

EXECUTIVE SUMMARY:

New Jersey Health Care Quality Institute Contraceptive Access Findings Document

Introduction

The New Jersey Health Care Quality Institute's (Quality Institute) Medicaid Policy Center (MPC) initiated research and formed a multi-stakeholder work group to assist in creating a findings document covering the significant access barriers to long-acting reversible contraceptives (LARCs) for all individuals in New Jersey, particularly those who rely on Medicaid. The committee was convened to provide a better understanding of the policy, payment, and operational components that contribute to this issue.

The New Jersey Health Care Quality Institute Contraceptive Access Findings Document (Findings Document) presents an overview of contraceptive policy and access to contraceptive services in New Jersey, with a focus on access to and use of LARCs.

Since the completion of this document, the Quality Institute has expanded its portfolio of work on this topic, with a focus on strategies to support providers, health systems, and the state in improving access to reproductive health services in a patient-centered manner through its New Jersey Reproductive Health Access Project (NJ-RHAP). NJ-RHAP is supported by Arnold Ventures. In June 2020, the Quality Institute released the NJ-RHAP Provider Access Commitment Toolkit (NJ-RHAP PACT) which is a set of resources for providers aimed at increasing access to the full range of contraceptive methods. For more information about NJ-RHAP and the toolkit, please visit: bit.ly/QIResourcesNJRHAP.

Note about Data and Research: *Research for the Findings Document was conducted in late 2018 and the document was finalized in January 2019. While some data points may have changed since this original research and analysis, the overall focus remains salient. This executive summary includes updates on key state level policy changes made since the completion of the original report. Readers should be aware that there may be more recent data available to evaluate state and federal measurement of contraceptive use.*

Note about LARCs: *For the purpose of this report, unless noted otherwise, LARCs are methods of contraception that include intrauterine devices (IUDs) and subdermal implants. LARCs are considered to be highly effective forms of birth control because they are not dependent on compliance with a pill-taking regimen, remembering to change a patch or ring, or coming back to the provider for an injection. Due to the cost and nature of this method that requires provider intervention, consumers can face additional barriers to accessing LARCs than they might for other methods. Reducing barriers to accessing all forms of contraception and promoting comprehensive contraceptive counseling is essential to providing high-quality patient-centered reproductive health care.*

Unintended Pregnancy, Teen Births and the Impact on Birth Outcomes:

Births resulting from unintended or closely spaced pregnancies dramatically impact public health outcomes, such as delayed prenatal care, premature birth, low birthweight and negative physical and mental health effects for children. In New Jersey, the extent of the problem of unintended pregnancy and the concomitant adverse health effects on both mothers and infants are significant.

- Unintended pregnancy and poor maternal and infant health outcomes are increasingly concentrated among poor and low-income women.
 - The Black infant mortality rate in the state is three times higher than the rate for White infants.
 - The rates of low birth weight for Black infants is double the rate for White infants.
- Poor health outcomes are part of the reason why unintended pregnancies have a high financial cost.
 - A Brookings Institute 2011 report estimates that unintended pregnancies cost about \$12 billion annually as publicly financed medical care; and about half of that cost could be saved if unintended pregnancies were prevented.
 - In New Jersey in 2010, more than half (52.4%) of unplanned births were publicly funded and the state spent \$477.1 million on unintended pregnancies (\$186.1 million paid by the state and \$291 million with federal funds).
- 2017 data from the Guttmacher Institute indicates that 70-74% of individuals between the age of 18-49 are at risk of an unplanned pregnancy and are using some form of contraceptive. However, the contraceptive method used has a powerful impact on its effectiveness in preventing pregnancy.
 - Data from 2017 shows that in New Jersey, 27% of individuals are using the least effective contraceptives and 17.8% are using only moderately effective contraceptives.

**Research and conversations with stakeholders continuously reinforce the fact that providing consumers with information about the full range of contraceptive options allows them to make decisions about what is best for them and that the best contraceptive method is the one that is used.*

- While New Jersey's rate of teen births is lower than the national average, some geographic regions and race/ethnic groups show significantly higher rates of teen births.
 - There are 15 teen births per 1,000 individuals between the ages of 15-19 in New Jersey, compared to 27 nationally.
 - Variation for teen birth rates exists by both race and county.
 - Teen births for different racial/ethnic groups in New Jersey range from 2 to 34 per 1,000.
 - The New Jersey teen birth rate among Hispanic and Black teens is 11 and 19 times higher, respectively, than the rate among Whites teens.

State and Federal Policy for Contraceptives:

Coverage: Both federal and New Jersey state laws and regulations mandate coverage of female contraception. Federal regulations include contraception in the list of preventive services provided without consumer co-payment. All plans sold on the Individual Marketplace must cover, in-network and without co-payment, at least one form of contraception. However, not all plans are subject to state and federal mandates for contraceptive coverage.

New Jersey Medicaid: Family planning is a mandatory Medicaid benefit per federal regulations. New Jersey Medicaid regulations prohibit preauthorization or co-pays for family planning services. The federal government pays 90% of the cost of Medicaid family planning services and products.

Title X: Title X is the only federal grant program dedicated solely to providing low-income families and uninsured individuals with comprehensive family planning and related preventive health services. To promote positive birth outcomes and healthy families, Title X provides low-income families and uninsured individuals with comprehensive family planning services. In 2018, 45 clinics in New Jersey received support from Title X.

Updates: Since the completion of this Findings Document, the following updates have been made to support increased access to contraceptive services in New Jersey:

- New Jersey Medicaid launched the Plan First Program in 2019. This limited benefit program provides family planning services to eligible New Jersey residents earning between 139%-205% of the federal poverty level (FPL).
- The federal government implemented a rule prohibiting those receiving Title X funding from discussing abortion or referring consumers to abortion services (also known as the “gag rule”).
 - As a response to this, Planned Parenthood, withdrew from Title X funding in August 2019.
 - In January 2020, New Jersey provided \$9.5 million in state funding for Planned Parenthood and other health centers to replace money lost from refusing to comply with the 2019 federal rule.
- As of mid-2019, two additional quality measures were added to the Core Measures Set for Medicaid Managed Care Organizations to support access and quality of contraceptive services
 - CCP: Contraceptive Care – Postpartum Women
 - CCW: Contraceptive Care- All Women
- Rates of unintended pregnancy in New Jersey and nationally have reduced over the past few years. In 2019 25.3% of pregnancy in the state were unintended.¹

Contraceptive Use:

Much of the information cited below was gathered from a variety of sources. Stakeholders agree that having one central place to consult for all state and federal laws, regulations, and policy would

¹ https://powertodecide.org/sites/default/files/2020-04/State%20Factsheet_New%20Jersey.pdf

be helpful. Confusion and conflicting understanding about prior authorization, reimbursement, co-pays, and other restrictions seem to be prevalent among stakeholders, consumers, and providers.

National Data: In the US, between 2008 and 2014, the three most common contraceptive methods have remained the pill, female sterilization and the condom. Growth in the use of IUDs replaced male sterilization as the fourth most common method in 2014. Use of the implant, although rising, remains far below that of IUDs.

New Jersey Data: There is little publicly available state and local data on contraceptive use.

- Compared to other states, the use of “most effective methods” in New Jersey is low. For example:
 - In 2016, 13% of Title X clients were using “most effective methods”; only six other states showed lower use of most effective methods than New Jersey.
 - In 2013, only 2% of Title X teen clients were using LARCs; only three other states showed lower teen use of LARCs.
- LARC use among Medicaid beneficiaries mirror use among Title X clients. Between 2015 and 2017, only about 1% of all female Medicaid beneficiaries were using LARCs.

Note about information gaps: Detailed data on patterns of contraceptive use in New Jersey, including LARC use, is needed. There is no publicly available detailed data on LARC access or its use by non-Medicaid beneficiaries, which is necessary to understand access issues and promote improvements across the state.

LARCs: Delivery, Billing and Payment

The process for providers to stock LARCs and be reimbursed for both the devices and the insertion/removal procedures can be very complicated. These challenges often result in delays and barriers for both the provider and the consumer. For example:

- **Reimbursement confusion:** There are numerous billing codes for family planning services. And in the case of LARCs, there are different codes for each encounter including the device, insertion, removal, and for removal and reinsertion in one visit – creating confusing and increased room for error when coding for these services.
- **Billing for Counseling:** Counseling may or may not be covered as a separate service depending on the payer.
- **Inventory for Same Day Access:** Few providers keep a ready stock of LARCs because up-front costs are prohibitive (up to \$1,000 per product). Typically, LARCs are ordered only after an individual chooses that option and the need to return for a second appointment greatly diminishes the likelihood of LARC usage.

¹ https://powertodecide.org/sites/default/files/2020-04/State%20Factsheet_New%20Jersey.pdf

Barriers to Contraceptive Access in New Jersey

The Quality Institute engaged stakeholders in a series of workgroup meetings in 2018 and conducted additional research to identify barriers to contraceptive access in New Jersey. These barriers included:

- **Informed Consent and Ethical Considerations:** Past abuses with minority populations included coercion toward sterilization and unwanted birth control. As a result of this history, justified mistrust and fear of contraceptive access campaigns among certain minority populations can present additional barriers to accessing services.
- **Requirements for Sterile Procedures:** Insertions and removals of LARCs may trigger certain regulatory requirements which can create burdensome licensing and regulatory barriers for some settings, such as Federally Qualified Health Centers (FQHCs).
- **Postpartum LARC Insertion:** Despite the American College of Obstetricians and Gynecologists (ACOG) support for immediate postpartum LARC use, operational details are needed to provide this service on labor and delivery floors. Remaining hesitancy among some providers about the procedure continues to present barriers to access.
- **Catholic Hospitals:** Postpartum LARC insertion may not be an option for individuals delivering in a Catholic hospital, as many of these facilities have policies that prevent this service.
- **Same-Day Insertion Barriers:** Costs inhibit practices from stocking LARCs, thereby reducing availability for same-day insertions, which in turn reduces the method's uptake.
- **Preauthorization:** Consumers and providers express confusion about the need for preauthorization for LARCs, creating a stumbling block to convenient and timely access.
- **Providers:** Inadequate education and/or misconceptions about LARCs, lack of expertise in insertion/removals, cultural competency for select populations, and reimbursement policies present barriers to service delivery and reduces access for consumers.
- **Consumers:** Limited understanding of contraceptive options, fear of side effects, confusion about coverage and cost, and lack of culturally and clinically experienced providers are some consumer concerns that result in reduced access and utilization of services.

Best Practices to Increase Contraceptive Access

Community Needs Assessment:

- Increase understanding of community needs, access, and barriers to comprehensive reproductive health education and services
- Implement strategies to increase access to contraception that are based on a thorough up-to-date understanding of a community's identified needs

Payment and Billing:

- Leverage CMS guidance on use of LARC in Medicaid programs

- Promote the use of highly effective contraceptive methods through enhanced reimbursement policies
- Address the barrier of high up-front costs of LARCs
- Regardless of payer, eliminate co-pays or pre-authorizations for any contraceptive method
- Regardless of payer, extend oral contraceptives supply to 12 months at a time

Provider Opportunities:

- Educate and train providers on all methods, including LARC insertions/removals
- Educate all providers on effective contraceptive counseling
- Leverage extensive community partnerships to reach broader populations

Public Education:

- Use multi-lingual and culturally sensitive messaging to include all contraceptive methods
- Educate in a patient-centered way to increase engagement
- Target community needs and use local influencers to increase impact

Conclusion:

While the results of this report highlight challenges that patients and providers face in accessing these essential health care services, it is important to acknowledge that this added understanding is a necessary first step towards making much needed improvements. Using the information gathered in this document, we can not only move towards increased access to patient-centered comprehensive reproductive health services in New Jersey but can do so in the most impactful and efficient manner.

This work was initiated as part of the [New Jersey Health Care Quality Institute's](#) (Quality Institute) [Medicaid Policy Center](#) (MPC). The MPC is supported by a grant from [The Nicholson Foundation](#). The MPC delivers independent research, analysis and policy solutions to improve health outcomes while also controlling costs — and works in partnership with other organizations and the state government agencies that operate the New Jersey Medicaid program.

¹ https://powertodecide.org/sites/default/files/2020-04/State%20Factsheet_New%20Jersey.pdf

New Jersey Health Care Quality Institute Contraceptive Access Project

A Report to The Nicholson Foundation to Evaluate Current Access to Long Acting Reversible Contraceptives, Identify Barriers and Find Best Practices for All Women for their Choices of Care

Findings Document

*This project was made possible by generous funding from
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Introduction

This paper is intended to capture an overview of the status of access and use of long-acting reversible contraceptives (LARCs) in New Jersey today. The New Jersey Health Care Quality Institute initially embarked on this research out of a need to clarify the issues raised through its work on the Medicaid 2.0 project and release of the Blueprint. Over the course of 18 months, stakeholders involved in the manufacture, delivery, payment and provision of LARCs convened to identify issues and discuss solutions. The Quality Institute supplemented the information gathered at these meetings with additional literature review as well as interviews of experts in other states. This Findings Document captures essential information to establish a base for future work needed to improve access for all New Jersey women to contraceptives, but LARCs in particular.

For the purpose of this report, unless noted otherwise, LARCs are a method of contraception that include intrauterine devices (IUDs) and subdermal implants.¹ IUDs are small, t-shaped, plastic devices inserted into the uterus that come in two forms: (1) a hormonal IUD that releases progesterone and (2) a copper IUD that does not contain hormones. IUDs can remain in place from three to six years for the hormonal type and up to 10 years for non-hormonal versions.² An implant is a short, thin rod about the size of a matchstick that is placed under the skin of a woman's upper arm. It releases hormones to prevent pregnancy for up to four years, or until removed. The medical procedures used for both forms of LARC require a licensed clinician to insert or remove the implant or IUD. LARCS can be implanted/inserted immediately after birth at the hospital or the procedure can be done in a physician's office or licensed ambulatory care facility.

LARC methods are cited as superior forms of birth control³ because they are “forgettable”; their effectiveness is better assured because it is not dependent on compliance with a pill-taking regimen, remembering to change a patch or ring, or coming back to the clinician for an injection.⁴ Inserted once, women are relieved of the daily responsibility of using birth control. And LARCs can be removed any time a woman wants to be open to conceiving. Postpartum insertion of LARCs can also play an important role in avoiding unintended pregnancy in the period immediately after giving birth.⁵

Safer and more effective, LARCs have been shown to reduce unintended pregnancies and help prevent insufficient birth spacing, thereby reducing negative health outcomes for women and infants. Improving access to effective birth control not only avoids unwanted pregnancies but also helps women to properly space pregnancies, which improves the health of both mother and child. Women should have access to a range of low to no cost options for birth control to meet their personal and health goals. LARC is an attractive option for many as it eliminates the need for daily compliance.

Unintended pregnancy, Teen Births and the Impact on Birth Outcomes

Unintended pregnancy is defined as a pregnancy that is either unwanted or mistimed. It can occur even though a woman used a contraceptive method or when a woman did not desire to become pregnant and did not use any method. According to the Guttmacher Institute, in 2011, 45 percent of all pregnancies in the United States were unintended.⁶ Unintended pregnancy has become increasingly concentrated among poor and low-income women.⁷ Births resulting from unintended or closely spaced pregnancies have a dramatic impact on public health. Some of the identified adverse maternal and child health outcomes are delayed prenatal care, premature birth, and negative physical and mental health effects for children.⁸ And the effect goes beyond the individual, affecting the entire community. Unintended pregnancy is associated with reduced levels of high school completion and lower labor-force participation.⁹ The public health impact of unintended pregnancy is so compelling that the US Department of Health and Human Services' Healthy People 2020 campaign established 16 objectives around family planning. The campaign focus ranges from the overall goal of increasing pregnancy intendedness to specific interventions including significant increases in the use of the most effective and moderately effective methods of contraception, which includes LARCs.¹⁰

In New Jersey, the extent of the problem of unintended pregnancy and the concomitant adverse health effects on both mother and infant is even greater than the national average. The 2010 Guttmacher Institute findings showed 97,000 New Jersey residents experienced an unintended pregnancy (a rate of 53 unintended pregnancies per 1,000 women aged 15-44 compared to 45 per 1,000 women nationally).¹¹ More recent 2017 data from Guttmacher indicate that 70-74 percent of women age 18-49 at risk of an unplanned pregnancy are using some form of contraceptive.¹² However, the type of contraceptive used has a powerful impact on its effectiveness in preventing pregnancy. The 2017 data show that in New Jersey, 27 percent are using the least effective contraceptives and 17.8 percent are using only moderately effective contraceptives.¹³ Ensuring that women are provided with information about the full range of contraceptive options allows them to make decisions about what is best for them. The best contraceptive method is one that is used.

While New Jersey's rate of teen births is lower than the national average, some geographic regions and race/ethnic groups show significantly high rates of teen birth. According to the 2018 State Health Assessment, there are 15 teen births per 1,000 female population ages 15-19 in New Jersey, compared to 27 nationally.¹⁴ New Jersey ranks 4 out of 50 in the teen birth rate and 18 out of 50 in the teen pregnancy rate.¹⁵ Wide variation for teen birth rates exist by both race and county. Teen births for racial/ethnic groups in New Jersey range from 2 to 34 per 1,000.¹⁶ For example Cumberland County's teen birth rate is three times the state average, at 44 births per 1,000 teens.¹⁷ There is still significant room for improvement. (See Appendix A for more details about pregnancy intention and teen birth rates.)

These rates have a negative impact in New Jersey on maternal health measures closely linked to unintended pregnancy: preterm delivery, premature rupture of membranes and low birthweight.¹⁸ New Jersey's Healthy 2020 interactive website shows a lack of progress on the State's goals to reduce the number of low birth weight babies.¹⁹ And racial disparities show a bleak picture for maternal and infant health as shown in the 2018 State Health Assessment: "The Black infant mortality rate is three times the White infant mortality rate...The low birth weight rate for Blacks is double that of Whites. The teen (ages 15-17 years old) birth rate among Hispanics is 11 times and among Blacks 19 times

the rate among Whites.”²⁰ This finding has led the First Lady, Tammy Murphy, to prioritize closing these gaps.

Poor health outcomes are part of the reason that unintended pregnancies have a high financial cost. The Brookings Institute estimates that unintended pregnancies cost about \$12 billion annually as publicly financed medical care; and about half of that cost could be saved if unintended pregnancies were prevented.²¹ In New Jersey in 2010, more than half (52.4 percent) of unplanned births were publicly funded and the State spent \$477.1 million on unintended pregnancies (\$186.1 million paid by the State and \$291 million with federal funds).²²

State and federal policy relating to provision, payment, and coverage for Contraceptives, with a specific focus on Long-Acting Reversible Contraceptives (LARCs).

Federal Policy

Regulations promulgated in the wake of the Affordable Care Act include female contraception in the list of preventive services provided without patient co-payment. Plans offered in the Marketplace 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.²³

This policy has been narrowed by recent actions of President Trump’s administration. In October 2017, his administration issued a narrowing of mandated coverage by allowing insurers and employers to refuse to provide contraception if it went against their religious or moral beliefs.²⁴ These new rules go into effect on January 14, 2019, unless injunctions sought by several states, including New Jersey, are granted by the courts.

Family planning is a mandatory benefit under Medicaid. 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.²⁵ New Jersey has construed the definition broadly including contraception services and products and the State prohibits preauthorization in Medicaid. (See State section below). The federal government provides 90 percent of the cost of Medicaid family planning services and products.

Under President Trump’s administration, additional federal funding of contraceptive services has been under attack. Title X is the only federal grant program dedicated solely to providing low-

income families and uninsured individuals with comprehensive 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. Recent administrative actions to the Title X program are creating potential barriers to access contraceptive methods and services. In February 2018, HHS released a revised Funding Opportunity Announcement (FOA) for Title X Family Planning grants that stressed natural family planning strategies to prevent pregnancy without contraceptives and promoted the “benefits of avoiding sexual risk or returning to a sexually risk-free status.”²⁶ Although the original announcement failed to mention contraception (a benchmark of the Title X program), the final announcement did specifically require any entity hoping to receive Title X grants to offer “hormonal methods”²⁷. Another concern was raised when HHS proposed new regulations that would overhaul Title X by requiring more frequent funding requests (annually, rather than every three years), and made changes which weaken fundamental patient confidentiality protections. Opponents of these changes argue that changing the requirements to access family planning grants under Title X will negatively impact health services provided through Planned Parenthood clinics that serve large portions of lower income women.²⁸ In New Jersey, 45 clinics receive support from Title X [Planned Parenthood clinics (24), federally qualified health centers (10), family planning health centers (10), and health department clinics (1)]²⁹.

Because 73 percent of female contraceptive clients served at New Jersey Title X funded health centers received services at Planned Parenthood³⁰, these changes have the potential to significantly affect access to all forms of contraceptives for many women. See Appendix B for more information on number of women served in family planning centers in New Jersey and for a map of Title X service locations.

State Policy

State policy pertaining to access and payment for contraceptives can be found in several sources: state law, regulations, the state Plan³¹ and the Managed Care Organization (MCO) Contract. The Department of Human Services also uses newsletters to communicate Medicaid policy to providers.³² Based on review of all sources of state policy, the following topics have emerged as important to the analysis of contraceptive access with an emphasis on access to LARCs.

Mandated Benefits for all Insurance

In addition to the federal ACA essential benefits, New Jersey requires health plans sold in the state to cover a set of mandated health benefits.³³ Among those mandated benefits for coverage in New Jersey is “Prescription Female Contraceptive” (NJSA 17B:27-46.1ee. (2005)) The coverage includes “expenses incurred in the purchase of prescription female contraceptives” which are defined as FDA drugs or devices “used for contraception by a female...that can only be purchased in this State with a prescription...and includes, but is not limited to, birth control pills and diaphragms.”³⁴

Funding for Family Planning

Recent activity under the Murphy administration has created a climate that should support efforts to improve maternal health outcomes by reducing unintended pregnancy through better access to family planning services.

- 1) Governor Murphy signed two bills that will increase funding to family planning services:
 - a) Public Law 2018, Chapter 2 allots \$7.5 million to the state Department of Health’s family planning services grant for the fiscal year 2018 budget. This money was a restoration of funding that had been cut in 2010 by Governor Christie.
 - b) Public Law 2018, Chapter 1 extends Medicaid eligibility for family planning services to women who make up to 200 percent³⁵ of the Federal Poverty Level (FPL). Prior to this bill, Medicaid eligibility for family planning services covered only women who made up to 138 percent of the federal poverty level. (Although this bill has been signed into law, as of January 15, 2019, the State Plan Amendment (SPA) is still in the process of being filed. Elements of the SPA are captured below.)
- 2) Governor Murphy also announced changes in Medicaid payment policy that will better support postpartum LARC insertion before a woman is discharged from the hospital after birth. As of July 1, 2018, new Medicaid policy provides “inpatient hospital coverage for LARC immediate postpartum, defined as within ten (10) minutes after delivery, with a patient’s signed consent.”³⁶ Available LARC products currently include Kyleena®, Liletta®, Mirena®, Nexplanon®, ParaGard® and Skyla®. Other states that have adopted a postpartum LARC reimbursement policy see net savings and improved maternal and child health outcomes.³⁷

The State Plan Amendment proposed by the State would allow men and women with income up to 200 percent of FPL to obtain family planning services. The State projects this program would enroll between 31,000 to 55,000 additional people (NJ resident, citizen or qualified alien) over a five-year period. There would be no presumptive eligibility for family planning services, which would include all FDA-approved forms of contraceptives, pregnancy testing, Family Planning counseling, sterilization, as well as HIV and STD screenings. The services would also include family planning related laboratory testing including PAP smears, urine, mammography and Hepatitis B testing. The SPA is in the process of being filed with the Centers for Medicaid and Medicare Services (CMS) for approval.

Medicaid Regulations

Existing New Jersey Medicaid regulations define family planning services to include “medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continued medical supervision, continuity of care, and genetic counseling.”³⁸ Regulations further ensure that family planning services and supplies are a covered benefit, including condoms, contraceptive devices, contraceptive supplies, diaphragms, Depo-Provera Contraception Injection and family planning supplies, such as pregnancy test kits.³⁹ Birth control implants are also a covered product.⁴⁰ Most women are receiving their services through a managed care organization and few are served in a fee-for-service program. Medicaid covered family planning services are also explicitly extended to pregnant women who are either US citizens or have permanent resident status and are at or below 200 percent of the poverty level.⁴¹ This extended coverage follows pregnant women up to 60 days post-partum.

Medicaid coverage in New Jersey includes expanded adolescent family planning services both for individuals under 21 years of age and Federally Qualified Health Centers (FQHCs) and Family Planning Clinics certified by the Department of Health to provide these services.⁴² Coverage

includes “contraception education and counseling.”⁴³ There is, however, no additional reimbursement to FQHCs or Title X family planning providers from Medicaid for counseling services. The counseling is considered to be part of a regularly billed visit.⁴⁴

Stakeholders are concerned that some Medicaid policies that are enforced in practice are not captured in writing or are counter to written policy. For example, a Medicaid newsletter in 2002 indicated that FQHCs and Family Planning Clinics would be paid separately for the intrauterine device (IUD), the insertion, and the office visit. However, after a few years, the State began denying payment, limiting these clinics to billing for either the insertion of a LARC or an office visit, but not both. Because the office visit reimbursement is higher, it appears that it is common practice to only use the “office visit” billing code, and therefore there is no billing for the insertion itself. (It is unclear whether this billing practice would affect accuracy of State data collection of LARC insertions). Practitioners, therefore, are not being paid for the LARC insertion procedure as a separate service. Additionally, the LARC device itself is reimbursed at cost only, and in some cases below Wholesale Acquisition Cost. This unwritten policy since the issuance of the directive in 2002 has been raised again with the Department of Human Services in Spring 2018 for review, but no response has been received to date.

Preauthorization

Preauthorization is precluded for family planning services under the Medicaid State Plan.⁴⁵ And Medicaid regulations do not list any contraceptives in their list of medications requiring prior authorization.⁴⁶ This policy is clearly stated in member handbooks for Aetna Better Health of NJ⁴⁷, AMERIGROUP of New Jersey⁴⁸, and United Healthcare Community Plan⁴⁹, WellCare and Horizon NJ.⁵⁰ For NJ FamilyCare plans C and D, there may be a \$5 per visit charge, unless the visit is for a Pap smear or other “preventive services.” Although LARCs are not specifically mentioned in the handbooks, Horizon NJ Health, United Healthcare Community Plan and WellCare confirmed that pursuant to their MCO provider contracts, they do not require prior authorization for LARCs. Preauthorization is not required for many other preventive or primary care services and is unnecessary for contraceptives.

Medicaid Managed Care Organization (MCO) Contract

Medicaid regulations require MCOs to provide for all Medicaid and NJ FamilyCare Plans A, B, and C enrollees certain services including “family planning services and supplies.”⁵¹ Family planning services from providers outside the MCO contractor's provider network shall not be available to NJ FamilyCare-Plan D enrollees, except for those Plan D enrollees with incomes below 134 percent of the FPL.⁵² Cost sharing is required under certain circumstances for NJ FamilyCare Part C & D enrollees.⁵³

For those enrolled in fee-for-service programs requiring MCO assistance, family planning services and supplies are also covered “when furnished by a non-MCO-participating provider.”⁵⁴

The MCO contract itself does not address contraceptive services specifically but does allow enrollees to access family planning services in multiple settings. Enrollees may use:

“family planning services and supplies from either the Contractor's family planning provider network or from any other qualified Medicaid family planning provider. The

[Division of Medical Assistance and Health Services] DMAHS shall reimburse family planning services provided by non-participating providers based on the Medicaid fee schedule.”⁵⁵

And

“The Contractor shall not deny coverage of family planning services for a covered diagnostic, preventive or treatment service solely on the basis that the diagnosis was made by a non-participating provider.”⁵⁶

It is of note that the tool used to assess patient needs, the Comprehensive Needs Assessment in the Care Management workbook, does not include any questions related to family planning or pregnancy intention.⁵⁷ Without this prompt, it is unclear how an MCO might identify needs for family planning services and products.

Medicaid regulations allow DMAHS to prescribe reporting requirements of each MCO contractor for “Division management, monitoring and evaluation purposes” in certain areas including, “utilization data for family planning services.”⁵⁸ The State, therefore, has the authority to require data collection by MCOs to track LARC usage and identify trends and access issues.

Ambulatory Care Requirements

Ambulatory Care facilities, including FQHCs, are regulated by the Department of Health, while private physician offices are regulated by the Board of Medical Examiners, within the Division of Consumer Affairs, Office of the Attorney General. There has been confusion in facility licensing for some FQHCs who have experienced additional barriers when expanding their license to include LARCs. Certain licensing requirements for LARCs should be reassessed, clarified and applied consistently across settings (FQHCs, family planning clinics and private office settings). Some questions have been raised by certain FQHCs relating to the Association for the Advancement of Medical Instrumentation (AAMI) standards for sterilization⁵⁹ and Department of Community Affairs architectural requirements for sizes of procedure rooms and their proximity to a sterilization room.⁶⁰ The goal of such regulations should be to ensure safety without overburdening facilities in a way that decreases provision of access to all contraceptive methods, including LARCs.

ERISA/Self-Insured Plans

The National Employee Benefit Research Institute found that 59.9 percent of New Jersey employees who have employer-provided insurance are enrolled in self-insured plans.⁶¹ These plans are exempt from the state mandated benefits.⁶² Very large employers typically have self-funded plans. Because the details of these plans are only available to the enrollees, it is not possible to generalize about their coverage for family planning and contraceptives.

Commercial Coverage

There is limited information online from different private commercial plans offered in New Jersey. Horizon Blue Cross Blue Shield of New Jersey provided information that their plans:

- do not require prior authorization for LARC across commercial and Medicaid plans⁶³;
- do provide reimbursement for LARC counseling; and
- do offer an “add on” to their bundled payment for labor and delivery, to pay for post-partum IUD insertions.

Scope of Practice: In New Jersey, under licensing guidelines which allow them to offer primary care services, physicians and nurse-midwives⁶⁴ can insert and remove LARCs. Advanced nurse-practitioners (APN) are also empowered to offer contraceptive services within the scope of primary care and have prescribing authority “in accordance with a written protocol” between the APN and the collaborating physician.⁶⁵ APNs are also allowed to provide “medical services” which include LARC insertions and removal if the supervising physician has delegated the service in writing and it “is within the [APN]’s skills and under supervision.”⁶⁶

Age of Consent: New Jersey law requires parental consent for minors under the age of 18 to receive any type of healthcare. The law is silent as to whether a minor has the power of consent to contraception but does explicitly give minors the power of consent to contraception if she is married, pregnant or has ever been pregnant.⁶⁷ However, these rules do not apply across the board because Title X regulations allow providers to maintain confidentiality for teens with no parental intervention.

NOTE: *Much of the information cited above was gathered from a variety of sources. Stakeholders agree that having one central place to consult for all state and federal laws, regulations, and policy would be helpful. Confusion and conflicting understanding about prior authorization, reimbursement, patient co-pays, and other restrictions seem to be prevalent among some stakeholders and Medicaid beneficiaries.*

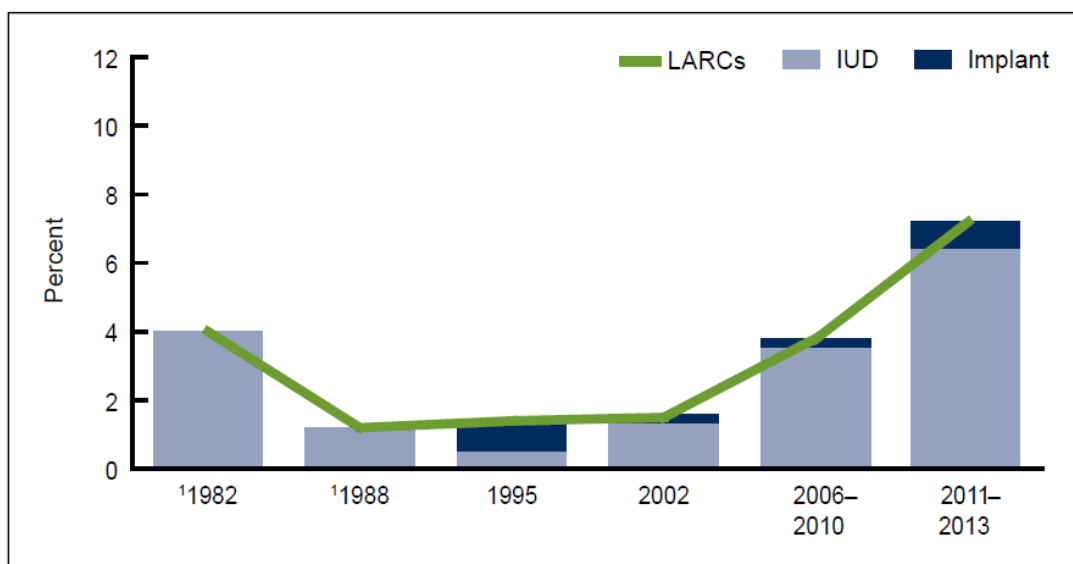
Data Related to Contraceptive Usage and Trends

Use of LARCs Nationally

Between 2008 and 2014, the three most common contraceptive methods in the US have remained the pill, female sterilization and the condom, however growth in use of IUDs supplanted male sterilization as the fourth most common method in 2014.⁶⁸ Use of the implant has also been steadily rising in recent years, although its use overall remains far below that of IUDs.

Cross-sectional data from the National Survey of Family Growth (NSFG) indicate a nearly five-fold increase in the prevalence of LARC use over a 10-year period, from 1.5% of U.S. women in 2002, to 7.2% in 2011-13 (see below chart).⁶⁹ Among the 7.2% of women using LARCs in 2011-13, 89% were using an IUD and 11% were using the implant. Although implant use remained low compared with IUD use over this period, its rate of growth between 2002 and 2011-13 was twice as high as growth in IUD use during this same period (167% versus 83%, respectively).

Figure 1. Trends in current long-acting reversible contraceptive use, by device



¹Implants were not available in 1982 and 1988.

NOTES: Linear decrease from 1982 to 1988 and linear increase from 2002 to 2011–2013 for all LARCs are statistically significant; linear increase in IUD use from 1995 to 2011–2013 is statistically significant. IUD is intrauterine device; LARCs are long-acting reversible contraceptives.

SOURCE: CDC/NCHS, National Survey of Family Growth, 1982, 1988, 1995, 2002, 2006–2010, and 2011–2013.

A separate analysis of NSFG data between 2009 and 2012 provides more detailed information related to recent LARC use over a shorter timeframe.⁷⁰ Key findings indicate that use increased by 36 percent during this period, from 8.5 percent in 2009 to 11.6 percent in 2012. Most of the increase was due to growth in IUD use. The most significant increases were among Hispanic females (from 8.5% to 15.1%), those with private insurance (from 7.1% to 11.1%), those with fewer than two sexual partners in the prior year (9.2% to 12.4%), and those who have never given birth (nulliparous) (2.1% to 5.9%). See Appendix C for a more comprehensive summary of results by demographic characteristics. One other notable finding is that there was no variation in LARC use based on poverty status.

Examination of LARC use among Title X clients provides a similar picture but suggests a steeper increase than what has been documented at the national level, particularly for implants. Between 2006 and 2016, for instance, LARC use among Title X clients increased from 2.5% to 14%, reflecting a four-fold increase in IUD use (from 2% to 8%) and a twelve-fold increase in implant use (from 0.5% to 6%).⁷¹ The overall number of LARC users at Title X clinics during this period grew from 112,500 to 500,000.

Of note, the rising use of both IUD and the implant have not paralleled a decrease in non-use of contraception, indicating that most of this increase can be attributed to women who were already contraceptive users or changing methods. The increase in LARC use also parallels a decrease in sterilization. For the most part, women are changing method type within the group of most or moderately effective methods and not shifting from less effective to more effective methods, with the notable exception of the increase in withdrawal during this period.⁷²

Yet even with rising use, the prevalence of LARCs in the U.S. is still considerably lower than in other developed countries such as France, where LARC use totals about one-quarter of all females of reproductive age.⁷³

Demographic characteristics of LARC clients

The characteristics associated with the highest prevalence of LARC use in recent years are: ages 25-34, women with one or more prior births, and Latina or white, non-Hispanic ethnicity. NSFG data from 2011-2013 indicate that use of LARCs among women aged 25-34 was double that of women aged 15-24 and aged 35-44 (11.1% versus 5.0% and 5.3%, respectively); it was three times as high among women who have had a prior birth (parous) as compared with nulliparous women (11.0% versus 2.8%); and it was highest among Latina women, followed by white, non-Hispanic women, and lowest among black, non-Hispanic women.⁷⁴

Use among teens

The proportion of women at risk of unintended pregnancy who are not using a method is highest among women aged 15-19 (18%) and lowest among women aged 40-44 (9%).⁷⁵ This supports the public health perspective that teenagers should have access to the most appropriate and effective contraceptive counseling and methods for pregnancy prevention. LARCs have been identified by ACOG, CDC and WHO as an appropriate, effective and acceptable method for the prevention of unintended pregnancy among adolescents and young people.

While pills and injectables remain the preferred methods among females under the age of 20, there has been a sharp rise in LARC use among this age group in recent years, at least among Title X clients. For example, of teens aged 15-19 who received contraceptive services at Title X sites, LARC use increased from 0.4 percent in 2005 to 7.1 percent in 2013 (implant use totaled 4.3% and IUD use totaled 2.8%).⁷⁶ There was wide variation in teen use of LARCs across states, however, ranging from 25.8 percent in Colorado to 0.7 percent in Mississippi (see Appendix D).

Disaggregation of LARC use by method and age group suggests that many young females prefer implants over IUDs. In 2016, for example, the prevalence of LARC use among those 15-17 years old at Title X clinics was 9 percent for implants and 3 percent for IUDs; among those 18-19 years old, 8 percent were using implants and 5 percent were using IUDs.⁷⁷

Use of LARCs in New Jersey

There is very little publicly available data on the use of contraception at the state and local level – and especially on the use of LARCs. This section pieces together information from disparate sources such as public health organizations and published articles, most of which used information collected by the Department of Health and Human Services (HHS) among Title X grant recipients. Title X grant funds often complement Medicaid coverage for contraceptive services: they support client outreach efforts and infrastructure improvements related to provision of contraceptive services, as well as service coverage for some individuals who do not qualify for Medicaid, including undocumented immigrants and those with income up to 250% of poverty.⁷⁸ To supplement this information, state-level Medicaid data were obtained through an Open Public Records Act (OPRA) request of billing and service data on the use of LARCs and other contraceptive methods between 2015 and 2017. While the data provided valuable information

about patterns of recent LARC use in New Jersey, they were not provided in a format to assess annual trends in use during this period.

LARC Use by Title X Clients

A recent study that examined state-level changes in LARC use among Title X clients between 2012 and 2016 found that national increases in LARC use have not been experienced uniformly across states.⁷⁹ The study also found that observed increases in LARC use among states with the highest need for publicly funded services are much lower than among states with the lowest need.

In comparison with other states, the use of “most effective methods” in New Jersey is notably low. In 2016, for instance, 13 percent of Title X clients were using “most effective methods” (this category included female and male sterilization as well as LARC methods).⁸⁰ In that same year, there were only six other states in the country for which use of “most effective methods” among Title X clients was lower than in New Jersey.⁸¹

Looking specifically at LARC use among females aged 15-19, New Jersey ranks low compared with other states. For instance, in 2013 just 2.1 percent of Title X clients in this age group in New Jersey were using LARCs. There were only three states in the nation with lower use of LARCs among Title X clients aged 15-19 that year: West Virginia, Indiana and Mississippi (see Appendix D).⁸²

Title X providers in NJ have seen some increases in LARC use over the past three years.

	2015		2016		2017	
Percentage of women aged 15-44 years at risk of unintended pregnancy that adopt or continue use of an FDA-approved, long-acting reversible method of contraception (LARC), i.e., implants, intrauterine devices or systems (IUD/IUS).	15-44	7.7	15-44	11.2	15-44	13.1
	15-19	2.7	15-19	5.9	15-19	7.4
	20-44	8.5	20-44	12.1	20-44	13.9

LARC Utilization Among Medicaid Beneficiaries in New Jersey: 2015 - 2017

State-level data on recent LARC use among Medicaid beneficiaries mirror findings on use among Title X clients. In both cases, use of LARCs is considerably lower than prevalence nationally. For instance, between 2015 and 2017, about 1 percent of all female Medicaid beneficiaries aged 15-54 were using LARCs, as compared to 7 percent of women nationally in 2011-13.^{83,84} In New Jersey, the majority (81%) of Medicaid LARC beneficiaries are using IUDs. While this is consistent with the general pattern of LARC use in most settings nationwide, it is worth noting that implant use among Medicaid beneficiaries in New Jersey appears to be slightly higher than use elsewhere: 19 percent versus 11 percent, respectively.⁸⁵

Needs and Use by County

When analyzing use of contraception across counties, an important factor to consider is access to the services, including financial access. Need of publicly-funded contraceptive services are an important measure of access. See Appendix E for a summary of the percentage of women in need of publicly funded contraceptive services, broken down by age group and poverty status. The five counties with the greatest percentage of women in need of contraceptive assistance are Union, Hudson, Bergen, Essex and Passaic. Not surprisingly, some of these same counties have the lowest

prevalence of contraceptive use in the state, as evidenced by the Medicaid data provided by the State through the OPRA request.

Initial analysis of the Medicaid data indicates that among all female Medicaid beneficiaries aged 15-54 in New Jersey, the use of any method of contraception was highest, at just under 20 percent, in Hunterdon and Salem counties; and lowest, at around 10 percent, in Bergen, Essex, Mercer, Middlesex and Union counties. County-level differences in the use of LARCs and other reversible contraceptives among Medicaid beneficiaries are presented in Appendix F. Between 2015 and 2017, the prevalence of LARC use among all female Medicaid beneficiaries aged 15-54 was highest (2.7%) in Hunterdon County and lowest (0.4%) in Essex County. At the same time, while there are relative differences in use of LARCs and other contraceptives across New Jersey counties, the absolute differences are small, and all counties show an opportunity for improvement.

Use by Age and Race or Ethnicity

Contraceptive use among female Medicaid beneficiaries aged 15-54 in New Jersey are broken down by age group in Appendix G and by ethnic group in Appendix H. While the demographic differences in state-level use of LARCs are similar to the national trends, overall prevalence remains low across all demographic groups in New Jersey—including for age and race or ethnicity—as compared to prevalence nationally. For instance, use of LARCs was highest (1.6%) among female Medicaid beneficiaries ages 18-<35 and lowest (0.3%) among beneficiaries ages 15-18 years. When broken down by race or ethnicity, LARC use was highest (1.3%) among Latinas/Hispanics and lowest (.6%) among Black women.

Research and information gaps

Detailed annual information on patterns of contraceptive use in New Jersey, including LARC use, is needed. Detailed data on LARC access or its use by non-Medicaid beneficiaries are not available in the public domain. The Medicaid data obtained for 2015-17 did not break down use by year. In addition, state-level data on provision of LARCs by provider type, facility and location are also important in documenting challenges and identifying opportunities to contraceptive access.

Delivery, Billing and Payment considerations for LARCs

The process of getting a LARC from the manufacturer to pharmacy to provider to client is extremely complex. Money flow and inventory delays are barriers to easy and quick access to LARC. See Appendix I for a visual of the flow of money and product.

Reimbursement confusion/limitations

Billing for contraceptives is a complex process. There are dozens of CPT codes and ICD-10 codes which must be used. Organizations compile lists and guides attempting to simplify it (see Appendix J). Different billing codes are required for family planning counseling and the contraceptive product itself. And in the case of LARCs, there is a different code for each procedure: for insertion, for removal, and for removal and reinsertion in one visit.

Billing for Counseling

Some commercial plans do not offer provider payment for counseling patients about contraceptive options.⁸⁶ Horizon Blue Cross Blue Shield says they do pay for counseling services across Medicaid and commercial plans.⁸⁷ Recent health policy changes have acknowledged the value of paying for counseling for certain health matters.⁸⁸ Because ICD-10 codes are not required to be captured for counseling during preventive services visits which do not result in a procedure, any collected data capturing counseling may not reflect the true numbers of counseling sessions. This data gap could be especially significant when a patient chooses LARC because it is rare for a LARC to be inserted on the same day. The insertion would be done on the second visit.

Payment under Medicaid

To encourage expansion of Medicaid family planning services, the federal government has paid for 90 percent of state expenditures for these services and related supplies since 1972.⁸⁹ To further encourage access, federal policy specifically prohibits cost sharing for family planning services. In 2010, Medicaid accounted for 75 percent of national 2010 expenditures on family planning, state appropriations accounted for 12 percent and Title X for 10 percent.⁹⁰

Inventory for Same Day Access

Because of the expense of LARC contraceptives (up to \$1000 per product), few facilities keep LARCs in stock. Without a ready inventory, it is impossible to offer same-day access to LARC. Women must wait for the LARC to be ordered and then must come for a second appointment after the facility receives the product. The need for a second appointment greatly diminishes the likelihood of LARC usage because many women will not or cannot return for a second appointment. When LARCs are ordered for a patient who does not return for the insertion appointment, facilities are prohibited from using the “abandoned” product for another patient. Some manufacturers do accept and offer a refund for a returned unused product, but the concern remains that the facility will not recover its outlay.

To address this inventory and buy/bill issue, Stellar Rx offers a solution⁹¹. This company provides an onsite medication dispensing unit called Xpedose™ which includes a full inventory of LARCs to providers, clinics and hospitals. The Xpedose™ offers multiple point of care contraceptive options and eliminates up-front inventory costs for the provider. The clinician submits the electronic prescription for LARC or other contraceptives directly to Stellar and within minutes has approval to retrieve the contraceptive method from the stocked machine. The charge for the contraceptive is directly billed to the patient’s health plan. State officials indicated they are in discussion with Stellar Rx about piloting a Medicaid program to address inventory barriers for immediate postpartum insertions by placing the machines in hospitals with a high volume of labor and delivery. Stellar Rx has successfully placed the machine in some Pennsylvania FQHCs where the health center has a patient mix covered by MCOs with which Stellar has a contractual agreement. Stellar Rx charges the MCO a contracted fee for supplying and restocking the machines. Although this technology solution may not be an option for smaller physician practices, piloting them in family planning clinics, FQHCs and large volume labor and delivery hospitals may increase LARC access. Success of this technology will be dependent on the willingness of health plans to contract with Stellar Rx to provide contraceptive methods.

Availability of Contraceptive Access settings:

Women covered by commercial insurance obtain family planning services from a variety of settings: family doctor, specialist, pediatrician and family planning clinics. Uninsured women and many on Medicaid obtain these services through Title X clinics (Planned Parenthood, family planning clinics, FQHCs). There are 48 Title X clinics in New Jersey, with at least one in each county.⁹² Passaic, Union and Burlington County have been identified as having contraceptive access issues, with fewer clinics per 1,000 women than other counties in the state.⁹³ It should be noted that there are women who are not in financial need of or eligible for publicly funded contraceptive services who rely on Title X clinics for contraceptive access.⁹⁴

Commercial

Horizon does have an “add on” to their bundled labor and delivery payment, paying for post-partum LARC insertions. Coverage through other commercial plans was not publicly available for this report.

Barriers to Contraceptive Access for All Women in New Jersey

Barriers as Identified in a National Survey

The major barriers to LARC, based on responses supplied by researchers of published LARC studies in the U.S. from 2013 to 2015⁹⁵:

Table 2
Percentage of respondents endorsing each barrier.

Barrier	Number	Percentage
Cost of the device to women	65	63%
Lack of information about safety and acceptability	63	61%
Fear of side effects	58	56%
Concern about having the device placed	53	51%
Lack of trained primary care providers	51	49%
Lack of insurance coverage for the device	49	47%
Requirement for multiple visits	35	34%
Lack of knowledge about efficacy	30	29%
Stocking challenges	26	25%
Low reimbursement rates for providers	20	19%
Billing challenges	20	19%
Lack of trained family planning providers	16	15%
Concern about being able to get the device removed	15	14%
Unnecessary screening tests	5	5%

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It is evident that some of the identified barriers combine to create an even larger hindrance for women to access LARC. Billing challenges can result in stocking limitations, which further complicates same-day access for women. Even with an absence of barriers, projected LARCs would be used by 25-29 percent of contracepting women.⁹⁶

Barriers identified by the Medicaid 2.0 Workgroup and in Research

Informed Consent and Ethical Considerations

There is a history of mistrust and fear of contraceptive access campaigns among certain minority populations. Past abuses with minority populations included coercion toward sterilization and unwanted birth control. Patient mistrust is a distinct barrier confirmed in many surveys. One study found Black and Latina women had more than twice the odds of believing “the government encourages contraceptive use to limit minority populations.”⁹⁷ And women fear their desire to remove their device might be met with opposition. One study revealed women who considered elective IUD removal within nine months of insertion reported “that their providers communicated a preference, explicitly or implicitly, for them to keep the IUD.”⁹⁸ Any effort to improve access to LARC, must be sensitive to these issues.

Facility Structure and Sterilization Requirements for Ambulatory Care Facilities:

Insertions/removals of IUDs and implants trigger regulatory requirements for Ambulatory Care Facilities for FQHCs. There is some confusion as to which regulations are applicable and achieving compliance can be challenging. The DOH requires compliance with the Association for the Advancement of Medical Instrumentation (AAMI) standards for sterilization.⁹⁹ These standards require the purchase of certain types of more expensive autoclaves and instruments, and sterilization rooms must meet temperature and humidity standards.¹⁰⁰ These added costs strain FQHC budgets and challenge them financially to undertake LARC insertion as an option in provided services in some locations. There are also Department of Community Affairs regulations that impact the structural requirements for exam and sterilization rooms.¹⁰¹ Some FQHCs struggle to meet these regulations because of their locations and/or the expense required to retrofit their existing locations. The most difficult regulations include:

- the minimum size for the procedure room is 150 square feet which is larger than a typical exam room
- two additional rooms are required when non-disposable instruments are used - one for cleaning and one for sterilization.
- unspecified minimum and maximum allowable distances between the cleaning room for the instruments and the procedure room.
- if an ultrasound is needed, the room must have an integrated bathroom in the ultrasound room. A bathroom nearby is insufficient; it must be co-located in the ultrasound room.

Although an ultrasound is not usually necessary for IUD placement, in more difficult cases an ultrasound may appropriate for proper placement of an IUD or to identify that it is in place if the strings are not evident.

These facility requirements are not applicable to private practice settings. Because some FQHCs cannot meet these various regulatory requirements, they report having trouble getting licensing approval to offer access to LARC onsite. As a result, their providers often do not even bring up the option of LARC as a method of contraception.

Postpartum insertion Barriers

- a. **Labeling:** No existing LARC product is labeled for immediate postpartum use. However, ACOG¹⁰² and other thought leaders¹⁰³ in women's health have taken a strong stance that immediate postpartum use should be standard of care.
“The American College of Obstetricians and Gynecologists supports immediate postpartum LARC insertion (i.e., before hospital discharge) as a best practice, recognizing its role in preventing rapid repeat and unintended pregnancy... Immediate postpartum IUD insertion (i.e., within 10 minutes after placental delivery in vaginal and cesarean births), should be offered routinely as a safe and effective option for postpartum contraception. Women should be counseled about the increased expulsion risk, as well as signs and symptoms of expulsion. Despite the higher expulsion rate of immediate postpartum IUD placement over interval placement, cost-benefit analysis data strongly suggest the superiority of immediate placement in reduction of unintended pregnancy, especially for women at greatest risk of not attending the postpartum follow-up visit.” (2011 ACOG Practice Bulletin)¹⁰⁴
Some plans may cover for this service and the Governor's announcement of unbundling this service from labor and delivery might open the doorway in Medicaid populations.
- b. **Postpartum IUD Expulsion:** ACOG's Committee Opinion paper on “Immediate Postpartum LARC” states that expulsion rates for immediate postpartum IUD insertions are higher than other insertions and may be as high as 10-27 percent.¹⁰⁵ Another study shows an expulsion rate of 5.08 percent.¹⁰⁶ ACOG recognizes that although the increased expulsion rate does not alter the recommendation for postpartum IUD insertion, it is something that clinicians will consider in their own practice.
- c. **Catholic Hospitals:** Catholic hospital policies prevent insertion of LARCs. In 2017, there were 16,267 OB admissions in New Jersey's Catholic hospitals.¹⁰⁷ This represents 15 percent of all OB admissions. Postpartum insertion may not be an option for women delivering in these Catholic facilities.

Same-Day Insertion Barriers

- a. **Two visit experiences:** Most providers in private practice and publicly funded clinics do not have a ready inventory of LARCs. High upfront costs are one reason that only about 50 percent of community health centers in New Jersey offer LARCs.¹⁰⁸ When devices are treated as a pharmacy benefit, providers avoid stocking costs, but a follow-up appointment is needed for insertion. A follow up appointment significantly impacts access in terms of choice and timing. A 2012 study found that 40-60 percent of women who expressed interest in LARC at the time of birth never returned for a follow-up gynecological visit for device insertion.¹⁰⁹ Postpartum insertion might address this concern for pregnant women, but it will not address the need for same day insertion for other women. There are no current measures tracking same-day insertion rates, but it is expected to be low. As initiatives are implemented to improve same-day insertion, it would be useful to track this same day service.
- b. **“Buy and Bill”:** “Buy and bill” reflects the process where providers stock the devices and receive payment after device is used in a procedure. It requires a provider to pay upfront and potentially bear the risk of absorbing the cost for unused devices. The price of an IUD can cost up to \$1,000 per device. The expense of LARCs and the need to pay in advance

for these devices makes it cost prohibitive for many sites to store LARCs. The inability to keep a supply of LARC in stock eliminates the availability for same-day insertions. This in turn minimizes the attractiveness of this contraceptive method.

- c. **Preauthorization:** Conversations with stakeholders indicate there is a lack of clarity by women and providers about the need for preauthorization for LARCs for commercial plans and in Medicaid fee for service populations for certain brands. Even the perception of the existence of a need for preauthorization is a stumbling block to convenient and timely access for both the provider and the patient.

Product Barriers

The Merck product Nexplanon has not been listed on the exempted/carve out list, unlike other LARC products. If a product is on the formulary list, the provider is paid for the encounter fee and the FQHC bills for the product separately. Because Nexplanon was not on this list, the FQHC could not bill separately for Nexplanon and the practical result has been that their providers did not offer this implant. In Fall 2018, new guidance was issued by DHS for immediate post-partum LARC access for the Medicaid fee-for-service population which includes Nexplanon in its list of products. Additionally, it is understood that Nexplanon will be listed on the formulary in January 2019, although no written policy to that effect has been released as of November 28, 2018.

Clinician Barriers

Stakeholders pointed out that family planning clinics often receive LARC referrals from providers in the community. Several factors may contribute to these provider referrals rather than offering the LARC in those clinicians' own offices.

- a. **Clinician Misconceptions.** Studies show that clinician misconceptions exist relating to IUD usage and risk, including a false belief in an association between IUDs and an elevated likelihood of pelvic inflammatory disease.¹¹⁰
- b. **Insertion/Removals:** Even if a clinician is confident in the safety and efficacy of LARCs, there is an acknowledged lack of expertise by many to offer LARC insertion or removal procedures in their own offices. One study showed clinicians who had recently finished training or saw a higher number of patients using contraceptives were more likely to insert an IUD than their counterparts.¹¹¹ Many clinicians will opt to refer out to family planning clinics that are more experienced in LARC procedures.
- c. **Cultural Competency:** Cultural and language skills can break down barriers by having appropriate conversations for different age groups, populations, and demographics. Although federal policy allows states to offer Medicaid reimbursement for translation services, this option has not been pursued by New Jersey.
- d. **Physician Support:** Stakeholders raised the issue that clinicians may be inexperienced and unfamiliar with supporting patients in addressing challenging side effects of LARCs, and therefore are more hesitant to offer them as an option.
- e. **Counseling:** Counseling is not paid for as a separate service in Medicaid. There are several billing codes for counseling, so it is possible that some commercial payers offer reimbursement for counseling services. Another barrier is that providers may not be well-trained to offer age-appropriate and culturally sensitive training. This might be especially true for pediatricians and family practice physicians when speaking with teens. It has been

raised that often the counseling done by providers is heavily influenced by biases of the person offering the counseling.

- f. **Inadequate Reimbursement:** Reimbursement amounts for LARCs are lower than the Wholesale Acquisition Cost in some cases and clinicians bear the burden of making up the cost difference.

Consumer Barriers

A 2016 national study of women in family planning and abortion clinics identified characteristics of contraceptive methods which were “extremely important” to them. Of 23 total items, the method’s effectiveness at preventing pregnancy was the item that most (89%) women said was “extremely important.”¹¹² The next most important characteristics were the method is easy to get (81%), affordable (81%), and easy to use (80%). Many women also consider other characteristics, such as a method’s potential side effects and non-contraceptive benefits, as well as partner preferences and peer experiences.

- a. **Inadequate consumer education:** Communication between the patient and provider is a significant barrier to LARC access and contraceptives in general. Most women report unfamiliarity with LARC or are misinformed about device safety. One recent study found that 55 percent of women (ages of 14 and 27) are unaware of the availability of IUDs.¹¹³
- b. **Coverage Limits and Access to Alternatives:** According to the New Jersey Family Planning League, it is relatively common because of side effects, for women to ask to have their IUD removed within one to two years (less than the three- to five-year life of the product). Although there are no written policies indicating limitations, there is a perception among some providers and patients that if a woman asks to have the LARC removed before the expected “life” of the LARC, that NJ Medicaid will not pay for another contraceptive method after LARC is removed.
- c. **Fear of Side Effects:** Women may avoid LARCs if they are not sure they will receive the support and interventions they will need to address the sometimes uncomfortable and challenging side effects of LARCs
- d. **Population Challenges:** Language barriers offer significant challenges, especially in Title X clinics where 26 percent of the clients have limited English language proficiency. No funding for translators has been available from Medicaid. Cultural barriers also become evident when discussing contraceptives. Special attention is needed to communicate with certain populations especially adolescents, clients with disabilities, uninsured, underinsured, non-English, undocumented, and women with Substance Use Disorders.

Confidentiality of Services

New Jersey law is silent as to whether a minor has the power of consent to contraception but does explicitly give minors the power of consent to contraception if she is married, pregnant or has ever been pregnant.¹¹⁴ Title X regulations allow providers to maintain confidentiality for teens with no parental intervention. But confidentiality policies, especially as to minors, vary in reviewing New Jersey handbooks. Lack of confidentiality may hinder access to family planning services and contraceptive options. According to the Aetna Member handbook, privacy for certain services is not guaranteed after services are provided.

“Even though parental permission is not needed for some services, parents still may learn of the services. When we pay the provider for the service, parents can see the payment. They can also see what the service was and the name of the patient. Also, the provider you see may want you to talk to your parents about the treatment. If the provider thinks it would be best for you, he or she may tell your parents about the treatment.”¹¹⁵

The United Healthcare Community Plan does not offer unconditional guaranteed confidentiality:

“You have the right: To ask us to limit use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. We will try to honor your request, but we do not have to do so.”¹¹⁶

The AmeriHealth Handbook indicates permission is necessary before information is shared. The Handbook states information will be shared

“with your family or a person, you choose who helps with or pays for your health care, if you tell us it’s OK”.¹¹⁷

Horizon NJ Health also allows privacy for minors for those

“[m]inors who want family planning services, maternity care or sexually transmitted diseases (STD) services.”¹¹⁸

WellCare’s handbook merely states that a member has a right to

“have your records kept private.”¹¹⁹

Data and Quality Measurement

The lack of timely statewide data for contraceptive usage, especially for LARC usage, makes it difficult to identify access problems and to assess whether New Jersey women can get the contraceptive they want at the time they want/need it. In November 2016, the National Quality Forum endorsed four contraceptive care measures which are captured through claims, FPAR (Title X programs) and soon through E-records. These performance measures acknowledge some contraceptive methods are more effective than others at preventing unintended pregnancy and are designed to encourage providers to offer the range of most and moderately effective methods.¹²⁰ The measures are as follows:

The Contraceptive Care Measures	
All Women	<p>Most & Moderately Effective Methods: The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (that is, sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (injectables, oral pills, patch, ring, or diaphragm) contraceptive method (NQF #2903)</p> <p>Access to LARC: The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible contraceptive (LARC) method (implants or IUD/IUS) (NQF #2904)</p>
Postpartum Women	<p>Most & Moderately Effective Methods: The percentage of women aged 15-44 years who had a live birth that is provided a most effective (sterilization, implants, IUD/IUS) or moderately effective (injectables, oral pills, patch, ring, or diaphragm) contraceptive method within 3 and 60 days of delivery (NQF #2902)</p> <p>Postpartum Access to LARC: The percentage of women aged 15-44 years who had a live birth that is provided a LARC method (implants or IUD/IUS) within 3 and 60 days of delivery (NQF #2902)</p>

The Postpartum measure (NQF#2902) definition includes women who receive a LARC between three and 60 days of delivery and therefore does not include women who are provided a LARC immediately after giving birth. An additional measure would be useful to capture women who receive a LARC within zero to two days postpartum; provision of LARCs immediately postpartum is a pilot initiative being considered by the State in the fee-for-service Medicaid population.

Best Practices to Increase Contraceptive Access

Community-Focused Needs Assessment

Establishing a base point for understanding of community access and needs

The Milken Institute of Public Health at George Washington University conducted a survey¹²¹ in Washington DC to understand access and perceptions. The survey included the following components.

- Survey of family planning clinics
- In-depth interview of providers
- Patient focus group
- Patient survey
- Analysis of available Medicaid data

Findings demonstrated a significant disconnect between young women and the available contraceptive services. Specific issues were identified, including widespread confidentiality concerns regarding adolescent reproductive health services and limited availability of adolescent-friendly services. These findings have informed the recommendations to improve reproductive health outcomes and reduce unplanned pregnancy in the District of Columbia.

Payment and Billing

Leverage Federal Guidance on Use of LARC in Medicaid Programs

CMS has issued guidance¹²² to encourage states to invest resources in women's health and contraceptive care. The guidance recommends modifying state Medicaid payment

strategies in both fee for service and managed care. The Guidance provides an overview of state strategies already in place. CMS also recommends using the NQF-endorsed measures to “encourage providers/service sites that are performing well below [average] to focus on removing unnecessary barriers to LARC access.”¹²³

Promoting the Use of Highly Effective Birth Control Methods

In 2014, Illinois, as part the Medicaid Family Planning Action Plan¹²⁴, changed its payment model to provide additional reimbursement for birth control methods that demonstrate higher efficacy. The new provider policy requires that Medicaid patients receive education and counseling on all FDA-approved birth control methods, from most effective to least effective, with the most effective options presented first. Additionally, Medicaid doubled the provider reimbursement for IUD insertion from \$44 to \$88 and increased 340B providers’ LARC dispensing fee from \$20 to \$35.¹²⁵ This method of using payments to incentivize providers to promote a certain method over another raises concerns among some advocates who want to protect the woman’s decision among all options.

Addressing Buy and Bill

South Carolina and Texas established a replacement program that enables providers to obtain LARC devices without having to absorb acquisition and stocking costs through a direct payment arrangement between the state agency and its pharmacies.¹²⁶ Texas Medicaid providers may order LARCs from select pharmacies and the pharmacy will bill Medicaid directly, thereby allowing providers to avoid upfront costs.¹²⁷ However, a second appointment is necessary for insertion. In South Carolina, the pharmacy ships the LARC overnight allowing access on the following day.¹²⁸ Providers in both states can return unused and unopened devices to the manufacturer’s third-party processor.

Removing Co-Pays, Regardless of payer

Delaware, as part of its multi-year Delaware CAN¹²⁹ Campaign, eliminated co-pays for contraception regardless of payer. An investment of \$1.75 million public health dollars with an additional \$10 million from private funders is projected to result in a net cost annual savings of \$16.2 million, and a three-year net cost savings of \$48.5 million.¹³⁰ As a comparison, Delaware used \$36 million in state funds in 2010 to pay for unintended pregnancies.¹³¹

Extending Supply for Oral Contraceptives

Twelve states have required health insurance companies to provide a 12-month supply of birth control instead of six months, which cuts costs and time of additional provider visits and possible unintended pregnancies.¹³² One study found that women who received a full year’s supply of oral contraceptives without cost sharing were less likely to become pregnant within a year than women who received a one- or three-month supply.¹³³

Provider Focus

Educating and Training Providers

As part of the Delaware CAN Campaign, Upstream’s efforts focused on teaching health center providers how to offer same-day access to LARCs by training staff on IUD insertions and implants in their own offices and implementing a “pregnancy intention”

question at every appointment to start the conversation about prenatal care or contraception. Allowing separate Medicaid payments for postpartum insertions and upgrading billing and coding to prevent up-front costs from being passed on to the patient were other key components of the effort.¹³⁴ The campaign claims to have reduced unwanted pregnancies by 15 percent between 2014 and 2016. Upstream training, also conducted in seven Title X sites in Ohio, improved knowledge of LARCs by both clinicians and support staff.¹³⁵ Trainings, combined with extensive public messaging, showed increased LARC usage in trained sites compared to the control sites.¹³⁶

NOTE: *Among Delaware Title X family planning clients (20 to 39 years old), LARC use increased from 13.7 percent to 27.0 percent between 2014 and 2016.¹³⁷ The increase in LARC use was primarily offset by a decrease in hormonal methods such as the Pill, patch, and ring. There was also a small decrease in non-use of contraception (2 percentage points).¹³⁸*

The CDC and the Office of Population Affairs collaborated to create recommendations for high quality family planning services in 2014 report: Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs.¹³⁹ This report is targeted to primary care providers in “offering family planning services that will help women, men, and couples achieve their desired number and spacing of children and increase the likelihood that those children are born healthy.” It emphasizes offering a full range of contraceptive methods and includes guidance for meeting the special needs of adolescent clients.

Contraceptive Counseling

Effective counseling is essential to access and patient-centered decision making. Contraceptive counseling protocols are being piloted. A review of various studies¹⁴⁰ show that four factors are implicated in unintended pregnancies and should be addressed in any patient counseling:

- (a) contraceptive choice - choosing/acquiring a method of contraception;
- (b) accuracy of use - using a method correctly;
- (c) consistency of use - using contraception at each instance of intercourse;
- (d) contraceptive switching - changing from one method to another (and the protection gaps that occur during switching).

Extensive Partnerships

Tennessee implemented similar billing/payment changes, provider education and trainings and public messages as found in Delaware. But the state also focused on reaching a broad range of stakeholders in their education efforts, including nontraditional sites, such as pharmacists, medication assisted treatment (MAT) clinics and jails.¹⁴¹ Contracts were established with five metro health departments and monthly calls with family planning centers, local advisory committees, and reproductive justice groups helped to coordinate efforts and messaging. Regular audits and measurements were also key components. Since January 2014, a total of 3,500 female inmates have attended classes, and 700 of them have chosen to receive contraception.¹⁴² Some criticized the program as coercive. Proponents highlight that almost 90 percent of Tennessee inmates are incarcerated because of a drug

addiction. Offering LARCs allows these women to return to life outside the prison without the fear of an unintended pregnancy when they are most vulnerable to relapse.

Colorado’s Family Planning Initiative¹⁴³ was launched through the state government with resources from a private funder in 2009. Funding went to purchasing LARCs and training providers. Operational support included adding sites and increasing hours, hiring clinic staff, as well as upgrading equipment and billing systems. Outreach involved schools and other community partners. A separately-funded campaign called Before-play provided clinics with a website to educate young people and help them find reproductive health services. Removing cost and access barriers nearly quadrupled the number of LARCs inserted in the first six years, and the percentage of LARC users in Title X clinics increased from 6.4 percent to 30.5 percent. The program cut unintended pregnancy rates by 40 percent among women aged 15-19 and 20 percent for women aged 20-24 between 2009 and 2014. Private funders were needed to bridge funding gaps but in 2016 the State increased funding for family planning services.

Public Education

Messaging

Public education campaigns for LARC access emphasize the importance of messaging that offers choice among all methods, with strong education to understand which are most effective. There is a complex history of coercion in contraceptives. When efforts are limited to promoting LARC use among “high-risk” populations, the effect is that the most vulnerable women may have their options restricted.¹⁴⁴ Certain communities have 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. Programs designed to promote LARC methods must prioritize needs and preferences of individual women first—not the promotion of specific technologies.¹⁴⁵ Sister Song - Women of Color Reproductive Justice Collective is a leader in reproductive justice and offers provider training to ensure LARCs are offered in a non-coercive way.¹⁴⁶ New York City’s Department of Health and Mental Hygiene brought together community leaders and stakeholders to achieve similar sensitive messaging, through collaborative monthly meetings and a website with extensive resources.¹⁴⁷ A Tennessee project stressed the importance of the terms “Voluntary” and “Reversible” in its efforts to encourage use of Voluntary Reversible Long Acting Contraceptives. Best practices in consumer education ensure that counseling is provided in a consistent and respectful manner that neither denies access nor coerces anyone into using a specific method.

Multi-lingual and Culturally Sensitive

Puerto Rico had an unintended pregnancy rate of 72 percent when the Zika outbreak occurred. It became a major public health emergency to prevent the births due to the birth defects associated with Zika virus. The Zika Contraception Access Network(Z-CAN)¹⁴⁸ program took the approach of “all contraceptive care”, provided elbow to elbow training for LARCs, and offered ongoing technical assistance for providers.¹⁴⁹ The CDC Foundation convened a diverse group of stakeholders to provide the first trainings to improve contraceptive care. The curriculum was delivered entirely in Spanish and recognizing

Puerto Rico's dark history of reproductive coercion, clinical trainings and public education was offered in a culturally competent, patient-focused way. Data show that over 21,000 women across Puerto Rico were able to choose from the full range of methods for the first time in many cases – and 68 percent chose and received a LARC method at their initial visit.¹⁵⁰ **NOTE:** *Contraception was offered at no cost, through public and private funding.*

Patient involvement

As part of Puerto Rico's Z-CAN program, a monitoring plan was established allowing participants to complete a patient satisfaction survey about whether they had obtained free, same-day access to their chosen contraceptive method after receiving comprehensive counseling, their perception of the quality of care they had received, and their satisfaction with their chosen method and services. Ninety-three percent of patients surveyed indicated they were very satisfied with the services they received.

Targeting Community Needs and Using Local Influencers

Efforts in Syracuse, New York and Onondaga County have centered around specialized local needs. Recognizing a 40 percent unintended pregnancy rate in the region, a further drill down of data highlighted rates are significantly higher among some populations in their communities (women on Medicaid and African-American women). Further exacerbating the problem is that all central New York counties are designated “contraceptive deserts,” according to the National Campaign to Prevent Teen and Unplanned Pregnancy.¹⁵¹ Contraceptive deserts are defined as a county where the number of public clinics with the full range of methods is not enough to meet the needs of the county's population, with at least one clinic to every 1,000 women in need of publicly funded contraception.

Stakeholders are involved in a four-part campaign:

- Increase the number of providers who offer the full range of birth control options
- Increase capacity at publicly-funded clinics
- Design a community-wide education and awareness campaign: *Be Proud! Be Responsible!*
- Improve coordination among local outreach and education

Outreach is informed by work from Public Goods which uses public health experts and marketers/advertising experts to identify and activate local influencers such as hairdressers, peer leaders, local heroes and celebrities. The program is using an app with an avatar for teens to access information about contraceptives. The app also helps users identify the closest providers offering contraceptives.

Additional Resources and Tools are provided in Appendix K.

Conclusion

Best practices in other states have proven that when barriers are removed, women take advantage of all contraceptive methods, and often choose LARC. Many opportunities are evident in New Jersey to eliminate policy, regulatory and workforce barriers and to streamline the processes for getting affordable contraception into the provider offices for patients to access. Other states have proven that when you remove barriers, women vote with their feet and take advantage of all methods and in particular, LARCs.

Appendix A – 2014 NJ Pregnancy Intention and Teen Pregnancy¹⁵²

Pregnancy Intention¹⁵³

- In 2014, the proportion of mothers who reported intended pregnancies was 67.1%, while 23.4% reported mistimed pregnancies, and 9.5% reported unintended pregnancies.
- Among mothers who reported having Medicaid for prenatal care, the frequency of mistimed pregnancies was 31.8%. Mothers who reported using private insurance for prenatal care had a mistimed pregnancy rate of 19.3%, an increase from 16.4% in 2013.
- Among mothers who received late or no prenatal, the unintended pregnancy rate (15.1%) was nearly twice as high as mothers who received early prenatal care (8.4%).
- Nearly three times as many Black, non-Hispanic mothers reported unintended pregnancies as White, NH mothers (17.5% and 6.1%, respectively).
- Unintended pregnancies were more likely to be reported by mothers who had a high school diploma or less (17.7%), unmarried (15.1%), had an annual household income of less than \$37,000 (14%), were uninsured (13.6%), and were 30+ years of age (11.6%).
- In 2014, more than half (55.6%) of WIC participants reported that their pregnancies were intended, 31.5% reported their pregnancies were mistimed, and 13% reported their pregnancies were unintended.

Teen Pregnancy by Race (2016)

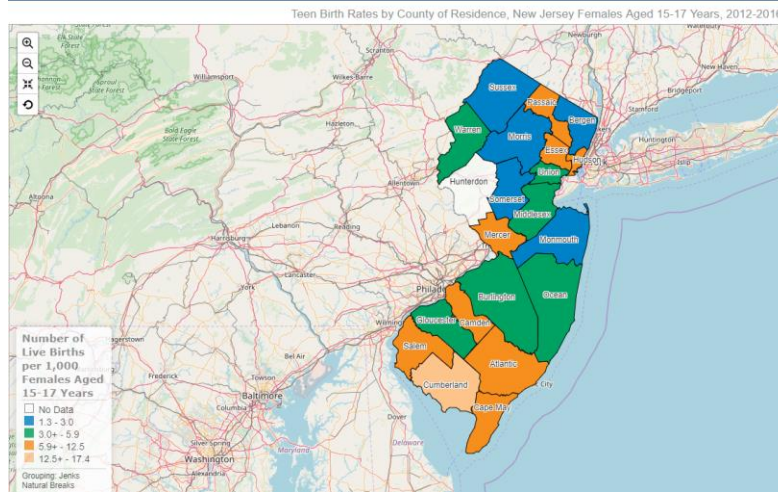
Teens (age 15- 17)¹⁵⁴ :

- .9 live births per 1,000 white teens age 15-17
- 7.9 live births per 1,000 black teens age 15-17
- 11.3 live births per 1,000 Hispanic teens age 15-17
- * numbers too small to measure for Asian teens

Teens (age 18- 19)¹⁵⁵ :

- 6.4 live births per 1,000 white teens age 18-19
- 36.6 live births per 1,000 black teens age 18-19
- 45 live births per 1,000 Hispanic teens age 18-19
- 2.5 live births per 1,000 Asian teens age 18-19

Breakdown by County for Teens (age 15-17) Birth Rates ¹⁵⁶



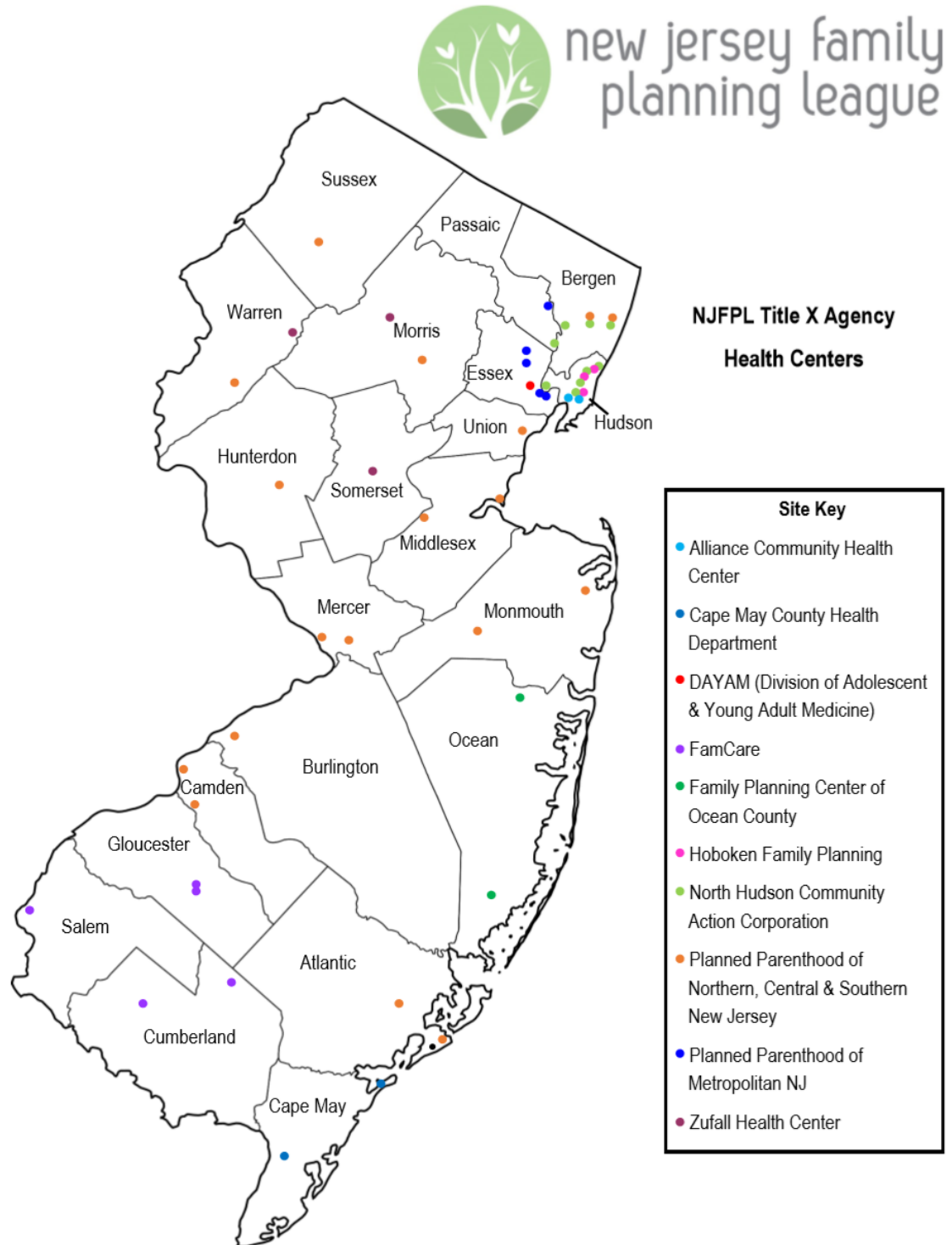
Appendix B – New Jersey Family Planning Clinics and Women Served

In 2017, the publicly supported family planning agencies in New Jersey provided quality, affordable care to 99,844 women, men, and adolescents.¹⁵⁷

- Over 70% of New Jerseyans who accessed care at a Title X family planning agency visited a Planned Parenthood health center, more than any other type of provider.¹⁵⁸
- Other statistics:
 - Total number of female contraceptive clients served at publicly funded clinics – 109,940
 - Total number of female contraceptive clients served at Title X-funded clinics – 82,950
 - Number of female contraceptive clients served at FQHCs – 35,510
 - Number of female contraceptive clients served at Title X-funded FQHCs – 14,360
 - Number of female contraceptive clients served at Title X-funded health department clinics – 880
 - Number of female contraceptive clients served at Title X-funded Planned Parenthood clinics – 59,530
 - Number of female contraceptive clients served at Title X-funded other clinics – 8,190

See map on next page -

Appendix B - continued



Appendix C – LARC Usage (2009-2012)

Table 1. Percentages of Current Long-Acting Reversible Contraceptive Users Among Current Contraception Users* by Selected Demographic Characteristics 2009 (n=6,428) and 2012 (n=5,601) and *P* Values and Percentage Point Change From Simple Logistic Regressions for the Difference in Long-Acting Reversible Contraception Use Between 2009 and 2012

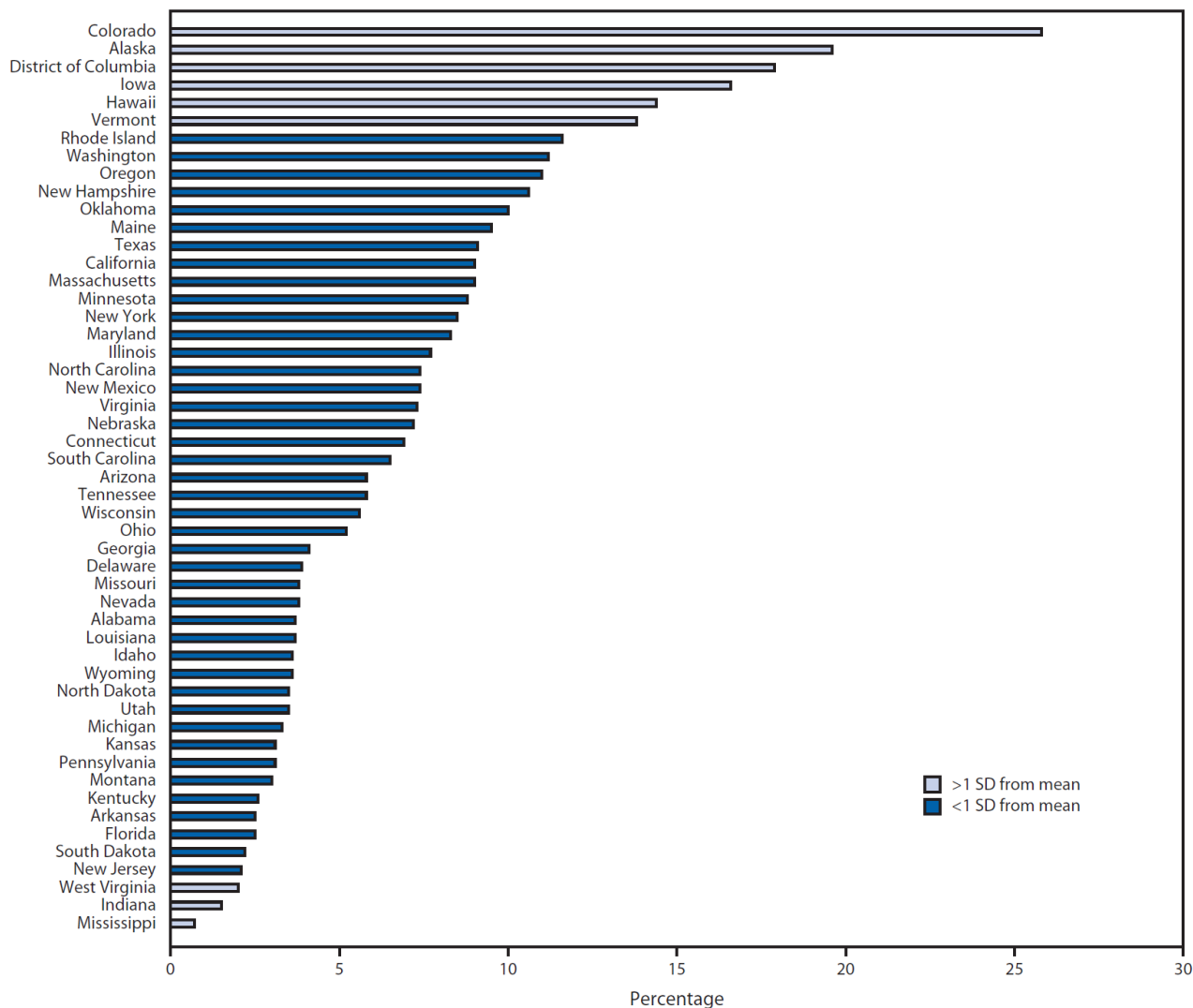
Demographic Characteristic	2009	2012	Percentage Point Change, 2009 Compared With 2012
All	8.5	11.6	3.2 [†]
IUD	7.7	10.3	2.6 [‡]
Implant	0.8	1.3	0.5
Race-ethnicity			
White, non-Hispanic	8.3	11.4	3.1 [‡]
Black, non-Hispanic	9.2	8.6	-0.6
Other or multiple races, non-Hispanic	9.2	10.6	1.3
Hispanic	8.5	15.1	6.6 [†]
Income as a % of federal poverty level			
Less than 100%	8.1	13.0	4.9 [‡]
100–199%	9.6	13.0	3.4
200–299%	7.7	10.1	2.3
300% or higher	8.3	10.5	2.2
Age (y)			
15–19	4.5	4.3	-0.2
20–24	8.3	13.7	5.4 [‡]
25–29	11.4	16.7	5.4 [‡]
30–34	10.3	16.3	6.0
35–39	10.8	9.9	-0.9
40–44	3.9	5.5	1.6
Born outside the United States			
No	8.3	10.8	2.5
Yes	9.5	17.1	7.6 [‡]
Region			
Northeast	NA	10.1	NA
South	NA	9.3	NA
Midwest	NA	10.0	NA
West	NA	17.3	NA
Relationship status			
Not married or cohabitating	5.7	9.4	3.7 [‡]
Married	10.2	12.8	2.7
Cohabitating	10.1	13.5	3.4
Education			
No high school diploma	7.3	11.0	3.7
High school or high school equivalency certificate	7.9	11.7	3.8 [‡]
Some college	9.1	12.2	3.1
College graduate	9.2	11.2	2.0
Employment			
Not working full-time	9.2	11.8	2.5
Working full-time	7.6	11.5	3.9 [‡]
Current insurance coverage			
Private	7.1	11.1	4.0 [†]
Medicaid	11.5	11.0	-0.4
Other [§]	8.0	14.0	5.9
None	10.6	13.1	2.4
Religious affiliation			
No religion	9.4	10.4	1.0
Catholic	7.6	11.2	3.6
Protestant	7.6	11.7	4.1 [‡]
Other religions	16.1	16.2	0.1
No. of male sexual partners in previous year			
Fewer than 2	9.2	12.4	3.3 [†]
2 or more	5.5	8.2	2.8

(continued)

Source: Kavanaugh ML, Jerman J, Finer LB. Changes in use of long-acting reversible contraceptive methods among US women, 2009-2012. *Obstet Gynecol* 2015; 126:917-27.

Appendix D – Teen usage of LARC, 2013

FIGURE 3. Percentage of female teens aged 15–19 years using long-acting reversible contraception (LARC) among those seeking contraceptive services at Title X service sites, by state — United States, 2013



Abbreviation: SD = standard deviation.

Source: Romero L, Pazol K, Warner L, Gavin L, Moskosky S, Besera G et al. (2015). *Vital signs: Trends in use of long-acting reversible contraception among teens aged 15-19 years seeking contraceptive services - united states, 2005-2013*. Atlanta: U.S. Center for Disease Control.

Appendix E – Percentage of uninsured women in need of publicly funded contraceptive services by county in New Jersey, 2014

County	Total % uninsured women in need of publicly funded contraceptive services	% uninsured women aged 20-44 and <138% of federal poverty level in need of publicly funded contraceptive services	% uninsured women aged 20-44 and 138-249% of federal poverty level in need of publicly funded contraceptive services	% uninsured women <20 years in need of publicly funded contraceptive services	Total uninsured women in need of publicly funded contraceptive services
Union	31	41	34	9	9,210
Hudson	29	33	31	10	13,870
Bergen	27	40	32	9	8,780
Essex	27	33	30	9	15,000
Passaic	26	32	27	9	9,260
Middlesex	25	36	28	7	10,420
Monmouth	24	35	28	7	6,260
Cumberland	24	31	24	10	2,430
Morris	23	38	29	6	3,430
Mercer	23	32	25	8	5,160
Ocean	23	31	24	9	5,900
Atlantic	22	30	22	11	4,080
Camden	22	29	23	7	6,630
Somerset	21	33	25	6	2,230
Cape May	21	26	21	10	1,050
Warren	20	30	23	8	960
Hunterdon	19	32	22	5	710
Sussex	18	28	20	7	980
Salem	18	26	20	8	490
Burlington	17	26	19	6	2,910
Gloucester	16	23	17	6	2,160
Sources: 1. Contraceptive Needs and Services, 2014 Update, Frost JJ, Frohwirth L and Zolna MR, 2016; 2. Special tabulations of data from Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2014 Update, New York: Guttmacher Institute, 2016.					

Appendix F – Contraceptive use among Medicaid beneficiaries aged 15-54 in New Jersey: 2015-17

Rank by % female Medicaid benefic 15-54y using LARC	County	% female Medicaid beneficiaries 15-54y using LARC	% female Medicaid beneficiaries 15-54y using contraception (any method)	% female Medicaid contraception clients using LARC	# LARC recipients (1-year estimate)~	# IUD recipients (1-year estimate)~	# Implant recipients (1-year estimate)~	# recipients other contraceptive methods (1-year estimate)~	# female Medicaid beneficiaries 15-54y Jan 2017^#
1	Hunterdon	2.7%	17.9%	15.2%	74	60	14	413	2,714
2	Ocean	1.4%	13.8%	10.3%	516	479	37	4,482	36,212
3	Cumberland	1.3%	13.6%	9.7%	191	122	69	1,769	14,415
4	Warren	1.3%	15.4%	8.3%	66	56	10	732	5,166
5	Burlington	1.3%	15.8%	8.0%	250	188	62	2,888	19,868
6	Gloucester	1.3%	16.8%	7.5%	207	153	54	2,569	16,502
7	Hudson	1.2%	12.1%	10.2%	665	564	101	5,827	53,713
8	Camden	1.2%	14.4%	8.2%	526	401	125	5,924	44,850
9	Passaic	1.1%	12.9%	8.7%	520	448	72	5,476	46,630
10	Monmouth	1.1%	12.6%	8.8%	275	206	69	2,837	24,709
11	Salem	1.1%	19.0%	5.6%	50	27	23	847	4,732
12	Cape May	1.0%	13.0%	7.6%	57	36	21	696	5,788
13	Bergen	0.9%	10.5%	8.3%	279	223	56	3,079	31,912
14	Somerset	0.8%	12.4%	6.8%	78	58	20	1,068	9,228
15	Middlesex	0.7%	10.2%	6.7%	258	216	42	3,602	37,838
16	Atlantic	0.6%	13.8%	4.4%	137	124	13	2,944	22,403
17	Union	0.6%	10.2%	5.8%	198	175	23	3,243	33,689
18	Mercer	0.6%	10.6%	5.4%	123	97	26	2,136	21,362
19	Sussex	0.5%	16.4%	3.3%	26	23	3	774	4,872
20	Morris	0.5%	12.0%	4.0%	57	47	10	1,383	11,955
21	Essex	0.4%	11.0%	3.4%	274	238	36	7,823	73,464

Note: Contraceptive recipients includes encounters for initial Rx, surveillance, counseling, insertions and removals.

~Source: NJ Department of Human Services, Medicaid data for CY2015-2017, adjusted for 1-year estimates

^Estimates for the # of beneficiaries 15-18 years were calculated as 29% of all beneficiaries aged 0-18; population proportion derived from US Census Bureau

*Source: <http://www.countyhealthrankings.org> (original data: National Center for Health Statistics)

**Source: <https://factfinder.census.gov> (original data: 2017 American Community Survey)

Appendix G – Contraceptive use by age group among Medicaid beneficiaries in New Jersey: 2015-17

Age in years	% female Medicaid beneficiaries 15-54y using LARCs	% female Medicaid beneficiaries 15-54y using contraception (any method)	% female Medicaid clients using LARC	# LARC recipients (1-year estimate)~	# IUD recipients (1-year estimate)~	# implant recipients (1-year estimate)~	# other contraceptive method recipients* (1-year estimate)~	# female Medicaid beneficiaries Jan 2017^#
15-<18	0.3%	6.2%	4.7%	332	164	168	6,789	114,819
18-<35	1.6%	22.4%	7.3%	3468	2872	596	44,352	213,610
35+	0.5%	5.8%	9.4%	1066	924	142	10,245	193,823

Note: Contraceptive recipients includes encounters for initial Rx, surveillance, counseling, insertions and removals.

~Source: NJ Dept of Human Services, Medicaid data for CY2015-2017, adjusted for 1-year estimates.

*Other contraceptive methods include oral pills, spermicides, injectables, condoms and diaphragms.

^Source: <http://www.njfamilycare.org/analytics>.

#Estimate for # of female Medicaid beneficiaries ages 15-18 was calculated as 29% of all beneficiaries aged 0-18; proportion derived from US Census Bureau data for New Jersey.

Appendix H – Contraceptive use by ethnic group among female Medicaid beneficiaries aged 15-54 in New Jersey: 2015-17

Ethnicity	% female Medicaid beneficiaries 15-54y using LARCs	% female Medicaid beneficiaries 15-54y using contraception (any method)	% female Medicaid clients using LARC	# LARC recipients (1-year estimate)	# IUD recipients (1-year estimate)~	# implant recipients (1-year estimate)~	# other contraceptive method recipients* (1-year estimate)~	# female Medicaid beneficiaries Jan 2017 [§]
Black	0.6%	12.6%	4.7%	874	662	212	17,659	146,580
Latina	1.3%	15.3%	8.7%	1,230	974	256	12,902	92,400
White	0.9%	11.6%	8.0%	1,988	1,700	288	23,020	216,048
Other ^{**}	1.1%	12.4%	8.9%	738	581	157	7,558	66,780

Note: Contraceptive recipients includes encounters for initial Rx, surveillance, counseling, insertions and removals.

~Source: NJ Dept of Human Services, Medicaid data for CY2015-2017, adjusted for 1-year estimates.

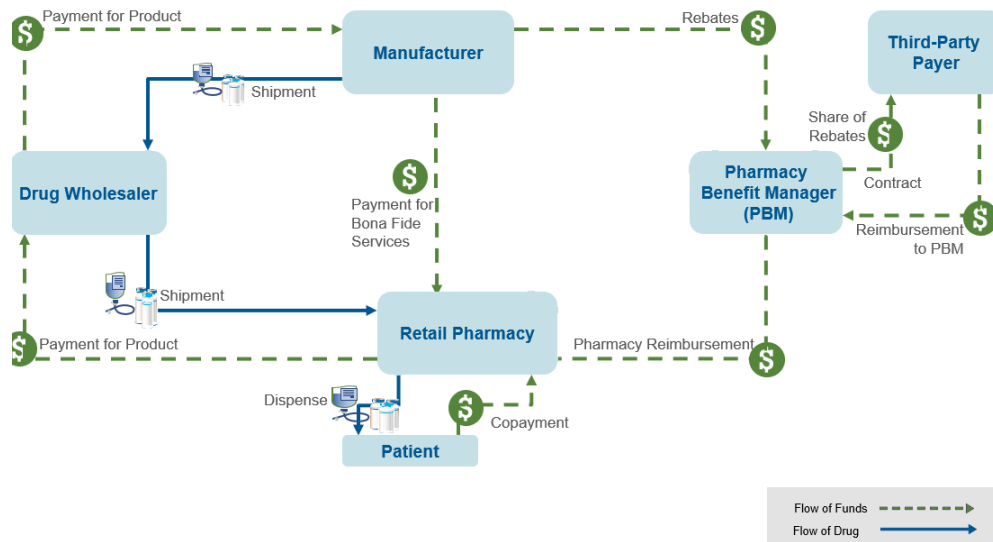
*Other contraceptive methods include oral pills, spermicides, injectables, condoms and diaphragms.

[§]Source: <http://www.njfamilycare.org/analytics>.

**Other includes Asian and all other Medicaid ethnic categories.

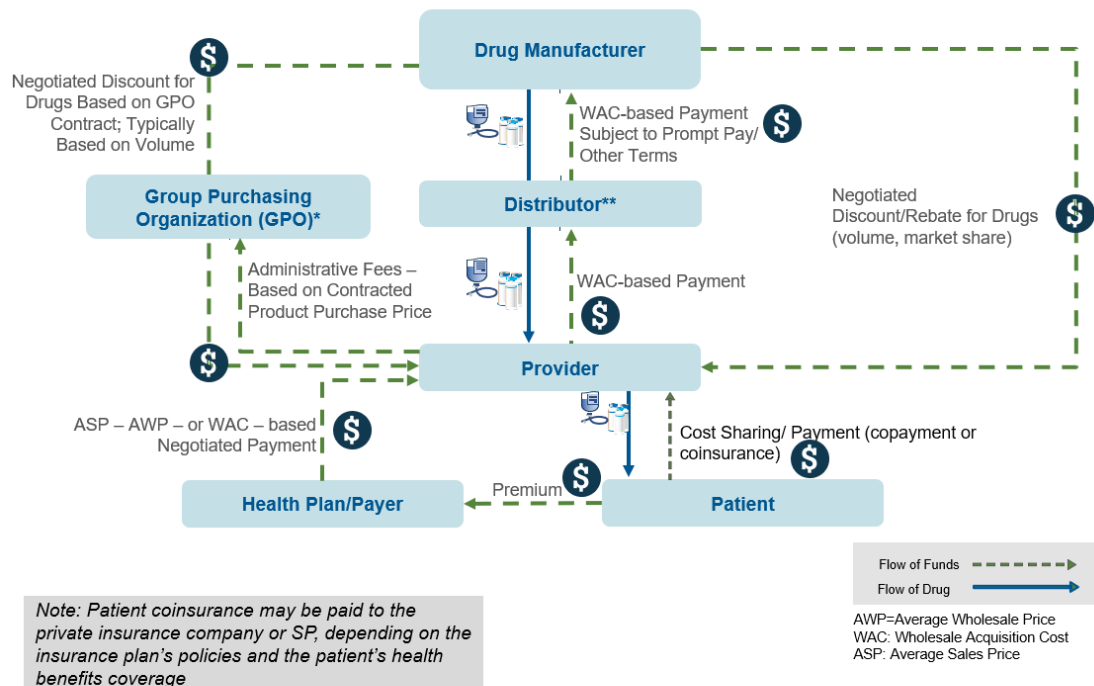
Appendix I – Business and Payment Models

Pharmacy Benefit Product and Reimbursement Flow



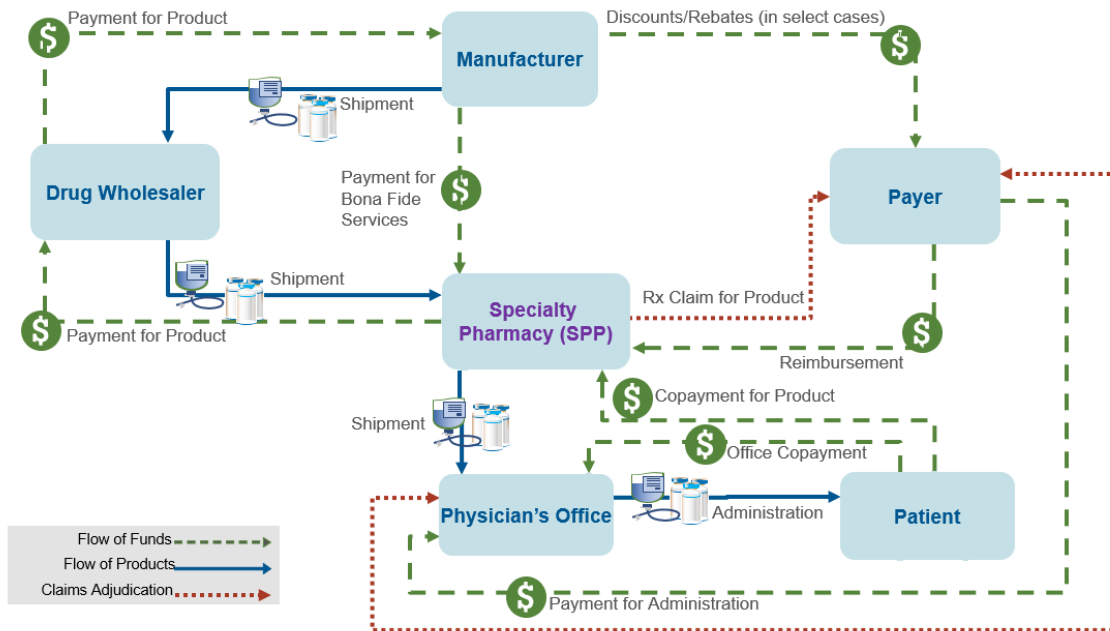
www.medicare.gov; Medicare Carriers Manual; Conceptual model adapted from Sood et al. Flow of Money through the Pharmaceutical Distribution System. June 2017
 2 HCP = Healthcare Professional

Medical Benefit Product and Reimbursement Flow



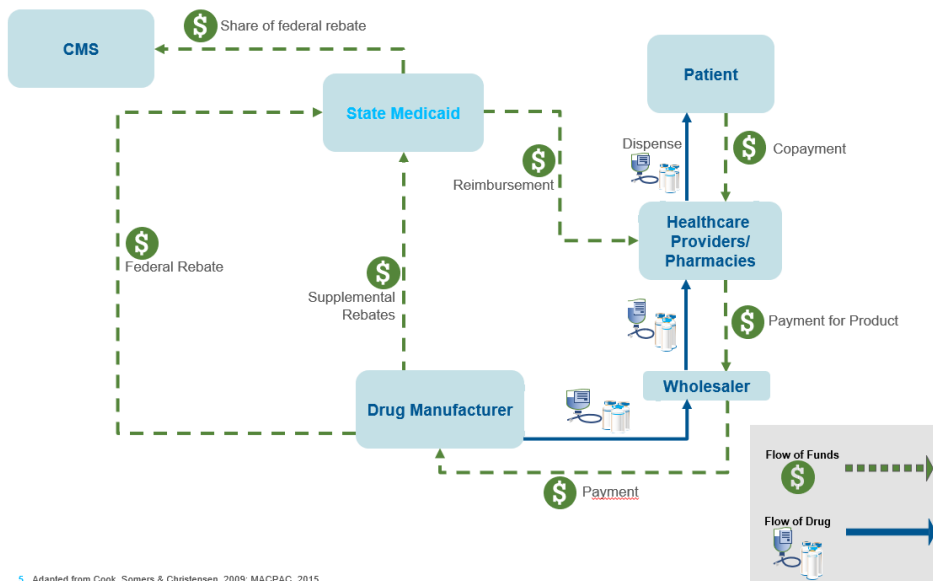
www.medicare.gov; Medicare Carriers Manual; Conceptual model adapted from Sood et al. Flow of Money through the Pharmaceutical Distribution System. June 2017
 3 HCP = Healthcare Professional

Medical Benefit Product and Reimbursement Flow – with Specialty Pharmacy



www.medicare.gov; Medicare Carriers Manual; Conceptual model adapted from Sood et al. Flow of Money through the Pharmaceutical Distribution System. June 2017
4 HCP = Healthcare Professional

Medicaid Pharmacy Payment and Rebate Funding Flow – Medicaid Fee-for-Service



5 Adapted from Cook, Somers & Christensen, 2009; MACPAC, 2015

Appendix J – Billing for Contraceptives

- UPSTREAM Guide: http://www.upstream.org/wp-content/uploads/2015/11/Upstream-Contraceptive-Coding-Guide_111215_1115A.pdf
- ACOG Guide: <https://www.acog.org/-/media/Districts/District-II/Public/PDFs/QuickGuideReimbursementLARCFINAL.pdf?dmc=1&ts=20180702T1925511319>

Appendix K – Resources/Tools

Strategies to Increase Access to Long-Acting Reversible Contraceptives

National Academy for State Health Policy. May 2016

https://nashp.org/wp-content/uploads/2017/04/Increasing-Access-To-LARC_CoIIN-NASHP.pdf

Contraceptive Access Change Package

Family Planning National Training Center. April 2017

https://www.fpntc.org/sites/default/files/resources/fpntc_cc_access_2017.pdf

Manual on how to assess clinic's processes and procedures to improve Title X grantee's performance on NQF contraceptive measures

One Key Question®

Select 360 Consulting

<https://powertodecide.org/select360-consulting#tab-1>

A provider program that asks all health providers and champions who support women to routinely ask: "Would you like to become pregnant in the next year?"

Increasing Access to Contraception Learning Community

Association of State and Territorial Health Officers

<http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Learning-Community/Materials/>

Learning community of 27 states and territories to facilitate reducing unintended pregnancy and improving access to the full range of contraceptive methods. ASTHO has a database of over 200 resources: <http://www.astho.org/Increasing-Access-to-Contraception/>

Reproductive Health Justice – Sister Song

<https://www.sistersong.net/reproductive-justice/>

membership organization which builds a network of individuals and organizations to improve institutional policies and systems that impact the reproductive lives of marginalized communities.

Long Acting Reversible Contraceptive Program

American College of Obstetricians and Gynecologists

<https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception>

Connects providers and patients with up-to-date information on LARC and works to increase overall access. Extensive resources related to LARC including clinical education and training, coding and reimbursement, and other topics.

Speaking to Teens

Family Planning National Training Center

<https://www.fpntc.org/training-packages/contraceptive-services>

Many resources including discussion guide on how to talk to adolescents/teens.

Bedsider App

<https://www.bedsider.org/>

An app that allows users to explore every available method of contraceptives, compare methods and includes a feature to remind users to keep up with their current method.

Planned Parenthood Quiz

<https://www.plannedparenthood.org/online-tools/what-right-birth-control-me>

Consumer facing decision-making tool to find birth control that meets an individual's needs and preferences. Optimized for mobile users.

CDC 6|18 Planning Tool

<https://www.618resources.chcs.org/priority-conditions/prevent-unintended-pregnancy/>

Assessment tool to evaluate evidence-supported best practices to prevent unintended pregnancy.

Endnotes

- ¹ As of 2015, there were five LARC devices available in the United States: one single-rod etonogestrel implant FDA-approved for up to three years and four brands of IUDs. ACOG Strengthens LARC recommendations. 22 Sept. 2015. <https://www.acog.org/About-ACOG/News-Room/News-Releases/2015/ACOG-Strengthens-LARC-Recommendations>
- ² The copper IUD is approved for up to 10 years of use. Additionally, three levonorgestrel-releasing intrauterine systems are available: two approved for use up to three years and one approved up to five years of use. ACOG Strengthens LARC recommendations. 22 Sept. 2015. <https://www.acog.org/About-ACOG/News-Room/News-Releases/2015/ACOG-Strengthens-LARC-Recommendations>
- ³ “Updated data, paired with new options for long-acting reversible contraceptive (LARC) methods, have led the American College of Obstetricians and Gynecologists (ACOG) to strengthen its recommendations regarding use of LARC methods as the most effective and safe forms of reversible contraception. The updated Committee Opinion, “*Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy*” ... urges obstetrician-gynecologists to encourage patient consideration of implants and intrauterine devices (IUDs), educate patients on LARC options, and advocate for insurance coverage and appropriate payment and reimbursement for every type of contraceptive method. ACOG Strengthens LARC recommendations. 22 Sept. 2015. <https://www.acog.org/About-ACOG/News-Room/News-Releases/2015/ACOG-Strengthens-LARC-Recommendations>
- ⁴ Efficacy and Safety of Long Acting Reversible Contraceptives, US Dept of Health and Human Services, 2011. New <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662967/>
- ⁵ Between 40-57 percent of women report having unprotected intercourse before the routine six-week post-partum visit. Long Acting Reversible Contraceptive, ACOG Practice Bulletin, No. 186, November 2017.
- ⁶ <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>.
- ⁷ Ibid.
- ⁸ Ibid. Links to specific research are provided for each of these adverse outcomes at this site.
- ⁹ <https://www.brookings.edu/research/the-high-cost-of-unintended-pregnancy/>
- ¹⁰ Preconception Health and Behaviors, MICH-16.6 <https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives>
- ¹¹ State Facts about Unintended Pregnancy: NJ, https://www.guttmacher.org/sites/default/files/factsheet/nj_17.pdf
- ¹² https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017?utm_source=Guttmacher+Email+Alerts&utm_campaign=0566ff36c-EMAIL_CAMPAIGN_2018_12_04_06_30&utm_medium=email&utm_term=0_9ac83dc920-0566ff36c-260651353
- ¹³ https://www.guttmacher.org/sites/default/files/report_downloads/table_2_state_level_estimates_of_contra_use.pdf
- ¹⁴ 2018 NJ State Health Assessment.
- ¹⁵ NJ Department of Health. <https://www.nj.gov/health/fhs/maternalchild/teens/teen-pregnancy-prevention/>
- ¹⁶ 2018 NJ State Health Assessment.
- ¹⁷ 2018 NJ State Health Assessment.
- ¹⁸ Pregnancy Intention and Its Relationship to Birth, Obstetrics & Gynecology, 2007. https://journals.lww.com/greenjournal/Abstract/2007/03000/Pregnancy_Intention_and_Its_Relationship_to_Birth.15.aspx
- ¹⁹ <https://www.state.nj.us/health/chs/hmj2020/maternal/improving/>
- ²⁰ <http://www.state.nj.us/health/chs/hmj2020/documents/sha2018.pdf#page=70>
- ²¹ <https://www.brookings.edu/research/the-high-cost-of-unintended-pregnancy/>
- ²² <https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-new-jersey>
- ²³ <https://www.healthcare.gov/coverage/birth-control-benefits/>
- ²⁴ CMS-9940-IFC; <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-21851.pdf>
- ²⁵ <https://www.kff.org/report-section/medicaid-and-family-planning-medicare-family-planning-policy/>
- ²⁶ FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants; <https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=61595>.
- ²⁷ <https://rewire.news/article/2018/11/09/trumps-hhs-reverses-course-on-including-hormonal-birth-control-in-title-x-grants/>
- ²⁸ Proposed Changes to Title X: Implications for Women and Family Planning Providers, Kaiser Family Foundation, June 2018.
- ²⁹ <https://powertodecide.org/what-we-do/information/national-state-data/new-jersey>
- ³⁰ NJ Family Planning League, conversation, August 2, 2018.
- ³¹ State Plan Under Title XIX of the Social Security Act Medical Assistance Program https://www.state.nj.us/humanservices/dmahs/info/state_plan.html
- ³² Newsletters are a form of communication from the Division of Medical Assistance and Health Services (DMAHS), are used to clarify Medicaid policy and procedures, and to notify providers of changes. They are available at www.njmmis.com
- ³³ https://www.state.nj.us/dobi/division_insurance/mhbac/mandatedhbac.htm#1
- ³⁴ C. 251, s.4 (2005)
- ³⁵ The change will be submitted in the Fall and may reach up to 205% which is the same as coverage for pregnant women. This slight bump will help avoid a drop off of coverage when a woman delivers a child.

- ³⁶ Dept of Human Services, DMAHS newsletter, Vol. 28, no. 18. October 2018
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- ³⁸ N.J.A.C. 10.66-2.5 (a)
- ³⁹ State Plan Amendment, Addendum to Attachment 3.1-A Page 4(c);
https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment3_Services_including_Scope_and_Limitations.pdf
- ⁴⁰ N.J.A.C. 10.66-2.5 (b)
- ⁴¹ <https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf> or N.J.A.C. 10:49-9.1
<https://www.state.nj.us/humanservices/dmahs/clients/medicaid/pregnant/index.html> and State Plan Amendment, Addendum to Attachment 3.1-A Page 20(a);
https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment3_Services_including_Scope_and_Limitations.pdf
- ⁴² State Plan Amendment, Addendum to Attachment 3.1-A Page 4(c) ;
https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment3_Services_including_Scope_and_Limitations.pdf
- ⁴³ State Plan Amendment, Addendum to Attachment 3.1-A Page 4(c) ;
https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment3_Services_including_Scope_and_Limitations.pdf
- ⁴⁴ FQHCs are paid a flat Prospective Payment System rate per patient visit regardless of the medical service provided. Title X clinics conduct counseling under the contraceptive management code.
- ⁴⁵ State Plan Amendment, Supplement:2 10 Attachment J, 1-1p. 19 ;
https://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment3_Services_including_Scope_and_Limitations.pdf
- ⁴⁶ Medicaid Regulations § 10:51-1.14
- ⁴⁷ <https://www.aetnabetterhealth.com/newjersey/assets/pdf/members/NJ-Medicaid-Member-Handbook-English.pdf>
- ⁴⁸ https://www.nyamerigroup.com/Documents/NINJ_CAID_MHB_ENG.pdf
- ⁴⁹ <http://www.uhccommunityplan.com/content/dam/communityplan/plandocuments/handbook/en/NJ-MemberHandbook-En.pdf>
- ⁵⁰ https://www.horizonnjhealth.com/securecms-documents/300/Medicaid_Member_Handbook_English.pdf
- ⁵¹ Medicaid Regulations: § 10:74-3.3
- ⁵² Medicaid Regulations: § 10:74-3.6
https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_74%20Managed%20Health%20Care%20Services%20for%20Medicaid%20and%20NJ%20FamilyCare%20Beneficiaries.pdf
- ⁵³ Kaiser chart: <https://www.kff.org/medicaid/state-indicator/prescription-drugs/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ⁵⁴ Medicaid Regulations: § 10:74-3.4
- ⁵⁵ <https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>
- ⁵⁶ <https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>
- ⁵⁷ Care Needs Assessment in NJ Care Management Workbook, p. 15
https://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf
- ⁵⁸ Medicaid Regulations: § 10:74-13.1 ;
https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_74%20Managed%20Health%20Care%20Services%20for%20Medicaid%20and%20NJ%20FamilyCare%20Beneficiaries.pdf
- ⁵⁹ ANSI/AAMI ST79:2017
- ⁶⁰ J.A.C. 8:43A-19.1 - Physical Plant General Compliance for New Construction or Alteration
FGI 3.7-3.2.3 Space Requirements (3.7-3.2.3.1 Area); *“Procedure rooms shall have a minimum clear floor area of 150 square feet (13.95 square meters) with a minimum clear dimension of 12 feet (3.65 meters).”*
- ⁶¹ <http://www.njspotlight.com/stories/12/12/02/new-jersey-employers-reflect-national-move-to-self-insurance/>
- ⁶² Mandated benefits do not apply to self-funded plans where the employer is responsible for the claims but uses an insurer or third-party administrator to process claims. https://www.state.nj.us/dobi/division_insurance/nhbac/mandatedhbac.htm
- ⁶³ This statement is based on representations from Horizon, we are awaiting formal confirmation.
- ⁶⁴ Postpartum Care and Well Woman Care: 13.35-2A.12 (a)(2) and 13.35-2A.13(a)(2). Primary care provider includes the following licensed individuals: physicians, physician assistants, advanced practice nurses and nurse midwives whose professional practice involves the provision of primary care, including internal medicine, family medicine, geriatric care, pediatric care or obstetrical/gynecological care. N.J. Rev. Stat. §30:4D-8.2
- ⁶⁵ NPs are recognized in state policy as a primary care provider. Primary care provider includes the following licensed individuals: physicians, physician assistants, advanced practice nurses and nurse midwives whose professional practice involves the provision of primary care, including internal medicine, family medicine, geriatric care, pediatric care or obstetrical/gynecological care. N.J. Rev. Stat. §30:4D-8.2
- ⁶⁶ N.J. Rev. Stat. §45:9-27.16
- ⁶⁷ <https://www.guttmacher.org/print/state-policy/explore/minors-access-contraceptive-services>
- ⁶⁸ [https://www.contraceptionjournal.org/article/S0010-7824\(17\)30478-X/fulltext#s0015](https://www.contraceptionjournal.org/article/S0010-7824(17)30478-X/fulltext#s0015)
- ⁶⁹ Brannum AM, Jones J. Trends in long-acting reversible contraception use among U.S. women aged 15-44. NCHS data brief, no 188. Hyattsville, MD: National Center for Health Statistics. 2015.
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- ⁷² Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, Megan L. Kavanaugh, January 2018 [https://www.contraceptionjournal.org/article/S0010-7824\(17\)30478-X/fulltext#back-bb0115](https://www.contraceptionjournal.org/article/S0010-7824(17)30478-X/fulltext#back-bb0115)
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- ⁷⁴ Branum AM, Jones J. Trends in long-acting reversible contraception use among U.S. women aged 15-44. NCHS data brief, no 188. Hyattsville, MD: National Center for Health Statistics. 2015.
- ⁷⁵ Contraceptive Use in the United States, Sept. 2016 https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states?gclid=Cj0KCQjwvZBRChARIsACE8vyLU7xcDdEUxHrAdcaolyKRuf1FybX9jsgMzNCuEBRFyAbrBKrlptMaAuDQEAALw_wcB
- ⁷⁶ Romero L, Pazol K, Warner L, Gavin L., Moskosky S, Besera G et al. (2015). *Vital signs: Trends in use of long-acting reversible contraception among teens aged 15-19 years seeking contraceptive services - united states, 2005-2013*. Atlanta: U.S. Center for Disease Control
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- ⁷⁸ Gold RB. Stronger together: Medicaid, Title X bring different strengths to family planning effort. *Guttmacher Policy Review* 2007;10(2):13-18
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<https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states>
- ⁹⁰ Information in this paragraph is informed by a conversation with Stellar Rx senior management on July 24, 2018. <https://nijpl.org/family-planning-clinics/>
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- ⁹² <https://powertodecide.org/what-we-do/access/access-birth-control>
- ⁹³ Projections and Opinions from 100 Experts in long-acting Reversible Contraceptives, Diana Green Foster, et al. October 2015.
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FGI 3.7-3.2.3 Space Requirements (3.7-3.2.3.1 Area); “Procedure rooms shall have a minimum clear floor area of 150 square feet (13.95 square meters) with a minimum clear dimension of 12 feet (3.65 meters).”
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- ¹⁰¹ The American College of Nurse-Midwives and the Society for Maternal-Fetal Medicine endorse the ACOG Opinion. The American Academy of Family Physicians and the Association of Women’s Health, Obstetric and Neonatal Nurses also support it. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Immediate-Postpartum-Long-Acting-Reversible-Contraception>

- ¹⁰⁴ <https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices>
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