Before, Between and Beyond Pregnancy: Reproductive Life Plan](#)
- [One Key Question](#)
- [PATH Framework Questions](#)

### Billing and Coding

- [American College of Obstetricians and Gynecologists \(ACOG\) Billing, Coding, and Payment Resources](#)
- [ACOG Coding Questions and Assistance Ticket Database](#)
- [LARC Quick Coding Guide](#)
- [LARC Billing Quiz](#)

### Contraceptive Access

- [Planned Parenthood Federation of America: Resources](#)
- [Family Planning National Training Center \(FPNTC\): Contraceptive Services](#)
- [FPNTC Contraceptive Access Assessment](#)
- [FPNTC Same-Visit Contraception Implementation Checklist](#)
- [FPNTC Contraceptive Access Quality Improvement Plan](#)
- [FPNTC Sample Policy for Same-Visit Contraceptive Services](#)
- [ACOG Same-Day Insertion for Long-Acting Reversible Contraception: Best Practice Checklist](#)

### Culturally Sensitive Care

- [Innovating Education in Reproductive Health: Structures & Self - Advancing Equity and Justice in Sexual and Reproductive Health](#)
- [Anne Marie Shrouder: Cultural Competency vs Cultural Humility](#)
- [ACOG: Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care](#)
- [National LGBTQ Task Force - Queering Reproductive Justice: A Toolkit](#)
- [CARDEA: Advancing Health Equity through Gender Affirming Health Systems](#)

## > *NJ-RHAP PACT Resources*

These resources are available as a supplement to the NJ-RHAP PACT to help support providers in implementing the best practices and core content of the toolkit. They are available at [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).

- Billing and Coding Guide for Contraceptive Services
- NWHN-SisterSong Joint Statement of Principles on LARCs
- 10 Steps to Verify Coverage for Contraceptive Services
- Reproductive Health Services for Uninsured and Underinsured Individuals in New Jersey
- LARC 'Buy and Bill' Models: Key Points and Considerations
- 5 Steps for Increasing Same-Day Access to LARC
- Priority Setting Worksheet for Front Desk Staff
- Community Engagement Planning Worksheet
- NJ-RHAP PACT Pledge

## NJ-RHAP Steering Committee

The representatives from the organizations mentioned below participated in the NJ-RHAP Steering Committee. This group met on a quarterly basis and provided additional ad-hoc support to ensure that this toolkit was responsive to the needs of providers throughout the state and emphasized patient-centric best practices for reproductive health services. The views of the toolkit do not necessarily reflect the views or opinions of these representatives and their organizations.

### Organizations

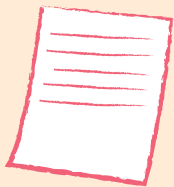
- Aetna Better Health of New Jersey
- Answer
- Anthem
- AmeriHealth New Jersey
- Bayer
- CentraState Family Residency Training Program at Rutgers Robert Wood Johnson Medical School
- Horizon Blue Cross Blue Shield of New Jersey
- MBI-GluckShaw
- Merck
- New Jersey Department of Consumer Affairs
- New Jersey Department of Health
- New Jersey Division of Medical Assistance and Health Services
- New Jersey Family Planning League
- New Jersey Policy Perspective
- Planned Parenthood Action Fund of New Jersey
- Planned Parenthood of Metropolitan New Jersey
- Planned Parenthood of Northern, Central and Southern New Jersey
- RWJBarnabas Health
- Summit Medical Group
- United HealthCare
- Visiting Nurse Association of Central Jersey
- WellCare

## Endnotes

- 1 New Jersey Health Care Quality Institute, Contraceptive Access Project Findings Document, January 2019.
- 2 American College of Obstetricians and Gynecologists, Long-Acting Reversible Contraception: Intrauterine Device and Implant, January 2018. <https://www.acog.org/patient-resources/faqs/contraception/long-acting-reversible-contraception-intrauterine-device-and-implant>
- 3 Sister Song: Women of Color Reproductive Justice Collective, Reproductive Justice. <https://www.sistersong.net/reproductive-justice>
- 4 Ross, L. Roberts, L. et al., Radical Reproductive Justice: Foundations, Theory, Practice, Critique. Feminist Press, 2017.
- 5 National Women's Health Network, The Great LARC Debate: Facilitating a Balanced Approach to Education and Promotion of LARCs. Volume 40, Issue 4, July/August 2015. [https://www.nwhn.org/wp-content/uploads/2015/07/070815\\_NWHN\\_Newsletter\\_F21.pdf](https://www.nwhn.org/wp-content/uploads/2015/07/070815_NWHN_Newsletter_F21.pdf)
- 6 America's Health Rankings United Health Foundation: Health of Women and Children – Unintended Pregnancy [https://www.america'shealthrankings.org/explore/health-of-women-and-children/measure/unintended\\_pregnancy/state/NJ](https://www.america'shealthrankings.org/explore/health-of-women-and-children/measure/unintended_pregnancy/state/NJ)
- 7 Power to Decide: Contraceptive Access in New Jersey, March 2020. [https://powertodecide.org/sites/default/files/2022-11/State%20Factsheet\\_New%20Jersey.pdf](https://powertodecide.org/sites/default/files/2022-11/State%20Factsheet_New%20Jersey.pdf)
- 8 Guttmacher Institute, State-Level Estimates of Contraceptive Use in the United States, 2017. <https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017>
- 9 United Nations, Reproductive Health Policies 2017: Data Booklet. [https://www.un.org/en/development/desa/population/publications/pdf/policy/reproductive\\_health\\_policies\\_2017\\_data\\_booklet.pdf](https://www.un.org/en/development/desa/population/publications/pdf/policy/reproductive_health_policies_2017_data_booklet.pdf)
- 10 Health and Human Services, Office of Population Affairs, Contraceptive Options and Effectiveness. May 2018. <https://opa.hhs.gov/reproductive-health/preventing-pregnancy-contraception>
- 11 Jackson, A.V., Karasek, D., Dehlendorf, C., and Foster, D.G. (2016). Racial and ethnic differences in women's preferences for features of contraceptive methods. *Contraception*, 93(5), 406-11
- 12 Hill, Amber L., et al. "Reproductive Coercion and Relationship Abuse Among Adolescents and Young Women Seeking Care at School Health Centers." *Obstetrics & Gynecology*, vol. 134, no. 2, 2019, pp. 351–359., doi:10.1097/aog.0000000000003374.
- 13 Rowlands S, Walker S, Reproductive control by others: means, perpetrators and effects. *BMJ Sexual & Reproductive Health* 2019;45:61-67.
- 14 Innovating Education in Reproductive Health: A Project of the Bixby Center for Global Reproductive Health, Changing the Conversation: Shared Decision-Making in Reproductive Health. April, 2016. <https://www.innovating-education.org/2016/04/changing-the-conversation-shared-decision-making-in-reproductive-health/>
- 15 American College of Obstetricians and Gynecologists (ACOG). Committee Opinion Number 777, April 2019. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/04/sexual-assault>
- 16 American College of Obstetricians and Gynecologists (ACOG). Committee Opinion Number 827, June 2012. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/06/access-to-postpartum-sterilization>
- 17 American Board of Family Medicine, National Graduate Survey Report, 2018.
- 18 Contraceptive Journal, Projections and opinions from 100 experts in long-acting reversible contraception. Volume 92, Issue 6. December 2015. [https://www.contraceptionjournal.org/article/S0010-7824\(15\)30139-6/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(15)30139-6/fulltext)
- 19 American College of Obstetricians and Gynecologists (ACOG). Committee Opinion Number 186, November 2017. <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices>
- 20 Taouk, L. et al., Provision of Reproductive Healthcare to Women with Disabilities. *Health Equity*. Vol 21.; 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6110183/>
- 21 Higgins, J et.al., Sexual Minority Women and Contraceptive Use. *AJPH*. December 2019, Vol 109. No. 12. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305211>
- 22 American College of Obstetricians and Gynecologists (ACOG). Committee Opinion Number 186, November 2017. <https://www.acog.org/sitecore/service/notfound.aspx?item=%2fferror%2f404&user=default%5cAnonymous&site=service>
- 23 Center for Disease Control and Prevention, US Medical Eligibility Criteria for Contraceptive Use. <https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html>
- 24 Center for Disease Control and Prevention, US Selected Practice Recommendations for Contraceptive Use. <https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html>
- 25 American College of Obstetricians and Gynecologists (ACOG). Committee Opinion Number 788, October 2019. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/over-the-counter-access-to-hormonal-contraception>



- 26 Healthcare.gov: Birth Control Benefits. <https://www.healthcare.gov/coverage/birth-control-benefits/>
- 27 Kaiser Family Foundation, New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women. November 2018. <https://www.kff.org/health-reform/issue-brief/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/>
- 28 NJSA 17B:27-46.1ee. (2005). <https://law.justia.com/codes/new-jersey/2013/title-17b/section-17b-27-46.1ee/>
- 29 Horizon Blue Cross Blue Shield of New Jersey: Important Changes to NJ Prescription Female Contraceptive Mandate. <https://www.horizonblue.com/employers/news/employer-news/changes-coverage-oral-combined-contraceptives-due-wide-range-generic-alternatives>
- 30 Kaiser Family Foundation, Medicaid and Family Planning: Background and Implications of the ACA, February 2016. <https://www.kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/>
- 31 N.J.A.C. 10.66-2.5 (a). [https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010\\_66%20Independent%20Clinic%20Services.pdf](https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_66%20Independent%20Clinic%20Services.pdf)
- 32 N.J.A.C. 10.66-2.5 (n). [https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010\\_66%20Independent%20Clinic%20Services.pdf](https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_66%20Independent%20Clinic%20Services.pdf)
- 33 New Jersey State Plan Amendment. [https://www.state.nj.us/humanservices/dmahs/info/state\\_plan.html](https://www.state.nj.us/humanservices/dmahs/info/state_plan.html)
- 34 N.J.A.C. 10.66-2.5 (b). [https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010\\_66%20Independent%20Clinic%20Services.pdf](https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_66%20Independent%20Clinic%20Services.pdf)
- 35 New Jersey FamilyCare Plan First Program. [https://njfamilycare.dhs.state.nj.us/plan\\_first.aspx](https://njfamilycare.dhs.state.nj.us/plan_first.aspx)
- 37 NJ Family Planning League. <https://njfpl.org/find-a-health-center/>
- 38 Planned Parenthood Action Fund of New Jersey Inc., Protect X: Title X in New Jersey. <https://www.plannedparenthoodaction.org/planned-parenthood-action-fund-new-jersey-inc/issues/title-x-in-new-jersey>
- 39 Governor Murphy Signs Legislation Appropriating \$9.5 Million for Family Planning Services. <https://www.nj.gov/governor/news/news/562019/approved/20200102a.shtml>
- 40 American Public Health Association, Reproductive and Sexual Health. <https://www.apha.org/topics-and-issues/reproductive-and-sexual-health>



## Billing and Coding Guide for Contraceptive Services

### > CPT Codes

#### ENCOUNTERS FOR COUNSELING:

- **99381-99386:** New Patient Comprehensive Preventive Visits (includes contraceptive counseling when performed)
- **99391-99396:** Established Patient Comprehensive Preventive Visits
- **99401-99404:** Individual counseling and/or risk factor reduction (15, 30, 45 or 60 minutes).
  - To be used when contraceptive counseling is the ONLY purpose of the visit and at least 15 minutes are spent counseling.
- **99202-99215:** Evaluation and Management Services
  - To be used for problem-oriented visits where contraceptive counseling may have been a component of the visit, but not the main purpose of the encounter.

#### PROCEDURES:

##### CONTRACEPTIVE IMPLANT:

- **81025:** Urine pregnancy test
- **11981:** Insertion
- **11982:** Removal
- **11983:** Removal with reinsertion
- **J7307:** Etonogestrel implant system and supplies (Nexplanon)

##### INJECTABLE CONTRACEPTION:

- **J1050:** Depo Provera 1mg (code 150 units)
- **96372:** Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)

##### IUDS:

- **81025:** Urine pregnancy test
- **58300:** Insertion of IUD
- **58301:** Removal of IUD
- **58301 + 58300-51:** Removal with reinsertion of IUD
- **J7296:** Levonorgestrel-releasing (LNG) IUD 19.5 mg (Kyleena)
- **J7297:** LNG-releasing IUD 52mg (Liletta)
- **J7298:** LNG-releasing IUD 52 mg (Mirena)
- **J7300:** Copper IUD (Paragard)
- **J7301:** LNG-releasing IUD 13.5 mg (Skyla)

##### MODIFIERS:

- **22:** Increased procedure services
  - Document the clinical circumstances (e.g. cervical stenosis, the need for ultrasound guidance) requiring increased services.
- **25:** Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.
  - Use this modifier attached to office visit code when performing a LARC insertion on the same day as significant counseling or other evaluation and management services.
- **24:** Unrelated evaluation and management service by the same physician or other qualified health care professional during a post-operative (or post-partum) period.
  - Use this modifier when performing significant additional services in the post-partum, post-abortion or post-surgical global period.

- **51:** Multiple procedures
  - This is used when performing insertion and removal of IUDs on the same date of service.
- **53:** Discontinued services.
  - This modifier is used when the insertion procedure is terminated without successful placement of the implant or IUD.
  - It could be related to patient intolerance, uterine perforation, or other events (contamination of the device) which

prevent completion of the procedure once initiated.

- **79:** Unrelated procedure or service by the same physician or other qualified health care professional during the post-operative period.
  - Use this when performing a procedure such as LARC or IUD insertion during the global obstetrical period or during the post-operative global period for D&C, LEEP, or conization.

## > ICD-10 Codes

- **Z30** is the general category for “Contraceptive Management”
  - **Z30.0:** Encounter for general counseling and advice on contraception
  - **Z32.02:** Pregnancy test/exam - negative

- **Z30.431:** Encounter for routine checking of intrauterine contraceptive device
- **Z30.432:** Encounter for removal of intrauterine contraceptive device
- **Z30.433:** Encounter for removal and reinsertion of intrauterine contraceptive device

## PROCEDURES:

### CONTRACEPTIVE IMPLANT:

- **Z30.017:** Encounter for initial prescription of implantable subdermal contraceptive
  - This code is reported for the initial prescription, counseling, advice, and insertion of the implant, even when the insertion is performed at a separate encounter.
- **Z30.46:** Encounter for surveillance of implantable subdermal contraceptive
  - This code is reported for checking, reinsertion, or removal of the implant.

### OTHER CONTRACEPTIVE OPTIONS:

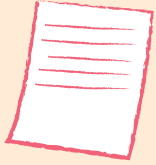
- **Z30.011:** Encounter for initial prescription of contraceptive pills
- **Z30.012:** Encounter for prescription of emergency contraception
- **Z30.013:** Encounter for prescription of injectable contraception
- **Z30.015:** Encounter for prescription of vaginal ring
- **Z30.016:** Encounter for prescription of transdermal patch
- **Z30.018:** Encounter for initial prescription of other contraceptive
- **Z30.41:** Encounter for surveillance of oral contraceptives
- **Z30.42:** Encounter for surveillance of injectable contraception
- **Z30.49:** Encounter for surveillance of other contraceptives

### IUDS:

- **Z30.014:** Encounter for initial prescription of intrauterine contraceptive device
  - This code includes the initial prescription of the IUD, counseling, and advice, but excludes the IUD insertion.
- **Z30.430:** Encounter for insertion of intrauterine contraceptive device

## > References:

- [ACOG LARC Quick Coding Guide](#)
- [Beyond the Pill: LARC Quick Coding Guide Supplement](#)
- [University of California, San Francisco: Intrauterine Devices & Implants — A Guide to Reimbursement](#)
- [Family Planning National Training Center: Common Codes for Billing — Contraceptive Management Visits](#)



## National Women's Health Network and SisterSong LARC Statement of Principles

The [National Women's Health Network](#) and [SisterSong: National Women of Color Reproductive Justice Collective](#) developed the [LARC Statement of Principles](#) to guide providers, associations, public health officials, foundations, and governmental agencies to promote reproductive justice in all aspects of care, specifically as it relates to the provision of long-acting reversible contraceptives (LARCs). The Quality Institute thanks these organizations for their tremendous work in this field and for granting permission to disseminate this important message through the NJ-RHAP PACT.

We believe that people can and do make good decisions about the risks and benefits of drugs and medical devices when they have good information and supportive health care. We strongly support the inclusion of long-acting reversible contraceptive methods (LARCs) as part of a well balanced mix of options, including barrier methods, oral contraceptives, and other alternatives. We reject efforts to direct women<sup>1</sup> toward any particular method and caution providers and public health officials against making assumptions based on race, ethnicity, age, ability, economic status, sexual orientation, or gender identity and expression. People should be given complete information and be supported in making the best decision for their health and other unique circumstances. We call on the reproductive health, rights, and justice communities, including clinicians, professional associations, service providers, public health agencies, private funders and others to endorse the following principles.

**We acknowledge the complex history of the provision of LARCs and seek to ensure that counseling is provided in a consistent and respectful manner that neither denies access nor coerces anyone into using a specific method.**

- Many of the same communities now aggressively targeted by public health officials for LARCs have also been subjected to a long history of sterilization abuse, particularly people of color, low-income and uninsured women, Indigenous women, immigrant women, women with disabilities, and people whose sexual expression was not respected.

**We commit to ensuring that people are provided comprehensive, scientifically accurate information about the full range of contraceptive options in a medically ethical and culturally competent manner in order to ensure that each person is supported in identifying the method that best meets their needs.**

- A one-size-fits-all focus on LARCs at the exclusion of a full discussion of other methods ignores the needs of each individual and the benefits that other contraceptive methods provide. A woman seeking care who is preemptively directed to a LARC may be better served by a barrier method that reduces the spread of HIV and other sexually transmitted infections (STIs); a pill, patch, or ring that allows her to control her menstrual cycle; or any method that she can choose to stop using on her own without the approval of clinician.
- Women—particularly young women, elderly women, women of color, LGBTQ individuals, and low-income women—frequently report that clinicians talk down to them, do not take their questions seriously, and treat them as though they do not have the basic human right to determine what happens with their bodies. Only affordable coverage of all options and a comprehensive, medically accurate, and culturally competent discussion of them will ensure treatment of the whole human being and truly meet the health and life needs of every woman.

**Advocates and the medical community must balance efforts to emphasize contraception as part of a healthy sex life beyond the fear of unintended pregnancy with appropriate counseling and support for people who seek contraception for other health reasons.**

- The current focus on straight, cisgender women limits the health information given to people whose primary need may not be for preventing pregnancy, but for treating endometriosis, ovarian cysts, heavy or painful menstrual cycles, and more. This current focus also reinforces a limited set of public health outcomes that have been historically problematic, rather than respecting the bodily autonomy and rights of all women.
- Health care providers need good information to effectively consult with their patients. We seek to ensure access to training and up-to-date information on the benefits and possible drawbacks or limitations of any given option so that health professionals and clinic staff are able to provide the highest quality counseling for each and every patient.

**The decision to obtain a LARC should be made by each person on the basis of quality counseling that helps them identify what will work best for them. No one should be pressured into using a certain method or denied access based on limitations in health insurance for the insertion or removal of LARC devices.**

- Too often, providers receive biased promotional information from funders and pharmaceutical companies. It is critical that providers receive information that doesn't privilege LARC over other methods.
- Governments, foundations, and providers should reject explicit and implicit targets or goals for total numbers of LARCs inserted, which inappropriately bias the conversation between women and clinicians and can lead to coercion.
- Governments, foundations, and providers should reject incentives that limit patient choice, such as vouchers that can only be redeemed for LARCs.

**The decision to cease using a long-acting method should be made by each individual with support from their health professional without judgment or obstacles.**

- A woman who wants her LARC removed should have her decision respected and her LARC promptly removed, even if her clinician believes that she might ultimately be happy with the device if she were to wait.
- Removal of a LARC can be more demanding than insertion, but many women face significant obstacles when they want their LARC removed. Every clinic that offers a LARC should also have clinicians trained and able to remove LARCs and should offer appointments for removal at that same site. Likewise, providers should make clear that if women are not insured at the time they want their LARC removed, they may have to pay for removal out of pocket.
- When programs are implemented to increase access to LARCs, they should clearly address issues of removal, particularly how the needs of patients will be met if and when a program ends.

**The current enthusiasm for LARCs should not distract from the ongoing need to support other policies and programs that address the full scope of healthy sexuality.**

- Comprehensive sexuality education must be fully funded and supported.
- LARCs are an important addition to the range of options, but they are not the only option. The medical community must not only ensure access to and information about the full range of current methods, but also support continued research to develop new options to continue to improve quality of care and support women and families.

Women should have the right and the ability to control their own fertility whether planning, preventing or terminating a pregnancy. Marginalized communities, and particularly women of color, have experienced many forms of reproductive oppression, from forced sterilization to restrictions on abortion access to coercive limits on their ability to have children, and they continue to face high rates of maternal mortality. We

believe articulating these principles is necessary to protect the bodily autonomy and to respect the agency, health and dignity of marginalized women so that those who have historically been oppressed or harmed feel safe when making reproductive decisions. This is a critical step forward.

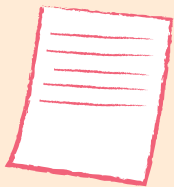
**This is what reproductive justice looks like.**

*For questions, please contact Sarah Christopherson at [schristopherson@nwhn.org](mailto:schristopherson@nwhn.org).*



## *Endnote*

<sup>1</sup> While we use “woman” and “women” throughout this statement, we recognize that these terms do not encompass the full range of people who utilize contraception and who may be impacted by coercive practices. We also use the gender-inclusive “their” and “them” as singular pronouns.



## 10 Steps to Verify Coverage for Contraceptive Services

### > Step 1

Call number on the back of patient's insurance card (This number should be collected upon scheduling of appointment).

### > Step 2

Verify that the patient is currently covered by the plan, the plan's coverage of contraceptive care and, if applicable, for long-acting reservable contraceptives (LARCs) or injectable contraceptives. (Refer to NJ-RHAP PACT Billing and Code guide for CPT and ICD-10 codes)

### > Step 3

If the patient wishes to receive a LARC, ask if there are specific devices that are covered (or not covered) by plan – provide the “J” codes for the devices if needed:

- **J7296:** Levonorgestrel-releasing (LNG) IUD 19.5 mg (Kyleena)
- **J7297:** LNG-releasing IUD 52mg (Liletta)
- **J7298:** LNG-releasing IUD 52 mg (Mirena)
- **J7300:** Copper IUD (Paragard)
- **J7307:** Etonogestrel implant system and supplies (Nexaplon)
- **J7301:** LNG-releasing IUD 13.5 mg (Skyla)
- **J1050:** Depo-Provera 1 mg

### > Step 4

Ask whether prior authorization is required for services and identify steps necessary to complete that process.

### > Step 5

Confirm provider(s) who will be providing services are in-network and ask for detailed coverage and payment levels for all possible encounters and procedures that may be billed.

### > Step 6

If the plan is exempt from ACA contraceptive mandate, which prohibits out of pocket patient costs for contraception, ask what the patient responsibility/cost-sharing amount will be. Confirm if a patient needs to meet a deductible before any coverage is applied.

### > Step 7

Repeat collected information to confirm, document the date and time of call and the representative's name.

### > Step 8

Document collected information in patient's chart, communicate any necessary updates to patient, and proceed with service delivery accordingly.

### > Step 9

Track information collected for all insurers in one spreadsheet (with no patient information) including coverage details, payment amounts, and other policies.

- Reconcile explanation of benefits and payments upon receipt to ensure payment is accurate.
- Analyze insurance denials and their reasons and reflect that in tracking document.

### > Step 10

If needed, modify or educate necessary staff about coverage and reimbursement details to improve patient experiences and outcomes while also maximizing reimbursement for services delivered.





## Reproductive Health Services for Uninsured and Underinsured Individuals in New Jersey

### > Coverage Options

#### COMMERCIAL INSURANCE COVERAGE:

- Depending on their income and family size, individuals in the state may be eligible for subsidies to help them pay for insurance on the Marketplace. More information can be found at: [Get Covered NJ](#).
- In New Jersey, health insurance can also be purchased directly from an insurance company or through an agent. The [Health Plan Comparison Tool](#) can help those interested shop for a plan.
- The [Individual Health Coverage Program](#) enables those without employer or government sponsored health plans to purchase coverage from a variety of private carriers.

#### NEW JERSEY MEDICAID PROGRAM:

- [NJ Medicaid](#) covers New Jersey residents who are either U.S. Citizens or “Qualified Aliens” with incomes below 133% Federal Poverty Level (FPL).
  - In addition to income requirements, individuals must also fall into one of the following categories: [pregnant women](#), the [blind or permanently disabled](#), or [families with dependent children](#).
- [NJ FamilyCare](#) offers coverage for children, pregnant women, parents/caretaker relatives, single adults and childless couples.
  - Parents/guardians with income up to 138% FPL are eligible if they have been legal permanent residents for at least 5 years.

- This 5-year rule does not apply to children or pregnant women and there are exceptions for some, including refugees and asylees.
  - Coverage is also offered for children age 18 and younger if their family’s total income before taxes is at or below 355% FPL.
- [Other Programs for Children Under the age of 21](#): Children who have aged out of Medicaid programs or who have other special circumstances may be eligible for Medicaid through programs such as “Medicaid Special” or “Medically Needy”. More information about these programs can be found through local County Board of Social Services or by calling 1-800-356-1561.
- Cover All Kids is an initiative to reach all uninsured children in New Jersey under the age of 19. It provides NJ FamilyCare coverage to all income-eligible kids in New Jersey, regardless of immigration status.
- The [Plan First Program](#) is a limited benefit program offered through the State’s Medicaid program which provides family planning services. The Plan First Program provides coverage such as birth control and family planning counseling. To be eligible for Plan First, individuals must be between 139%-205% FPL, New Jersey residents, U.S. citizens or Qualified Immigrants, and not currently pregnant or sterile. Plan First does not provide minimum essential health care coverage, such as physicals, and does not count as coverage for New Jersey’s mandate for coverage.
- The New Jersey Supplemental Prenatal and Contraceptive Program (NJSPCP) is run by NJ FamilyCare. NJSPCP is a limited-benefit program. It provides prenatal and family planning services, including contraceptive care, to women who are undocumented. It does not provide complete healthcare coverage, such as hospital visits or labor and delivery.

For additional resources, as well as the full New Jersey Reproductive Health Access Project Provider Access Commitment Toolkit (NJ-RHAP PACT), please visit: [bit.ly/QIResourcesNJRHAP](http://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](http://njhcqi.org).

## > Care Delivery Sites

### FEDERALLY QUALIFIED HEALTH CENTERS:

[New Jersey's Federally Qualified Health Centers](#) (FQHCs) offer health care to all regardless of their ability to pay. Health centers offer many primary and preventive care services as well as pediatric services, dental, women's health, behavioral/mental health, lab services, and HIV/AIDS counseling and testing. FQHCs serve the uninsured as well as those with Medicaid, NJ FamilyCare, Medicare and private insurance. If uninsured, fees are charged using a sliding fee scale. To find a nearby site, use the State's [Search for Federally Qualified Health Centers](#) tool.

### FAMILY PLANNING CLINICS:

Federal and state funds support reproductive health care delivered through 10 agencies at 50 sites throughout New Jersey. To find the closest Family Planning Clinic, visit the [NJ Family Planning League website](#).

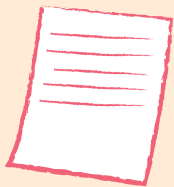
### PLANNED PARENTHOOD HEALTH CENTERS:

There are 21 Planned Parenthood Health Centers across the state that offer comprehensive reproductive health services. Individuals who are uninsured or underinsured can receive services on a sliding scale and/or establish payment plans with health centers. To locate a Planned Parenthood Health Center, use their [Find a Health Center](#) tool.

## > Financial Supports

### PATIENT ASSISTANCE RESOURCES FOR FREE OR LOW-COST CONTRACEPTION:

- [RxAssist](#) is a directory of various patient assistance programs. It offers resources for patients and providers.
- Large box stores may offer discounts at their pharmacies. For example, Walmart offers low cost birth control pills. Only \$9/28 day supply or \$24/84 day supply for the following:
  - Norethindrone 0.35mg
  - Sprintec
  - Tri-Sprintec
- [GoodRx](#) is a free service that gathers prices from pharmacies and identifies low prices at specific locations. It also shows the average price for prescriptions and offers other tips to save money on prescriptions such as filling them for 3 months, rather than monthly.
- Contraception manufacturers may also offer financial support for consumers as well as bulk purchasing discounts for providers, which could be passed on to the consumer. Examples of the patient assistance programs include:
  - [Bayer US Patient Assistance Foundation](#)
  - [Merck Patient Assistance Program](#)
  - [Paraguard Patient Assistance Program](#)
  - [Pfizer Rx Pathways](#)



## Long-Acting Reversible Contraception (LARC) 'Buy and Bill' Model

### > Key Points and Considerations

Long-acting reversible contraceptives (LARCs), including IUDs and implants, are considered highly effective in preventing pregnancy. However, they can be difficult for patients to access because the nature of this contraceptive method requires a provider to obtain a device that can range in cost from \$500-\$1,000. Providers can purchase devices through specialty pharmacies that process reimbursement for the device through a patient's insurance. However, this process can take multiple days or weeks to complete and requires the patient to return for a second visit after the initial contraceptive counseling occurs and a LARC is chosen as their desired method of contraception. This two-visit experience can be burdensome to the patient and may result in them not returning for the insertion at all or becoming pregnant between the first and second visit.

Providers can overcome these barriers by adopting a **"buy and bill"** model. This practice pattern requires providers to order and pay the upfront costs to stock LARC devices in their office. After the provider uses a stocked LARC for a patient, the provider bills the patient's insurance for the device and gets reimbursed accordingly.

*Regardless of a practice's available stock of LARCs in the office, providers should promote patient education and shared decision-making models that include all methods of contraception. Providers should never steer a patient towards a form of contraception because of the up-front cost the office paid for the stocked devices or because it is more convenient for them.*

### Benefits of having an inventory of available LARCs in office:

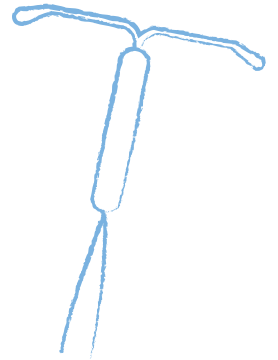
- LARC becomes a more viable option for the patient because same-day insertion is made possible with ready inventory.
- Greater convenience for the patient, as no second visit is required.
- Same-day availability reduces the possibility of an unwanted pregnancy between the initial consult and the insertion of the contraceptive method.

### Challenges of a "buy and bill" model:

- Requires practices/providers to invest in inventory. At a cost of \$500-\$1,000 per device, this can be challenging depending on the size and financial status of the practice.
- Careful inventory control and coding is necessary to ensure reimbursement for devices.
- Potential for inventory waste if ordered numbers of devices are not used before their expiration date, which makes appropriate projection of needs important.

## > Questions to consider when moving to a Buy and Bill Model

1. What data does your practice have to forecast inventory needs based on past service delivery (including provider/patient preferences and coverage by insurers)?
2. Does the office have available space to securely stock LARCs?
3. Which staff will be responsible for managing the ordering and inventory process?
4. What internal approval or financial/operational steps must be in place to use practice capital to order inventory?
5. What, if any, discounts are available to your practice?
  - Bulk purchasing discounts – some brands offer discounts for as few as 5 devices
  - 340B discounts
6. What is the return policy from each manufacturer if stocked devices are not used before their expiration date or are damaged before insertion?



## > Resource

- [ACOG Long-Acting Reversible Contraception \(LARC\) Administrative & Infrastructure Support \(in-office & hospital use\)](#)



## Priority Setting Worksheet for Front Desk Staff

From the first call to schedule an appointment, the intake process on arrival, and everything during and after the visit, front desk staff generate the “culture” and experience a patient will have in accessing reproductive health services. The attitude and knowledge of front office personnel can make a big difference in a patient’s willingness to disclose what services they might be seeking when scheduling an appointment, as well as their likelihood to return for any necessary follow-up appointments. As such, offices should ensure that these essential personnel understand the importance of their role and are provided with training and resources to facilitate high-quality interactions with patients.

### > How to Use this Worksheet

1. Use the information in the NJ-RHAP PACT to facilitate a discussion about opportunities to adjust behavior or implement new strategies to increase access to care.
2. Use a team-based care approach to identify opportunities that front desk and related office staff can play in making these ideas successful.
3. Based on those goals, identify priorities for each patient interaction for front desk staff. Document those priorities on page 2 of this resource.
4. Use role playing and other interactive methods to practice implementing these strategies, increase staff comfort with them, and demonstrate the effectiveness they can have on the patient experience.

### Sample Priorities

1. Provide all patients with a package of comprehensive educational materials to be sent to them in advance of their visit (either by mail, email, or patient portal).
2. If a patient is new or seeing a new provider, share some information about the provider – such as how long they have been with the practice or a specialty they have.
3. Provide patients with a pen and paper while they are waiting for their appointment to jot down questions they may have for the provider.
4. When scheduling appointments, remind or inform patients of things like unique parking situations, or where in the building complex the office is located.
5. Avoid making assumptions about patients, such as their sexual orientation, and using gendered terms, such as pronouns, unnecessarily.
6. Ask questions in a way that does not imply a certain answer is correct or expected, such as “Will you be using insurance for this visit?” rather than “What is your insurance?”

*\*Note, these priorities should be created in collaboration with front-desk staff and should avoid additional significant administrative burden– as that will decrease the likelihood they are adhered to. These should be revisited on an ongoing basis, as well as when new staff members are onboarded or when there are policy or procedure changes in the office.*

# 5 PRIORITIES FOR EACH PATIENT INTERACTION: WORKSHEET

Date Completed: \_\_\_\_\_

1.
2.
3.
4.
5.



## 5 Steps to Increase Same-Day Access to LARC

If your office or health system is interested in increasing same-day access to long-acting reversible contraception (LARC), consider these 5 steps to guide your work.

### > Step 1

Solicit input from internal staff (finance, pharmacy, operations, etc.), and external contacts (pharmaceutical representatives and insurers) to identify barriers to provision of same-day LARC and initiatives that could be undertaken collaboratively to make this model successful.

- Discuss the concerns – both clinical and operational – that prevent implementation.
- Identify areas for improvement and possible discounts or processes that can help support implementation.
- Get necessary approval to begin or expand upfront purchasing of LARC.

### > Step 2

Analyze billing data to understand how many LARCs are used quarterly and how long it takes manufacturers to supply product once ordered.

- Based on these figures, determine how many of each type of IUD and how many implants are needed for a typical month of services.

### > Step 3

Coordinate with necessary finance and operations staff and sales representatives to order appropriate stock of LARC for office and to store boxes in an accessible location upon delivery.

- Due to the high cost of these devices, some practices will choose to keep their supply locked.
- Ensure that all the devices are well-labeled so that staff do not inadvertently open the wrong product.

### > Step 4

Modify office scheduling to accommodate this change in patient flow and provide links to materials for patients to review prior to appointment to prepare them for contraceptive counseling and potential LARC insertion.

- For example, a schedule might begin with a patient meeting a provider for counseling and, once shared decision-making has occurred and the patient has chosen a LARC, signing of consent forms and a urine pregnancy test (if needed) are completed. While patient provides sample and changes for appointment, staff can prepare procedure room and perform pregnancy test and the provider can complete a shorter patient visit before the insertion.

### > Step 5

Develop a spreadsheet to monitor LARC utilization over time and project future stocking needs. Document challenges with same-day visit model to be addressed with key staff. Use these tools and input from staff to complete process improvement measures. Questions to consider might include:

- What questions do providers and patients have about the process?
- What strategies are in place to increase access while keeping patient choice and education at the center of care?
- What quality and fiscal impact can be seen from implementation?





## Community Engagement Worksheet

When providers and organizations engage beyond their typical environment and more within their community, they can develop a true partnership, create greater trust, improve patient satisfaction, and promote better organizational decision-making that reflects community needs. Community engagement can range from single information gathering conversations to more formal focus groups with community members. Maintaining substantive, ongoing relationships is essential in building trust and being responsive to changing needs and priorities.

*\*Note authentic community engagement is much more than extending an invitation to participate in an event or sit on a board. Program organizers must work to create space for diverse viewpoints and promote active engagement with community members who are willing to participate in these activities. They also must move beyond listening to active response and incorporation of issues/ideas brought by the community.*

### > Step 1

Fill out the table below to use as pillars of engagement planning. In identifying these priorities, consider the following questions:

- What would successful community engagement look like for our practice?
- What resources and staff skills can the practice leverage for community-related activities?
- What related efforts have been successful or challenging in the past?

#### OFFICE PRIORITIES FOR COMMUNITY ENGAGEMENT

1.

2.

3.

4.

5.

### > Step 2

Complete the Community Engagement Planning Document (on the back of this page) to identify activities specific to reproductive health access.

# Community Engagement Planning Document

Date Completed: \_\_\_\_\_

**ACTIVITY/EVENT/ENGAGEMENT:**

**GOAL:**

**STAFF LEAD(S):**

**MATERIALS/RESOURCES NEEDED:**

**FOLLOW-UPS:**

**ACTIVITY/EVENT/ENGAGEMENT:**

**GOAL:**

**STAFF LEAD(S):**

**MATERIALS/RESOURCES NEEDED:**

**FOLLOW-UPS:**

**ACTIVITY/EVENT/ENGAGEMENT:**

**GOAL:**

**STAFF LEAD(S):**

**MATERIALS/RESOURCES NEEDED:**

**FOLLOW-UPS:**

**ACTIVITY/EVENT/ENGAGEMENT:**

**GOAL:**

**STAFF LEAD(S):**

**MATERIALS/RESOURCES NEEDED:**

**FOLLOW-UPS:**



# NJ-RHAP Provider Access Commitment Pledge

*NJ-RHAP is a statewide initiative created to expand access to the full range of contraceptive options available. The goal of NJ-RHAP is to reduce the policy and payment system barriers that prevent individuals from accessing the contraceptive method(s) they most desire through provider education efforts. The NJ-RHAP Provider Access Commitment Toolkit (NJ-RHAP PACT) is a comprehensive resource for providers (clinical and administrative) on policies, procedures, and best practices for the provision of reproductive health services in New Jersey.*

***We encourage you to sign this pledge and commit to advancing access to comprehensive, high-quality, and patient-centered reproductive health care in New Jersey. Signing the NJ-RHAP PACT Pledge means that you support and will promote these concepts in your own office setting.***

**1) Understand and Utilize a Reproductive Justice Lens:** I commit to placing an individual's personal bodily autonomy and self-determination at the center of decision-making in all my interactions with patients. I recognize the role that power dynamics and privilege can have within these interactions and will therefore keep the concept of the patient as an expert in their own experience at the forefront. I understand the negative impact that the history of reproductive coercion has had and continues to have on patient experiences and understand the need to prioritize respectful care.

**2) Commit to Comprehensive Contraceptive Counseling:** I will prioritize comprehensive, patient-centered, and culturally informed contraceptive counseling as an essential component of the provision of contraceptives. I will promote scheduling models that permit sufficient time for comprehensive contraceptive counseling and will utilize a shared decision-making approach to support patients in selecting the contraceptive method of their choice.

**3) Support a Team Approach:** I will commit to including all members of a care team in the delivery of reproductive health care. I acknowledge that a team approach, with all members working together on shared goals, will optimize care. I will encourage strategies that support this approach, such as consistent and clear communication, team meetings, well defined roles, and encouragement of feedback.

**4) Obtain Further Education and Training:** I will seek out opportunities to fill gaps in my knowledge about reproductive health, specifically those focused on areas where I lack expertise or that can support my practice and patients. I will stay current on clinical best practices and methods of contraception so I can provide comprehensive services to my patients.





# NJ-RHAP Provider Access Commitment Pledge

**5) Learn About Insurance Coverage:** I commit to increasing my understanding of health care coverage in New Jersey, including free or low-cost services, and the coverage of contraceptive care for various insurers. I will do my best to provide detailed information to patients about potential out-of-pocket costs to help inform their decision-making.

**6) Address Billing, Coding and Reimbursement Issues:** I will prioritize efficient and effective coding practices that reflect the full scope of services provided to ensure accurate and swift reimbursement of services. In doing so, I will reduce the staff time needed to correct coding errors and will decrease the likelihood that patients face unnecessary costs.

**7) Tackle Stocking Challenges:** I will be open and engaged in conversations about how to increase access to the full range of contraceptive options within my practice, including opportunities that reduce the need for patients to return to the office or pharmacy for additional visits to receive the contraceptive method of their choice.

**8) Value Community Engagement:** I recognize the important role that community members bring to improving policies, procedures, and programing. I will engage community members in my efforts to provide education about reproductive health services, seek their input on key decisions, and support community-based efforts that promote shared goals.

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***What's Next?*** *Print this pledge and hang it somewhere you will see every day and in a place that can spark conversation with others about reproductive health access.*

For additional resources, as well as the full New Jersey Reproductive Health Access Project Provider Access Commitment Toolkit (NJ-RHAP PACT), please visit: [bit.ly/QIResourcesNJRHAP](https://bit.ly/QIResourcesNJRHAP) or the Quality Institute website: [njhcqi.org](https://njhcqi.org).

