# UNBUNDLING REIMBURSEMENT FOR **LONG-ACTING, REVERSIBLE CONTRACEPTION AT FEDERALLY QUALIFIED HEALTH CENTERS**:

# A CASE STUDY OF GEORGIA MEDICAID'S EXPERIENCE


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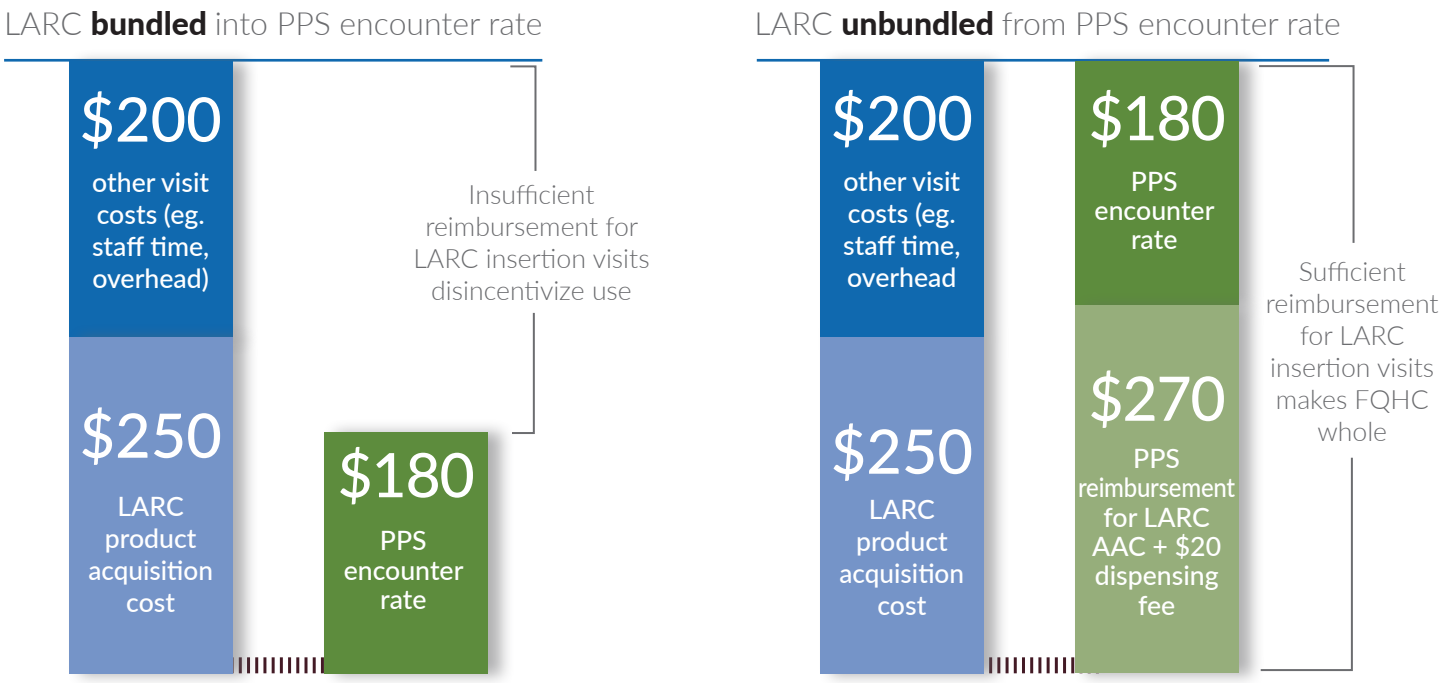
# PURPOSE

**The purpose of this case study is to document the Georgia Medicaid program's experience with unbundling long-acting, reversible contraception (LARC) devices and services from the Medicaid prospective payment system (PPS) for reimbursement in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).** This analysis is intended for policymakers and stakeholders in other states pursuing Medicaid reimbursement strategies with the overall goal of improving women's equitable access to high-quality contraception across healthcare providers, particularly in FQHCs. The hypothesis was that unbundling reimbursement of LARC devices from the Medicaid PPS reimbursement rate would increase LARC availability and utilization in FQHCs. Please note this case study only considers the policy change's impact on Medicaid fee-for-service (FFS) because the LARC unbundling reimbursement policy only applies to Medicaid (FFS). Where possible, we provide information gathered on Medicaid Managed Care to enable stakeholders' future evaluation of these policies in the Medicaid Managed Care setting.

# INTRODUCTION

Medicaid is of particular importance for women of reproductive age throughout the United States. Medicaid accounts for 75% of federal expenditures for family planning services.[i] The Centers for Disease Control and Prevention (CDC) recommends that women be provided with patient-centered counseling and services related to the full range of contraceptive methods, but low-income women often face barriers in accessing high-quality, comprehensive counseling and services, particularly to higher-cost methods such as LARCs. Reimbursement policies for LARC methods and services are complex, particularly under Medicaid, and often do not account for the cost of LARCs. Unbundling reimbursement for LARC devices and services from bundled payment systems so that the state can provide adequate reimbursement may increase the likelihood that safety net clinics, such as FQHCs, will purchase and provide these methods to more women. Removing reimbursement barriers to both insertion and removal of LARC devices is a key component of these policies, to make sure that provider incentives are aligned with women's autonomy and choice in use of LARC methods. In 2019, research conducted by Medicines360 and Waxman Strategies identified unbundling LARC reimbursement from the PPS encounter rate as a key enabler to LARC access in FQHCs as demonstrated in Figure 1.[ii] For more background information on this reimbursement strategy please see Enhancing Long-Acting Reversible Contraception (LARC) Uptake and Reimbursement at Federally Qualified Health Centers: A Toolkit for States.

**Figure 1:** Example Reimbursement Comparison:
FQHC PPS Encounter Rate vs. LARC Costs Unbundled from PPS Encounter Rate*




*Number provided in Figure 1 are illustrative in nature and should not be cited as actual costs.

The Georgia Medicaid program has taken several steps to increase access to family planning services, particularly for beneficiaries covered through FFS:

- In 2011, Georgia established the Planning for Healthy Babies (P4HB) Program as a Section 1115 Demonstration Waiver that provides family planning services at no cost, including LARC services, to low-income women otherwise not eligible for Medicaid.
- In 2014, Georgia Medicaid adopted a policy that allows FFS Medicaid to reimburse facility, physician, and ultrasound costs for LARC devices inserted immediately post-partum after childbirth in an inpatient hospital setting.
- In 2015, Georgia Medicaid began allowing FFS Medicaid to unbundle reimbursement of LARC devices from the PPS for FQHCs and RHCs. Georgia received State Plan Amendment (SPA) approval[iii] from the Centers for Medicare and Medicaid Services (CMS) to separately reimburse FQHCs/RHCs for the actual acquisition cost when those clinics purchase a LARC device through the 340B program.[iv]

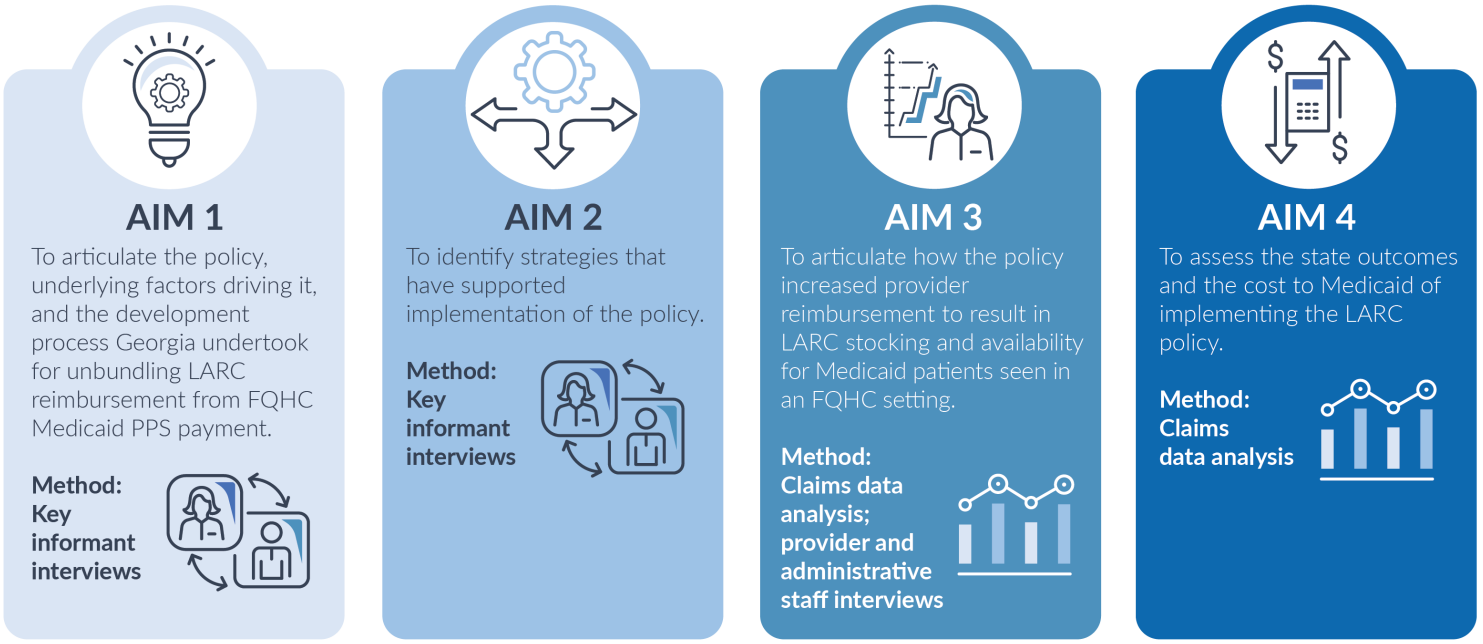
The policy change in Georgia for LARC reimbursement post-partum foreshadows and offers lessons for implementing the FQHC policy. This case study offers a summary of the state's post-partum reimbursement implementation experience followed by an in-depth analysis of the implementation and impact of the FQHC/RHC LARC unbundling policy. Based on Georgia's experience, we summarize the most important elements required for successful implementation and optimal impact of the policy change.

Health Management Associates and Medicines360 conducted interviews with key stakeholders in Georgia to understand the state's decision to unbundle reimbursement for LARC devices and services from the Medicaid PPS for FQHCs. We have also analyzed Medicaid claims data for the period following the FQHC policy change to assess the policy's impact.

# GEORGIA FQHC LARC UNBUNDLING CASE STUDY AIMS AND METHODS

This case study intends to be an educational tool for other states interested in considering similar policy changes. The primary research question was: How has the development and implementation of unbundling LARC reimbursement from the FFS Medicaid PPS in FQHCs/RHCs impacted utilization of services among Medicaid beneficiaries in Georgia? It further involved the following four aims, with aligned data collection methods to explore them.

**Figure 2:** Case Study Aims and Methods




Over the course of 2020, the Medicines360 and Health Management Associates teams collaborated with Georgia stakeholders including the Healthy Mothers, Healthy Babies Coalition of Georgia, Georgia Family Planning System, and the Georgia Department of Community Health (DCH) to gather data from health care provider, researcher, and policymaker interviews, as well as Medicaid claims data. The COVID-19 pandemic limited the research team's ability to schedule and complete some key informant interviews and the planned patient focus groups; however, despite these limitations the team was still able to gather a substantial amount of quantitative and qualitative data to inform the findings below.

# GEORGIA FAMILY PLANNING EXPANSION EFFORTS

In 2010, 60 percent of all pregnancies in Georgia (119,000) were unintended.[v] Unintended or closely spaced pregnancies can have negative health and economic consequences for women and their families. Georgia ranks 47 out of 50 in the CDC's low birth weight measures.[vi] Approximately 80 percent of unplanned births in Georgia were publicly funded, compared with 68 percent nationally.[vii] This suggests that Georgia has less access to comprehensive, patient-centered contraceptive counseling and services.

Access to LARCs is an important part of comprehensive and patient-centered family planning and broader measures to support women's health and economic well-being. The following summary details the two LARC reimbursement policies that Georgia's Medicaid program passed to improve LARC access and utilization.

## *Post-Partum LARC Reimbursement Policy Change*

In preparing this case study, we determined that an earlier policy passed by the Georgia Medicaid program set the stage for the FQHC LARC unbundling policy. On April 1, 2014, the Georgia FFS Medicaid program began reimbursing facility, physician, and ultrasound costs for the placement of LARC devices inserted immediately post-partum in an inpatient hospital setting, enabling hospitals to offer LARC placement to interested patients immediately (within 10 minutes) after childbirth.[viii] (See Appendix A for a more detailed discussion of this policy.) Lessons from this effort included:

- **Implementation Process:** Initial implementation challenges contributed to a lower-than-expected impact of the policy change, including: 1) lack of communication to all necessary hospital departments, and 2) confusion over hospital billing instructions and problems with claims system edits/denials.
- **Cost Effectiveness:** Georgia Medicaid had previously reported savings from the Planning for Healthy Babies Program implemented in 2011 which included a LARC initiative. Additionally, the post-partum LARC reimbursement policy has shown success in preventing repeat very low birth weight births for Medicaid enrollees.[ix]

## *FQHC and RHC LARC Reimbursement Policy Change*

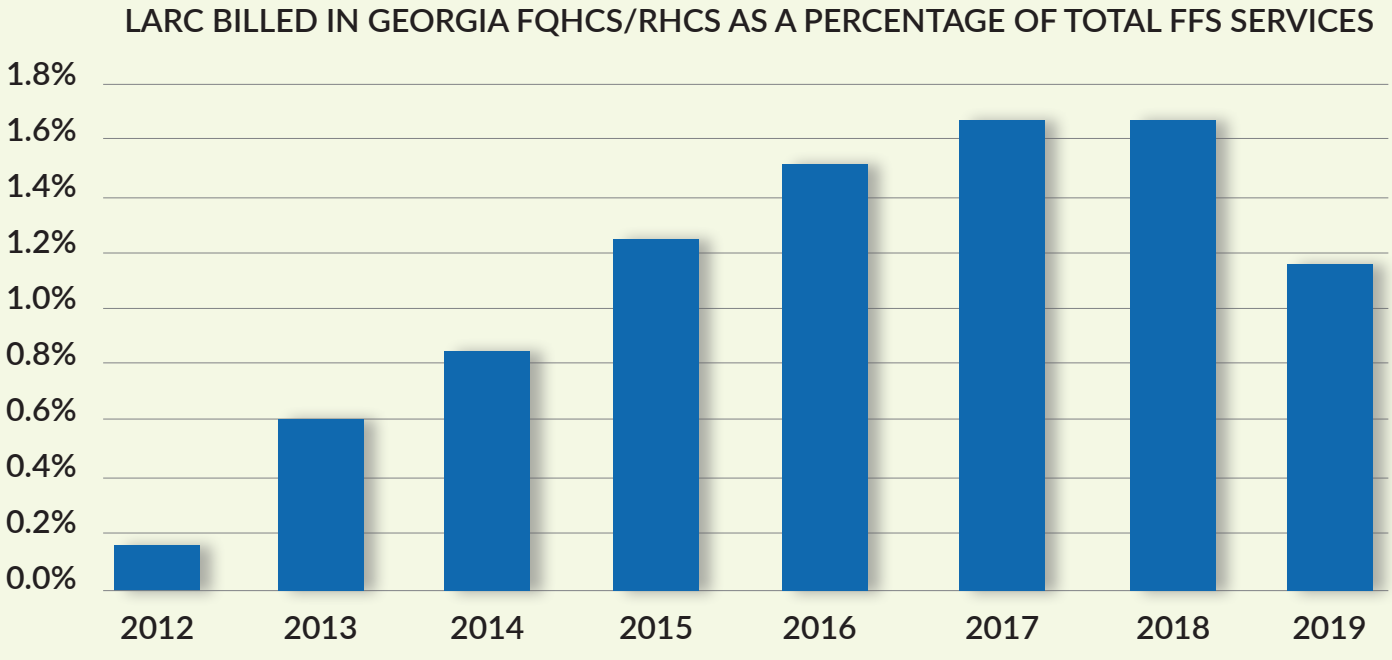
Following the LARC post-partum reimbursement policy change, the Georgia Medicaid program used a Medicaid State Plan Amendment (SPA) to change its Medicaid payment policy for LARCs to address the payment disincentive for FQHCs and RHCs to offer LARC methods. Prior to unbundling the reimbursement of LARC devices from the PPS in FQHCs and RHCs, administrators and providers in these types of clinics were disincentivized from offering consistent LARC services as the PPS rates were not considered sufficient to cover provision of comprehensive LARC services. Effective May 15, 2015, the state Medicaid program instituted a policy that: 1) reimburses FQHCs and RHCs for the purchase of LARC devices outside of the PPS rate, and 2) provides separate fee-for-service reimbursement to hospital-based practitioners in these settings for LARC insertion. Clinicians providing LARC services in freestanding outpatient FQHC and RHC settings can bill for the LARC device but are reimbursed for insertion and removal through the existing PPS all-inclusive rate which typically does not adequately cover these costs. Provider-based RHCs that operate as part of a hospital can bill separately for the device, insertion, and removal. These changes apply to FFS Medicaid only, not to Medicaid Managed Care.

# KEY FINDINGS FROM THE LARC UNBUNDLING POLICY CHANGE IN FQHCS AND RHCS

Health Management Associates analyzed Georgia Medicaid claims data to understand whether the unbundling reimbursement policy change could have increased LARC utilization. HMA analyzed FFS and managed care LARC utilization data from 2012 to 2019 to identify trends in the proportion of LARC services for Medicaid enrolled women of reproductive age. The total number of Women of Reproductive Age (WRA) in Georgia's Medicaid FFS is 15% of the total Medicaid population, with Medicaid Managed Care covering 85%.

**Modest Increases Observed in FFS Medicaid Funded LARCs.** The Georgia Medicaid FFS data for the period following the unbundling policy change shows that the percentage of FQHC/RHC services that were LARC encounters gradually increased through 2018 and does correlate with the timing of the LARC FQHC unbundling policy. The claims data show the rate of increase was most prominent in 2015 and 2016: 36.8% in 2015 and 23.5% in 2016. Overall, the rate of LARC utilization increased from 1.2% of Medicaid enrolled women of reproductive age receiving services at FQHCs/RHCs in 2015 to 1.7% in 2018 (Figure 3). The explanation for the decrease in 2019 utilization is unclear based on our interviews with key informants. However, the Family Planning Annual Report shows a 21% decrease in number of Title X program family planning users from 2018 to 2019 nationwide.[x] For women enrolled in Medicaid Managed Care, LARC utilization increased in 2015 by 98%, but we do not see sustained growth in utilization over the following years. This is despite continued growth in managed care enrollment. Managed care data is not included in Figure 3 because the focus of this

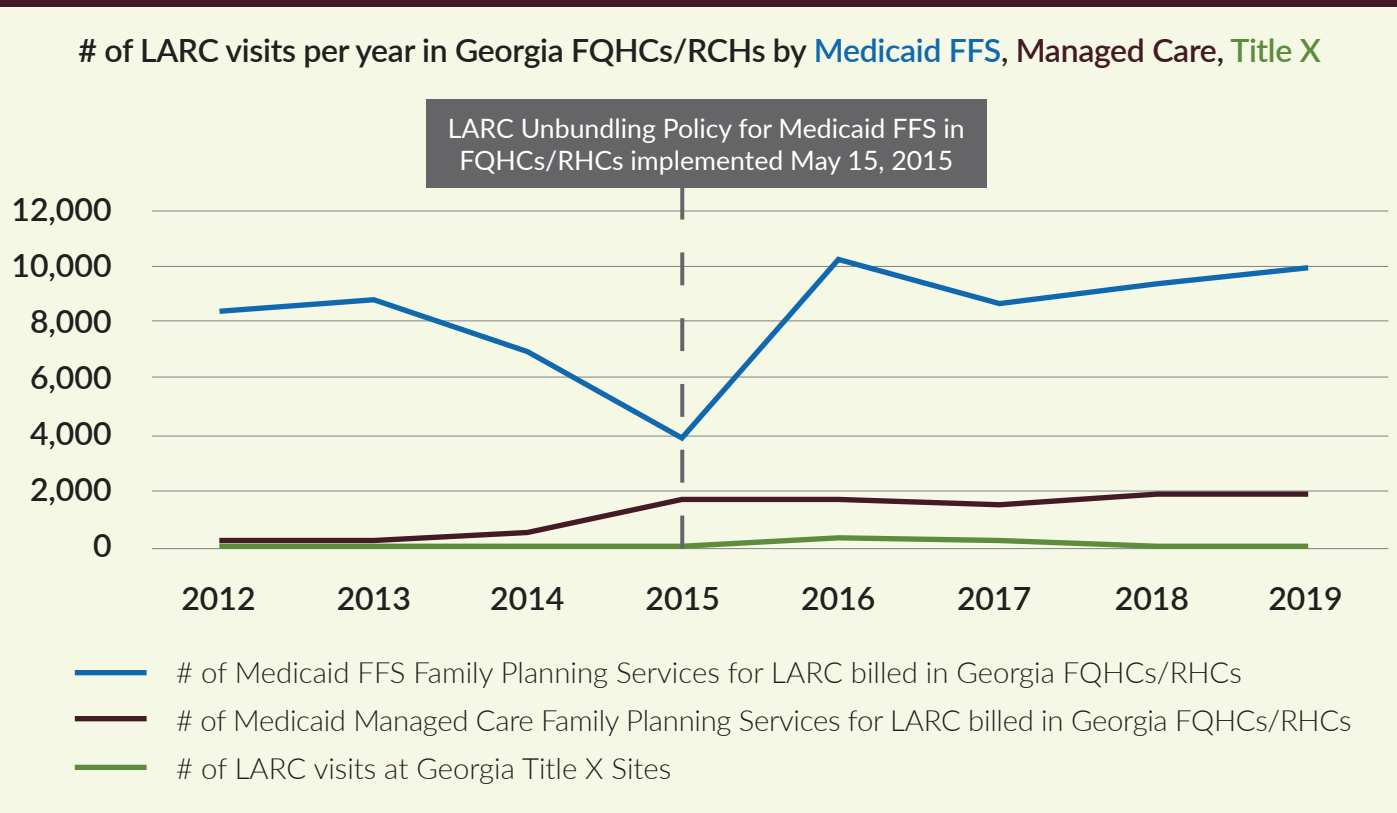
**Figure 3:** Percentage of Family Planning Services for LARC billed in Georgia FQHCs/RHC's



study was on FFS payments. However, further research is warranted to fully understand how managed care plans are incorporating state unbundling reimbursement polices into their own reimbursement arrangements with FQHCs.

**Title X Funding may have Impacted Medicaid Trends.** The transition of Title X grantee status from Georgia Department of Public Health to The Family Health Centers of Georgia, Inc. (FHCGA), an FQHC, which occurred in 2014, may be a confounding factor in the findings related to Medicaid-funded LARC utilization. The Title X program transition occurred one year before we would expect to see the impact of the unbundling policy. LARC utilization at Georgia Title X sites did not show an increase in 2014 or 2015. However, LARC utilization in Title X did show an increase in 2016 that is mostly sustained over subsequent years (Figure 4). There are several factors that may have played a role in Title X providers' ability to increase LARC utilization. First, the FHCGA Title X program, known as Georgia Family Planning System, established a LARC purchasing pool for FQHCs to fund the purchase of LARCs and assist providers in addressing device stocking challenges. Second, the Title X program's clinical training for providers likely played a role in helping providers to increase LARC utilization. See detailed data in Appendix B.

**Figure 4:** LARC visits per year in Georgia FQHCs/RHCs by Medicaid FFS and Medicaid Managed Care Vs. Title X funded LARC visits per year*



# IMPLEMENTATION LESSONS LEARNED

While the Georgia Medicaid claims data does support the hypothesis that the unbundling policy contributed to an increase in LARC utilization, it is possible that several factors in the policy implementation process blunted the full effects of the policy. Several key implementation-related challenges may have impacted Georgia's outcomes during the study period and provide important lessons for other states considering the best approach to implementation:

**Policy Champions and Stakeholder Engagement:** The lead supporters for the LARC reimbursement reforms were the Obstetrics and Gynecology (OB/GYN) Society of Georgia, Georgia Department of Public Health, and the Association of State and Territorial Health Officials (ASTHO). These three entities, but primarily the OB/GYN Society, provided political and technical support to DCH as staff worked through the budget and policy analysis. One unanticipated consequence, however, is that the OB/GYN Society of Georgia was mostly focused on the post-partum policy, rather than the FQHC/RHC unbundling policy. As a result, providers may have been less aware of the FQHC/RHC unbundling policy during development and subsequently during implementation. *Strong support from policy champions and key stakeholders, along with widespread and sustained engagement on the policy development process, are essential to helping providers become engaged in the implementation process.*

**Provider Training and Education:** The provider communication about the unbundling policy was limited to an update in the DCH's monthly provider bulletin. In hindsight, key informants believed the lack of a broader communication plan may have contributed to providers' limited awareness or understanding of the new unbundling policy. Additionally, because several FQHC and RHC providers have limited expertise in LARC insertion and removal, provider training needs may have contributed to the lower-than-expected increase in LARC utilization. FQHCs/RHCs have a smaller infrastructure, with fewer medical staff and less staff dedicated to billing, and may have less capacity to implement billing changes. *FQHCs and RHCs with low staffing levels, high turnover, or low volume of family planning services need to have ongoing access to training related to LARC insertion and removal as well as billing protocols.*

**Complexity of Family Planning Funding Sources:** As noted, another potential influence of lower-than-expected Medicaid billing was the transition of Georgia's Title X grant from Department of Public Health to The Family Health Centers of Georgia, Inc., in 2014. This transition caused confusion among some providers regarding whom to bill. Title X funding can be used for a variety of infrastructure, training, and family planning services. Title X funding covers family planning services for individuals not eligible for Medicaid as well as some services for Medicaid enrollees that are not included in the state's Medicaid benefit. Because there is some overlap in services covered as well as ambiguity related to obtaining third-party payment for Title X eligible patients, some providers may have viewed the flexibility of Title X grant funds as easier to use than billing Medicaid for LARC. Key informants also shared that stocking LARCs to facilitate timely availability was initially a challenge for FQHCs who were previously unaccustomed to offering this service. The Georgia Title X program's use of a purchasing pool for LARCs was designed to assist with this stocking challenge, but also may have led to a larger share of LARC services being billed to Title X versus Medicaid in FQHCs. *Clarifying guidance from federal agencies would assist providers' understanding of the hierarchy and eligibility requirements related to Medicaid and Title X family planning funding. States should include related technical assistance to providers as a key component of their implementation process.*

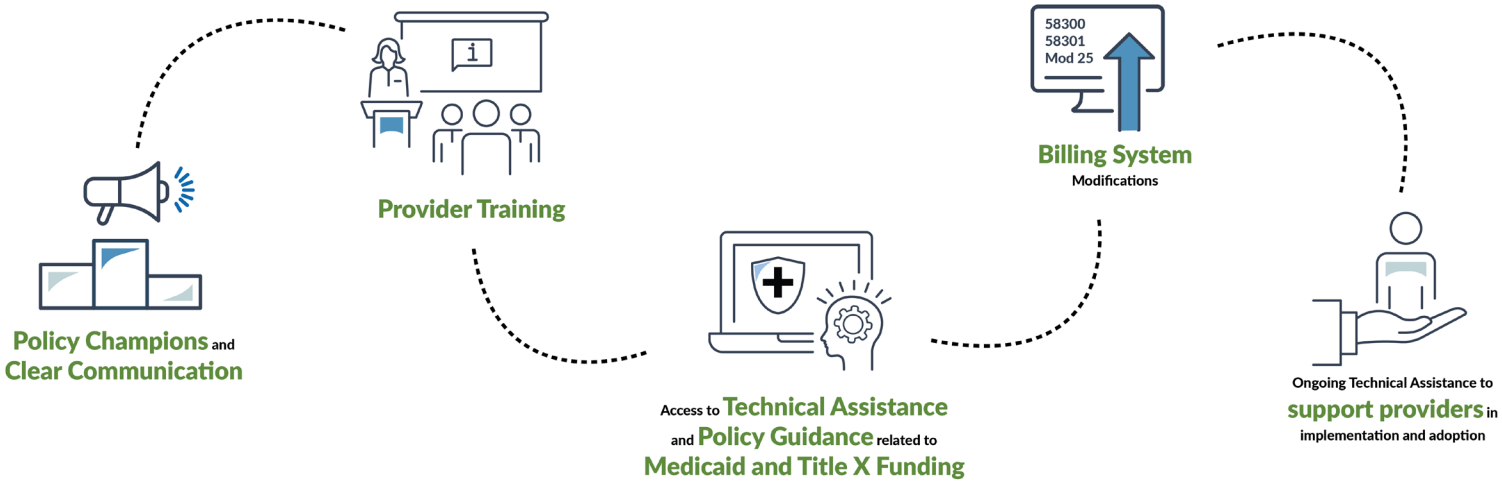
**System Programming:** To implement the reimbursement policy changes, Georgia DCH needed to make programming changes to its claims payment system, the Medicaid Management Information System. The required reprogramming took almost one year, much longer than expected. During this same timeframe, the state's online Medicaid eligibility determination system, Georgia Gateway, was only available during business hours, limiting access for women to apply for coverage. *As part of the implementation process, states should plan for related information systems modifications and allow adequate time for completion prior to policy start date.*

**Other Considerations:** This case study did not aim to assess the patient populations outside of Medicaid FFS in the FQHC/RHC setting. However, the data suggests that all patient populations should be considered in policy changes to address equitable access to care. FQHCs/RHCs care for Medicaid FFS, managed care, uninsured and privately insured patients. Title X data from the Family Planning Annual Report[xi] suggest that all patient populations still face unmet need. FQHCs/RHCs play a vital role in serving a wide variety of patient populations. *Future research is needed to evaluate how the FQHC unbundling policy for LARC services can address unmet need for populations other than those covered under FFS Medicaid.*

# CONCLUSION

The Georgia Medicaid claims analysis shows a correlation between the timing of the LARC unbundling policy and modest increases in LARC utilization at FQHCs and RHCs. The Georgia Medicaid program's implementation experience shows that the unbundling policy change alone is not sufficient to substantially increase access to LARC methods. Key informant interviews suggest that the policy change could have been more impactful with improved provider awareness, communication, and other mitigations to implementation challenges – highlighting the critical importance of addressing implementation factors in addition to policy change. These factors are illustrated below in Figure 5. An additional reason for the modest impact of the policy change may be the award of the Title X grant

**Figure 5:** Implementation Factors in Addressing LARC Access Barriers



to The Family Health Centers of Georgia, an FQHC, in Georgia in 2014, just after the Medicaid unbundling policy was approved. This award, combined with lack of clarity regarding Medicaid versus Title X reimbursement, may have resulted in Title X funding playing a larger role for FQHCs in funding LARC access. For states considering implementing an FQHC/RHC LARC unbundling policy, several key elements need to be in place to support the greatest impact. A comprehensive provider communication plan is essential to inform providers of the policy. Training opportunities should be made available to FQHC and RHC providers to address administrative and clinical barriers that may arise, such as billing questions and comfort level with LARC insertion and removal. Finally, time and resources required for the necessary system reprogramming should be prioritized in the early planning stages given that these steps often take longer than projected.

# APPENDIX A: GEORGIA POST-PARTUM LARC REIMBURSEMENT BACKGROUND

Starting April 1, 2014, the Georgia FFS Medicaid program reimbursed facility, physician, and ultrasound costs for placement of LARC methods inserted immediately post-partum after childbirth in an inpatient hospital setting. The post-partum policy change made LARC coverage an additional benefit separate from the reimbursement for labor and delivery costs, enabling hospitals to offer LARC placement to interested Medicaid patients immediately (within 10 minutes) after childbirth.[xii] The new covered benefits included: 1) device insertion immediately post-partum in hospital setting, and 2) ultrasound for guiding placement. The revised payment methodology included: 1) add-on payment outside of the applicable DRG, and 2) physician allowance to bill for insertion and device, if applicable.

## *Lessons from Georgia's Post-partum LARC Policy Change*

**Implementation Process:** Initial implementation challenges contributed to lower-than-expected impact of the policy change, including: 1) lack of communication to all necessary hospital departments, and 2) confusing hospital billing instructions and problems with claims system edits/denials. For learnings and good practice information, the Georgia post-partum LARC process has shown that policy changes alone do not equal successful implementation and that quality improvement is challenging when there is no set process to improve. Recognizing that change is not a linear process, creating the opportunity to share ideas/barriers, shared learning opportunities, and resource development are critical.[xiii]

**Cost Effectiveness:** Georgia had previously reported savings from the LARC initiative, and that the program had shown success in preventing repeat very low birth weight births for Medicaid enrollees. While LARC use alone is not the key metric, because providing access to and choice of the full range of methods is the goal of such policies, use does reflect access to some degree when put in context against the national Medicaid average of 11.5% LARC utilization.[xiv] This suggests a need to better understand the provider training, billing, 340B Drug Pricing Program status, Title X Grantee status, and other dynamics that may still be impacting access. Also, actual enrollment in the P4HB program has fallen short of initial projections, leading to lower than anticipated utilization rates.

**Provider Engagement and Education:** Support from health center leadership, communication between leadership and staff, and staff attitudes and beliefs facilitated the implementation of new billing, stocking, and clinical practices.[xv] Gaining provider buy-in to offer LARCs may require:[xvi,xvii]

1. considering a more feasible billing methodology to ease administration for both providers and payers,
2. testing claims for both billing system and claims system compatibility and communicate to all stakeholders.
3. building the capacity of health center leadership to mobilize staff and resources so that new policies are well-understood and implemented consistently from both a clinical perspective (LARC insertion and removal) and administrative perspective (stocking and billing).

# APPENDIX B: GEORGIA LARC UTILIZATION DATA

### Georgia FQHC and RHC FFS Medicaid Data

The Georgia Medicaid program's FQHC/RHC LARC unbundling policy was approved May 15, 2015, through a State Plan Amendment (SPA). Medicaid FFS data shows that the share of services provided in FQHC/RHCs that were LARC encounters increased through 2018 and decreased in 2019. Of the total number of Women of Reproductive Age (WRA) in Georgia's Medicaid, FFS program covers 15% of the total Medicaid population, with Medicaid Managed Care covering 85% of the WRA.

Table B.1 FQHC and RHC Services - FFS

| Year | Number of WRA on Medicaid Across all Categories of Aid who received any services at FQHC/ RHC at any point in the year | % Change | Total number of family planning services for LARC billed in FQHCs/RHCs | % Change | % of FFS services for LARC billed at FQHC/RHCs |
|---|---|---|---|---|---|
| 2012 | 8,928 | | 13 | | 0.1% |
| 2013 | 9,063 | 1.51% | 55 | 323.1% | 0.6% |
| 2014 | 10,245 | 13.04% | 87 | 58.2% | 0.8% |
| 2015 | 9,697 | -5.35% | 119 | 36.8% | 1.2% |
| 2016 | 9,689 | -0.08% | 147 | 23.5% | 1.5% |
| 2017 | 6,842 | -29.38% | 113 | -23.1% | 1.7% |
| 2018 | 6,605 | -3.46% | 110 | -2.7% | 1.7% |
| 2019 | 6,402 | -3.07% | 73 | -33.6% | 1.1% |

### Title X Family Planning Annual Report - Georgia Data (2012-2019)

Title X Family Planning Annual Report data shows that in Georgia, the total number of LARC encounters in Title X sites increased over time, with a substantial jump in 2016 following the grant award change to The Family Health Centers of Georgia from Georgia's Department of Public Health.

**Table B.2: Title X LARC Use**

| Year | # of LARC users at exit from the encounter |
|---|---|
| 2012 | 8,273 |
| 2013 | 8,711 |
| 2014 | 6,770 |
| 2015 | 4,010 |
| 2016 | 10,261 |
| 2017 | 8,671 |
| 2018 | 9,102 |
| 2019 | 9,974 |

*Source: https://fpar.opa.hhs.gov/Public/ReportsAndForms*

# APPENDIX C: GEORGIA LARC CARVE-OUT LANGUAGE AND BILLING AND CODING REQUIREMENTS

Georgia used the following SPA language for both FQHCs and RHCs: "Effective for dates of services on or after May 15, 2015, FQHCs may elect to receive reimbursement for Long-Acting Reversible Contraceptives (LARCs) (specifically intrauterine devices and single rod implantable devices) for contraceptive purposes. Reimbursement for the LARCs shall be made in accordance with the following:

1. To the extent that the LARCs were purchased under the 340B Drug Pricing Program, the FQHC must bill the actual acquisition cost for the device.
2. Reimbursement shall be made at the FQHC's actual 340B acquisition cost for LARCs purchased through the 340B program. For LARCs not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or the rate on the Department's practitioner fee schedule, whichever is applicable.
3. Reimbursement is separate from any encounter payment the FQHC may receive for LARCs."[xviii]

**Specific Billing and Coding Requirements**[xix]

To identify members receiving Family Planning services for Long Acting Reversible Contraceptive (LARC) in FQHC and RHC (COS 540, 541 & 542), all of the following criteria must be met.

**COS 540 & 542:**

- The rendering provider COS equals to 540 & 542
- Enter "FP" in item 24H on the CMS-1500 claim form
- Enter appropriate J code (J7296, J7297, J7298, J7300, J7301, J7302 or J7307) with FP modifier **Note:** J7302 was terminated by the Centers for Medicare and Medicaid (CMS) on 12/31/15.
- Bill appropriate J code at acquisition cost
- E & M billable codes are CPT 99201 thru 99215 with FP modifier (based on level of evaluation rendered during the encounter)
- Insertion and/or removable procedure codes (11981, 11982, 11983, 58300 and 58301) with FP modifier
- Bill with an appropriate diagnosis code as listed (ICD-10: Z30.430, Z30.431, Z30.432, Z30.433, Z30.49)

**COS 541:**

- The rendering provider COS equals to 541
- Enter "FP" in item 42 on the UB-04 claim form
- Enter appropriate J code (J7296, J7297, J7298, J7300, J7301, J7302 or J7307) with rev code 250 **Note:** J7302 was terminated by the Centers for Medicare and Medicaid (CMS) on 12/31/15.
- Bill appropriate J code at acquisition cost
- E & M billable codes are CPT 99201 thru 99215 with FP modifier (based on level of evaluation rendered during the encounter)
- Insertion and/or removable procedure codes are (11981, 11982, 11983, 58300 and 58301) with FP modifier
- Bill with an appropriate diagnosis code as listed (ICD-10: Z30.430, Z30.431, Z30.432, Z30.433, Z30.49)

[i] https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/

[ii] Waxman Strategies. (2019). "Factors Influencing Access to Long-Acting Reversible Contraceptives at Federally Qualified Health Centers." Retrieved from https://waxmanstrategies.com/wp-content/uploads/2019/07/FQHC-LARC-Project_Policy-White-Paper.pdf

[iii] Idaho and Illinois also received SPA approval in 2015 for the LARC reimbursement unbundling policy.

[iv] If the device is not purchased through the 340B program, Medicaid pays the lesser of charges or the amount listed on the Medicaid fee schedule (whichever is applicable)

[v] https://www.guttmacher.org/sites/default/files/factsheet/ga_5.pdf

[vi] https://www.americashealthrankings.org/explore/annual/measure/birthweight/state/ALL

[vii] State Facts About Unintended Pregnancy: Georgia, Guttmacher Institute, 2015. https://www.guttmacher.org/sites/default/files/factsheet/ga_5.pdf

[viii] NICHQ and NASHP "State Strategies to Increase Access to LARC in Medicaid: Unbundling Reimbursement for LARC in Georgia." 2017. Retrieved from https://www.nichq.org/sites/default/files/resource-file/NASHP_LARC_Georgia.pdf

[ix] Ibid

[x] Title X Family Planning Annual Report. 2019 National Summary. U.S. Department of Health and Human Services, Office of Population Affairs. September 2020. Retrieved from https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf

[xi] Ibid

[xii] NICHQ and NASHP "State Strategies to Increase Access to LARC In Medicaid: Unbundling Reimbursement for LARC in Georgia." 2017. Retrieved from https://www.nichq.org/sites/default/files/resource-file/NASHP_LARC_Georgia.pdf

[xiii] GA Dept. Of Public Health: Implementation of IPP LARCs https://www.astho.org/MCH/LARC-Georgia-LARC/

[xiv] NICHQ and NASHP "State Strategies to Increase Access to LARC In Medicaid: Unbundling Reimbursement for LARC in Georgia." 2017. Retrieved from https://www.nichq.org/sites/default/files/resource-file/NASHP_LARC_Georgia.pdf

[xv] Wachino, V. (2016). State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. Center for Medicaid and Medicare Services. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB040816.pdf

[xvi] Barriers and Facilitators to Health Center Implementation of Evidence-Based Clinical Practices in Adolescent Reproductive Health Services https://www.jahonline.org/article/S1054-139X(15)00666-7/pdf

[xvii] GA Dept. Of Public Health: Implementation of IPP LARCs https://www.astho.org/MCH/LARC-Georgia-LARC/

[xviii] Barriers and Facilitators to Health Center Implementation of Evidence-Based Clinical Practices in Adolescent Reproductive Health Services https://www.jahonline.org/article/S1054-139X(15)00666-7/pdf

[xix] https://www.nirhealth.org/wp-content/uploads/2016/11/LARC-Toolkit.pdf

[xx] Part II Policies and Procedures for Federally Qualified Health Center Services and Rural Health Clinic Services, GA Dept. of Community Health, Division of Medicaid

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