CECA
Coalition to Expand Contraceptive Access

Issue Brief #4: Expanding Contraceptive Access Through Funding Strategies

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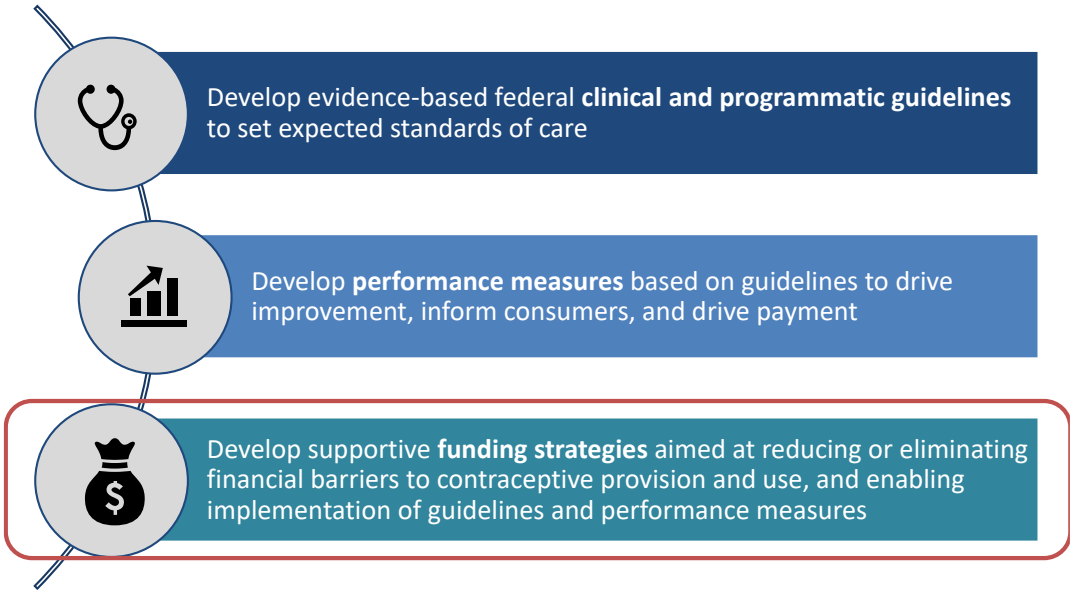
Introduction

The U.S. federal government funds contraception through a variety of mechanisms, enabling people to access needed care and supplies. Nearly all people who can become pregnant have used or are using contraception.[1,2] Yet access to contraception is not distributed equitably. Federal funding mechanisms are particularly critical for those who might otherwise have limited access, including low-income people and adolescents. These mechanisms constitute one essential component of achieving the goal of contraceptive equity, meaning that all persons in need of contraception have access to their desired contraceptive method and services for initiation, management, and discontinuation, free of coercion, regardless of age, income, insurance type, location, or any other factor.[3]

Exhibit 1. Federal Processes to Improve Contraceptive Access: Funding Strategies



This briefing document provides an overview of federal government funding strategies for contraception, with particular attention toward Medicaid payment strategies, currently identified gaps, and future directions for improvement.[4] Funding strategies are the variety of policies, processes, and programs aimed at reducing or eliminating financial related barriers to contraception. Examples include reimbursement for services and supplies, grant funding, and discount programs. Most funding strategies are directed at defraying costs to health care providers with the ultimate goal of reducing or eliminating costs for patients. Supportive funding strategies are needed to enable providers to implement guidelines, meet performance expectations, and integrate new

[1] Kimberly Daniels, Jill Daugherty, and Jo Jones, "Current Contraceptive Status among Women Aged 15-44: United States, 2011-2013," *NCHS Data Brief*, no. 173 (December 2014): 1–8.
[2] Alexis Light et al., "Family Planning and Contraception Use in Transgender Men," *Contraception* 98, no. 4 (2018): 266–69, https://doi.org/10.1016/j.contraception.2018.06.006.
[3] The term "contraceptive equity" is often used in the context of legislation, particularly state laws that aim to expand the cost-sharing provisions of the federal Affordable Care Act. We use the term more broadly, as described in the text of this document. This terminology is influenced by the work of the National Latina Institute for Reproductive Justice and In Our Own Voice: National Black Women's Reproductive Justice Agenda.
[4] Usha Ranji et al., "Financing Family Planning Services for Low-Income Women: The Role of Public Programs," The Henry J. Kaiser Family Foundation, May 11, 2017, https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/. Though a number of government mechanisms provide funding for contraceptive access, Medicaid contributes 75% of federal expenditures on family planning and is therefore a focus of this document.

delivery innovations. In this framework, gaps are any areas (i.e., contraceptive methods, populations) where funding strategies fall short and cost-related barriers persist. Sources for this document include published scientific literature, when available, as well as gray literature (i.e., expert white papers from research and advocacy organizations and public-facing government and non-government organization documents, including websites).

The Context

The Need for Publicly Funded Contraception

As of 2014, 20.2 million U.S. women were in need of publicly funded contraception.[5,6] This represents more than half of all U.S. women in need of contraception. In addition to contraception, people seek a broad range of sexual and reproductive health services at publicly funded family planning clinics, including testing and treatment for sexually transmitted infection (STIs) and cervical cancer screening. Infrastructural support and service reimbursement, including through federal mechanisms, are essential for the delivery of the full scope of sexual and reproductive health care.

Current Structures and Processes for Publicly Funded Contraception

The federal government supports the provision of contraceptive care through direct support of family planning providers, as well as through reimbursement to providers, pharmacists, or directly to users, for services and supplies. Federal funding for contraception is delivered **primarily** through Medicaid, the Title X program, and Section 330 of the Public Health Service Act. Various other federal funding sources, including the Title V Maternal Health Block Grant,[7] the Title XX Social Services Block Grant Program,[8] TRICARE (the health insurance program for people enrolled in the Armed Forces and their dependents),[9] and the Indian Health Service,[10] also support contraceptive access but are not described in detail below. The federal government also indirectly supports the provision of contraceptive care through workforce development grants and loan forgiveness programs, many of which are aimed at bolstering the primary care clinician workforce in medically underserved areas.[11]

[5] Jennifer Frost, Lori Frohwirth, and Mia Zolna, "Contraceptive Needs and Services, 2014 Update," September 9, 2016, https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.
[6] Guttmacher Institute researchers define need for publicly funded contraception as adults living below 250% of the federal poverty level, or being under age 20. Women in need of contraception are defined as being between the ages of 13–44, sexually active, able to conceive, and neither "intentionally" pregnant nor trying to become pregnant.
[7] Association of Maternal & Child Health Programs, "AMCHP Case Study - Coordinating Efforts Across the Title V MCH Services Block Grant and the Title X Family Planning Program," July 2014, http://www.amchp.org/programsandtopics/womens-health/resources/Documents/Case%20Study%20-%20Coordinating%20Efforts%20Across%20Title%20V%20and%20Title%20X.pdf.
[8] K Spar, "Title XX of the Social Security Act: Program Description, Current Issues (81-58 EPW)," 1981, https://www.govinfo.gov/content/pkg/GPO-CPRT-105WPRT37945/pdf/GPO-CPRT-105WPRT37945-2-10.pdf.
[9] Julia Rugg and Donna Barry, "Access to Contraception for Women Serving in the Armed Forces," Center for American Progress, February 4, 2015, https://www.americanprogress.org/issues/women/reports/2015/02/04/106121/access-to-contraception-for-women-serving-in-the-armed-forces/.
[10] Kaiser Family Foundation, "Private and Public Coverage of Contraceptive Services and Supplies in the United States," July 10, 2015, https://www.kff.org/womens-health-policy/fact-sheet/private-and-public-coverage-of-contraceptive-services-and-supplies-in-the-united-states/.
[11] Health Resources & Services Administration, "What Is a Shortage Designation?," August 2019, https://bhw.hrsa.gov/shortage-designation/what-is-shortage-designation.

Federal Funding Sources for Contraceptive Care

Primary Funding Sources	Additional Funding Sources
• Medicaid • Medicare • Title X • Section 330 of the Public Health Service Act • 340B Drug Discount Program	• Title V Maternal Health Block Grant • Title XX Social Services Block Grant Program • TRICARE • Indian Health Service

Medicaid

The Medicaid program was authorized in 1965, under Title XIX of the Social Security Act, to provide health care coverage for low-income people.[12] The federal Medicaid program is administered by the Centers for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS). All states, territories, and the District of Columbia have their own Medicaid programs. While the states are bound to follow certain federal mandates, they have discretion over optional services and eligibility categories and administer their programs independently, resulting in differences in coverage and, therefore, access by location. The federal government matches state Medicaid spending and the matching rate for most populations and services varies by state. In the context of sexual and reproductive health care, federal statute dictates that all states must cover family planning services, but there is no uniform definition of what this encompasses. For example, states vary in the extent to which they cover over-the-counter contraceptives, infertility testing, vaccination for human papillomavirus (HPV), and other services related to STIs.[13]

Medicaid beneficiaries generally have the right to obtain medical services from any qualified provider.[14] This provision, often referred to as "any willing provider" or "free choice of provider," dates to 1965, with special, explicit protections for family-planning services added in 1981.[15]

Medicaid is of particular importance for women of reproductive age. Medicaid accounts for 75% of federal expenditures for family planning services. The federal government share is 90% for all family planning services and supplies, with states paying 10%. This is a higher share than the Federal Medical Assistance Percentage (FMAP), the share the Federal government pays for most other services.[16,17] Medicaid also finances family planning-*related* services at a state's regular FMAP rate.[18] Seventeen percent of non-elderly women in the U.S. are covered by Medicaid, and this varies by income, race, location, and other factors.[19] Approximately 70% of adult women on Medicaid are between the ages of 15 and 49.[20]

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[12] "Program History," Centers for Medicare and Medicaid Services, accessed August 22, 2019, https://www.medicaid.gov/about-us/program-history/index.html.
[13] Jenna Walls et al., "Medicaid Coverage of Family Planning Benefits: Results from a State Survey," September 15, 2016, https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/.
[14] Vikki Wachino, "Clarifying 'Free Choice of Provider' Requirement in Conjunction with State Authority to Take Action against Medicaid Providers," April 19, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf.
[15] Sara Rosenbaum, "Medicaid Coverage for Family Planning - Can the Courts Stop the States from Excluding Planned Parenthood?," *The New England Journal of Medicine* 377, no. 23 (December 7, 2017): 2205–7, https://doi.org/10.1056/NEJMp1711490.
[16] Ranji et al., "Financing Family Planning Services for Low-Income Women."
[17] Department of Health & Human Services, "Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2018 Through September 30, 2019," *Federal Register*, November 21, 2017, 55383–86.
[18] Cindy Mann, "Family Planning and Family Planning Related Services Clarification," April 16, 2014, https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf.
[19] "Medicaid's Role for Women," The Henry J. Kaiser Family Foundation, March 28, 2019, https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/.
[20] Kaiser Family Foundation, "Private and Public Coverage of Contraceptive Services and Supplies in the United States."

Since the Affordable Care Act (ACA) was passed in 2010 and implemented, Medicaid coverage may be obtained through various pathways, described briefly below.

Traditional Medicaid. Under the traditional Medicaid program, eligibility is determined primarily by family size (including pregnancy) and income, with specific guidelines varying by state. Pregnancy-related Medicaid coverage extends to 60 days postpartum. Infants are covered for their first year of life. While all states must cover family planning services in their Medicaid program with no cost sharing by patients, there is no single uniform definition of these services.

Medicaid Expansion. Since the passage of the ACA, states can elect to expand eligibility for Medicaid, thus covering more previously or potentially uninsured residents. Expanded Medicaid enables women with incomes below 138% of the federal poverty limit to enroll in the program, regardless of (dis)ability, pregnancy, or parenting status. As of August 1, 2019, 36 states and the District of Columbia had expanded their Medicaid programs, and 14 states had not.[21]

The ACA also established a new benefits package, the "Alternative Benefit Plan" (ABP), which all states offer to individuals who qualify for Medicaid expansion. The ABP includes ten essential health benefits, which insurance plans must cover. These essential benefits also apply to plans available on the health insurance marketplaces, established under the ACA. These marketplaces, or exchanges, enable consumers to compare plans, understand eligibility and subsidies, and enroll more easily.[22] In the context of sexual and reproductive health, mandatory benefits include all FDA-approved contraceptives with a prescription, testing for STIs, screening for breast and cervical cancer, HPV vaccination, and screening for intimate partner violence.[23] As mentioned above, these requirements do not apply to other aspects of a state's Medicaid program, though states may offer these benefits to other enrollees, or adopt even more robust standards.[24]

Family Planning Eligibility. States may also expand eligibility for Medicaid family planning services by seeking a Section 1115 waiver from CMS. This pathway has been in place since the 1990s. Since the passage of the ACA, states also have access to a second and more permanent pathway, a State Plan Amendment (SPA). Both types of programs expand Medicaid coverage for family planning services to people who would not otherwise be eligible for Medicaid. As such, these waivers play a key role in ensuring low-income people's access to family planning services, especially in non-expansion states. These programs also provide coverage for people with incomes above Medicaid eligibility cutoffs, and for adolescents and others who may have private insurance but require confidential care.[25] As of August 1, 2019, 25 states operated a family planning expansion program, though eligibility and services covered vary widely among states.[26,27]

Medicaid Managed Care. Historically, Medicaid operated as a fee for service program, in which health care providers submitted claims for services rendered to patients enrolled in Medicaid. Over time, Medicaid's

[21] "Status of State Medicaid Expansion Decisions: Interactive Map," The Henry J. Kaiser Family Foundation, August 1, 2019, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.
[22] Kaiser Family Foundation, "FAQs: Health Insurance Marketplace and the ACA," The Henry J. Kaiser Family Foundation, 2019, https://www.kff.org/health-reform/faq/health-insurance-marketplace-aca/.
[23] Walls et al., "Medicaid Coverage of Family Planning Benefits."
[24] Liz McCaman, "Fact Sheet: State Contraceptive Equity Laws" (National Health Law Program, January 29, 2018), https://healthlaw.org/wp-content/uploads/2018/01/Fact-Sheet-State-Contraceptive-Equity-Laws.pdf.
[25] Allison Orris et al., "Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States," White Paper, May 2019, https://www.manatt.com/Insights/White-Papers/2019/Enhancing-Access-to-Family-Planning-Services-in-Medicaid.
[26] "Medicaid Family Planning Eligibility Expansions," Guttmacher Institute, August 11, 2019, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[27] Walls et al., "Medicaid Coverage of Family Planning Benefits."

delivery system has grown to rely on managed care. As of 2016, more than 80% of Medicaid beneficiaries receive services through managed care programs.[28] These systems are contracted arrangements between state Medicaid agencies and managed care organizations, designed to control costs and increase quality. While most Medicaid Managed Care contracts include family planning services, some states contract with managed care entities that have religious objections to contraception, and referral processes or alternative procedures for patients are not always available or accessible.[29,30] Insurers may also impose other barriers inconsistent with freedom of choice, including requirements that beneficiaries "fail" use of another method before accessing their desired contraception.

Medicare

Also authorized in 1965 under Title XIX of the Social Security Act, Medicare's primary aim is to provide health care coverage for people age 65 and over. Medicare also provides coverage for people under age 65 with certain disabilities or with end-stage renal disease. There is no federal requirement that Medicare cover the cost of contraception. Of the nearly one million women under age 65 who are Medicare beneficiaries, 70% are enrolled in both Medicare and Medicaid ("dual eligibles").[31] Typically, dual eligible individuals must seek documentation of a Medicare coverage refusal before seeking coverage through Medicaid. This had posed challenges for dual eligible individuals seeking to obtain contraception, particularly long-acting methods. In 2017, CMS issued guidance stating that such documentation was not required for contraceptive services.[32]

Title X

The Title X federal family planning program was established in 1970, as part of the Public Health Service Act. Title X is "the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services."[33] The Title X program provides family planning access for low-income individuals, including those (e.g., undocumented persons) who may not be able to access other coverage pathways. In 2018, 40% of Title X users were uninsured; this was more than four times the national rate of non-insurance for adults (13%).[34] For 60% of women who seek contraceptive care from Title X-funded health centers, it is their sole source of health care.[35]

Title X is administered by the Office of Population Affairs (OPA) within HHS as a discretionary grant program. Recipients compete for grants, and funds may then be passed along to subrecipients who are bound by the same requirements as grantees. In 2018, 99 grantees received Title X funds, which supported approximately 4,000 clinics nationwide, including Planned Parenthood health centers, primary care providers, health departments, and faith-based and other private nonprofit organizations.[36] Recent changes in program

[28] Orris et al., "Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States."
[29] Walls et al., "Medicaid Coverage of Family Planning Benefits."
[30] National Women's Law Center, "The Affordable Care Act's Birth Control Benefit: Progress On Implementation and Continuing Challenges," July 29, 2016, https://nwlc.org/resources/the-affordable-care-acts-birth-control-benefit-progress-on-implementation-and-continuing-challenges/.
[31] Kaiser Family Foundation, "Private and Public Coverage of Contraceptive Services and Supplies in the United States."
[32] Centers for Medicare & Medicaid Services, "Frequently Asked Questions (FAQs) Medicaid Family Planning Services and Supplies," January 11, 2017, https://www.medicaid.gov/federal-policy-guidance/downloads/faq11117.pdf.
[33] Office of Population Affairs, "Title X Family Planning," Text, HHS.gov, September 7, 2018, https://www.hhs.gov/opa/title-x-family-planning/index.html.
[34] Christina Fowler et al., "Family Planning Annual Report: 2018 National Summary" (Research Triangle Park, NC: RTI International, August 2019).
[35] Megan L. Kavanaugh, Mia R. Zolna, and Kristen L. Burke, "Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X–Funded Facilities in 2016," *Perspectives on Sexual and Reproductive Health* 50, no. 3 (2018): 101–9, https://doi.org/10.1363/psrh.12061.
[36] Fowler et al., "Family Planning Annual Report: 2018 National Summary."

requirements for Title X recipients have led approximately one-fifth of these grantees and clinics to freeze the use of these funds or to withdraw from the program.[37]

Section 330 of the Public Health Service Act

Section 330 of the Public Health Service Act, commonly known as the "330 grant," provides funding for a nationwide network of community health centers (CHCs), a safety net for people in need, including low-income people, homeless people, agricultural workers, and the uninsured. CHCs include Federally Qualified Health Centers (FQHC) and other community-based health centers. One in six Medicaid beneficiaries receives care in a CHC, and roughly half of CHC patients are Medicaid beneficiaries.[38] These health centers are required to provide comprehensive services, including dental care, mental health services, and family planning, either on site or by arrangement with another provider. Despite this requirement, CHCs vary widely in the extent to which they provide family planning services. For instance, many FQHCs do not dispense the full range of contraceptive methods, particularly long-acting reversible methods. A number of factors, including participating in the Title X program, affect FQHCs' likelihood of offering all contraceptive options.[39]

Under Section 330, FQHCs receive enhanced Medicaid and Medicare reimbursement. Congress created a prospective payment system (PPS) for FQHCs, in recognition of the fact that many FQHC services, including case management, were not typically covered in a fee-for-service Medicaid model. Under PPS, FQHCs receive a single, bundled rate for qualifying visits. States can also initiate alternative payment methodologies as long as each affected FQHC agrees and total reimbursement is not less than it would have been under PPS.

340B Drug Discount Program

The HRSA 340B program is an additional way that the federal Executive Branch enables access to contraception. Qualified entities, as defined by Section 340B of the Public Health Service Act, may access discounted drugs and devices through this program. Estimated drug cost reductions through the program range from 20 to 50 percent.[40] Eligible providers include safety net providers, such as FQHCs and FQHC look-alikes, as well as federal grantees through the Title X Program and the Indian Health Service, as well as STI clinics that receive 318 funds. The limited definition of "qualified entities" prohibits some providers of reproductive health care, including private abortion clinics as well as clinics receiving Title V Maternal Child Health funds, from accessing these discounts and, thus, delivering affordable contraception to their patients.

These funding structures and others often overlap at the facility and patient levels. For instance, an FQHC may receive funding through Medicaid, Medicare, Title X, and Section 330, as well as discounted drugs through the 340B program. A patient may attend a health center that receives Title X funding and discounted drugs through 340B, regardless of their insurance coverage, or lack thereof.

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[37] Brittni Frederiksen et al., "Data Note: Impact of New Title X Regulations on Network Participation," The Henry J. Kaiser Family Foundation, August 27, 2019, https://www.kff.org/womens-health-policy/issue-brief/data-note-impact-of-new-title-x-regulations-on-network-participation/.
[38] Robert S. Nocon et al., "Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings," October 7, 2016, http://ajph.aphapublications.org/.
[39] Waxman Strategies, "Factors Influencing Access to Long-Acting Reversible Contraceptives at Federally Qualified Health Centers," July 2019, https://waxmanstrategies.com/wp-content/uploads/2019/07/FQHC-LARC-Project_Policy-White-Paper.pdf.
[40] Waxman Strategies.

The Challenges

Despite the existence of multiple funding strategies for contraception, critical gaps persist in access to contraception. As of 2010, half of the women in need of publicly funded contraception remained unserved by the existing system.[41] According to data compiled by Power to Decide, over 19 million U.S. women currently live in "contraceptive deserts," defined as lacking reasonable access to a health center with the full range of methods.[42] **Exhibit 3** and the section that follows detail specific gaps identified through an environmental scan of published scientific literature and expert white papers. This does not represent an exhaustive list of gaps in contraceptive access.

Exhibit 2. Challenges Related to Contraceptive Care

Method-Specific	Population-Specific
• Long-Acting Reversible Contraception (LARC) • Vasectomy • Over-the-Counter Contraceptives	• People Without Health Insurance • People Living in Rural Areas

Method-Specific Gaps

Long-Acting Reversible Contraception (LARC)

LARC encompasses two types of contraceptive methods, the implant and intrauterine devices. Cost-related barriers to LARC methods have been well-documented and have been the subject of numerous interventions at the institutional, state, and national levels over the past two decades. Examples include the Contraceptive CHOICE Project,[43] the Colorado family planning initiative,[44] and the Association of State and Territorial Health Officials (ASTHO) multistate Immediate Postpartum LARC Learning Community.[45] CMS released thorough guidance for states in 2016, aimed at reducing barriers to LARC access; this is described in greater detail in the section below on Previous Work to Expand Access.[46]

Despite efforts to improve LARC access, a recent analysis of fee-for-service state Medicaid programs documented gaps in reimbursement for critical associated services, including contraceptive counseling and follow-up care.[47] The high up-front cost of stocking LARC devices also continues to be a barrier for many providers, especially those who cannot access HRSA's 340B program. Strategies suggested by CMS, professional

[41] Christine Dehlendorf et al., "Disparities in Family Planning," *American Journal of Obstetrics and Gynecology* 202, no. 3 (March 2010): 214–20, https://doi.org/10.1016/j.ajog.2009.08.022.
[42] Power to Decide, "Access to Birth Control and Contraceptive Deserts | Power to Decide," April 2019, https://powertodecide.org/what-we-do/information/resource-library/access-birth-control-and-contraceptive-deserts. Power to Decide defines "reasonable access" as at least one health center or provider for every 1,000 women in need of publicly funded contraception.
[43] Colleen Mcnicholas et al., "The Contraceptive CHOICE Project Round Up: What We Did and What We Learned," *Clinical Obstetrics and Gynecology* 57, no. 4 (December 2014): 635–43, https://doi.org/10.1097/GRF.0000000000000070.
[44] Sue Ricketts, Greta Klingler, and Renee Schwalberg, "Game Change in Colorado: Widespread Use Of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women," *Perspectives on Sexual and Reproductive Health* 46, no. 3 (2014): 125–32, https://doi.org/10.1363/46e1714.
[45] Charlan D. Kroelinger et al., "State-Identified Implementation Strategies to Increase Uptake of Immediate Postpartum Long-Acting Reversible Contraception Policies," *Journal of Women's Health* 28, no. 3 (November 2, 2018): 346–56, https://doi.org/10.1089/jwh.2018.7083.
[46] Vikki Wachino, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," April 8, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf.
[47] Veronica X. Vela et al., "Rethinking Medicaid Coverage and Payment Policy to Promote High Value Care: The Case of Long-Acting Reversible Contraception," *Women's Health Issues* 28, no. 2 (March 1, 2018): 137–43, https://doi.org/10.1016/j.whi.2017.10.013.

organizations,[48] and advocates[49] have been implemented unevenly by states.[50] Utilization controls may also limit access to LARC methods. Despite CMS guidance against medically inappropriate quantity limits, some states continue to report imposing such limits.[51] Dispensing limits also undermine access to hormonal contraceptives, like the oral contraceptive pill.

Vasectomy

The ACA's requirement that health plans cover contraception with no cost sharing is limited to methods used by "women" and specifically excludes "services for male reproductive capacity, like vasectomies." In the absence of insurance coverage, the cost of a vasectomy ranges from $300 to $3,500.[52] Providers also cite low reimbursement rates as a reason that they do not offer vasectomy. As a result of these payment barriers, as well as a dearth of trained providers, only 7% of family planning clinics in the U.S. provide vasectomy services.[53]

Over-the-Counter Contraceptives

Medicaid coverage for over-the-counter contraceptives varies between states and within states by pathway to coverage (traditional Medicaid, Medicaid managed care, or family planning expansion program). In 2016, 22 states reported covering all four methods of over-the-counter contraception in their Medicaid programs.[54] However, even within those states, many require a prescription for reimbursement. For instance, 35 states cover levonorgestrel emergency contraception in their Medicaid program, but 27 of these require patients to obtain a prescription.

Population-Specific Gaps

People Without Health Insurance

While the ACA considerably reduced the number of U.S. adults without health insurance, in 2017, over 27 million non-elderly U.S. adults (approximately 10% of the population) lacked coverage.[55] Many uninsured people cite high cost as the reason they lack health insurance**.**

While most of the uninsured (75%) are U.S. citizens, non-citizens face additional challenges to obtaining insurance coverage. Undocumented immigrants are not eligible for Medicaid or other federally funded health coverage. Consequently, 45% of undocumented non-elderly people lack health insurance.[56] Even documented

[48] Kroelinger et al., "State-Identified Implementation Strategies to Increase Uptake of Immediate Postpartum Long-Acting Reversible Contraception Policies."
[49] The National Institute for Reproductive Health, "Enhancing Long-Acting Reversible Contraception (LARC) Uptake and Reimbursement at Federally Qualified Health Centers: A Toolkit for States," October 2016, https://www.nirhealth.org/wp-content/uploads/2016/11/LARC-Toolkit.pdf.
[50] Orris et al., "Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States."
[51] Walls et al., "Medicaid Coverage of Family Planning Benefits."
[52] Kari White et al., "Barriers to Offering Vasectomy at Publicly Funded Family Planning Organizations in Texas," *American Journal of Men's Health* 11, no. 3 (May 2017): 757–66, https://doi.org/10.1177/1557988317694296.
[53] White et al.
[54] Walls et al., "Medicaid Coverage of Family Planning Benefits." The four over-the-counter methods of contraception are the male condom, the sponge, levonorgestrel emergency contraception, and spermicides.
[55] Kaiser Family Foundation, "Key Facts about the Uninsured Population," The Henry J. Kaiser Family Foundation, December 7, 2018, https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.
[56] Samantha Artiga and Maria Diaz, "Health Coverage and Care of Undocumented Immigrants" (Henry J. Kaiser Family Foundation, July 15, 2019), https://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/.

("legal") immigrants must live in the U.S. for at least five years before they can qualify for Medicaid coverage.[57] Title X is, thus, an especially important contraceptive access pathway for immigrants.

Of the 20.2 million women likely in need of publicly funded contraceptive services, 4.5 million (23%) are uninsured.[58] In a 2018 survey, only 68% of uninsured respondents reported that they received the contraceptive care they wanted, compared to 84% of Medicaid beneficiaries and 94% of those with employer-sponsored insurance.[59]

People Living in Rural Areas

Women living in rural areas are less likely than their urban counterparts to report receipt of reproductive health services in the past year and report traveling farther to seek care.[60] High up-front costs for stocking devices and provider shortages are among the barriers cited by rural health clinics.[61] People using TRICARE or Indian Health Services, who are often required to use specific pharmacies, may be particularly susceptible to access barriers.[62]

The Potential Solutions

Previous Efforts to Expand Contraceptive Access Through Funding Strategies

Federal Stakeholder Work to Expand Access

In 2014, OPA, CMS, and the Centers for Disease Control and Prevention (CDC) jointly convened a partners' meeting to understand payment structures that posed barriers to contraceptive access, as well as solutions that states had developed to overcome them. Partners represented professional medical organizations, state and local health departments, and experts in healthcare policy and economics.

The meeting was intended to inform CMS's Maternal and Infant Health Initiative.[63] This initiative, launched in 2014, focuses efforts in two areas:

1. Improving the rate and content of postpartum visits.
2. Increasing the use of effective methods of contraception among women in Medicaid and the Children's Health Insurance Program (CHIP).

The OPA/CMS/CDC partners' meeting addressed the second area within the Maternal and Infant Health initiative (i.e., increasing the use of effective contraception). In response to feedback obtained at that meeting,

[57] Kaiser Family Foundation, "Key Facts about the Uninsured Population."
[58] Frost, Frohwirth, and Zolna, "Contraceptive Needs and Services, 2014 Update."
[59] Perry Undem, "Exploring Women's Experiences Around Contraceptive Access," 2018, https://www.plannedparenthood.org/uploads/filer_public/a9/f5/a9f59ce1-a3ac-4447-a5a5-ae6380316188/perryundem_exploring_womens_experiences_around_contraceptive_access.pdf.
[60] The American College of Obstetricians and Gynecologists, "Health Disparities in Rural Women, ACOG Committee Opinion No. 586," *Obstet Gynecol* 123 (February 2014): 384–88.
[61] Association of State and Territorial Health Officials, "Rural Health: Increasing Access to Contraception," 2017, https://www.astho.org/ASTHOBriefs/Increasing-Access-to-Contraception_Rural-Health/.
[62] Orris et al., "Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States."
[63] Centers for Medicare & Medicaid Services, "Maternal & Infant Health Care Quality," accessed August 30, 2019, https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-and-infant-health/index.html.

CMS integrated the new payment strategies identified in **Exhibit 4** into the initiative. This guidance was issued as a State Medicaid Director Letter and clarified in a subsequent letter.[64,65,66]

Exhibit 3. Funding Strategies Included in the Maternal and Infant Health Initiative

- Provide timely, patient-centered, comprehensive coverage for the provision of contraceptive services (e.g., contraception counseling; insertion, removal, replacement, or reinsertion of LARC or other contraceptive devices) for people of child-bearing age.
- Raise payment rates to providers for LARC or other contraceptive devices to ensure that providers offer the full range of contraceptive methods.
- Remove logistical barriers for supply management of LARC devices (e.g., addressing supply chain, acquisition, stocking cost, and disposal cost issues).
- Remove administrative barriers for provision of LARC (e.g., allowing for billing office visits and LARC procedures on the same day; removing preauthorization requirements).

Non-federal Stakeholder Work to Expand Access

In addition, non-governmental organizations have undertaken complementary efforts to share guidance and best practices among their stakeholders. For instance, the ASTHO convened a multi-year learning collaborative among its members to explore mechanisms to increase access to immediate postpartum LARC. The findings of this project were disseminated publicly to facilitate broad uptake of the identified strategies, which included provider training, stakeholder engagement, and outreach.[67]

States, including Delaware, South Carolina, and Colorado, have implemented statewide projects aimed at increasing contraceptive access, with particular focus on ensuring access to LARC.[68]

Much of the past work to expand access to contraception has focused on LARC, which are particularly costly for providers to stock and for patients to afford, and for which public funding has been shown to influence uptake.[69] Enthusiasm over LARC's effectiveness within the medical and public health communities also drove the focus on LARC, prompting calls for caution from scholars and reproductive justice advocates.[70,71]

[64] Wachino, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," April 8, 2016..
[65] Vikki Wachino, "Medicaid Family Planning Services and Supplies," June 14, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.
[66] State Medicaid Director (SMD) letters further clarify and communicate policies set forth in regulations. They provide Medicaid-related guidance and clarify statutory and regulatory issues. "Federal Policy Guidance | Medicaid.Gov," accessed September 3, 2019, https://www.medicaid.gov/federal-policy-Guidance/index.html.
[67] Kroelinger et al., "State-Identified Implementation Strategies to Increase Uptake of Immediate Postpartum Long-Acting Reversible Contraception Policies."
[68] Jacobs Institute of Women's Health, The George Washington University, "Long-Acting Reversible Contraception (LARC): State-Level and Regional Research on Reducing Barriers to Access," accessed August 29, 2019, http://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/LARC_State_Research.pdf.
[69] Kirsten M. J. Thompson et al., "Public Funding for Contraception, Provider Training, and Use of Highly Effective Contraceptives: A Cluster Randomized Trial," *American Journal of Public Health* 106, no. 3 (January 21, 2016): 541–46, https://doi.org/10.2105/AJPH.2015.303001.
[70] "NWHN-SisterSong Joint Statement of Principles on LARCs," *National Women's Health Network* (blog), November 14, 2016, https://www.nwhn.org/nwhn-joins-statement-principles-larcs/.
[71] Anu Manchikanti Gomez, Liza Fuentes, and Amy Allina, "Women or LARC First? Reproductive Autonomy and the Promotion of Long-Acting Reversible Contraceptive Methods," *Perspectives on Sexual and Reproductive Health* 46, no. 3 (September 2014): 171–75, https://doi.org/10.1363/46e1614.

Future Directions

To address gaps in the current systems of coverage and care delivery, innovative pathways to expand care have been proposed. However, funding strategies for these have not been well-articulated. Three of these proposed pathways, and associated payment issues, are highlighted in **Exhibit 5** and described in the text that follows. All focus on circumventing practical barriers (e.g., transportation, childcare) that people face in seeking care in clinic-based settings.

Exhibit 4. Current Gaps and Proposed Strategies to Address Them

Gaps		Proposed Strategies
Method-Specific Gaps • Long-Acting Reversible Contraception (LARC) • Vasectomy • Over-the-Counter Contraceptives	**Population-Specific Gaps** • People Without Health Insurance • People Living in Rural Areas	• Over-the-Counter Hormonal Contraception • Pharmacist-Provided Hormonal Contraception • Telemedicine • Value-Based Payment for Contraceptive Care

Over-the-Counter Hormonal Contraception

Over-the-counter oral contraception has been endorsed by many scientific and health care organizations as a crucial strategy to improve access to contraception and reduce related health disparities. Self-care strategies for sexual and reproductive health care have the potential to enhance autonomy, while reducing cost, but only if appropriately financed, with payors reimbursing users fully for the costs of supplies.[72] As described above, coverage for over-the-counter methods, like levonorgestrel emergency contraception and male condoms, is already an identified gap, with variation between state Medicaid programs and between coverage pathways.[73] Unless this gap is addressed, payment issues will hinder the capacity of over-the-counter oral contraception to meaningfully expand contraceptive access.

Pharmacist-Prescribed Hormonal Contraception

Research has shown that the necessity of obtaining a prescription from a clinician is a barrier to timely use of short-acting hormonal contraceptives, including oral contraceptives, the patch, the ring, and the injection.[74] Pharmacist prescribing of hormonal contraception is currently enabled by statute in nine states and the District of Columbia and has the potential to reduce these barriers.[75] Other states, including Washington, have embraced collaborative practice agreements as a strategy to enhance access to hormonal contraception.[76] Pharmacy access models have the potential to benefit patients, as well as provide cost savings to states and

[72] Michelle Remme et al., "Self Care Interventions for Sexual and Reproductive Health and Rights: Costs, Benefits, and Financing," *BMJ* 365 (April 1, 2019): l1228, https://doi.org/10.1136/bmj.l1228.
[73] Walls et al., "Medicaid Coverage of Family Planning Benefits."
[74] Anu Manchikanti Gomez et al., "Facilitators and Barriers to Implementing Pharmacist-Prescribed Hormonal Contraception in California Independent Pharmacies," *Women & Health*, July 2, 2019, 1–11, https://doi.org/10.1080/03630242.2019.1635561.
[75] National Alliance of State Pharmacy Associations, "Pharmacist Prescribing for Hormonal Contraceptive Medications," NASPA, May 24, 2019, https://naspa.us/resource/contraceptives/.
[76] Sally Rafie and Natalie DiPietro Mager, "Pharmacists Provide Contraception for Zika Preparedness," Pharmacy Times, June 21, 2018, https://www.pharmacytimes.com/contributor/sally-rafie-pharmd/2018/06/pharmacists-provide-contraception-for-zika-preparedness.

health systems. Using a decision-analytic model, researchers estimated that Oregon's state Medicaid program saved $1.6 million dollars in the 24 months after the policy was implemented.[77]

While many pharmacists are knowledgeable about contraception and interested in providing these services, reimbursement is a primary concern.[78] Payment strategies vary state-by-state. For instance, in California, the state Medicaid program began reimbursing pharmacists for providing hormonal contraception in 2019, three years after pharmacist provision became legal.[79] In December 2017, only 11% of California pharmacies offered the service.[80]

Telemedicine

Telemedicine services have been proposed as a mechanism to expand access to contraception and other reproductive health services, particularly for people living in rural areas or in other locations where providers are scarce. Telemedicine access to hormonal contraception may be particularly useful for adolescents, who face steeper barriers to care, including transportation, cost, and confidentiality.[81]

The various federal funding mechanisms for contraception described earlier in this document, including Medicaid and Section 330, vary in their coverage of telemedicine services. All currently reimburse only for certain services (e.g., behavioral health) and in limited circumstances (e.g., residing in a Health Professional Shortage Area).

There is little comprehensive information available about existing programs, or about potential funding strategies. One recent study compared platforms on various criteria, including adherence to evidence-based standards and affordability.[82] As of February 2018, nine online platforms prescribed hormonal birth control to women across various states. Six of these platforms charged fees for consultation, and only two of these six accepted insurance for these fees. For instance, Virtuwell, which offered services in 12 states, charged a $49 consult/prescribing fee and accepted some forms of insurance but not Medicaid. Platforms also varied in whether they accepted insurance, including Medicaid, for contraceptive supplies and pharmaceuticals. Since this analysis was completed in February 2018, services for hormonal contraception have continued to grow. As of August 1, 2019, there were 14 online services providing hormonal contraception.[83] Two of the new services will submit prescribing fee charges to insurance companies, though one platform accepts Medicaid in only one state.

Value-Based Payment for Contraceptive Care

Expanding contraceptive access must include mitigating current payment gaps and identifying payment strategies for innovative approaches to expanding care, as described above. In addition, a comprehensive approach will also include broader reforms, consistent with ongoing health care industry transformation. Health care reimbursement in a fee-for-service model has traditionally rewarded the volume of services provided.

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[77] Maria I. Rodriguez et al., "Association of Pharmacist Prescription of Hormonal Contraception With Unintended Pregnancies and Medicaid Costs:," *Obstetrics & Gynecology* 133, no. 6 (June 2019): 1238–46, https://doi.org/10.1097/AOG.0000000000003265.
[78] Gomez et al., "Facilitators and Barriers to Implementing Pharmacist-Prescribed Hormonal Contraception in California Independent Pharmacies."
[79] Fran Kritz, "Pharmacists Can Now Prescribe Birth Control, But Few Do," *California Health Report* (blog), February 15, 2019, https://www.calhealthreport.org/2019/02/15/pharmacists-can-now-prescribe-birth-control-but-few-do-%ef%bb%bf/.
[80] Anu Manchikanti Gomez, "Availability of Pharmacist-Prescribed Contraception in California, 2017," *JAMA* 318, no. 22 (December 12, 2017): 2253–54, https://doi.org/10.1001/jama.2017.15674.
[81] Krishna K. Upadhya et al., "Over-the-Counter Access to Oral Contraceptives for Adolescents," *Journal of Adolescent Health* 60, no. 6 (June 1, 2017): 634–40, https://doi.org/10.1016/j.jadohealth.2016.12.024.
[82] Carmela Zuniga et al., "Breaking down Barriers to Birth Control Access: An Assessment of Online Platforms Prescribing Birth Control in the USA," *Journal of Telemedicine and Telecare*, January 21, 2019, 1–10, https://doi.org/10.1177/1357633X18824828.
[83] Kate Grindlay, "Who Prescribes the Pill Online?," Free the Pill, August 1, 2019, http://freethepill.org/online-pill-prescribing-resources/.

Advocates of health reform have sought to shift reimbursement from this volume-based model to a model based on value. Throughout the past decade, CMS has sought to catalyze this shift, particularly within Medicare.

Value-based payment (VBP) aims to incentivize the provision of high quality care through a variety of mechanisms, including capitation, bundled payments, and by linking reimbursement or other financial incentives to specific patient health outcomes, through performance measurement.[84] In capitation models, providers are reimbursed based on the number of patients they care for, rather than the individual services provided to those patients, while bundled payment models cover all services involved in a single episode of care.

The PPS for FQHCs, described earlier in this document, is an example of a per visit bundled payment model. FQHCs' challenges providing comprehensive contraceptive care under PPS are instructive. In particular, FQHCs identified the PPS model as a barrier to providing LARC methods, which can be costly to purchase. States, with guidance from CMS and national organizations, have implemented various strategies to overcome these barriers.[85,86,87]

Though performance measures for contraceptive care have been developed, endorsed, and implemented in various health systems, there is no model for how these measures should be integrated into VBP. Pay for performance for contraceptive care has been approached, appropriately, with caution, due to the high potential for coercion.[88] There are numerous historical examples of coercive contraceptive practices, primarily affecting people of color, people with disabilities, and incarcerated persons.[89] Studies exploring patients' experiences of contraceptive counseling document continued coercive practices, both implicit and overt, by providers.[90,91]

Given this historical and cultural context, various potential directions for integrating performance measures and funding strategies could be considered, including:

- Developing VBP models in meaningful partnership with community-based organizations, advocates, and patients.
- Linking financial incentives only to the reporting of performance data, rather than linking incentives to particular outcomes.
- Delaying implementation of VBP until tandem performance measures, meant to balance patient experience and outcome, have been developed and endorsed.

[84] NEJM Catalyst, "What Is Value-Based Healthcare?," NEJM Catalyst, January 1, 2017, https://catalyst.nejm.org/what-is-value-based-healthcare/.
[85] The National Institute for Reproductive Health, "Enhancing Long-Acting Reversible Contraception (LARC) Uptake and Reimbursement at Federally Qualified Health Centers: A Toolkit for States."
[86] Wachino, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," April 8, 2016.
[87] National Association of Community Health Centers, "Advancing Quality Family Planning Practices: A Guide For Health Centers," April 2017, http://www.nachc.org/wp-content/uploads/2017/06/NACHC_FPBooklet_FINAL-WEB-06-05-17.pdf.
[88] The American College of Obstetricians and Gynecologists, "Value-Based Payments in Obstetrics and Gynecology, ACOG Committee Opinion No. 744," *Obstet Gynecol* 132 (July 25, 2018): e53–9.
[89] Though these categories are listed separately, individuals and communities can – and often do – possess multiple marginalized identities and experience intersecting forms of discrimination.
[90] Anu Manchikanti Gomez and Mikaela Wapman, "Under (Implicit) Pressure: Young Black and Latina Women's Perceptions of Contraceptive Care," *Contraception* 96, no. 4 (October 1, 2017): 221–26, https://doi.org/10.1016/j.contraception.2017.07.007.
[91] Kristyn Brandi et al., "An Exploration of Perceived Contraceptive Coercion at the Time of Abortion," *Contraception* 97, no. 4 (2018): 329–34, https://doi.org/10.1016/j.contraception.2017.12.009.

The Call to Action

Multiple federal policies, processes, and programs support contraceptive access, yet gaps remain. Comprehensive funding strategies, linked to clinical and programmatic guidelines and performance measures, can improve individuals' ability to access needed contraceptive care, medications, and supplies, as well as associated services. **Exhibit 6** lists potential actions that could expand contraceptive access through funding strategies. This work will set the stage for subsequent recommendations that can be made to the federal Executive Branch. This list is not exhaustive and additional suggestions are welcomed.

Exhibit 5. Potential Actions to Expand Funding Strategies

Commission a systematic review or other formal review of the literature

This briefing document is based on an informal environmental scan of the limited published literature, white papers, other expert reports, publicly available government documents, and informal communication with experts. A more formal review of the literature may provide a needed foundation for future evidence-based reforms.

Devise a single, comprehensive definition of family planning services for adoption by federal agencies

The minimum floor of family planning services that must be provided differs between Medicaid coverage pathways and between federal programs (e.g., Title X). The absence of a consistent minimum federal definition of family planning care underlies many of the method- and population-specific gaps in contraceptive access. A single federal definition of family planning services, aligned with clinical and programmatic guidelines (e.g., "Providing Quality Family Planning Services"), could facilitate greater consistency across coverage pathways and between states, enabling people to access the same range of methods and services regardless of their source of coverage.[92] Devising and implementing this definition would need to be undertaken with care to avoid unintended consequences, like reductions in coverage within states using broader definitions. This process would require engagement with a wide range of non-federal and federal stakeholders.

Convene diverse stakeholders to generate recommendations to advance current funding strategies

The 2014 partners meeting convened by OPA serves as a model for gathering and integrating input about funding strategies (policies, payment strategies, use of grant funds) from various stakeholders, including health care providers, patient advocates, legal organizations, and experts in reimbursement and health economics. A stakeholders meeting could generate new recommendations for CMS and other federal stakeholders. Such a convening could constitute an important opportunity to engage individuals and communities directly affected.

[92] Loretta Gavin et al., "Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population Affairs," *MMWR Recommendations and Reports* 63, no. RR-4 (April 25, 2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

Coordinate with those advancing innovative care delivery approaches to identify appropriate funding strategies

Various organizations are working to explore innovative strategies to enhance contraceptive access, including over-the-counter contraception, pharmacy provision, and telemedicine. These efforts should be coordinated and emerging strategies should be aligned with and potentially incorporated into recommendations for federal agencies.

Facilitate the development of value-based payment models for contraception

VBP can help to drive the delivery of higher quality clinical care. Yet the integration of contraception into VBP must be undertaken with sensitivity to historical and cultural context, and without disincentivizing thorough contraceptive care or the provision of particular methods. A multi-stakeholder effort should underlie the development of a strategy for integrating contraception into VBP and guide its implementation. This may involve convening experts in health care reform, health economics, reproductive health and justice, and health equity, among other fields, in order to map a path forward.

Identify opportunities to leverage federal processes and funding strategies for workforce development

An adequate, appropriately trained workforce is essential for the provision of family planning services. Recommendations to expand training programs, loan reimbursement, and other funding strategies could emerge from workforce analyses, evaluations of state-based initiatives, and expert input.

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