Barriers to Contraceptive Access in Mississippi

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People's contraceptive method preferences vary based on their prior experiences using birth control, perceived risk of pregnancy, and medical history, among other factors. A person's ability to use their preferred method is an important component of reproductive autonomy[1] and is associated with higher method satisfaction and continuation.[2,3,4]

Previous studies in Mississippi have noted that people are not always able to access the contraceptive methods they want to use. This discrepancy has been especially pronounced among self-identified women who want to use an intrauterine device (IUD), implant, or permanent method. Additionally, Mississippians have reported that timely appointments often are not available at their source of care.[5] Barriers to accessing the full range of methods and timely appointments may be related to cuts in state funding impacting direct service provision at public health department sites that serve people living on low incomes, the persistence of commercial insurance plans that are not compliant with Affordable Care Act requirements,[a] or short-term plans that do not cover contraception without cost sharing.[6,7] Furthermore, Mississippi has a low provider to population ratio, and the geographic distribution of family planning providers across the state is uneven.[8]

Key Findings

- Intrauterine devices (IUDs) and contraceptive implants were available less often than other contraceptive methods, particularly at FQHCs.
- Callers frequently encountered appointment wait times of 4 weeks or more and would have to attend 2 appointments to get the method they requested, owing to limited onsite availability of some contraceptives and trained providers.
- People who are unhoused, unable to access a social security number, and living on low incomes may experience greater challenges obtaining care because some sites requested an address or social security number to schedule an appointment or did not accept Family Planning Medicaid for all methods.

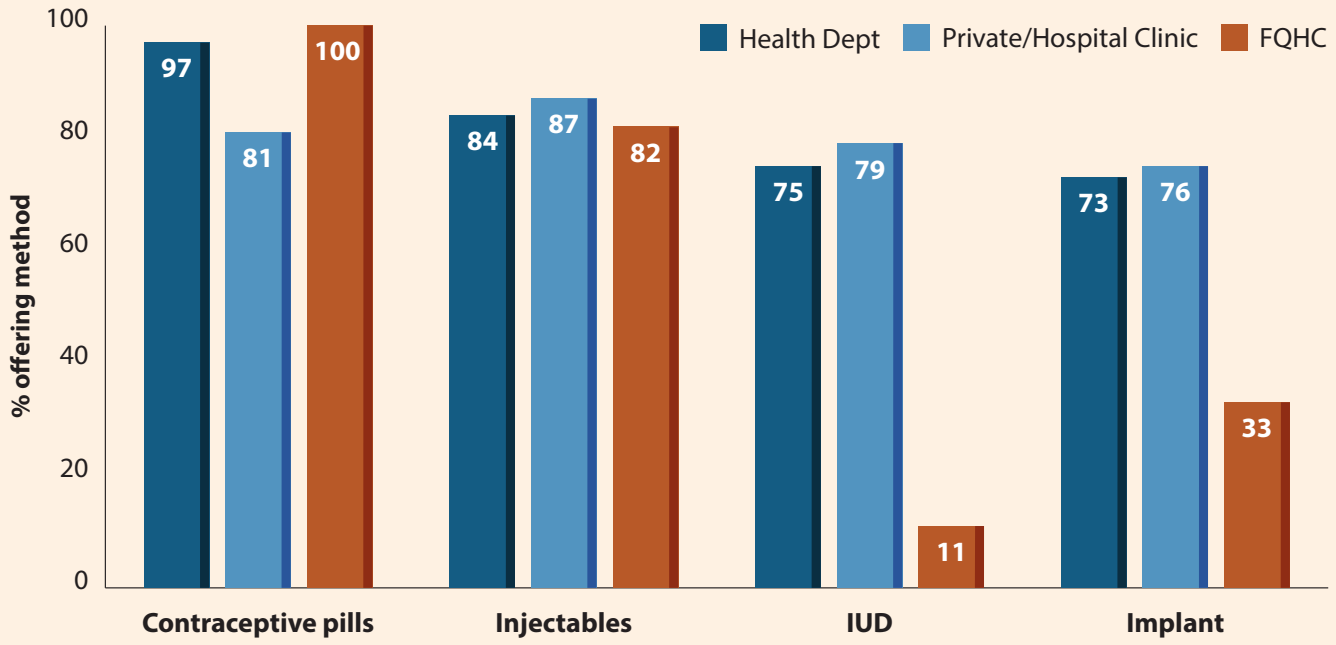
In this research brief, we summarize findings from 498 mystery client calls placed to health department sites, private practices and hospital-based clinics (e.g., clinics owned and operated by hospitals), and federally qualified health centers (FQHCs) in Mississippi in 2019. We report on the availability of methods, time to appointment, and other potential barriers to contraceptive care.

Results

The full range of contraceptive methods was not available at all sites. Although most sites we contacted indicated that appointments for prescriptions for contraceptive pills were available, fewer sites stated that they offered injectable contraception, IUDs, and contraceptive implants (Figure 1). FQHCs were less likely to offer IUDs and implants than health departments and private and hospital-based clinics. At all sites, callers were told that the method was not offered for a variety of reasons, including not having providers available onsite who were able to place or administer these methods.

[a.] Commercial insurance plans that are not compliant with the Affordable Care Act (ACA) may not cover the full range of contraceptive methods or may require those enrolled in the plan to pay some out of pocket costs. Some of these plans were in place before the signing of the ACA in 2010 (i.e., grandfathered plans) and others are transitional plans that took effect between 2010 and 2014 (i.e., grandmothered plans); states must request an extension to continue these plans on an annual basis.

Figure 1. IUDs and implants were less often available than other methods, particularly at FQHCs.



When sites did not offer a method, 74% of callers were directly referred elsewhere for care. Small health departments most commonly referred callers to a larger health department site, while private clinics, hospitals and FQHCs were more likely to refer callers to other private practices. Health department sites that did not have IUDs or implants available or a regular provider that could place these devices often referred callers to "supersites," where a provider was more frequently on site. Callers were told they could complete an initial exam at a smaller health department site in their community and then schedule a second exam to have the IUD or implant placed at a "supersite." However, it was also difficult to schedule initial exams at many smaller clinical sites because of limited provider availability.

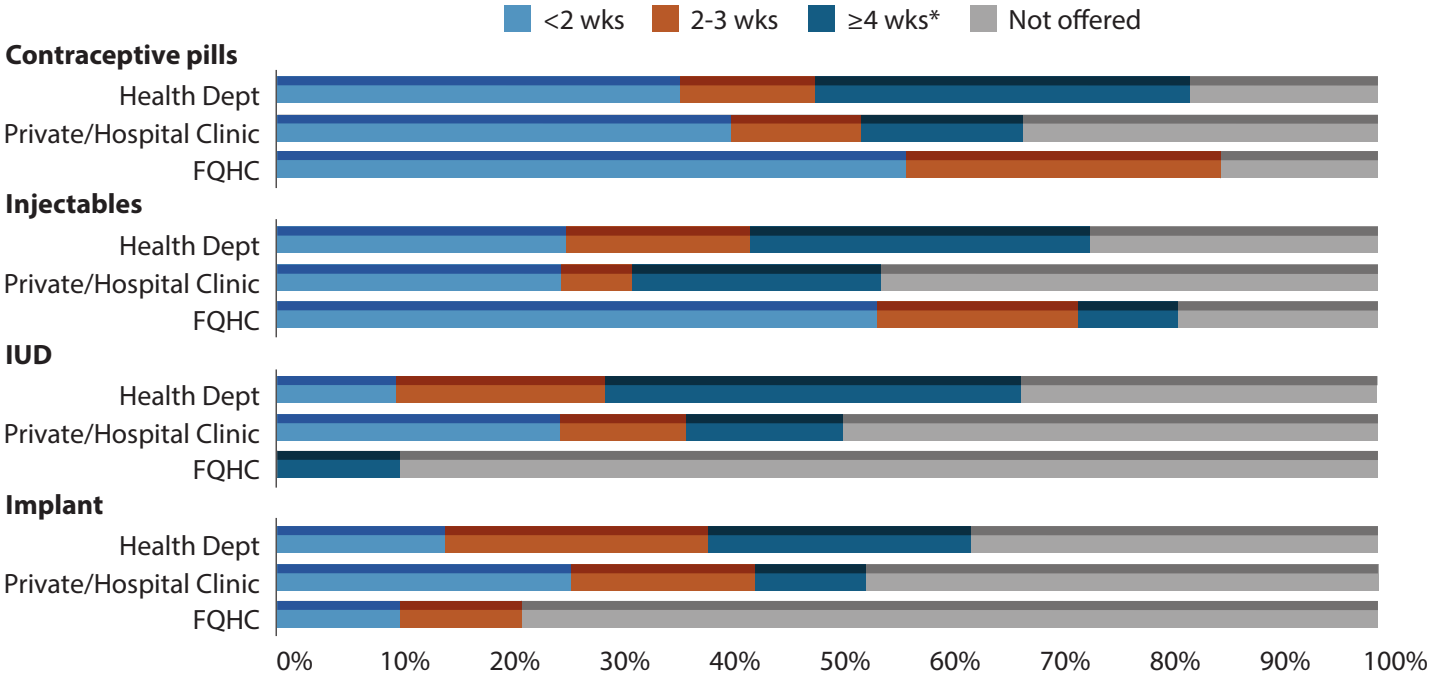
For injectable contraception, callers to health departments and private and hospital-based clinics were told they would have to fill a prescription at an offsite pharmacy and bring it to the clinic or have an initial exam at one clinic and receive the injection at another site on a different day.

The remaining 26% of callers, who were not referred elsewhere, were told to call unspecified locations, such as "an OBGYN," "a doctor," "a women's clinic," or to "Google it." This was most common at private and hospital-based clinics (55%), followed by FQHCs (27%) and health departments (18%). Callers requesting IUDs and implants, versus contraceptive pills or injectable contraception, encountered this more often.

Callers faced long wait times for appointments. One in seven callers (13%) were told they would have to wait between 2 and 3 weeks for the next available appointment at sites that had their preferred method. One in four (25%) were told the next available appointment was 4 or more weeks away, and up to 3 months away in some cases.

Appointment wait times were longer for those interested in injectables, IUDs, and implants (Figure 2). In addition to the wait time between scheduling and attending an appointment, callers who inquired about IUDs and implants were often told the site would have to order the devices because they were not in stock at the location. Before ordering, clinic staff told callers the provider would have to obtain approval from insurance (both commercial insurance and Family Planning Medicaid, which covers contraception for people ≤194% of the federal poverty level). The estimated wait times between ordering the device and a site receiving it ranged from 3 days to 12 weeks, further extending the timeline for obtaining a desired method.

Figure 2. Many callers could not get an appointment within 4 weeks for their desired contraceptive method.



*Wait times were 4 weeks or more, or the site was unable to provide the date of the next available appointment.

Wait times were long at health department sites, and half of callers (or less) were able to schedule an appointment within 4 weeks, regardless of their preferred method. Callers were told that physicians or nurse practitioners, particularly those who were trained to place IUDs or implants, were not on site every day of the week, and, in some cases, providers were only available to place methods a few days per month.

Callers were often told they had to make two appointments to get the IUD, implant, or injectable contraception. Only 53 (16%) callers who asked about the IUD or implant were specifically told that they could receive these methods during a same-day appointment. A primary reason that same-day appointments were not available was that callers would need to be established as a new patient by having an initial exam, after which they could make another visit to obtain a method. The other reasons same-day appointments were not available were because sites needed to order the IUD or implant after an initial exam and had to process an uninsured patient's new application to enroll in Medicaid, which could take between 30-45 days.

In some cases, staff responding to the calls indicated that patients may not have complete autonomy in choosing a method. For example, some callers were told they would need to try injectable contraception for a few months before they could get an implant or that the doctor would ultimately decide what method was best for the patient:

> *"The woman on the phone said they do Mirena [IUD] sometimes, but not often. It is up to what the doctor wants. The doctor is rarely in, so it is difficult to get an appointment. She said I would have to come in and get a pap smear/annual and have the doctor decide what method, and then I can come back in for another appointment."*

Administrative barriers to scheduling appointments. When methods were available, callers commonly reported being asked for additional identification information before they could schedule an appointment.

Overall, 70 (20%) callers were asked to provide their social security number, and 51 callers (15%) were asked to provide their address before they could schedule an appointment. When callers were unable to provide this information, some clinic staff were willing to find workarounds to schedule appointments in the system.

However, many callers noted that clinic staff were unable to schedule an appointment or even give the caller an estimate of when the next new patient appointment would be without a social security number. Others were told to “call back when I have an address.” Callers further noted that staff seemed frustrated or irritated with them for not having this information. Overall, 7% of callers were unable to find out when the next available appointment was without providing this information.

A small number of callers (n=21) were not able to schedule an appointment for their preferred method because the private and hospital-based clinic or FQHC site they contacted did not accept Family Planning Medicaid. Additionally, a few callers noted that they felt they were treated differently when they indicated they did not have insurance or had Family Planning Medicaid. Clinic staff told callers to contact another private clinic or health department or said, "I don't know anyone who takes [Family Planning Medicaid]. Sorry,” and “hung up right after.”

Conclusions and Recommendations

Contraceptive access is uneven across Mississippi, which affects people’s ability to obtain their preferred method. The full range of contraceptive methods was not available at all sites, and callers encountered long wait times for the next available appointment and requirements to make multiple visits, sometimes at different locations. These barriers were more common for callers requesting IUDs and implants. Two-day appointment protocols for IUDs and implants unnecessarily delay method initiation and do not improve quality of care.[2,9,10]

These barriers to obtaining contraception disproportionately affect people who already face other economic and social barriers to accessing healthcare. In places with high poverty levels, such as Mississippi, many people with low-wage jobs have limited flexibility with their work schedules and do not have the ability to travel to multiple sites to obtain care. These socioeconomic disparities contribute to unequal healthcare access, insurance coverage, and outcomes which disproportionately impact low-income people of color.[10,11] Additionally, those who may not have access to a social security number (e.g., teens and recent immigrants) or who are experiencing housing instability may face even greater barriers to care if they are required to provide a social security number or an address before they can schedule an appointment.

This study was conducted prior to the onset of the COVID-19 pandemic, and the availability of services may have become more limited at some sites as they responded to the public health emergency.[10]

Improving onsite availability of the full range of methods across clinic sites will support people’s reproductive autonomy. Additionally, all contraceptive methods should be provided in person-centered ways. This includes ensuring that people’s preferences for the type of method they would like to use are elicited and respected, providing methods in as few visits as is medically necessary, and offering methods at no or low cost.[5]

Strategies to improve onsite access to contraceptive care in Mississippi

- **Create a comprehensive contraceptive access dashboard that includes information on clinic locations, methods offered, and insurance accepted.** While not every clinic can meet the contraceptive care needs of each patient, there is an opportunity to make it easier for people to find a location that offers their desired method. A dashboard could also indicate which insurance plans are accepted or what payment options are available at a site so patients can more easily determine if their care would be covered.
- **Increase the number of providers trained in best practices for providing contraceptive methods.** Professional education that allows providers to gain competence in both placing and removing IUDs and implants would help ensure sites can offer a wider variety of options that meet the varied needs of patients. This could also decrease wait times for appointments and reduce the driving and time burdens that people experience trying to access reproductive health care.
- **Create funding mechanisms that allow providers to stock a small quantity of IUDs, implants, and injectable contraceptives for patients who need same-day appointments.** This will reduce the financial and logistical burdens on patients who would otherwise have to take time off from work or school or find childcare to attend multiple visits. If several devices are in stock, sites will not have to order them for each patient, but rather can bill insurance after each appointment to replenish the supply.
- **Increase administrators' awareness of changes in insurance coverage.** Recent Medicaid policy allows FQHCs to receive reimbursement for IUDs and implants separate from the standard encounter rate, and many FQHCs may be unaware of this change.[12] Increased awareness and use of this option may increase accessibility of these methods at FQHCs.

Methods

We used a mystery client call approach to document the availability of contraceptive services at 83 health department sites, 65 private practices and hospital-affiliated clinical locations, and 18 Federally Qualified Health Centers (FQHCs) across Mississippi. We conducted three rounds of mystery client calls in April, June, and October of 2019, contacting 166 providers in each round, for a total of 498 calls. Trained researchers, calling as a woman seeking contraception, inquired about whether specific methods were available, time to next appointment and whether the site accepted certain types of insurance or uninsured clients. For each round of calls, we randomized sites such that callers asked about the availability of IUDs or implants and contraceptive pills or injectables. Callers were also randomized to indicate that they had no insurance, Family Planning Medicaid, or commercial health insurance (Blue Cross Blue Shield). This research protocol was approved by the institutional review board at the University of Alabama at Birmingham.

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The Mississippi Reproductive Health Access Project, conducted by researchers at The University of Texas at Austin, focuses on the experiences of Mississippi residents accessing contraception and abortion services. The project is funded by a grant from the David and Lucile Packard Foundation.