

JUNE 2023

Implementing State-Level Policy and Operational Processes That Enhance Access to Medicaid Family Planning Program Services

Kinda Serafi, Partner

Cindy Mann, Partner

Michelle Carrera, Manager

Marielle Kress, Former Senior Advisor

Nathan Pauly, Senior Manager

Adam Striar, Senior Manager

Manatt Health

About Arnold Ventures

Arnold Ventures is a philanthropy dedicated to tackling some of the most pressing problems in the United States. We invest in sustainable change, building it from the ground up based on research, deep thinking and a strong foundation of evidence. For more information on Arnold Ventures and its health care work, visit www.arnoldventures.org.

About Manatt Health

Manatt Health integrates legal and consulting services to better meet the complex needs of clients across the health care system.

Combining legal excellence, firsthand experience in shaping public policy, sophisticated strategy insight and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players.

Our diverse team of more than 180 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions and lead health care into the future. For more information, visit <https://www.manatt.com/Health> or contact:

Kinda Serafi

Partner
Manatt Health
212.790.4625
kserafi@manatt.com

Marielle Kress

Former Senior Advisor
Manatt Health

Cindy Mann

Partner
Manatt Health
202.585.6572
cmann@manatt.com

Nathan Pauly

Senior Manager
Manatt Health
312.477.4788
npauly@manatt.com

Michelle Carrera

Manager
Manatt Health
202.624.3315
mcarrera@manatt.com

Adam Striar

Senior Manager
Manatt Health
202.585.6512
astriar@manatt.com

Implementing State-Level Policy and Operational Processes That Enhance Access to Medicaid Family Planning Program Services

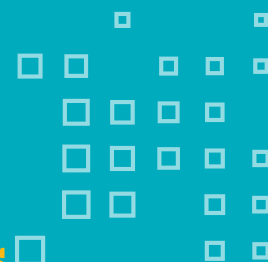


Table of Contents

Introduction.....	4
Background.....	5
States Implementing Medicaid Family Planning Programs.....	5
Services Covered by Medicaid Family Planning Programs.....	7
Administration of Medicaid Family Planning Programs.....	8
The Value of Medicaid Family Planning Programs.....	9
Assessment of Medicaid Family Planning Program Enrollment and Service Utilization.....	10
State-Level Program Enrollment Rate Analysis.....	10
State-Level Service Utilization Rate Analysis.....	13
Best Practice Strategies to Strengthen Enrollment and Increase Utilization in Medicaid Family Planning Programs.....	15
1. Eligibility and Enrollment.....	18
2. Consumer Outreach and Education Support.....	26
3. Covered Services.....	32
4. Confidentiality.....	36
5. Provider Access.....	39
Conclusion.....	43
Appendices.....	44
Appendix A. Comparison of Family Planning Program 1115 Waiver and SPA Requirements.....	44
Appendix B. Federal Guidance on Family Planning-Related Services.....	45
Appendix C. Family Planning Program Enrollment Rate and Percentage of Family Planning Enrollees Using Family Planning Services by State.....	46
Appendix D. Ranking of Most Commonly Used Family Planning Services Across All States, 2018–2020.....	47
Appendix E. Data Analysis Methodology.....	48
Appendix F. Issue Brief Methodology.....	52
Endnotes.....	53

Introduction

Given its role as a critical source of health care coverage for low-income individuals in the United States, including 13 million women of reproductive age,¹ Medicaid is the primary source of family planning coverage in the nation. In 2015, Medicaid accounted for 75% of public expenditures for family planning services in the United States.^{2,3} Family planning services enable individuals to choose and control contraceptive use, plan for and space births, and contributes to improved health outcomes for individuals, children and families.⁴ For many individuals, a family planning provider is also their entry point into the health care system and their usual source of care.⁵ Despite the importance of Medicaid coverage for family planning services, access to these services continues to be a lottery of geography determined by the state in which an individual lives.

State Medicaid programs have a long-standing requirement to provide family planning services. Since 1972, federal law has required that family planning services be included in the benefits package that is provided to individuals enrolled in full-scope coverage.⁶ In order to expand the number of people who can access family planning services, states have sought to expand Medicaid-financed family planning coverage to populations with incomes above the state's eligibility limits.⁷ For years, the Centers for Medicare & Medicaid Services (CMS) has allowed this optional limited family planning Medicaid benefit coverage through Section 1115 waivers; in 2010, Congress amended the law to permit states this option through a State Plan Amendment (SPA), without having to seek a waiver.⁸

These limited-benefit programs, collectively referred to as Medicaid family planning programs throughout this issue brief, provide an important coverage vehicle for low-income individuals who do not qualify for the full-scope Medicaid benefits package. These programs play a key role in enabling individuals' access to services and are especially needed in states that have not yet expanded Medicaid to their adult population.^{9,10} To date, 30 states have established Medicaid family planning programs (see Figure 1).

States have considerable flexibility in designing their Medicaid family planning programs. As a result, access to and utilization of Medicaid family planning programs is largely impacted by the policies and operational processes in that state. The decisions a state makes related to its application process, consumer outreach, confidentiality policies, scope of covered benefits and provider network are all critical programmatic features that drive how easy or difficult it is for an individual to enroll in and receive services through Medicaid family planning programs. Design and implementation decisions will also affect how well the program serves underserved communities and addresses racial and ethnic disparities.

To promote access and utilization, this issue brief provides an array of best practice strategies in place across the nation to serve as an actionable road map for states that might be considering adopting such a program as well as states with existing programs looking to bolster participation and utilization rates. The strategies are derived from a review of national literature and policies and practices across the country and informed by an analysis of participation rates and utilization of services in 22 of the 30 states with programs in place.

This is a particularly important moment for states and stakeholders to identify strategies that will improve access to family planning services and assist individuals in making informed choices about their reproductive health care. In light of the Supreme Court's recent decision overturning the constitutional right to abortion services in *Dobbs v. Jackson Women's Health Organization*,¹¹ ensuring access to Medicaid family planning

services has never been more important. In addition, millions of Medicaid enrollees are likely to lose coverage as the requirement for states to maintain continuous enrollment for individuals in Medicaid that has been in place throughout the COVID-19 public health emergency (PHE) comes to an end.¹² In response to this significant coverage loss event, this is an opportune time for states to adopt or strengthen a Medicaid family planning program because individuals who may have been receiving full-scope Medicaid may lose their eligibility and will need other sources of coverage for family planning services. Finally, implementing or strengthening a Medicaid family planning program could be part of a state's larger effort to improve health care coverage for birthing individuals. For example, states could link improvements made to Medicaid family planning programs to the implementation of broader reproductive and maternal health policies currently underway, such as the option to extend Medicaid's postpartum period to 12 months.¹³

Background

States Implementing Medicaid Family Planning Programs

Medicaid family planning programs are limited-benefit programs that states can choose to implement to cover a suite of family planning services for individuals who are otherwise not eligible for full-scope Medicaid coverage. For example, states are mandatorily required to cover children, parents/caretaker relatives, the elderly and the disabled, consistent with established minimum eligibility levels and state options, and those individuals are entitled to receive a comprehensive set of benefits that include family planning services.¹⁴ Medicaid family planning programs offer coverage for individuals who do not fall into a state's other eligibility groups. The passage of federal legislation in 2010 allowed states the option to cover a Medicaid family planning eligibility group through a SPA instead of through a Section 1115 waiver (see Appendix A for a breakdown of requirements for programs authorized through SPAs and 1115 waivers). States with Medicaid family planning programs authorized through SPAs are required to provide coverage regardless of gender (e.g., men must be eligible to enroll), while states with waiver programs have the discretion to limit family planning program eligibility (e.g., states may limit eligibility to include only women).^{15,16}

A total of 30 states currently have federal approval to establish Medicaid family planning programs.¹⁷ Of these 30 states, 21 states have also adopted Medicaid expansion. In these states, adults aged 19–64 years old with income up to 138% of the federal poverty level (FPL) are eligible for full-scope Medicaid, while limited-benefit Medicaid family planning programs provide access to family planning services for individuals whose incomes are above the Medicaid income limits. In expansion states, individuals who are not eligible for Medicaid under the expansion adult group can be eligible for a Medicaid family planning program; Medicaid family planning eligibility levels in expansion states range from 138% of the FPL to 265% of the FPL.¹⁸ Medicaid family planning programs can also fill an important coverage gap for individuals who are not eligible for or otherwise have not accessed a qualified health plan offered through a state-based or Federally Facilitated Marketplace or want to supplement their Marketplace coverage with no-cost access to family planning services.¹⁹

In states without Medicaid expansion, Medicaid family planning programs serve as a critical coverage vehicle for individuals who fall into the “coverage gap,” where they are ineligible both for full-scope Medicaid and for premium tax credits for qualified health plans through a state-based or the Federally Facilitated Marketplace. In non-expansion states, eligibility levels start at the upper income limit for parents and caretakers (between 13% and 95% of the FPL) and go up to 216% of the FPL.²⁰ Of the country’s 11 states without Medicaid expansion, nine states implement Medicaid family planning programs, while two states (Kansas and Tennessee) do not.

Twenty states currently do not have a Medicaid family planning program.²¹ Two of these states, Iowa and Missouri, have state-funded Medicaid family planning programs in order to circumvent Medicaid’s “freedom of choice” requirements and exclude providers who perform abortion services from participating in the program. (As described below, Medicaid family planning programs, like full-scope Medicaid programs, are prohibited from using federal funds for abortions except under very limited circumstances.) With the transition to state-funded programs, these states have subsequently forgone millions of dollars in federal funding and have observed marked decreases in utilization of family planning services.^{22,23,24}

States continue to take up the option of implementing Medicaid family planning programs to enable greater access to affordable family planning services, with New Jersey implementing in 2019 and Colorado (see callout box) and Illinois²⁵ being the most recent states to do so in 2022.

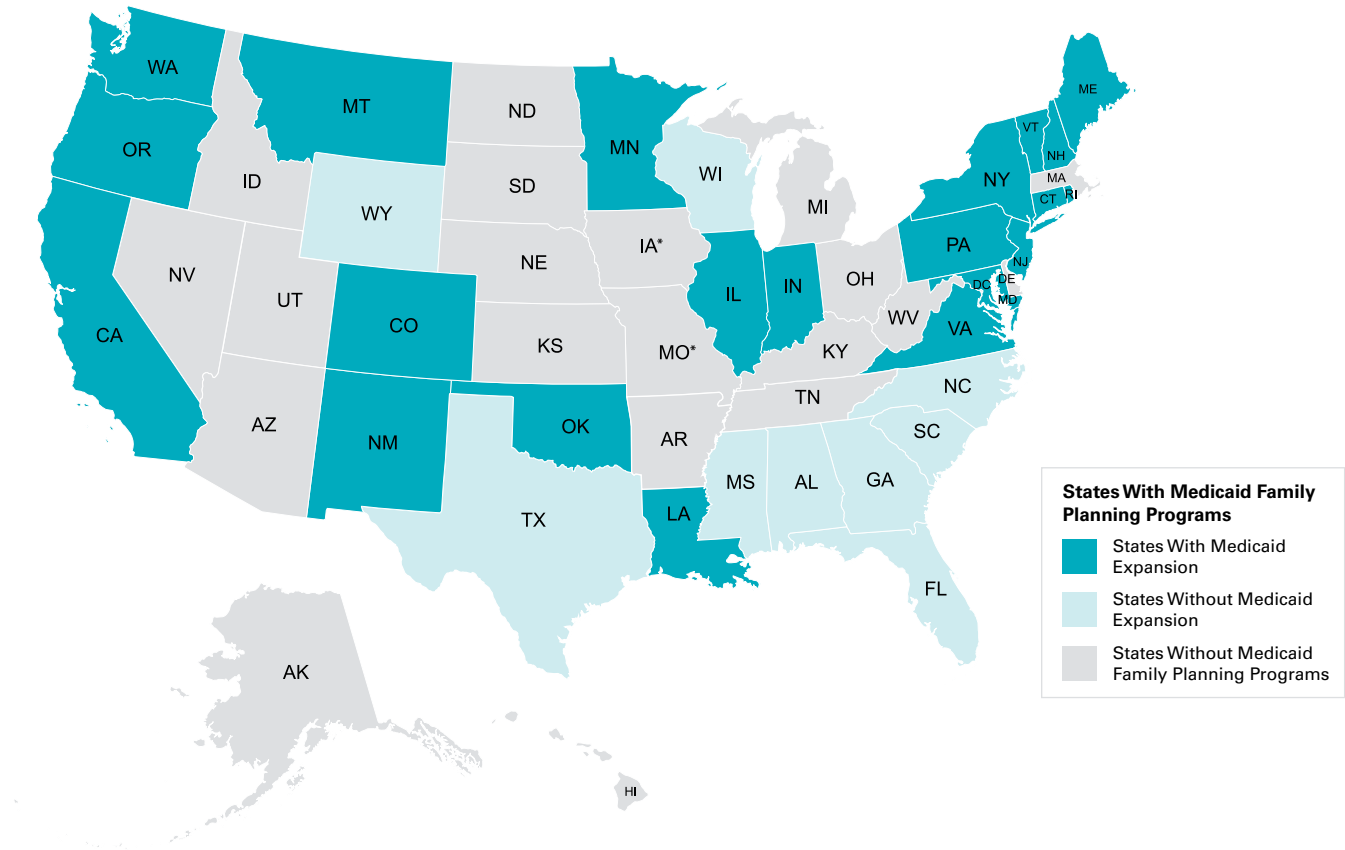
State Example



Colorado’s state legislature enacted a law in 2021 (Senate Bill 21-025) that directed the state Medicaid agency to seek authorization from CMS to expand Medicaid family planning services to individuals with incomes up to 265% of the FPL. In advocating for passage of the bill, the Colorado Children’s Campaign and 22 supporting organizations emphasized that the program was critical to “support the health and wellbeing of families and children by reducing unintended pregnancies, empowering people who can become pregnant to attain their education goals, helping create financially secure and strong families, and reducing the number of people who need to use Medicaid and CHP+ for pregnancy and postpartum coverage.”²⁶ Additionally, implementing the Medicaid family planning program was projected to yield \$3 million in state savings in the first year of the program alone. The state’s Medicaid family planning program became effective July 1, 2022, through a SPA.²⁷

Colorado designed its family planning program with braided funding, using state funds to cover services for individuals residing in Colorado who do not meet immigration requirements for Medicaid coverage but meet all other family planning program eligibility requirements. Due to the state’s recent implementation, data on enrollment or utilization is not yet publicly available.

Figure 1. Map of Expansion and Non-Expansion States With Medicaid Family Planning Programs



Services Covered by Medicaid Family Planning Programs

States have broad flexibility in designing the scope of services that are covered through their Medicaid family planning programs. CMS State Health Official Letter #10-013 separated family planning services into two categories for the purpose of distinguishing federal matching rates: (1) family planning services and supplies, and (2) family planning-related services.²⁸ Neither is defined in detail in law or regulation; rather, states define the services they will cover within the parameters set forth in federal guidance. Enrollees in programs authorized by a SPA must receive the same family planning services and nonemergency transportation services that are available to enrollees who receive full-scope Medicaid.^{29,30} Further, federal rules require family planning services and supplies to be provided without any imposed cost-sharing.³¹

Table 1 summarizes the relevant federal guidance. Throughout this issue brief, the term family planning services is used to refer to both family planning services and supplies and family planning-related services unless otherwise specified.

Table 1. Family Planning Service Types

	Family Planning Services and Supplies	Family Planning-Related Services
Overview	<ul style="list-style-type: none"> As indicated by Section 4270 of the State Medicaid Manual, states are free to define the family planning services they will cover, as long as covered services include those that prevent pregnancy or delay pregnancy. States may also more broadly include services that treat infertility. Services must be sufficient in amount, duration and scope to reasonably achieve their purpose. 	<ul style="list-style-type: none"> As indicated in federal guidance issued through the State Medicaid Director Letter #10-013, at state option, these services are provided in a family planning setting as part of or as follow-up to a family planning visit (i.e., services are provided because they were identified, or diagnosed, during a family planning visit).³²
Federal Matching Rate	<ul style="list-style-type: none"> The federal government pays 90% of the cost of services for all states. 	<ul style="list-style-type: none"> The federal government pays its share based on the state's regular Federal Medical Assistance Percentage (FMAP) rate.
Example Services^{33,34}	<ul style="list-style-type: none"> Methods of contraception approved by the U.S. Food and Drug Administration (FDA) (e.g., oral contraceptives, vaginal ring, intrauterine device (IUD)). Education and counseling in the method of contraception desired or currently in use by the individual. A medical visit to change the method of contraception. Sterilization, when provided with the informed consent of the enrollee (e.g., vasectomies may be offered as a covered service in states where men are eligible for the Medicaid family planning program).³⁵ Care coordination services, including assistance with arranging a family planning visit, follow-up to ensure appointments are kept and family planning education.³⁶ 	<ul style="list-style-type: none"> Vaccination to prevent cervical cancer. Treatment/drugs for sexually transmitted diseases (STDs)/sexually transmitted infections (STIs). Screening for STIs/STDs based on the Centers for Disease Control and Prevention guidelines. Treatment of a major medical complication resulting from a family planning visit.

While family planning and family planning-related services are not defined in law or regulation, it is important to note that the federal Hyde Amendment restricts state Medicaid programs (coverage for both the full-scope program and the limited family planning programs) from using federal funds to cover abortions other than in cases of life endangerment, rape or incest.³⁷

Administration of Medicaid Family Planning Programs

Nearly all states administer their Medicaid family planning programs using a fee-for-service delivery model. Even states that have shifted the majority of their Medicaid enrollees to a Medicaid managed care delivery system have typically carved out their Medicaid family planning programs from managed care.³⁸ Only two states, Georgia and Rhode Island, administer their Medicaid family planning program through Medicaid managed care plans. Based on interviews with state Medicaid officials and a national literature review, the reasons for carving out limited-benefit Medicaid family planning programs from managed care include, but are not limited to, wanting to maintain a focus on the patient-provider relationship for family planning services and limiting involvement from other entities to preserve confidentiality.

To ensure adequate family planning provider networks and compliance with the federal requirement that individuals be provided freedom of choice of family planning providers, most states rely on the broader Medicaid provider network to deliver services rather than establish a provider network specific to the Medicaid family planning program. Therefore, most states do not require a separate application or enrollment process for providers already participating in Medicaid in order to be reimbursed for the delivery of services to individuals through the Medicaid family planning program.³⁹

The Value of Medicaid Family Planning Programs

As articulated in states' approved Section 1115 waivers, the goals of Medicaid family planning programs generally include the following:⁴⁰

- Increase access to family planning services, including contraceptive methods;
- Increase the interval between pregnancies and births to improve positive birth and health outcomes;
- Enable individuals to choose whether and when to become pregnant, thereby reducing state and federal Medicaid expenditures from unplanned pregnancies; and
- Improve health outcomes as a result of access to family planning services and/or family planning-related services.

As indicated by these program goals, while Medicaid family planning programs offer a limited set of services, they enable access to critical family planning and reproductive health care services that are essential to promoting optimal health outcomes. By ensuring individuals have access to the contraceptive method of their choice and the support necessary to use their chosen method effectively, family planning programs enable individuals to control whether and when to become pregnant and improve the health of individuals of reproductive age, pregnant individuals and children.⁴¹ Research shows that unplanned pregnancies are associated with negative health outcomes for pregnant individuals and their children, including postpartum depression, preterm birth and infant low birth weight.⁴²

In addition to contraception, Medicaid family planning programs play an important role in providing access to critical preventive services. For example, research has shown that in states with Medicaid family planning programs, there was a significant observed increase in Pap smears and screenings for breast and cervical cancers among low-income women, which contributed to narrowing the gap in the utilization of these services when compared with higher-income women.⁴³ By providing family planning-related services such as STD/STI screenings, states support the prevention of avoidable medical conditions that can emerge if STDs/STIs are not detected and treated. For example, untreated chlamydia and gonorrhea can lead individuals to develop more health problems such as pelvic inflammatory disease, ectopic pregnancy and infertility.⁴⁴ Overall, financing family planning services through public funds, including Medicaid, is estimated to save \$4.83 for every \$1 spent.⁴⁵

Medicaid family planning programs are a valuable coverage vehicle for individuals in different circumstances, including those who are uninsured, individuals who are unable to access Marketplace coverage, and individuals who are covered by private insurance but seeking confidentiality for their family planning services, such as adolescents or individuals experiencing intimate partner violence.⁴⁶

Assessment of Medicaid Family Planning Program Enrollment and Service Utilization

Understanding Medicaid family planning program enrollment rates and service utilization can help guide states and stakeholders in determining how effective programs are at reaching eligible individuals and helping them access services. These types of analyses are a critical first step in identifying opportunities to ensure state program goals are met. Historically, states have not consistently reported data on Medicaid family planning enrollment rates or service utilization due in part to disparate federal reporting requirements for programs implemented with 1115 waivers versus SPAs.

To address this gap, a state-by-state data analysis was conducted using Medicaid claims data and data from the American Community Survey (ACS) in order to (1) estimate enrollment rates in Medicaid family planning programs among potentially eligible individuals and (2) examine utilization of family planning services among individuals enrolled in Medicaid family planning programs. Results from this analysis helped identify states with the highest rates of Medicaid family planning program enrollment and service utilization and were used to identify potential best practices and barriers to program enrollment and service utilization. Detailed descriptions of the methods used for these analyses may be found in Appendix D.

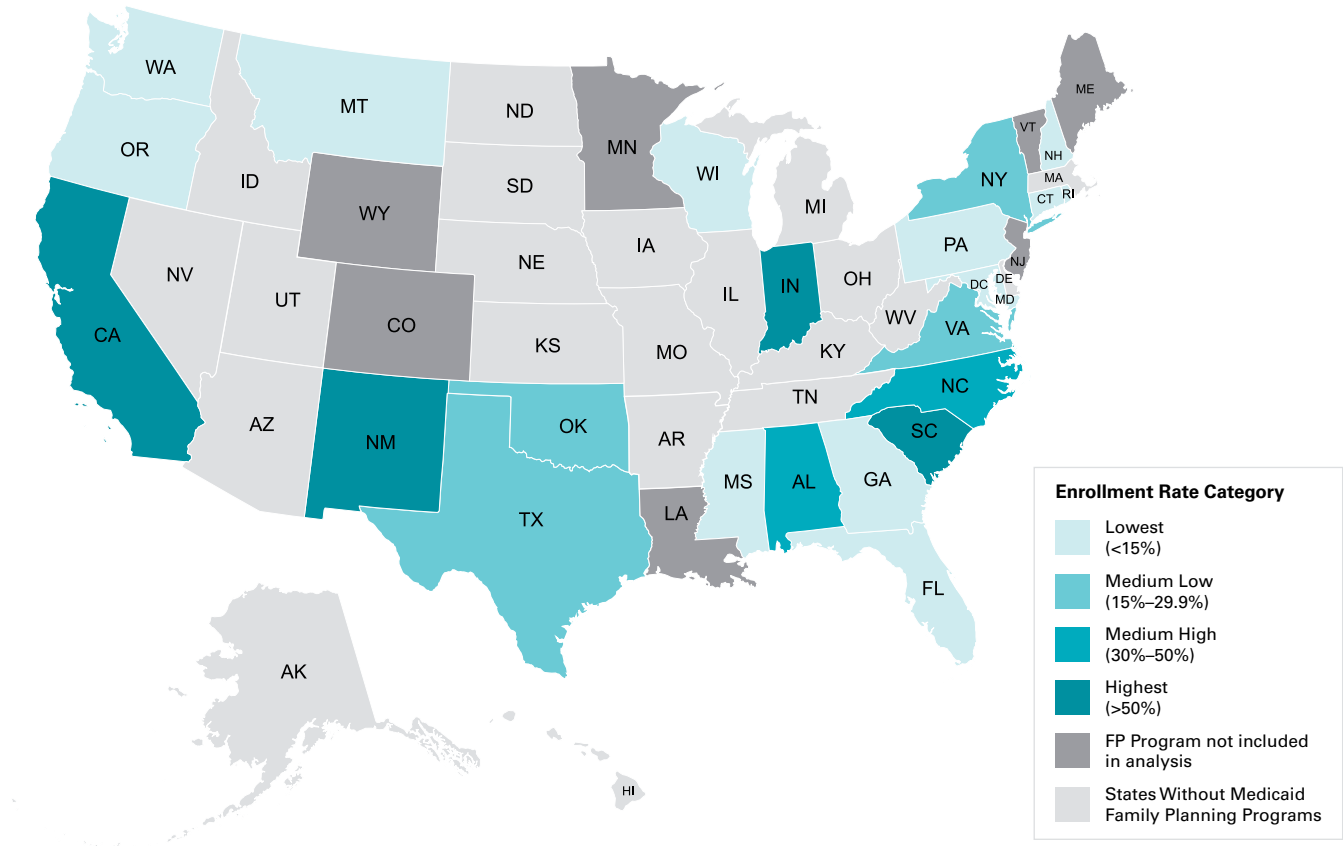
State-Level Program Enrollment Rate Analysis

This analysis estimates the annual share of Medicaid family planning program enrollees among the population of individuals who are eligible to enroll in each state. Data from the ACS were used to estimate the number of potentially eligible individuals in each state, and Medicaid enrollment data from CMS were used to identify the number of family planning program enrollees in each state. Potentially eligible individuals were classified as women aged 18–65 with any type of insurance that had family income levels between the highest income eligibility level for adults in their given state (i.e., either for childless adults or parents/caretaker relatives in non-expansion states) and the eligibility level for family planning coverage.⁴⁷ For additional information on this analysis, see the detailed methodology in Appendix E.

The analysis captures results from 22 states with available data out of the 30 states with Medicaid family planning programs.⁴⁸ For the 22 states captured in this data analysis, states were classified as having “lowest” to “highest” program enrollment rates based on their percentage of potentially eligible individuals enrolled:

• Highest (> 50%)	4 states
• Medium High (30%–50%)	2 states
• Medium Low (15%–29.9%)	4 states
• Lowest (< 15%)	12 states

Figure 2. Mean Annual Rate of Medicaid Family Planning Program Enrollment Among Potentially Eligible Women, 2018–2020



The decisions a state makes related to the programmatic features of its Medicaid family planning program impact how easy or difficult it is for an individual to learn about, enroll in and receive family planning services. While many factors will drive enrollment, a closer look at the policies and operational processes implemented by the top six states with the highest program enrollment rates brings to light some common policies and processes that may be associated with their results in these areas.

The six states with the highest estimated enrollment rates (i.e., ranked “medium high” or “highest” as part of this data analysis) are California, South Carolina, Indiana, New Mexico, North Carolina and Alabama. These states have a limited number of common programmatic features that may promote high enrollment rates. These programmatic features are described at a high level in Table 2 below.

Table 2. Programmatic Features of States With Highest Estimated Medicaid Family Planning Program Enrollment Rates

Medicaid Family Planning Programmatic Feature	States With Highest Estimated Medicaid Family Planning Program Enrollment Rates					
	CA	SC	IN	NM	NC	AL
Maximum income eligibility level allowable		✓		✓	✓	✓
12-month continuous eligibility	✓	✓	✓			✓

Four of these six states⁴⁹ set the income eligibility levels for their Medicaid family planning programs to the highest level allowable by CMS,⁵⁰ which for these four states ranged from an income limit of 146% FPL to 255% FPL.⁵¹ The relatively generous eligibility levels for Medicaid family planning programs in these states may reflect a more serious commitment by these states to promote broad access to these programs relative to states with narrower eligibility. In addition, a notable policy decision states adopted to promote high enrollment rates is continuous eligibility; four out of these six states implemented a requirement for 12-month continuous eligibility.⁵² Implementing continuous eligibility allows individuals to maintain their enrollment and coverage through the Medicaid family planning program for a full 12-month period, regardless of any changes in their eligibility, such as income or household composition (see “Eligibility and Enrollment” section for additional information). Additional state-level policy and operational features that may impact Medicaid family planning program enrollment rates are described in greater detail in the “Best Practice Strategies to Strengthen Enrollment and Increase Utilization in Medicaid Family Planning Programs” section. These features may impact enrollment rates in individual states even if they are not consistently associated with enrollment rates across the board.

Program enrollment analysis also found that the legal authority that authorized a state’s family planning program—an 1115 waiver or SPA—was not consistently associated with the state’s enrollment rate. For example, both the state with the highest enrollment rate (California) and the state with the lowest enrollment rate (Connecticut) are states with SPA programs. This suggests that the federal authority through which a state seeks to implement a Medicaid family planning program alone does not contribute to high enrollment rates.

Enrollment rates were also not consistently associated with whether a state has implemented Medicaid expansion or not. Both states with and without Medicaid expansion ranked in the “medium high”/“highest” and “medium low”/“lowest” enrollment rate categories. States without Medicaid expansion are expected to have a larger income eligibility range for the Medicaid family planning program (due to the lower income eligibility levels for full-scope Medicaid in non-expansion states). However, results show that 16 of the 22 states captured in the analysis, including expansion and non-expansion states, were classified as having “medium low” or “lowest” enrollment rates, demonstrating the need for both expansion and non-expansion states to make efforts to improve enrollment in their family planning programs.

aligned with previous research that also found significant variability in the use of contraceptive services and other family planning services among Medicaid enrollees across states. Only five of the 22 states included in this analysis had an average of 50% or more of enrolled women using any family planning services on an annual basis.^{54,55}

The six states with the highest service utilization of any family planning service are Connecticut, New York, Mississippi, California, Wisconsin and Washington. The Medicaid family planning programs in these states feature several common programmatic characteristics that may promote high rates of service utilization. These characteristics are summarized in Table 3.

Table 3. Programmatic Features of States With Highest Estimated Medicaid Family Planning Program Service Utilization

Medicaid Family Planning Programmatic Feature	States With Highest Estimated Medicaid Family Planning Program Service Utilization					
	CT	NY	MS	CA	WI	WA
Coverage of optional family planning-related services	✓	✓	✓	✓	✓	✓
Presumptive eligibility as part of Medicaid determination process	✓	✓			✓	
Consumer-facing website for Medicaid family planning program		✓	✓	✓	✓	✓
Information on covered services included on Medicaid family planning program website		✓	✓	✓	✓	✓
Website functionality to search for and locate local family planning providers		✓		✓		✓

In addition to being required to cover family planning services, all six states have elected to also cover the optional family planning-related services (e.g., STD/STI testing). (See additional detail in “Services Covered by Medicaid Family Planning Programs” section).⁵⁶ Additionally, three of these states have implemented presumptive eligibility (PE).⁵⁷ PE allows for individuals who appear to meet the eligibility criteria for the Medicaid family planning program to receive same-day services prior to a full eligibility determination, facilitating the rapid provision of services (see “Eligibility and Enrollment” section for additional detail).⁵⁸ Five of these highest service utilization states currently maintain detailed consumer-facing websites specifically for their Medicaid family planning programs, serving as an important source of information for applicants and enrollees, which is not the case for around half of the other states that operate Medicaid family planning programs.⁵⁹ All five state websites currently contain some level of information on the services covered by their family planning program (e.g., a list of covered services). Further, three states currently include on their websites a “provider locator” function, which allows individuals to search for and locate local providers of family planning services.⁶⁰

Best Practice Strategies to Strengthen Enrollment and Increase Utilization in Medicaid Family Planning Programs

While CMS sets out the federal minimum requirements for operationalizing a Medicaid family planning program, states generally have broad flexibility in designing their program policies and processes. This section lays out best practice strategies that could strengthen enrollment and increase utilization in Medicaid family planning programs across five domains: eligibility and enrollment, consumer support, covered services, confidentiality, and provider access.

States that already have Medicaid family planning programs in place should first assess whether they are fully compliant with the federal requirements as laid out in each section. They should then conduct an analysis to identify if there are additional best practices to implement in order to improve enrollment and utilization. States without a Medicaid family planning program in place can use this checklist of best practice strategies as an actionable road map for implementing a high-performing program.

Checklist of Best Practice Strategies to Strengthen Enrollment and Increase Utilization in Medicaid Family Planning Programs

1. Eligibility and Enrollment

- ✓ **Offer Separate Medicaid Family Planning Application Pathway:** Provide individuals with the option to apply for coverage through a standalone short Medicaid family planning program-only application, in addition to the mandatory single streamlined application pathway.
- ✓ **Establish Presumptive Eligibility to Ensure Access to Same-Day Services:** Establish presumptive eligibility for the Medicaid family planning program, enabling an individual to attest to their eligibility and receive services on the same day that their application is submitted, prior to a full eligibility determination.
- ✓ **Implement 12-Month Continuous Eligibility:** Implement 12-month continuous eligibility to allow individuals to stay continuously enrolled in the Medicaid family planning program without the need to report any changes in circumstances, such as changes in income or household size.
- ✓ **Raise the Medicaid Family Planning Income Eligibility Limit:** Align the Medicaid family planning program's eligibility levels with the state's eligibility levels for pregnant individuals, the highest level permissible by the Centers for Medicare & Medicaid Services (CMS).
- ✓ **Apply Flexible Household Composition Eligibility Rules:** Apply different income and household composition rules for Medicaid family planning programs than what is applied to other populations in order to increase enrollment and protect individuals who are seeking to apply confidentially.

2. Consumer Outreach and Education Support

- ✓ **Develop Effective Consumer-Facing Outreach Materials:** Develop materials to promote program awareness, such as brochures, flyers and fact sheets that describe the separate Medicaid family planning program and provide key information on eligibility requirements, covered services, providers and how to apply.
- ✓ **Maintain Consumer-Facing Family Planning Program Information on State Agency Web Page:** Maintain a consumer-facing web page dedicated to the Medicaid family planning program that informs individuals about the eligibility for the program, covered services and the appropriate application pathways.
- ✓ **Build Partnerships With Local Entities to Provide Training and Technical Assistance on the Medicaid Family Planning Program:** Build partnerships with local entities (e.g., local health departments, providers, community-based organizations and health clinics), and offer training on the Medicaid family planning program to enable these entities to relay information about the program to potentially eligible individuals.
- ✓ **Issue a Family Planning Program-Specific Medicaid Identification Card:** Issue a program-specific identification card to help enrollees distinguish their coverage from full-scope Medicaid and facilitate understanding that the program covers only a limited set of family planning services.

3. Covered Services

- ✓ **Guarantee Coverage of All FDA-Identified Contraceptive Methods:** Cover all FDA-identified contraceptive methods for enrollees, including both prescription and nonprescription methods, as recommended by CMS.
- ✓ **Provide Coverage for Services Classified as Family Planning-Related Services:** Strengthen the service array available to enrollees by including family planning-related services in the Medicaid family planning program.
- ✓ **Enable Continued Access to Contraceptives Through 12-Month Dispensing Limits:** Enact policies that allow for a 12-month dispensing limit for contraceptives, as opposed to shorter limits such as one or three months.
- ✓ **Establish Pharmacist Ordering Policies That Enable Access to Over-the-Counter Hormonal Contraceptives:** Implement policies that expand pharmacists' scope of practice to allow them to prescribe over-the-counter contraceptives.

4. Confidentiality

- ✓ **Emphasize in Consumer-Facing Materials That Medicaid Family Planning Program Services Are Confidential:** Clearly indicate in member-facing materials that services provided through the Medicaid family planning program are confidential and that enrollees have a right to privacy regarding the services they access.
- ✓ **Exclude Family Planning Services From Explanation of Benefits (EOBs) to Protect Confidentiality:** Refrain from sending EOBs to enrollees in the Medicaid family planning program to protect patient privacy and minimize written documentation on the services enrollees access.
- ✓ **Implement Application and Consumer Communication Processes That Maintain Confidentiality and Enhance Access to Services for Adolescents:** Provide consumer communication explaining that adolescents can utilize services confidentially, without notifying parents or guardians, and that all notices will be mailed to the individual's requested address.

5. Provider Access

- ✓ **Strengthen Monitoring of Access to Family Planning Providers:** Take proactive steps to monitor network adequacy for its family planning providers, including augmenting existing Access and Monitoring Review Plans to include family planning providers.
- ✓ **Develop and Regularly Update a Provider Locator or Directory:** Develop resources that assist enrollees in identifying local family planning providers so that they can access family planning services and/or receive assistance applying for the program.
- ✓ **Allow Providers to Deliver Family Planning Services via Telehealth:** Enact permanent policies that allow individuals to access clinically appropriate family planning services via telehealth.

1. Eligibility and Enrollment

Federal Medicaid Application and Renewal Requirements

States that implement a Medicaid family planning program through a SPA are required to follow the same Medicaid eligibility and enrollment income and household composition eligibility rules as those that apply to most of the individuals enrolled in the program: children, parents/caretaker relatives, pregnant individuals and expansion adults, if applicable. These individuals are known as Modified Adjusted Gross Income (MAGI) populations. A key requirement that applies for all MAGI populations (including those eligible for Medicaid family planning programs, if a state has one) is that states must use a “single streamlined application” that assesses eligibility for Medicaid MAGI, the Children’s Health Insurance Program (CHIP) and Qualified Health Plan coverage.⁶¹

All states with Medicaid family planning programs must ensure that individuals are able to apply for coverage through the state’s existing single streamlined application. States also have the option to supplement the single streamlined application with a shorter standalone application that is exclusively for the Medicaid family planning program. Notably, states that only have a standalone application for the Medicaid family planning program without assessing eligibility through the single streamlined application are not in compliance with federal requirements. States that implement a Medicaid family planning program, either through a SPA or 1115 waiver, must also enable individuals to submit applications via multiple modalities, including online via a website, by telephone, by mail, in person, and “other commonly available electronic means.”⁶²

For renewals, all states with Medicaid family planning programs must first attempt to redetermine eligibility using an ex parte process as is required for all MAGI and non-MAGI eligibility groups.⁶³ Conducting ex parte renewals means that states must attempt to determine eligibility without relying on information supplied by the individual by first reviewing available data sources to confirm if an individual continues to be eligible for Medicaid.⁶⁴ If a state successfully confirms ongoing Medicaid eligibility for individuals through an ex parte review, individuals are sent a notice that their coverage has been renewed, and no further action on their part is needed to maintain coverage. For individuals who are unable to have their eligibility redetermined ex parte, states must send a pre-populated renewal form and give individuals at least 30 days to respond to the renewal form. Individuals must be able to submit their renewal forms through multiple modalities, including in person, by mail, by telephone and online. In addition, prior to determining whether an individual is ineligible for Medicaid, states must screen the individual’s eligibility for all other Medicaid eligibility groups, including the Medicaid family planning program. Finally, if an individual’s coverage is terminated, the state must redetermine eligibility without requiring a new application if the individual returns to the state within 90 days. These renewal requirements are intended to minimize the burden to both the state and the individual, ensure eligible individuals retain coverage and help minimize gaps in care.^{65,66}

States that currently have family planning programs in place should assess whether they are complying with federal Medicaid eligibility and enrollment MAGI requirements and implement new processes if they are not.

Eligibility and Enrollment Best Practice Strategies

States could further improve their programs' ability to reach eligible people by implementing the following eligibility and enrollment best practice strategies:

- **Offer Separate Medicaid Family Planning Application Pathway:** In use in many states, short, family planning-only applications facilitate enrollment into Medicaid family planning programs. These applications may appeal to individuals who have other health care coverage (e.g., through private insurance or through state-based or Federally Facilitated Marketplace coverage) but are also interested in applying for Medicaid family planning coverage. For example, in states that have not expanded Medicaid, an adult may have little interest in completing a full-scope Medicaid application, knowing that they do not qualify for Medicaid coverage; however, they might be interested in applying for Medicaid family planning coverage, especially if the application is tailored to the one program for which the individual might be eligible. Additionally, this application pathway may enable access to an individual's family planning provider of choice and/or to protect their confidentiality. Of note, if individuals who apply for coverage through a shorter Medicaid family planning program-only application are found ineligible for family planning coverage, states must conduct an eligibility determination to assess whether they are eligible for Medicaid coverage based on other eligibility categories.
- **Establish Presumptive Eligibility to Ensure Access to Same-Day Services:** States have the option to establish presumptive eligibility (PE) for the Medicaid family planning program. PE allows an individual to attest to their Medicaid family planning program eligibility and receive services on the same day that their PE application is submitted, prior to a full eligibility determination.⁶⁷ A PE determination can be made by a clinic, other health provider, or other entity the state Medicaid agency deems qualified. Under PE policy, individuals can access services immediately if they attest that they are not pregnant and have an income that is at or below the income eligibility level established by the state for the Medicaid family planning program.⁶⁸ Through the PE process, individuals are allowed to attest to the information needed to make a PE determination, such as income and household size; states are not required to collect citizenship and residency information and cannot require individuals to provide a Social Security number to make a PE determination.⁶⁹

Of note, individuals are only presumptively enrolled in a Medicaid family planning program until the end of the month after the date the PE application was filed. They must file a full application for Medicaid to maintain coverage. Coverage may be terminated if the state ultimately finds them ineligible for coverage or the individual does not file an application or respond to requests for additional information. As such, a state that utilizes PE needs to make sure there is robust consumer communication and follow-up outreach processes to ensure individuals complete the full application, if appropriate, so that they can maintain coverage.

Under federal Medicaid requirements, a state Medicaid agency designates "qualified entities" to make PE determinations which, as noted above, are based on an individual's attestations.⁷⁰ Qualified entities may include health care providers, schools, child care and Head Start centers, community-based organizations, and agencies that determine eligibility for other health or social services programs (e.g., county health departments)—all places that have a high likelihood of reaching individuals who are potentially eligible

for Medicaid family planning programs. Qualified entities, therefore, can efficiently conduct PE for the Medicaid family planning program when interacting with an individual seeking to access other health or social services programs.⁷¹

While 18 states with Medicaid family planning programs have implemented PE processes for other eligibility groups (e.g., children and pregnant individuals), according to the latest data available from 2020, only six of these states have extended PE to their family planning program.^{72,73} States implementing PE in their Medicaid family planning program should assess data on the number of individuals enrolled through this pathway and consider whether modifications are needed to strengthen this option, such as expanding the number of qualified providers or making additional training available to existing qualified providers. Other states that have not adopted this policy for their Medicaid family planning program should do so to increase enrollment.

States with SPA programs have the option to elect whether they will provide PE for the Medicaid family planning program group. States with waiver programs can include this policy in their proposed design when submitting a new, or amending an existing, 1115 waiver demonstration to CMS.

Of note, three of the six states with the highest service utilization of any family planning service in their Medicaid family planning program (based on this brief's data analysis) have facilitated enrollment and prompt utilization of services by implementing PE (Connecticut, New York, Wisconsin). Individuals determined to be presumptively eligible for a state's Medicaid family planning program by a provider can access services on the same day that they are visiting their provider, thereby reducing barriers to access. Accessing same-day services is especially important for contraception services since research shows that requiring two visits to initiate contraception is a barrier to care, and some individuals are less likely to return for a second visit to obtain contraception.⁷⁴ Adopting PE helps simplify the complex Medicaid application process, reduce barriers to health care access and increase Medicaid enrollment through community-based provider settings.⁷⁵

State Example



Wisconsin established PE, which the state refers to as “Express Enrollment,” for both its full-scope Medicaid program (BadgerCare Plus) and its family planning program (Family Planning Only Services). For the Family Planning Only Services program, the state certifies entities, including hospitals, county health departments, family planning clinics and primary care providers, as qualified providers who can make PE determinations for individuals seeking to enroll in the program. Prior to the COVID-19 PHE, the state was enrolling approximately 4,000 individuals in the Family Planning Only Services Program each quarter through PE.⁷⁶ The state includes a member notice about the availability of Express Enrollment directly on the web page for its Family Planning Only Services Program.⁷⁷

How to get temporary coverage

If you need family planning services right away, you may be able to enroll for temporary coverage (also known as Express Enrollment [<https://dhs.wisconsin.gov/forwardhealth/express-enrollment.htm>]). You will need to meet the eligibility criteria.

Your health care provider or hospital would start your Express Enrollment. Some community partners may be able to start Express Enrollment for children. You cannot apply for temporary benefits on your own. If your provider cannot help you, call Member Services at 800-362-3002. They can tell you the qualified hospitals, providers, or partners near you.

Temporary coverage starts the day you enroll. It ends on the last day of the following month. If you want to keep getting services after this temporary coverage ends, you will need to fill out an application for the Family Planning Only Services Program.

Source: Wisconsin Department of Health Services, *Family Planning Only Services Program* (April 13, 2023), available at <https://www.dhs.wisconsin.gov/fpos/index.htm>.

State Example



New York maintains a list of Family Planning Service Providers where individuals can obtain a PE screening and/or get application and enrollment assistance for the state’s Family Planning Benefit Program. These providers span county health departments, health systems/providers, community-based organizations and community health centers, with a total of 164 provider sites across the state.

Type of Provider	Provider Name	Number of Sites per Provider
County Health Departments	Allegany County Health Department	2
	Cattaraugus County Health Department	3
	Erie County Department of Health	1
	Greene County Family Planning	1
	Livingston County Center for Sexual Health & Wellness	3
	Rockland County Health Department	2
Health Systems/ Providers	Anthony L. Jordan Health Corporation	1
	Family Planning of South Central New York	6
	Kaleida Health	1
	Lincoln Medical and Mental Health Center	2
	Long Island Jewish Medical Center	1
	Morris Heights Health Center	7
	Mount Sinai Adolescent Health Center	1
	Nassau Health Care Corporation	5
	New York Presbyterian Hospital	2
	NYC Health & Hospitals	12
	Planned Parenthood	58
	Public Health Solutions	2
	Staten Island University Hospital	2
Sun River Health	17	
Community-Based Organizations	Oswego County Opportunities, Inc.	4
	The Children’s Aid Society	2
	The Door—A Center for Alternatives	1
	Tioga Opportunities, Inc.	1
Community Health Centers	Community Health Center of Buffalo, Inc.	4
	Community Health Center of Richmond	2
	Community Healthcare Network	11
	Finger Lakes Community Health	7
	William F. Ryan Health Center	3
Total Provider Sites		164

Source: New York State Department of Health, *How do I apply for the FPBP?* (May 2022), available at https://www.health.ny.gov/health_care/medicaid/program/longterm/familyplanbenprog.htm.

- **Implement 12-Month Continuous Eligibility:** States have the option to provide their Medicaid family planning enrollees with 12-month continuous eligibility. Four of the six states with the highest Medicaid family planning enrollment rates (based on this issue brief’s data analysis) implement a requirement for 12-month continuous eligibility (Alabama, New Mexico, North Carolina, South Carolina). States with SPA programs would need to obtain 12-month continuous eligibility authority through an 1115 waiver; states with 1115 waiver programs can amend their waiver to include this authority. Under this policy, an individual who is determined eligible for the Medicaid family planning program will be continuously enrolled for 12 months and does not need to report any changes in income or household size.⁷⁸ Without this policy, individuals may lose Medicaid at some point during their coverage year if they experience a change in circumstances, such as temporary overtime pay or a divorce.⁷⁹

Twelve months continuous eligibility helps ensure individuals covered through the Medicaid family planning program avoid gaps in coverage that can hamper their access to services. This is especially critical for individuals who require uninterrupted access to services such as contraceptive methods, which must be used consistently. For example, to be effective, contraceptive methods such as birth control pills must be taken daily, hormonal patches must be changed every week, vaginal rings must be changed every month and contraceptive injections must generally be received every three months.⁸⁰ Preventing lapses in access to services through continuous eligibility is key to ensuring people who desire to prevent pregnancy or who opt to space the intervals between births have the ability to do so.

In addition, 12-month continuous eligibility helps mitigate the cycle of enrollment, disenrollment and re-enrollment when individuals experience a temporary change in circumstance, also referred to as Medicaid “churn.”⁸¹ Mitigating churn benefits state Medicaid agencies by reducing the administrative burden and costs of processing program terminations and re-enrollments, which have been found to generate a significant share of Medicaid expenses, ranging from \$400 to \$600 per person.⁸²

State Example



Alabama operates its “Plan First” family planning program through an 1115 waiver. Through the waiver, the state has approval from CMS to provide 12-month continuous eligibility for individuals who are determined eligible for the Plan First program. Therefore, an individual found to be income-eligible for the program upon their initial application or annual redetermination will not need to report any changes in income or household size for a 12-month period.⁸³

- **Raise the Medicaid Family Planning Income Eligibility Limit:** Per CMS guidance, states that authorize their Medicaid family planning programs through either a SPA or an 1115 waiver may set the upper income level for the Medicaid family planning program to be at the same income level that is used to determine eligibility for pregnant individuals.⁸⁴ Aligning a Medicaid family planning program’s eligibility levels with the state’s eligibility levels for pregnant individuals will increase program enrollment, as most states generally set the income level for pregnant individuals at significantly higher levels than the income limit set for adults.⁸⁵ States that leverage this flexibility will likely experience an increase in the number of individuals who are eligible to enroll in and receive Medicaid family planning program services. Four of the six states

with the highest Medicaid family planning enrollment rates based on the data analysis in this issue brief (South Carolina, New Mexico, North Carolina, Alabama) align the eligibility levels for their Medicaid family planning programs with that of pregnant individuals (see South Carolina example below).

- **Apply Flexible Household Composition Eligibility Rules:** In order to increase enrollment and protect individuals who are seeking to apply confidentially, states may also apply different income and household composition rules for their Medicaid family planning programs than what is applied to other MAGI populations.⁸⁶ Specifically, states are permitted to choose one of the following options when calculating the income and household size for Medicaid family planning program eligibility:⁸⁷
 - Include all members in the applicant’s household when calculating household size, but count only the applicant’s income;
 - Include only the applicant when calculating household size, and count only the applicant’s income; or
 - Use either option above and increase the applicant’s total family size by one.⁸⁸

States that use either the first or third flexible option can increase the likelihood that an individual will be found eligible for a family planning program because income eligibility limits increase as household size increases. Additionally, all three of these options allow states to evaluate eligibility for a single applicant apart from a household, thereby ensuring confidentiality for individuals seeking to receive services without involvement from their parents, spouses or other household members, such as adolescents and individuals experiencing intimate partner violence. (See “Confidentiality” section for additional information on adolescent enrollment.)

State Example



In the approved SPA for its Medicaid family planning program, **South Carolina** implemented the flexibility to consider only the applicant when determining household size (i.e., a household of one) and calculating income.

In addition, the state set the income limit for the program at the maximum income standard of 194% FPL, equivalent to the income limit for the Pregnant Women eligibility group. In comparison, the income limit for parents applying to the state’s full-scope Medicaid program is 95% FPL, which translates to \$753.30 monthly for an individual.⁸⁹ As a non-expansion state, childless adults in South Carolina are not eligible at any income level. In contrast, individuals may enroll in the Medicaid family planning program without regard to whether they are parents (that is, childless adults may also qualify) if they have income below 194% FPL, which translates to \$2,357.10 monthly for an individual.⁹⁰

State Example

Medicaid Family Planning SPA Template Page

The following is South Carolina's Medicaid family planning program SPA, where the State elected their MAGI income and household composition rules.⁹¹

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

The individual may be a male or a female.

Income standard used for this group

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is the highest of the following:

The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.

The state's current effective income level for pregnant women under a Medicaid 1115 demonstration.

The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.

The state's current effective income level for pregnant women under a CHIP 1115 demonstration.

The amount of the maximum income standard is: 194 % FPL

Income standard chosen

The state's income standard used for this eligibility group is:

The maximum income standard

Another income standard less than the maximum standard allowed.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

In determining eligibility for this group, the state uses the following household size:

All of the members of the family are included in the household

Only the applicant is included in the household

The state increases the household size by one

In determining eligibility for this group, the state uses the following income methodology:

The state considers the income of the applicant and all legally responsible household members (using MAGI-based methodology).

The state considers only the income of the applicant.

Source: South Carolina Department of Health and Human Services, Title XIX State Plan Amendment SC-16-0001-MM1 (January 20, 2017), available at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/SC/SC-16-0001.pdf>.

2. Consumer Outreach and Education Support

Federal Notice and Language Requirements

States are required to provide all Medicaid applicants, including individuals applying for a Medicaid family planning program, with a notice of their eligibility determination.⁹² Federal regulations require that the eligibility determination notice include information on the covered Medicaid services in order to ensure individuals understand the scope of services to which they are entitled.⁹³ This is particularly important for individuals enrolled in limited-benefit family planning programs. For example, while there are many benefits to determining an individual's eligibility for all Medicaid programs through the single streamlined application, some individuals who applied for full-scope Medicaid may not understand that they were found eligible for limited Medicaid family planning services or know how to access those services.

In addition, states must meet language access requirements and ensure “meaningful access” to health programs for individuals with limited English proficiency.^{94,95}

States have general obligations to inform people about coverage programs and the opportunity to apply, with more specific requirements applicable to children and youth under age 21. States generally do not undertake family planning program outreach, and they vary in the extent of information available on their websites. Some states post member handbooks, program brochures and fact sheets on a dedicated web page about the Medicaid family planning program, while other states have limited or no information on their programs. Further, some states' websites include information on family planning programs that are exclusively focused on provider-facing resources, such as provider manuals, which provide information that is of limited use to consumers seeking to enroll in coverage.

Consumer Outreach and Education Best Practice Strategies

To promote understanding of the services offered through a Medicaid family planning program and avoid confusion about how the Medicaid family planning program is different from full-scope Medicaid, states should consider implementing the following best practices:

- **Develop Effective Consumer-Facing Outreach Materials:** Materials such as brochures, flyers and fact sheets that describe the separate Medicaid family planning program and provide key information on eligibility requirements, covered services, providers and how to apply can promote program awareness when written in a concise and clear way. CMS has developed resources on developing effective written materials for enrollees that states can leverage.⁹⁶ Additionally, to comply with limited English proficiency language access requirements, states should provide materials in languages other than English based on the languages most commonly spoken by the population enrolled in the state's Medicaid program.

State Example



Virginia developed a variety of consumer-facing materials that provide information on the state’s Plan First Medicaid family planning program—a fact sheet, brochure, poster and member handbook. The materials describe what services are covered under Plan First (e.g., birth control methods such as contraceptive implants, vaginal rings, hormonal patches, IUDs, birth control pills, diaphragms, Depo-Provera and condoms) as well as what is not covered (treatment for medical problems). The state has developed program brochures in an array of different languages and all other consumer-facing materials in both English and Spanish; materials are available on the state’s Plan First website.⁹⁷

- Program Brochure ([English](#) | [Spanish](#) | [Arabic](#) | [Amharic](#) | [Dari](#) | [Pashto](#) | [Vietnamese](#) | [Urdu](#))
- Brochure for Postpartum Individuals ([English](#) | [Spanish](#))
- Poster ([English](#) | [Spanish](#))
- Fact Sheet ([English](#) | [Spanish](#))
- Member Handbook ([English](#) | [Spanish](#))

State Example



California’s Family Planning, Access, Care, and Treatment (Family PACT) relies primarily on providers to conduct outreach about the availability of the program and covered services. To facilitate provider outreach, the state has developed over 60 client education materials that providers are able to order from the state free of charge. Providers are allowed to brand the materials with information about their clinic or practice.⁹⁸ Once individuals are enrolled, the state reimburses providers for delivering a Family PACT orientation that covers the scope of Family PACT services and information about family planning methods and select related conditions. This orientation may be provided by either a clinician or counselor. This approach incentivizes providers to deliver this program orientation to enrollees, which in turn benefits providers financially and supports enrollees in understanding their coverage.^{99,100}

- **Maintain Consumer-Facing Family Planning Program Information on State Agency Web Page:** A consumer-facing web page on the state Medicaid agency’s website that is dedicated to the Medicaid family planning program is a simple way for states to share important information in a way that is readily accessible to most people. The web page should inform individuals about eligibility for the program and covered services and direct individuals who are interested in applying to the program to the appropriate application pathways. For example, states should provide a link on the Medicaid family planning program’s web page to the state’s single streamlined online application and to other available methods to access the application (e.g., copy of paper application and address for where to apply in person). States that implement PE should provide clear information on how to locate local providers authorized to make PE determinations and access immediate services.

State Examples

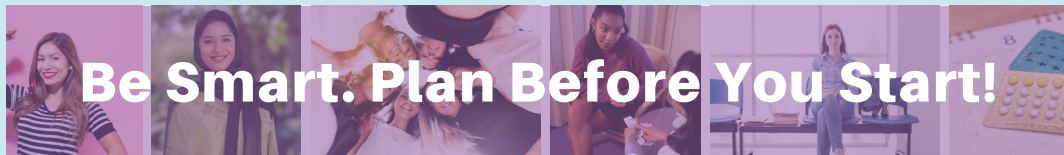


New York maintains a web page¹⁰¹ that provides information on the state’s Family Planning Benefit Program. In addition to including key information about eligibility requirements and covered services, the web page provides details on what information individuals will need to provide when applying for the program. The website informs individuals where applications can be completed in person with a Family Planning Services provider and directs individuals to a list of these providers. The list of Family Planning Service providers can be filtered by county so individuals can reference local providers and obtain provider addresses and phone numbers.



Georgia maintains a web page with detailed information on its Planning for Healthy Babies program.¹⁰² The state’s web page links individuals to different resources to learn more about the program, such as:

- A Frequently Asked Questions (FAQ) section that answers questions such as “What’s covered?”, “Who is eligible?” and “How do I apply?”
- A chart describing the maximum monthly income an individual can earn (based on their family size) and still qualify for the program
- A “postcard” for prospective enrollees, providing an overview of the program and how to apply (see images)



DO YOU NEED ACCESS TO FREE BIRTH CONTROL?

WHAT IS PLANNING FOR HEALTHY BABIES (P4HB)?

Planning for Healthy Babies provides no-cost family planning services to eligible Georgia residents. The goal of P4HB is to help women be healthy and plan ahead in order to have healthy babies when they are ready to start their families! P4HB members get family planning, interpregnancy care and/or Resource Mother outreach services.

WHAT IS COVERED?

- Family planning initial or annual exams
- Follow up family planning visits
- Pap smears and pelvic exams
- Birth control and multivitamins with folic acid
- Patient education and counseling
- Select immunizations for participants aged 18-20
- Counseling and referrals to social services

WHAT ARE THE ELIGIBILITY REQUIREMENTS?

- Uninsured individuals ages 18-44
- Georgia state resident
- Family income at or below 211 percent of the Federal poverty level
- Ability to become pregnant
- Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP)



PLANNING FOR HEALTHY BABIES (P4HB)

State Examples



Be Smart. Plan Before You Start!

HOW DO I APPLY?

You can apply online at: gateway.ga.gov

If you are unable to apply online, you can pick up a physical application at your local:

- Public Health Department
- Division of Family and Children Services (DFCS) Office

Completed physical applications and required documentation should be faxed (912-632-0389) or mailed to:

**Division of Family and Children Services
Customer Contact Center
P.O. Box 4190
Albany, GA 31706**



WHERE CAN I GO FOR MORE INFORMATION?

 **1-877-427-3224**  <https://medicaid.georgia.gov/planning-healthy-babies>

 **PLANNING FOR HEALTHY BABIES (P4HB)**

Source: Georgia Department of Community Health, Planning for Healthy Babies, Post Card for Young Women (updated February 22, 2021), available at <https://medicaid.georgia.gov/document/document/p4hb-young-women-feb-2021-post-card/download>.

- **Build Local Partnerships to Provide Training and Technical Assistance on the Medicaid Family Planning Program:** Individuals eligible for, but not enrolled in, a Medicaid family planning program are likely to have relationships with local entities such as departments of social services, local health departments, providers, community-based organizations and health clinics. States should seek to build partnerships with these local entities and offer training on the Medicaid family planning program to enable these entities to relay information about the program to potentially eligible individuals. States can also review their available data on program enrollment and utilization to identify if there are specific geographic areas in the state that would benefit from targeted outreach and training efforts (e.g., counties that are observed to have low utilization of family planning services).

State Example



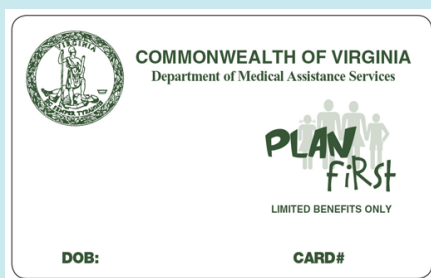
North Carolina convened a Strategic Planning Partners Group for its Be Smart Family Planning Program, which included representation from state Medicaid agency representatives, community members, county health departments and providers. The group contributed to the development of a five-year strategic plan to guide implementation and increase awareness of the Be Smart program. The strategic plan identified six key strategies for the program, including a focus on increasing training and outreach to local agencies and potential program enrollees. As part of the strategic plan, the state identified a list of counties prioritized to receive training and outreach on the Be Smart program based on counties with low service utilization from program enrollees. The state has since conducted training directly with local entities covering a range of information, including an overview of the Be Smart program and services available through the program. The state has also made efforts to engage both public and private providers and provide applicable technical assistance such as billing and reimbursement guidance.

- **Issue a Family Planning Program-Specific Medicaid Identification Card:** States can opt to provide a program-specific Medicaid family planning program identification card to enrollees that is different from the identification card for full-scope Medicaid. This can be done by issuing an identification card that is different in color, includes the family planning program name and/or directly notes that the card provides access to a limited-benefit program. Issuing a program-specific identification card can help enrollees distinguish their coverage from full-scope Medicaid and facilitate understanding that the program covers a limited set of family planning services. Additionally, a program-specific card can help prevent providers from delivering services not covered under the Medicaid family planning program, which in turn mitigates any billing confusion for providers.

State Examples



Virginia provides a card with the program’s name and a clear statement noting that coverage is for “limited benefits only.”¹⁰³ **Georgia**, which operates its Planning for Healthy Babies family planning program through Medicaid managed care, has its Medicaid managed care plans issue cards branded with both the managed care plan name and the Medicaid family planning program name.¹⁰⁴



Sources: Commonwealth of Virginia Department of Medical Assistance Services, Plan First Member Handbook (March 1, 2016), available at <https://www.dmas.virginia.gov/media/1621/plan-first-member-handbook-english.pdf>; CareSource, Georgia Planning for Healthy Babies® (P4HB®), 2022–2023 Member Handbook, available at <https://www.caresource.com/documents/ga-planning-for-healthy-babies-member-handbook-508/>.

3. Covered Services

Federal Requirements for Family Planning Services

As described above in the “Services Covered by Medicaid Family Planning Programs” section, there is no federally defined list of family planning services that states must offer.¹⁰⁵ Instead, states define the family planning services they will provide in the 1115 waiver application or SPA in line with federal guidance. Current guidance requires states to (1) cover services that are sufficient in amount, duration and scope to prevent pregnancy, delay pregnancy or treat infertility; and (2) ensure enrollees are able to choose the method of family planning they wish to use, free from coercion or mental pressure.^{106,107} Per the federal guidance, states must cover a range of contraceptive methods to ensure enrollees have a choice of which method to use, and they are not allowed to require enrollees to use a particular method first (e.g., step therapy).¹⁰⁸

In addition, Medicaid family planning programs that are implemented through SPAs are also subject to additional covered service requirements. Specifically, enrollees in programs authorized by a SPA must receive the same family planning services and nonemergency transportation services that are available to enrollees who receive full-scope Medicaid.^{109,110}

Covered Services Best Practice Strategies

States can cover a broad range of family planning services in their SPA or waiver programs that empower individuals to make choices about their reproductive health and improve overall health outcomes. Best practices regarding covered services include the following:

- **Guarantee Coverage of All FDA-Identified Contraceptive Methods:** CMS recommends states cover all FDA-identified contraceptive methods for enrollees, including both prescription and nonprescription methods.¹¹¹ By doing so, states can provide a range of options for contraceptive methods and ensure enrollees can make their preferred choice of contraceptive method. The list of all FDA-approved methods is available at the [FDA’s Birth Control Guide](#).¹¹²
- **Provide Coverage for Services Classified as Family Planning-Related Services:** CMS separates family planning services into two categories, family planning services and supplies and family planning-related services, for the purpose of distinguishing federal matching rates (see the “Services Covered by Medicaid Family Planning Programs” section above). In contrast to family planning services and supplies that must prevent pregnancy, delay pregnancy or treat infertility, family planning-related services are provided as part of or as follow-up to a family planning visit and can include medical, diagnostic and treatment services that ensure individuals can receive high-quality, comprehensive care.^{113,114} States have authority to define the scope of family planning-related services, and examples provided by CMS include follow-up visits and treatment for STDs/STIs and preventive services such as vaccinations to prevent cervical cancer.

CMS has issued guidance on family planning-related services through the State Medicaid Director, State Health Official, and FAQ letters listed below. Appendix B lists examples of permissible family planning-related services as detailed in State Medicaid Director Letter #10-013. States should reference CMS guidance to review permissible services and consider other services that can be defined as family planning-related in their program design to strengthen the service array available to enrollees.

- **State Medicaid Director Letter (SMD) #10-013:** Family Planning Services Option and New Benefit Rules for Benchmark Plans (issued July 2, 2010)
- **State Medicaid Director Letter (SMD) #14-003:** Family Planning and Family Planning-Related Services Clarification (issued April 16, 2014)
- **State Health Official Letter (SHO) # 16-008:** Medicaid Family Planning Services and Supplies (issued June 14, 2016)
- **Frequently Asked Questions (FAQs):** Medicaid Family Planning Services and Supplies (issued January 11, 2017)

State Examples



CMS has approved other state definitions for family planning-related services beyond the permissible examples laid out in previously published guidance. For example, **Mississippi** covers colposcopy (a procedure conducted when results of cervical cancer screening tests are abnormal)¹¹⁵ and repeat Pap smears as preventive family planning-related services.¹¹⁶ Additionally, **Louisiana** covers nonemergency transportation services as a family planning-related service, despite this not being a requirement for states that implement their family planning programs through waivers.¹¹⁷

- **Enable Continued Access to Contraceptives Through 12-Month Dispensing Limits:** Ensuring individuals can obtain their desired method of contraception is central to the goals of the Medicaid family planning program. States can support an individual's adherence to contraceptive methods by enacting policies that allow for a 12-month dispensing limit for contraceptives, as opposed to shorter limits such as one-month or three-months. Research from California's Family PACT program has shown that following the state's implementation of a 12-month dispensing policy, there was an estimated 30% reduction in unplanned pregnancies compared with individuals who received a one- or three-month supply of oral contraceptives.¹¹⁸ In addition to promoting access for individuals, 12-month dispensing limits have been demonstrated to generate significant cost savings for states. The Washington State Health Care Authority estimates that by facilitating continued access to contraception for individuals who choose to prevent or delay pregnancy, the state generated \$1.5 million in savings by averting costs related to pregnancy and infant care in one year alone following the implementation of a 12-month dispensing limit for oral contraceptives.¹¹⁹

Implementation of these policies generally requires state legislation; states have enacted policies allowing for 12-month dispensing not just of oral contraceptives but also of vaginal rings, hormonal patches and injectable contraceptives.¹²⁰ A 2021 survey of states conducted by the Kaiser Family Foundation found that at least 9 out of the 30 states with Medicaid family planning programs have laws allowing 12-month dispensing, and additional states have continued to pursue this option, the most recent being New Jersey with new legislation effective January 2023.^{121,122} However, some states have adopted shorter dispensing limits, such as New Mexico and Louisiana, which allow only six months of contraceptive dispensing at a time.¹²³ Various states that now require a 12-month dispensing limit have made their legislation applicable to both the Medicaid program and private insurance.¹²⁴

State Example



In 2010, **Washington** established the option of dispensing 12 months of oral contraceptives for Medicaid enrollees. However, despite the new policy, most oral contraceptives were still dispensed in one-month or three-month amounts. Recognizing that 12-month dispensing enabled access to oral contraceptives, promoted continuation rates and contributed to reducing unintended pregnancies, in 2014, the state clarified its policy to require 12-month dispensing of oral contraceptives for Medicaid enrollees unless there is a medical indication not to or the client requests a smaller supply.¹²⁵ In 2017, the state extended this policy to private insurers.¹²⁶ As of 2021, the state permits dispensing a 12-month supply of vaginal rings, hormonal patches and injectable contraceptives, in addition to oral contraceptives.¹²⁷

- **Establish Pharmacist Ordering Policies That Enable Access to Over-the-Counter Hormonal Contraception:** Clinical experts, including the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP), have continuously supported enabling access to hormonal contraception over the counter, including oral contraceptive pills, vaginal rings and hormonal patches.^{128,129} While ACOG and AAFP have emphasized that hormonal contraception should be available over the counter **without** a prescription, federal Medicaid rules indicate that only “prescribed drugs” in state Medicaid programs are eligible for federal reimbursement.¹³⁰ In order to both comply with federal rules and be able to provide over-the-counter access to hormonal contraceptives, states can implement policies that expand a pharmacist’s scope of practice to allow them to prescribe over-the-counter contraceptives. Doing so breaks down barriers to access for individuals who have transportation barriers to reaching providers in order to obtain a prescription or who may want more convenient access to a contraceptive method.¹³¹

States can pursue one of three options in their legislative approaches, listed below in order of least to most prescriptive.^{132,133}

- Statewide protocol laws authorizing pharmacists to independently prescribe contraceptives
- Laws that authorize a state health officer to issue a statewide “standing order” for pharmacists to prescribe contraceptives without a separate physician/prescriber order
- Laws establishing a collaborative practice agreement between pharmacists and a separate physician/prescriber

As of 2022, 24 states across the country have enacted legislation through the approaches listed above.¹³⁴

State Example



In 2021, the **North Carolina** legislature passed Session Law 2021-110/House Bill 96, authorizing the State Health Director to issue a standing order allowing pharmacists practicing in the state of North Carolina and licensed by the North Carolina Board of Pharmacy to “dispense, deliver, or administer contraceptives.”¹³⁵ The standing order was since released and effective February 2023. Specifically, the standing order allows pharmacists to provide specific contraceptive methods: combined oral contraceptives, transdermal contraceptives and the progestin-only pill.¹³⁶

4. Confidentiality

Confidentiality Federal Requirements

State Medicaid programs are required to accommodate enrollee requests to receive communications by alternative means or at an alternative location when the individual clearly states that disclosure could endanger the individual.^{137,138} States are responsible for ensuring that enrollees are informed of this option. Given the sensitive nature of accessing family planning services and the specific circumstances enrollees may experience, ensuring confidentiality for enrollees receiving family planning services is both a matter of compliance with federal requirements^{139,140} and a central tenet of providing quality health care to individuals.¹⁴¹ For individuals experiencing intimate partner violence, assurance that family planning services will be confidential can help individuals access the services and care they need. As recommended by national research and professional medical organizations,¹⁴² confidentiality should also be assured for adolescents seeking family planning services, as adolescents with concerns about confidentiality are less likely to access needed services.^{143, 144}

Confidentiality Best Practices

Many states do not include pertinent information about confidentiality practices in consumer-facing materials to help consumers understand their rights and available privacy protections that can incentivize them to access services. Examples of best practices states can implement to maintain confidentiality for Medicaid family planning program enrollees are as follows:

- **Emphasize in Consumer-Facing Materials That Medicaid Family Planning Program Services Are Confidential:** States should clearly indicate in member-facing materials that services provided through the Medicaid family planning program are confidential and that enrollees have a right to privacy regarding the services they access.
- **Exclude Family Planning Services From Explanation of Benefits (EOBs) to Protect Confidentiality:** EOBs provide individuals with a summary of the costs of medical treatment and include information on the specific services and date of services received. While state Medicaid programs are not required to send EOBs to enrollees, some state Medicaid agencies opt to or require their managed care plans to send EOBs to enrollees in order to verify receipt of services as a means of combating fraud.¹⁴⁵ In order to protect patient privacy and minimize written documentation on the services enrollees access, states can refrain from sending EOBs to enrollees in their Medicaid family planning program.
- **Implement Application and Consumer Communication Processes That Maintain Confidentiality and Enhance Access to Services for Adolescents:** Medical guidance from entities such as ACOG and the Society for Adolescent Health and Medicine maintains that reproductive life planning is an important topic to address with adolescents, and access to family planning services is both a right for adolescents and important for the prevention of STDs/STIs transmission. ACOG recommends that initial reproductive health visits should take place when adolescents are between age 13 and age 15 and should encompass a discussion about contraception and STIs in addition to preventive medicine services such as human papillomavirus (HPV) vaccination (to protect against multiple forms of HPV-related cancers, including cervical cancer)¹⁴⁶—all services that can be offered through Medicaid family planning programs.

The importance of facilitating access to family planning services is further underscored by the fact that the United States has the highest adolescent pregnancy rate among developed countries.¹⁴⁷ As such, Medicaid family planning programs have been demonstrated to reduce adolescent births in states that have

implemented them.¹⁴⁸ As referenced above in the “Apply Flexible Household Composition Eligibility Rules” section, states have the option to apply rules that evaluate eligibility for a single applicant who is separate from a household; providing a single-applicant pathway can provide greater opportunity for minors to access confidential services through Medicaid family planning programs.

In addition to the single-applicant option, individuals should be provided consumer communication that explains that their parents/guardians will not be contacted and that all notices will be mailed to the individual’s requested address.

State Example



As part of the member handbook **Virginia** has developed for its Plan First program, the state has included a section dedicated to information for enrollees about privacy information. The member handbook details the rights enrollees have regarding their privacy and information on how individuals can request confidential communications.

Virginia’s Plan First Member Handbook Language

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

State Example

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.
- We will not retaliate against you for filing a complaint.

Source: Commonwealth of Virginia Department of Medical Assistance Services, Plan First Member Handbook (March 1, 2016), available at <https://www.dmas.virginia.gov/media/1621/plan-first-member-handbook-english.pdf>.

State Example



Wisconsin allows members under age 18 to apply individually for the state's family planning program and have a separate "case" in the Medicaid system. Members are informed that their parents/guardians will not be contacted if they submit an application, and any mail correspondence is addressed to the minor at the address of their choosing.

5. Provider Access

Federal Requirements on Provider Access

Federal Medicaid requirements mandate “freedom of choice” for family planning services, including those offered by Medicaid family planning programs.¹⁴⁹ The freedom of choice provision allows individuals to see any Medicaid provider of their choice to access family planning services and prohibits states from denying access to qualified providers.¹⁵⁰ In practice, an individual’s freedom of choice of family planning providers can be hampered by the lack of geographic accessibility to providers. Nationally, research has found that an estimated 19 million individuals of reproductive age in the United States live in “contraceptive deserts” where they lack “reasonable access” in their county to a provider that offers the full range of FDA-approved contraceptive methods.¹⁵¹

Provider Access Best Practice Strategies

To facilitate access to available providers, states should implement the following best practices:

- **Strengthen Monitoring of Access to Family Planning Providers:** A review of available state reporting on Medicaid family planning programs for this brief showed that the majority of states do not provide information on the number and geographic location of family planning providers, thereby diminishing a state’s ability to identify and address any potential gaps in provider access. Reporting requirements for states with waiver programs requires states to describe any “changes in provider participation.” However, states generally indicate only the number of providers participating in the Medicaid family planning program without additional context on their geographic location or on whether the provider is taking new patients. States would benefit from taking more proactive steps to monitor network adequacy for their family planning providers.

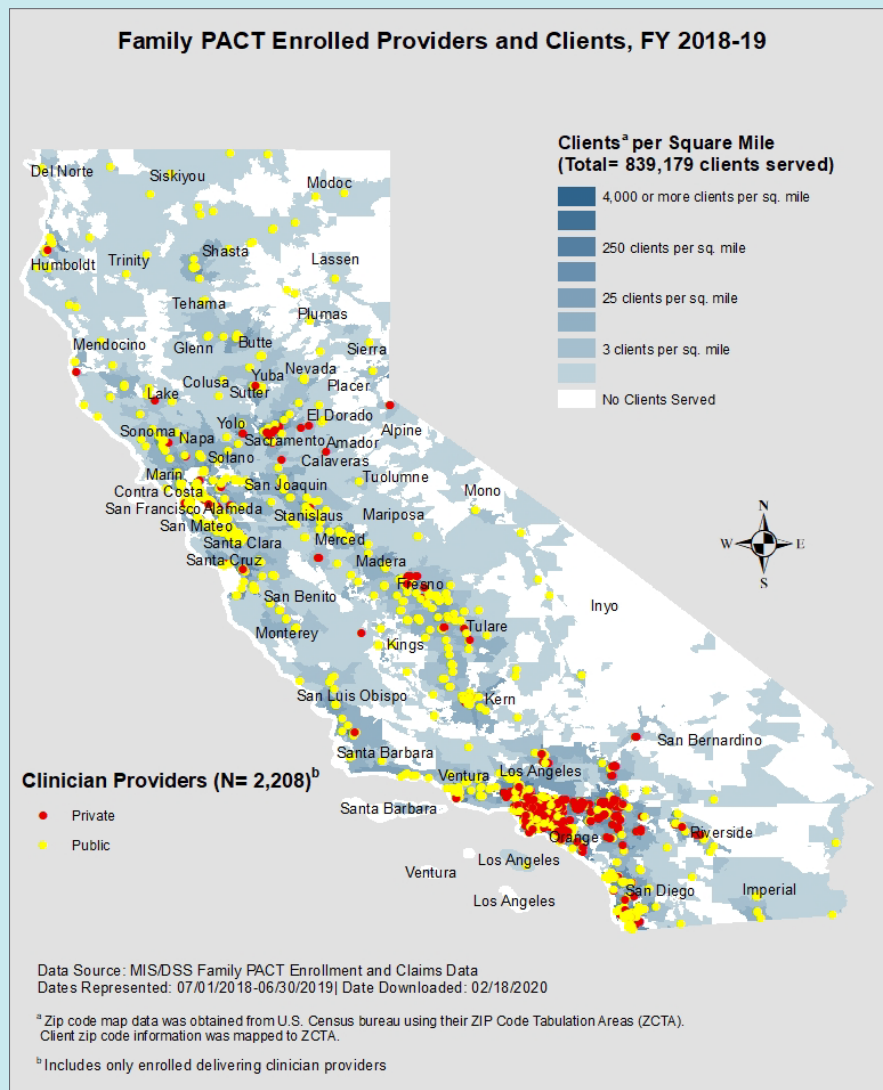
For example, every three years, states are required to submit Access and Monitoring Review Plans (AMRPs) documenting that provider payment rates are sufficient to ensure access comparable to the general population.¹⁵² AMRPs, reporting required for the fee-for-service delivery system, are currently required for a limited subset of service categories, including primary care services, behavioral health services, pre-and post-natal obstetric services, and home health services. States could augment existing AMRPs to include family planning providers in order to gain a more refined understanding of access challenges for these services.

To encourage providers to participate in family planning programs, states could also offer training on how to obtain reimbursement through the Medicaid family planning program. A simplified provider enrollment process can also improve provider participation.

State Example



California's Family PACT program is the largest Medicaid family planning program in the country. The state produces an annual report on its program and includes detailed information on the provider demographics, including the number and percentage of private and public providers (e.g., Federally Qualified Health Centers) that participate in the Family PACT program. Additionally, the state includes a map of participating providers overlaid with the concentration of program enrollees.¹⁵³



Source: California Department of Health Care Services, Office of Family Planning, Family Pact Program Report, Fiscal Year 2017–2018 and Fiscal Year 2018–2019, available at https://familypact.org/wp-content/uploads/2022/04/FPACT-Program-Report-FY17-18-and-FY18-19-_published.pdf.

- **Develop and Regularly Update a Provider Locator or Directory:** States should develop resources that assist enrollees in identifying local family planning providers so that they can access family planning services and/or receive assistance applying for the program if that is required. Provider locators or directories that are regularly updated and maintained allow individuals to identify providers by their city, county and/or ZIP code to enable enrollees to determine which providers are most geographically accessible. States with dedicated websites for their Medicaid family planning programs can include this functionality directly on their websites. In addition, states can provide information on how to access the dedicated provider locator or directory in all enrollee-facing materials.

State Example



Minnesota's enrollee-facing materials inform individuals about how to access the state's directory of Medicaid providers either online or via phone. Individuals accessing the provider locator online can search specifically for family planning providers and filter results by city, county or ZIP code.¹⁵⁴

Can I get health care services right away?

You can apply for short-term family planning coverage at certain clinics. To get the names of these clinics, call 651-431-3480 (Twin Cities metro area) or 888-702-9968 (outside the Twin Cities metro area). You can also find the list of clinics where you can apply for short-term coverage at <http://mn.gov/dhs/MN-Family-Planning-Program/>.

- Short-term coverage starts right away.
- Short-term coverage ends on the day eligibility for ongoing family planning services is determined or, if no application is submitted, on the last day of the next month.
- You can get short-term coverage only once a year.
- To get family planning services for a full year, you must send an application to the Minnesota Family Planning Program. The clinic that gives you short-term coverage can help you apply.

The Minnesota Family Planning Program may also pay for family planning services going back three months before the month of application.

Source: Minnesota Department of Human Services, The Minnesota Family Planning Program (July 1, 2022), available at <https://edocs.dhs.state.mn.us/lfserver/public/DHS-4750-ENG>.

- **Allow Providers to Deliver Family Planning Services via Telehealth:** States have flexibility to allow Medicaid services, including family planning services, to be provided via telehealth if clinically appropriate. In light of the COVID-19 pandemic, CMS has encouraged states to take up telehealth policies and has issued guidance on how states can expand the use of telehealth.¹⁵⁵ The guidance reminds states that they do not need to

seek federal approval to reimburse telehealth services at the same rate that a state pays for face-to-face services.¹⁵⁶ Providers have expressed that apart from enabling continuity of care during the COVID-19 pandemic, leveraging telehealth for family planning helps enable access for individuals who would have otherwise faced difficulty attending in-person visits, such as individuals who have transportation barriers or live in rural areas far from accessible clinics or providers.¹⁵⁷

Family planning services that have been identified as clinically appropriate to be delivered via telehealth include:

- Contraceptive counseling (e.g., taking a thorough patient history, discussing different contraceptive options and deciding on a method)
- Prescriptions to initiate or continue hormonal contraceptive methods (e.g., oral contraceptive pills, hormonal patches or vaginal rings)
- Counseling prior to insertion, removal or replacement of long-acting reversible contraceptives (LARCs)
- Follow-up visits to assess whether patients are satisfied or if they experience any issues or side effects with the prescribed contraceptive methods¹⁵⁸

States that adopted family planning telehealth policies during the COVID-19 pandemic should seek to make these policies permanent post the PHE in order to allow individuals to access services in the modality that is most convenient to them. States that have not enacted telehealth policies related to family planning should review the relevant CMS guidance and strengthen state policies to include family planning services.¹⁵⁹

State Examples



States including **Washington** and **North Carolina** have issued provider-facing guidance to clarify temporary flexibilities specifically for the provision of family planning services via telehealth. Currently, these policies are intended to be in effect through the end of the COVID-19 PHE and have not been extended as of the date of publication. North Carolina's policy authorizes family planning services to be delivered via the following modalities: telemedicine (two-way real-time, audio and visual) or virtual patient communication (telephone call only). Washington's policy noted permissible telehealth modalities include online digital exchange through a patient portal, telephone calls, video visits, email and texting. Both states provide guidance on reimbursement for telehealth services, including the applicable codes for services that providers may bill for.

- **North Carolina:** [SPECIAL BULLETIN COVID-19 #86: Telehealth and Virtual Patient Communications Clinical Policy Modifications - Family Planning Services for MAFDN Beneficiaries](#)
- **Washington:** [Family Planning Only \(FPO\) Program billing guide for telemedicine/telehealth services offered during the COVID-19 pandemic](#)

Conclusion

As the source of critical health coverage for low-income individuals, state Medicaid programs have an extraordinary opportunity and responsibility to ensure enrollment in and utilization of Medicaid family planning programs. The federal opportunities and flexibilities are available, but optimal implementation at the state and local levels requires ongoing attention, engagement and collaboration among state policymakers and program administrators, individuals of reproductive age, providers and community-based organizations.

States have many levers through which they can achieve more meaningful access to Medicaid family planning program services. States can improve their eligibility and enrollment policies and processes, consumer communication materials, and outreach and education efforts. States can also improve the scope of covered services as well as strengthen confidentiality policies, which will impact utilization. Finally, states can improve the monitoring of their provider networks and provider location policies in order to help individuals connect to the services that they need.

This can be a time of great opportunity to improve reproductive health care, as an increasing number of states and collaborating partners are focusing their attention on the continuum of reproductive health from family planning to birth and postpartum. The best practice strategies described in this issue brief can help stakeholders identify gaps in current practices, develop effective action plans and create sustainable systems for improving access to critical family planning program services.

Appendices

Appendix A. Comparison of Family Planning Program 1115 Waiver and SPA Requirements¹⁶⁰

The passage of the Affordable Care Act (ACA) in 2010 allowed states the option to cover a Medicaid family planning eligibility group using Modified Adjusted Gross Income (MAGI) rules through a State Plan Amendment (SPA) instead of through a Section 1115 waiver. States that implement their programs through SPAs are allowed to provide coverage to this eligibility group following CMS approval of their program, as opposed to programs implemented through 1115 waivers, which require renewal every five years.¹⁶¹ States implementing Medicaid family planning programs through SPAs are required to follow all federal eligibility and enrollment rules for MAGI populations. However, states implementing programs through Section 1115 waivers may waive certain federal rules that apply to Medicaid State Plan enrollees, such as retroactive coverage and the provision of transportation services. The following table breaks down the requirements for programs authorized through 1115 waivers and SPAs.

1115 Waivers		SPAs
Eligibility Conditions for Potential Enrollees		
Age	May be limited at state's discretion	All beneficiaries of reproductive age are eligible (states may limit coverage only to target a specific optional population, such as individuals under age 21, 20, 19, or 18) ⁱ
Gender	May be limited at state's discretion	Men and women are both eligible
Income Limit	Defined at state's discretion	Defined by the state up to the limit for: ⁱⁱⁱ <ul style="list-style-type: none"> • Pregnant women under Medicaid or • Pregnant women under the Children's Health Insurance Program (CHIP)
Covered Services		
Family Planning Services/Supplies	Must be covered	Must be covered
Other Services	At state discretion and subject to budget neutrality	Family planning-related services ^{iv} must be covered (state has discretion over which related services to provide)
Administrative Requirements and Considerations		
Public Notice and Transparency Rules	Must follow Section 1115 public process rules	States establish public notice requirements, which CMS approves
Approval Timeframe	CMS has no deadline by which it must reach a determination	CMS must make a determination within 90 days of SPA submission or the proposed change automatically takes effect (unless the SPA clock is paused by CMS or the state for questions)
Duration of Approval	5-year initial term, followed by periodic renewals	Permanent (a state can end or modify coverage with another SPA)
Monitoring and Evaluation	Required	Not required
Budget Neutrality	Required	Not required

Source: Allison Orris, Gayle Mauser, Deborah Bachrach & April Grady, Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States, Manatt Health (May 2019), available at <https://www.manatt.com/getattachment/4dfc897e-6f05-42dd-b82b-a0bbc8725c52/attachment.aspx>.

Appendix B. Federal Guidance on Family Planning-Related Services

States that opt to include family planning-related services in their Medicaid family planning programs generally include the following services:¹⁶²

- Drugs for the treatment of sexually transmitted diseases (STDs) or sexually transmitted infections (STIs), except for HIV/AIDS and hepatitis, when the STD/STI is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered. In addition, subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered.
- Other medical diagnosis, treatment and preventive services that are routinely provided pursuant to a family planning service in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
- Treatment of major complications—The following are examples of treatment of major complications that states may cover:
 - Treatment of a perforated uterus due to an intrauterine device insertion;
 - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
 - Treatment of surgical or anesthesia-related complications during a sterilization procedure.

Appendix C. Family Planning Program Enrollment Rate and Percentage of Family Planning Enrollees Using Family Planning Services by State

State	Program Type	Medicaid Expansion	Program Enrollment Rate Category	Mean Annual Enrollment Rate, 2018–2020	Mean Enrollment Rate Rank, 2018–2020	Mean Annual Percentage of Family Planning Enrollees with Any Contraceptive Service, 2018–2020	Mean Annual Percentage of Family Planning Enrollees With Any Family Planning Service, 2018–2020 ⁱ
California	SPA	Yes	Highest (> 50%)	95.9%	1	24%	53%
South Carolina	SPA	No	Highest (> 50%)	67.1%	2	15%	24%
Indiana	SPA	Yes	Highest (> 50%)	59.2%	3	13%	24%
New Mexico	SPA	Yes	Highest (> 50%)	50.9%	4	9%	18%
North Carolina	SPA	No	Medium High (30%–50%)	40.4%	5	7%	21%
Alabama	Waiver	No	Medium High (30%–50%)	31.7%	6.67	15%	29%
Virginia	SPA	Yes	Medium Low (15%–29.9%)	24.2%	6	10%	18%
New York	SPA	Yes	Medium Low (15%–29.9%)	22.8%	8.67	13%	66%
Oklahoma	SPA	Yes	Medium Low (15%–29.9%)	21.6%	9.33	16%	26%
Texas	Waiver	No	Medium Low (15%–29.9%)	17.0%	10	16%	33%
Mississippi	SPA	No	Lowest (< 15%)	14.2%	12.33	38%	55%
Wisconsin	SPA	No	Lowest (< 15%)	13.7%	11	38%	50%
Oregon	Waiver	Yes	Lowest (< 15%)	12.1%	13	32%	42%
Georgia	Waiver	No	Lowest (< 15%)	10.7%	13	15%	28%
Florida	Waiver	No	Lowest (< 15%)	8.1%	15.33	14%	36%
Pennsylvania	SPA	Yes	Lowest (< 15%)	7.6%	16	11%	19%
Washington	Waiver	Yes	Lowest (< 15%)	7.1%	17	29%	48%
Maryland	SPA	Yes	Lowest (< 15%)	6.3%	18.33	13%	28%
Montana	Waiver	Yes	Lowest (< 15%)	5.1%	18	23%	33%
New Hampshire	SPA	Yes	Lowest (< 15%)	3.8%	21	22%	37%
Rhode Island	Waiver	Yes	Lowest (< 15%)	3.2%	21	17%	29%
Connecticut	SPA	Yes	Lowest (< 15%)	1.9%	23	42%	73%

ⁱ Including contraceptive services, counseling, STD/STI screening or Pap smears.

Appendix D. Ranking of Most Commonly Used Family Planning Services Across All States, 2018–2020

Service	Rank
Pregnancy/Fertility Counseling	1
STD/STI Screening	2
Oral Contraceptive Pill	3
Pap Smear	4
Injectable Contraceptive	5
LARC	6
Vaginal Ring	7
Contraceptive Patch	8
Sterilization	9
Infecundity Treatment	10
Diaphragm Fitting	11

Appendix E. Data Analysis Methodology

Overview

Enrollment rates in Medicaid family planning programs were estimated through a joint analysis of T-MSIS Analytic Files (TAF) data sets and data from the U.S. Census Bureau's American Community Survey (ACS). TAF data was used to assess the number of individuals enrolled in standalone Medicaid family planning programs by state from 2018 to 2020. ACS data was then used to estimate the number of individuals potentially eligible for Medicaid family planning programs in each state from 2018 to 2020. Multiple assumptions were tested to isolate individuals in the ACS data who were likely not eligible for other types of Medicaid coverage. Finally, family planning program enrollment as a share of potentially eligible individuals was calculated in each state to estimate program enrollment rates. To estimate service utilization, TAF data was used to assess utilization of family planning services among women enrolled in family planning programs from 2018 to 2020. First, the number of women enrolled in family planning programs in each state from 2018 to 2020 was assessed. Next, claims for relevant services among family planning program enrollees were identified. Finally, service utilization was calculated as the proportion of women enrolled in family planning programs who used different services of interest, as well as the proportion who used any family planning services in a given year for each state from 2018 to 2020.

Enrollment Rate Analysis

Enrollment rates were calculated for each state by comparing the number of family planning enrollees in the TAF data to the number of potentially eligible individuals in the ACS data. Numerators (the number of individuals enrolled in a Medicaid family planning program) in each state were calculated using TAF data, and annual denominators (the number of individuals potentially eligible for enrollment in a Medicaid family planning program) were estimated using ACS data. TAF data was used to assess the number of individuals enrolled in family planning programs in each state in each year from 2018 to 2020. Family planning enrollees were identified using a restricted benefits code in the TAF data that corresponds to family planning enrollment.¹⁶³

ACS data was then used to estimate the number of individuals potentially eligible for Medicaid family planning programs in each state from 2018 to 2020 based on individuals' state of residence, family income level, gender, age and insurance status. In this analysis, the focus was on individuals who were not eligible for full Medicaid coverage. Specifically, individuals were classified as being potentially eligible for Medicaid family planning program enrollment if their family income was between the highest income eligibility level for adults in their given state (i.e., either for childless adults or parents/caretaker relatives in non-expansion states) and the eligibility level for family planning coverage.¹⁶⁴ Additionally, only individuals aged 18–65 were included, as these individuals are most likely to enroll in Medicaid family planning programs.

Three different approaches were used to estimate program enrollment rates by state from 2018 to 2020. For the first enrollment rate analysis, denominators were calculated to reflect the entire universe of individuals who were potentially eligible in a given state, including both men and women (in states that allow both men and women to enroll) and individuals with any type of insurance coverage (because most states allow

individuals to enroll in family planning programs as well as Marketplace or other coverage). The numerator for this analysis included all individuals who were enrolled in Medicaid family planning programs according to the TAF data.

Next, more narrow denominators were calculated to focus on individuals most likely to enroll in Medicaid family planning programs. For the second enrollment rate analysis, denominators were calculated that only included women who were uninsured or enrolled in Medicaid. For the final enrollment rate analysis, denominators were calculated that included women with any type of insurance coverage. The numerators for these analyses only included women who were enrolled in Medicaid family planning programs according to the TAF data.

States were ranked according to their family planning enrollment rate assessed with each approach; the mean rank was then calculated for each state across all three approaches to reflect which states generally have the highest and lowest enrollment rates. State rankings did not vary significantly across the three approaches. Finally, each state was classified as having the lowest to highest program enrollment rates according to the enrollment rate assessed with the final approach (including women with any type of insurance in the denominator and women in the numerator). These categorizations were based on results from the final enrollment rate analysis because these results are believed to most likely reflect program enrollment rates at the state level accurately.

Utilization and Race/Ethnicity Analysis

The number and percentage of women enrolled in family planning programs who used different types of family planning services in each state were examined in each year using TAF data from 2018 to 2020. This portion of the analysis focused on women as they comprise the vast majority of family planning program enrollees and are more likely to utilize family planning services. Once again, women were classified as being enrolled in a Medicaid family planning program in a given year if they had a “restricted benefits code” equal to “6” at any point in the calendar year. Utilization of family planning services was assessed by analyzing claims and encounter data for women who were enrolled in family planning programs. Family planning services of interest included contraceptive services, pregnancy counseling, STI/STD screening and Pap smears. Family planning services were identified using procedure codes and National Drug Codes recorded on claims and encounter records. Women were classified as using a family planning service if they had at least one claim or encounter for a relevant service at any point during a given calendar year. The number and proportion of women who utilized each service was calculated, as well as the number and proportion who used any service at least once during a given calendar year. Finally, services were ranked according to the number of enrollees by state to assess which family planning services are most frequently utilized.

TAF data was also used to characterize the race/ethnicity of women enrolled in family planning programs from 2018 to 2020. Each individual’s race/ethnicity was identified using information recorded in TAF demographic data. The race/ethnicity distribution among the population of women enrolled in family planning programs was compared to the race/ethnicity distribution for the general Medicaid population in each state over this period. Notably, this analysis was significantly hampered by frequently missing data on enrollee race/ethnicity. This degree of data missingness prevented us from drawing strong conclusions from this analysis, and hence results are not described in this report.

Limitations

This analysis has four notable limitations, each of which is discussed in more detail below:

1. Not all states with family planning programs have individuals in the TAF data who are classified as being enrolled in family planning programs.
2. Denominators for the enrollment rate analysis were estimated using ACS data and may not be a precise reflection of the number of individuals eligible for these programs due to inherent data limitations and assumptions used to identify potentially eligible individuals.
3. Results of this analysis were likely impacted by the COVID-19 PHE.
4. Information on enrollee race/ethnicity is frequently missing from the TAF data for some states.

First, enrollment in family planning programs was assessed using the restricted benefits code indicator in TAF enrollment data per guidance issued by CMS. However, numerous states with operational Medicaid family planning programs were identified that do not have any individuals with an appropriate restricted benefits code in the TAF data. In some cases (e.g., Missouri), this may be due to the state having a state-funded Medicaid family planning program where it may not be required to report enrollment in the program when submitting data to TAF. However, at least one state with a state-funded program (Iowa) does report this information in the TAF data, and it is unclear why. In other cases, individuals did not appear in the TAF data as being enrolled in these programs even though the programs are not state-funded (e.g., Maine and New Jersey).

Second, denominators for the enrollment rate analysis were estimated using ACS data, and these may not accurately reflect the true number of individuals who are eligible for these programs. ACS data do not include an indicator to identify individuals who are eligible for family planning programs, so eligibility was estimated based on several assumptions that do not capture the full nuance of eligibility restrictions by state. For example, program eligibility is impacted by immigration status, which is not thoroughly documented in the ACS data. In some cases, the estimated proportion of individuals enrolled at the state level was not reasonable. For example, when estimating enrollment rates using more narrow denominators, several states were identified where the number of women enrolled according to the TAF data was greater than the number of individuals who were estimated to be eligible using ACS data. The impact of this limitation was mitigated by using multiple approaches to estimate program enrollment rates and focusing on ranking states according to enrollment rates rather than the specific proportions of individuals enrolled by state.

Third, results from this analysis in 2020 were likely impacted by the COVID-19 PHE. The COVID-19 PHE has impacted Medicaid enrollment overall and may have also impacted access to services for individuals enrolled in Medicaid family planning programs.¹⁶⁵ These results suggest that utilization of family planning services among program enrollees decreased slightly in 2020 relative to previous calendar years. Finally, the COVID-19 PHE significantly impacted data collection processes for the ACS, which led the Census Bureau to employ an experimental method for weighting survey responses.¹⁶⁶ The Census Bureau has cautioned that results from the 2020 ACS may not be directly comparable to previous years. The impact of the COVID-19 PHE on results from this analysis was mitigated by focusing on results assessing mean enrollment rates and utilization rates over the three-year period from 2018 to 2020.

Finally, the TAF data is frequently missing information on enrollee race/ethnicity for some states. General issues related to the coding of race/ethnicity information in administrative claims data are well documented. Race/ethnicity information in TAF is prone to missingness and, in some cases, misclassification because Medicaid enrollees are not required to report this information, and states vary in terms of data collection processes and the instructions they provide to enrollees on how to report this information. According to the TAF Data Quality Atlas, 20 states had race/ethnicity data in TAF that was classified as “high concern” or “unusable” in calendar year 2020, including nearly half of the 22 states that were included in this data analysis. Results from this analysis are not described in this report due to these prevalent data issues.

Data Sources

This analysis relied on both TAF data sets as well as ACS data from 2018 to 2020. TAF data contain information on every Medicaid enrollee in all 50 states and territories in the United States, including data on enrollee eligibility, service utilization, expenditure data, and fee-for-service claims and managed care encounters.

The ACS is an annual demographic survey fielded by the U.S. Census Bureau that collects data on a variety of topics, including employment, income, housing characteristics, educational attainment and health care coverage. The ACS is completed by a sample of individuals throughout the United States, but responses to the survey are weighted so they can be used to estimate the total number of individuals meeting given criteria (e.g., estimating the number of individuals nationwide with Medicaid coverage who have family income within a certain range).

Appendix F. Issue Brief Methodology

This issue brief builds on thought leadership from the 2019 publication “Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States”¹⁶⁷ but focuses specifically on the state option to implement a separate Medicaid family planning program and the policy, operational and implementation best practices that can lead to improved access to family planning coverage through these limited-benefit programs.

This issue brief was developed based on a review of national research; an analysis of federal regulations and sub-regulatory guidance; a national landscape scan informed by a state-by-state review of 1115 waiver approvals, SPAs, public websites and publicly available information for all approved family planning programs (including associated state reporting); an analysis of state enrollment and utilization data (see the “Assessment of Medicaid Family Planning Program Enrollment and Service Utilization” section for additional information); and targeted interviews with national subject matter experts and officials from five states: California, North Carolina, Oregon, Virginia and Wisconsin.

Endnotes

¹ Guttmacher Institute, Why Protecting Medicaid Means Protecting Sexual and Reproductive Health (March 9, 2017), available at <https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health>.

² Kinsey Hasstedt, Adam Sonfield & Rachel Benson Gold, *Guttmacher Institute*, Public Funding for Family Planning and Abortion Services, FY 1980–2015 (April 2017), available at https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-family-planning-abortion-services-fy-1980-2015.pdf.

³ Elayne J. Heisler, Taylor R. Wyatt, et al., *Congressional Research Service*, Federal Support for Reproductive Health Services: Frequently Asked Questions (July 1, 2022), available at <https://crsreports.congress.gov/product/pdf/R/R46785/11>.

⁴ Centers for Medicare & Medicaid Services, Medicaid Covers Family Planning Services (2019), available at <https://www.medicaid.gov/about-us/program-history/medicaid-50th-anniversary/entry/47702>.

⁵ Jennifer J. Frost, *Guttmacher Institute*, U.S. Women’s Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010 (May 2013), available at <https://www.guttmacher.org/report/us-womens-use-sexual-and-reproductive-health-services-trends-sources-care-and-factors>.

⁶ Centers for Medicare & Medicaid Services, Medicaid Covers Family Planning Services (2019), available at <https://www.medicaid.gov/about-us/program-history/medicaid-50th-anniversary/entry/47702>.

⁷ Centers for Medicare & Medicaid Services, SMDL #10-013 Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010), available at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf>.

⁸ *Id.*

⁹ Kaiser Family Foundation, Status of State Medicaid Expansion Decisions: Interactive Map (March 27, 2023), available at <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

¹⁰ *Id.*

¹¹ Supreme Court Of The United States, Dobbs, State Health Officer Of The Mississippi Department Of Health, Et Al. V. Jackson Women’s Health Organization Et Al. (June 24, 2022), available at https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf.

¹² Patricia Boozang, Kinda Serafi & Kaylee O’Connor, *State Health and Value Strategies*, New CMS Guidance on Unwinding Provisions in the CAA (February 3, 2023), available at <https://www.shvs.org/new-cms-guidance-on-unwinding-provisions-in-the-cao-2023/>.

¹³ Kaiser Family Foundation, Medicaid Postpartum Coverage Extension Tracker (April 24, 2023), available at <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker>.

¹⁴ Jocelyn Guyer, Elizabeth Osius, Sharon Woda, Jacqueline Marks, Usha Ranji & Alina Salganicoff, *Kaiser Family Foundation*, Medicaid Family Planning Programs: Case Studies of Six States After ACA Implementation (April 2017), available at <https://files.kff.org/attachment/Report-Medicaid-Family-Planning-Programs-Case-Studies-of-Six-States-After-ACA-Implementation>.

¹⁵ 42 C.F.R. § 435.214.

¹⁶ Centers for Medicare & Medicaid Services, Implementation Guide: Medicaid State Plan Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Service (July 2017), available at <https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-individuals-eligible-for-family-planning-services.pdf>.

¹⁷ Eighteen states have authorized their Medicaid family planning programs through an 1115 waiver, while 11 states have their programs authorized through a SPA.

¹⁸ Kaiser Family Foundation, States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid (September 1, 2021), available at <https://www.kff.org/medicaid/state-indicator/family-planning-services-waivers/>. Individuals may also be enrolled in a Medicaid family planning program if they are receiving employer-sponsored insurance. As such, in Medicaid expansion states, individuals with income below 138% FPL could also receive Medicaid family planning program coverage.

¹⁹ Allison Orris, Gayle Mauser, Deborah Bachrach & April Grady, Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States (May 2019), available at <https://www.manatt.com/getattachment/4dfc897e-6f05-42dd-b82b-a0bbc8725c52/attachment.aspx>.

²⁰ The Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Non-Aged, Non-Disabled, Non-Pregnant Adults by State, July 2021 (December 2021), available at <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-36.-Medicaid-Income-Eligibility-Levels-as-a-Percentage-of-the-Federal-Poverty-Level-for-Non-Aged-Non-Disabled-Non-Pregnant-Adults-by-State-July-2021.pdf>.

²¹ The following states do not have a Medicaid family planning program: Alaska, Arizona, Arkansas, Delaware, Hawaii, Idaho, Kansas, Kentucky, Massachusetts, Michigan, Nebraska, Nevada, North Dakota, Ohio, South Dakota, Tennessee, Utah and West Virginia. Michigan and Ohio previously implemented Medicaid family planning programs but have since discontinued them following Medicaid expansion in the state. See Phil Galewitz & Anna Gorman, *Kaiser Family Foundation Health News*, States Extend Medicaid For Birth Control, Cutting Costs — And Future Enrollment (March 22, 2018), available at <https://khn.org/news/states-extend-medicaid-for-birth-control-cutting-costs-and-future-enrollment/>.

²² Guttmacher Institute, Reproductive Health Impact Study: Iowa (February 2023), available at <https://www.guttmacher.org/fact-sheet/reproductive-health-impact-study-iowa>.

²³ Barbara Rodriguez, *The Des Moines Register*, Family planning program that excludes Planned Parenthood has nearly 75% drop in people using services (December 11, 2019), available at <https://www.desmoinesregister.com/story/news/health/2019/12/10/iowa-family-planning-program-significant-drop-excludes-planned-parenthood/4383891002/>.

²⁴ Durrie Bouscaren, *NPR*, Missouri Rejects Federal Money In Order To Set Up Its Own Abortion Restrictions (March 29, 2017), available at <https://www.npr.org/sections/health-shots/2017/03/29/521248820/missouri-rejects-federal-money-in-order-to-set-up-its-own-abortion-restrictions>.

²⁵ Illinois Department of Human Services, MR #22.28 Family Planning (December 7, 2022), available at <https://www.dhs.state.il.us/page.aspx?item=146077>.

²⁶ Colorado Children's Campaign, Fact Sheet: Expanded Income Eligibility for Medicaid Family Planning Services SB21-025 (March 26, 2021), available at <https://www.coloradokids.org/data/publications/fact-sheet-expanded-income-eligibility-for-medicaid-family-planning-services-sb21-025/>.

²⁷ Colorado Department of Health Care Policy & Financing, Medical Assistance New Limited Family Planning Services Income Expansion (June 2, 2022), available at <https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20PM%2022-004%20Medical%20Assistance%20New%20Limited%20Family%20Planning%20Services%20Income%20Expansion.pdf>.

²⁸ Centers for Medicare & Medicaid Services, SMDL #10-013 Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010), available at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf>.

²⁹ *Id.*

³⁰ Rachel Benson Gold, Rian Frachele & Robin Summers, CMS Guidance on Family Planning State Plan Amendments (October 25, 2010), available at <https://www.nationalfamilyplanning.org/document.doc?id=283>.

³¹ The prohibition on cost-sharing does not extend to family planning-related services. See 42 C.F.R. § 447.56.

³² Centers for Medicare & Medicaid Services, SMDL #10-013 Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010), available at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf>.

³³ Centers for Medicare & Medicaid Services, SHO #16-008 Medicaid Family Planning Services and Supplies (June 14, 2016), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>.

- ³⁴ Centers for Medicare & Medicaid Services, SMDL #10-013 Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010), available at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf>.
- ³⁵ Jenna Walls, Kathy Gifford, Usha Ranji, Alina Salganicoff & Ivette Gomez, *Kaiser Family Foundation*, Medicaid Coverage of Family Planning Benefits: Results from a State Survey (September 15, 2016), available at <https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey-sterilization-procedures/>.
- ³⁶ Example from Alabama's service array. See: Alabama Medicaid Agency, Alabama Plan First Section 1115 Demonstration Special Terms and Conditions (November 27, 2017), available at https://medicaid.alabama.gov/documents/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning/4.2.4.2_FP_1115_Waiver/4.2.4.2_Application_Attachment_C_7-28-21.pdf.
- ³⁷ P.L. 117-103. Div. H, §§ 506–507.
- ³⁸ Kaiser Family Foundation, Mapping Medicaid Managed Care Models & Delivery System and Payment Reform (March 6, 2023), available at <https://www.kff.org/medicaid/issue-brief/mapping-medicaid-managed-care-models-delivery-system-and-payment-reform/>.
- ³⁹ Texas has a constrained network in its program; it received approval of an 1115 waiver in 2020 that allows the state to waive freedom of choice and exclude certain providers that provide abortion care from participating in its Medicaid family planning program. See: 2020 CMS approval: Texas Health and Human Services Commission, Healthy Texas Women Special Terms and Conditions (January 22, 2020), available at <https://www.medicare.gov/medicaid/section-1115-demonstrations/downloads/tx-healthy-women-demo-appvl-01222020.pdf>.
- ⁴⁰ For examples of program goals for specific states, see: Washington Health Care Authority, Washington Family Planning Only Program Section 1115 Demonstration Special Terms and Conditions (March 30, 2021), available at <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/wa-family-planning-only-program-ca.pdf>; Florida Agency for Health Care Administration, Annual Monitoring Report Florida Family Planning Section 1115 Demonstration April 1, 2021–June 30, 2021 (2021), available at https://ahca.myflorida.com/medicaid/family_planning/pdf/DY23_Q4_AND_ANNUAL_REPORT_FINAL.pdf; and Georgia Department of Community Health, Annual Report Planning for Healthy Babies Program® (P4HB®) 1115 Demonstration in Georgia July 1–December 31, 2020 (March 31, 2021), available at <https://medicaid.georgia.gov/document/document/p4hbannualreportmarch2021/download>.
- ⁴¹ Centers for Medicare & Medicaid Services, Contraception in Medicaid: Improving Maternal and Infant Health, available at <https://www.medicare.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/contraception-medicare-improving-maternal-and-infant-health/index.html>.
- ⁴² Heidi D. Nelson, Blair G. Darney, Katherine Ahrens, et al., *JAMA*, Associations of Unintended Pregnancy With Maternal and Infant Health Outcomes: A Systematic Review and Meta-analysis (November 1, 2022), available at <https://jamanetwork.com/journals/jama/article-abstract/2797874>.
- ⁴³ Laura R. Wherry, *American Journal of Public Health*, Medicaid Family Planning Expansions and Related Preventive Care (September 2013), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780682/>.
- ⁴⁴ Adam Sonfield, *Guttmacher Institute*, Beyond Preventing Unplanned Pregnancy: The Broader Benefits of Publicly Funded Family Planning Services (December 9, 2014), available at <https://www.guttmacher.org/gpr/2014/12/beyond-preventing-unplanned-pregnancy-broader-benefits-publicly-funded-family-planning>.
- ⁴⁵ Jennifer J. Frost, Mia R. Zolna, Lori F. Frohwirth, et al., *Guttmacher Institute*, Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016 (October 2019), available at <https://www.guttmacher.org/report/publicly-supported-FP-services-US-2016>.
- ⁴⁶ Allison Orris, Gayle Mauser, Deborah Bachrach & April Grady, Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States (May 2019), available at <https://www.manatt.com/getattachment/4dfc897e-6f05-42dd-b82b-a0bbc8725c52/attachment.aspx>.
- ⁴⁷ Although many states allow both men and women to enroll in Medicaid family planning programs, they predominantly serve women. As such, men were excluded from this analysis in order to more accurately estimate enrollment rates among individuals most likely to enroll in these programs.

⁴⁸ Maine, New Jersey and Vermont were excluded because TAF data from these states did not include any Medicaid enrollees with family planning program enrollment indicators during the study time period. Louisiana and Minnesota were excluded from the analysis because the family planning program income limit in these states is the same as the income limit for childless adults, making it impossible to differentiate full-scope and limited-scope Medicaid enrollees. The analysis of program enrollment rates using ACS data identified potentially eligible individuals as individuals with family income between the upper limit for childless adults and the limit for the family planning program. Given that these limits are the same in Louisiana and Minnesota, the analysis did not identify any potentially eligible individuals in these states. Colorado and Illinois were excluded from the analysis because their Medicaid family planning program was not operational during the study time period. Wyoming was excluded from the analysis due to a small sample size of individuals enrolled in the family planning program. Per CMS restrictions, TAF data users are not permitted to report results where the sample size is fewer than 11 individuals.

⁴⁹ South Carolina, New Mexico, North Carolina, Alabama.

⁵⁰ States implementing Medicaid family planning programs can establish program income level limits that do not exceed the highest income level for pregnant women under the State's Medicaid/CHIP State plan or Medicaid 1115 waiver demonstration. See: Centers for Medicare & Medicaid Services, Implementation Guide: Medicaid State Plan Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Service (July 2017), available at <https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-individuals-eligible-for-family-planning-services.pdf>.

⁵¹ Tricia Brooks, Allexa Gardner, Peyton Yee, Jennifer Tolbert, Bradley Corallo, Sophia Moreno & Meghana Ammula, *Kaiser Family Foundation*, Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision (March 2023), available at <https://files.kff.org/attachment/REPORT-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf>.

⁵² California, South Carolina, Indiana, Alabama.

⁵³ For the purposes of this analysis, family planning services were defined as the following services: pregnancy/ fertility counseling, STD/STI screening, oral contraceptive pill, Pap smear, injectable contraceptive, Long-Acting Reversible Contraception (LARC), vaginal ring, contraceptive patch, sterilization, infecundity treatment, and diaphragm fitting.

⁵⁴ Brittni Frederiksen, Usha Ranji & Alina Salganicoff, *Kaiser Family Foundation*, Family Planning and Contraceptive Provision Among Females Enrolled in Medicaid (February 17, 2022), available at <https://www.kff.org/womens-health-policy/issue-brief/family-planning-and-contraceptive-provision-among-females-enrolled-in-medicaid/>.

⁵⁵ Maria I. Rodriguez, Thomas H. A. Meath, Kelsey Watson, Ashley Daly, Kyle Tracy & K. John McConnell, *Health Affairs*, Geographic Variation In Effective Contraceptive Use Among Medicaid Recipients In 2018 (April 2023), available at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00992?journalCode=hlthaff>.

⁵⁶ CMS separates family planning services into two types for the purposes of reimbursement: Family Planning Services & Supplies and Family Planning-Related Services. See the "Services Covered by Medicaid Family Planning Programs" section in this issue brief.

⁵⁷ Connecticut, New York, Wisconsin.

⁵⁸ 42 U.S.C. § 1396r-1c(a).

⁵⁹ New York, Mississippi, California, Wisconsin, Washington.

⁶⁰ New York, California, Washington.

⁶¹ 42 C.F.R. § 435.907(b).

⁶² 42 C.F.R. § 435.907(a).

⁶³ 42 C.F.R. § 435.916(a).

⁶⁴ Patricia Boozang & Kinda Serafi, *State Health and Value Strategies*, New CMS Guidance on Unwinding Provisions in the CAA (June 2022), available at <https://www.shvs.org/wp-content/uploads/2022/11/Improving-Ex-Parte-Renewal-Rates.pdf>.

⁶⁵ Jennifer Wagner, *Center on Budget and Policy Priorities*, Streamlining Medicaid Renewals Through the Ex Parte Process (March 4, 2021), available at <https://www.cbpp.org/research/health/streamlining-medicaid-renewals-through-the-ex-parte-process>.

⁶⁶ Patricia Boozang, Kinda Serafi, Kaylee O'Connor & Michelle Savuto, *State Health and Value Strategies*, Ensuring Compliance With Federal Renewal Requirements: State Diagnostic Assessment Tool (March 2023), available at https://www.shvs.org/wp-content/uploads/2023/03/SHVS_Ensuring-Compliance-with-Federal-Renewal-Requirements.pdf.

⁶⁷ 42 U.S.C. § 1396r-1c(a).

⁶⁸ Centers for Medicare & Medicaid Services, Implementation Guide: Medicaid State Plan Eligibility Individuals Eligible for Family Planning Services – Presumptive Eligibility (July 2017), available at <https://www.medicaid.gov/resources-for-states/downloads/macprog-individuals-eligible-for-family-planning-services-presumptive-eligibility.pdf>.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Ellelan Degife, Howard Forman & Sara Rosenbaum, *JAMA Health Forum*, Expanding Presumptive Eligibility as a Key Part of Medicaid Reform (February 5, 2021), available at <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776306>.

⁷² Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham & Rachel Dolan, *Kaiser Family Foundation*, Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey (March 2020), available at <https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf>.

⁷³ Tricia Brooks, Allexa Gardner, Peyton Yee, Jennifer Tolbert, Bradley Corallo, Sophia Moreno & Meghana Ammula, *Kaiser Family Foundation*, Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision (March 2023), available at <https://files.kff.org/attachment/REPORT-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf>.

⁷⁴ Tracey A. Wilkinson, Brownsyne Tucker Edmonds & Erika R. Cheng, *Contraception*, Outcomes of a Two-Visit Protocol for Long-Acting Reversible Contraception for Adolescents and Young Adults (July 28, 2021), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9116877/>.

⁷⁵ Ellelan Degife, Howard Forman & Sara Rosenbaum, *JAMA Health Forum*, Expanding Presumptive Eligibility as a Key Part of Medicaid Reform (February 5, 2021), available at <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776306>.

⁷⁶ Interview with Wisconsin Department of Health Services (February 13, 2023).

⁷⁷ Wisconsin Department of Health Services, Family Planning Only Services Program (April 13, 2023), available at <https://dhs.wisconsin.gov/fpos/index.htm>.

⁷⁸ Individuals would be disenrolled if they moved out of state, died or voluntarily terminated coverage, or the agency determined eligibility was erroneously granted.

⁷⁹ Tricia Brooks & Allexa Gardner, *Georgetown University Center for Children and Families (CCF)*, Continuous Coverage in Medicaid and CHIP (July 2021), available at <https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf>.

⁸⁰ American College of Obstetricians and Gynecologists, Effectiveness of Birth Control Methods (April 2023), available at <https://www.acog.org/womens-health/infographics/effectiveness-of-birth-control-methods>.

⁸¹ Tricia Brooks & Allexa Gardner, *Georgetown University Center for Children and Families (CCF)*, Continuous Coverage in Medicaid and CHIP (July 2021), available at <https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf>.

⁸² Katherine Swartz, Pamela Farley Short, Deborah R. Graefe & Namrata Uberoi, *Health Affairs*, Evaluating State Options for Reducing Medicaid Churning (July 2021), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4664196/pdf/nihms708512.pdf>.

⁸³ Alabama Medicaid Agency, Alabama Plan First Section 1115 Demonstration Special Terms and Conditions (November 27, 2017), available at https://medicaid.alabama.gov/documents/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning/4.2.4.2_FP_1115_Waiver/4.2.4.2_Application_Attachment_C_7-28-21.pdf.

⁸⁴ Centers for Medicare & Medicaid Services, Implementation Guide: Medicaid State Plan Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Service (July 2017), available at <https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-individuals-eligible-for-family-planning-services.pdf>.

⁸⁵ This applies in both expansion and non-expansion states. See: Centers for Medicare & Medicaid Services, Medicaid, Children's Health Insurance Program & Basic Health Program Eligibility Levels (July 1, 2022), available at <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html>.

⁸⁶ 42 C.F.R. § 435.603(k).

⁸⁷ Centers for Medicare & Medicaid Services, Implementation Guide: Medicaid State Plan Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Service (July 2017), available at <https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-individuals-eligible-for-family-planning-services.pdf>.

⁸⁸ Priscilla Huang, *National Health Law Program (NHELP)*, An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program (September 17, 2019), available at <https://healthlaw.org/resource/an-advocates-guide-to-reproductive-and-sexual-health-in-the-medicaid-program/>.

⁸⁹ Centers for Medicare & Medicaid Services, Medicaid, Children's Health Insurance Program & Basic Health Program Eligibility Levels (July 1, 2022), available at <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html>.

⁹⁰ South Carolina Department of Health and Human Services, Am I eligible?, available at <https://www.scdhhs.gov/income-limits>.

⁹¹ South Carolina Department of Health and Human Services, Title XIX State Plan Amendment SC-16-0001-MM1 (January 20, 2017), available at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/SC/SC-16-0001.pdf>.

⁹² 42 C.F.R. § 435.917.

⁹³ 42 C.F.R. § 435.917(b).

⁹⁴ Priscilla Huang, *National Health Law Program (NHELP)*, An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program (September 17, 2019), available at <https://healthlaw.org/resource/an-advocates-guide-to-reproductive-and-sexual-health-in-the-medicaid-program/>.

⁹⁵ 42 C.F.R. § 92.201.

⁹⁶ Centers for Medicare & Medicaid Services, Guidelines for effective writing (February 2, 2023), available at <https://www.cms.gov/outreach-and-education/outreach/writing-guidelines>.

⁹⁷ Virginia Department of Medical Assistance Services, Plan First, available at <https://coverva.dmas.virginia.gov/learn/insurance-for-adults/plan-first/>.

⁹⁸ Interview with California Department of Health Care Services (January 26, 2023).

⁹⁹ California Department of Health Care Services, Family Planning, Access, Care & Treatment (Family PACT) Billing (April 2022), available at https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/modules/hap/workbook_fpactbil_hap.pdf.

¹⁰⁰ Interview with California Department of Health Care Services (January 26, 2023).

¹⁰¹ New York State Department of Health, Family Planning Benefit Program (May 2022), available at https://www.health.ny.gov/health_care/medicaid/program/longterm/familyplanbenprog.htm.

¹⁰² Georgia Department of Community Health, Planning for Healthy Babies, available at <https://medicaid.georgia.gov/programs/all-programs/planning-healthy-babies>.

- ¹⁰³ Virginia Department of Medical Assistance Services, Plan First Handbook (March 1, 2016), available at <https://www.dmas.virginia.gov/media/1621/plan-first-member-handbook-english.pdf>.
- ¹⁰⁴ CareSource, Georgia Planning for Healthy Babies® (P4HB®) 2022–2023 Member Handbook, available at <https://www.caresource.com/documents/ga-planning-for-healthy-babies-member-handbook-508/>.
- ¹⁰⁵ Centers for Medicare & Medicaid Services, The State Medicaid Manual (Chapter 4 - Services, Section 4270), available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927>.
- ¹⁰⁶ *Id.*
- ¹⁰⁷ 42 C.F.R. § 441.20.
- ¹⁰⁸ Centers for Medicare & Medicaid Services, SHO #16-008 Medicaid Family Planning Services and Supplies (June 14, 2016), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>.
- ¹⁰⁹ Centers for Medicare & Medicaid Services, SMDL #10-013 Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010), available at <https://downloads.cms.gov/cmmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf>.
- ¹¹⁰ Rachel Benson Gold, Rian Frachele & Robin Summers, CMS Guidance on Family Planning State Plan Amendments (October 25, 2010), available at <https://www.nationalfamilyplanning.org/document.doc?id=283>.
- ¹¹¹ Centers for Medicare & Medicaid Services, SHO #16-008 Medicaid Family Planning Services and Supplies (June 14, 2016), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>.
- ¹¹² U.S. Food and Drug Administration, Birth Control (December 2022), available at <https://www.fda.gov/consumers/free-publications-women/birth-control>.
- ¹¹³ Centers for Medicare & Medicaid Services, SMDL #10-013 Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010), available at <https://downloads.cms.gov/cmmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf>.
- ¹¹⁴ Centers for Medicare & Medicaid Services, Family Planning and Family Planning Related Services Clarification (April 2014), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-003.pdf>.
- ¹¹⁵ American College of Obstetricians and Gynecologists, Colposcopy (December 2022), available at <https://www.acog.org/womens-health/faqs/colposcopy>.
- ¹¹⁶ When performed as a follow-up to an abnormal Pap smear. See: Mississippi Division of Medicaid, Mississippi Section 1115 Family Planning Medicaid Waiver (December 28, 2017), available at <https://medicaid.ms.gov/wp-content/uploads/2021/01/Mississippi-Family-Planning-Waiver-STCs-with-Attachment-A.B.pdf>.
- ¹¹⁷ Louisiana Department of Health, Take Charge Plus (Family Planning Services) Provider Manual (October 16, 2014), available at <https://www.lamedicaid.com/provweb1/Providermanuals/manuals/TCP/TCP.pdf>.
- ¹¹⁸ Diana Greene Foster, Denis Hulett, Mary Bradsberry, Philip Darney & Michael Policar, *Obstetrics & Gynecology*, Number of oral contraceptive pill packages dispensed and subsequent unintended pregnancies (March 2011), available at <https://pubmed.ncbi.nlm.nih.gov/21343759/>.
- ¹¹⁹ Z. Joyce Fan, Dorothy Lyons, Barbara E.M. Felver & Andrew J. Glenn, *Washington Health Care Authority*, The Effect of Dispensing One-Year Supply of Oral Contraceptive Pills Findings from Washington State (November 2018), available at <https://www.dshs.wa.gov/sites/default/files/rda/reports/research-7-113.pdf>.
- ¹²⁰ Usha Ranji, Ivette Gomez, Alina Salganicoff, Carrie Rosenzweig, Rebecca Kellenberg & Kathy Gifford, *Kaiser Family Foundation*, Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey (February 17, 2022), available at <https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey-report/>.
- ¹²¹ Power to Decide, Coverage for an Extended Supply of Contraception (August 8, 2022), available at <https://powertodecide.org/sites/default/files/2022-08/Extended%20Supply%20of%20Contraception.pdf>.

¹²² Usha Ranji, Ivette Gomez, Alina Salganicoff, Carrie Rosenzweig, Rebecca Kellenberg & Kathy Gifford, *Kaiser Family Foundation*, Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey (February 17, 2022), available at <https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey-report/>.

¹²³ Power to Decide, Coverage for an Extended Supply of Contraception (August 8, 2022), available at <https://powertodecide.org/sites/default/files/2022-08/Extended%20Supply%20of%20Contraception.pdf>.

¹²⁴ *Id.*

¹²⁵ Washington State Take Charge Medicaid Section 1115 Demonstration Waiver 01/01/2014–03/31/2014 (May 30, 2014), available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/Take-Charge/wa-take-charge-qtr-rpt-jan-mar-2014.pdf>.

¹²⁶ State of Washington, Substitute House Bill 1234 Contraceptive Drug Coverage—Twelve-Month Refill (May 16, 2017), available at <https://lawfilesexternal.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/1234-S.SL.pdf>.

¹²⁷ Usha Ranji, Ivette Gomez, Alina Salganicoff, Carrie Rosenzweig, Rebecca Kellenberg & Kathy Gifford, *Kaiser Family Foundation*, Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey (February 17, 2022), available at <https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey-report/>.

¹²⁸ American College of Obstetricians and Gynecologists, Over-the-Counter Access to Hormonal Contraception (October 2019), available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/over-the-counter-access-to-hormonal-contraception>.

¹²⁹ American Academy of Family Physicians, Over-the-Counter Oral Contraceptives (2019), available at <https://www.aafp.org/about/policies/all/otc-oral-contraceptives.html>.

¹³⁰ Centers for Medicare & Medicaid Services, Medicaid Drug Rebate Program Notice Release No. 178 For State Technical Contacts (October 5, 2016), available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Prescription-Drugs/Downloads/Rx-Releases/State-Releases/state-rel-178.pdf>.

¹³¹ Usha Ranji, Ivette Gomez, Alina Salganicoff, Carrie Rosenzweig, Rebecca Kellenberg & Kathy Gifford, *Kaiser Family Foundation*, Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey (February 17, 2022), available at <https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey-report/>.

¹³² Allison Orris, Gayle Mauser, Deborah Bachrach & Morgan Craven, Implementing Pharmacist Contraceptive Prescribing: A Playbook for States and Stakeholders (January 2021), available at https://www.manatt.com/Manatt/media/Documents/Articles/Implementing-Pharmacist-Contraceptive-Prescribing_v3.pdf.

¹³³ Centers for Medicare & Medicaid Services, CMCS Informational Bulletin Subject: State Flexibility to Facilitate Timely Access to Drug Therapy by Expanding the Scope of Pharmacy Practice using Collaborative Practice Agreements, Standing Orders or Other Predetermined Protocols (January 17, 2017), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib011717.pdf>.

¹³⁴ Power to Decide, Pharmacist Prescribing of Hormonal Contraceptives (March 21, 2022), available at <https://powertodecide.org/sites/default/files/2022-03/Pharmacist%20Prescribing.pdf>.

¹³⁵ General Assembly Of North Carolina, House Bill 96: An Act to Authorize Immunizing Pharmacists to Dispense, Deliver, and Administer Certain Treatment and Medications and to Require Parental Consent for Administration of Vaccines Under An Emergency Use Authorization to a Minor (August 20, 2021), available at <https://www.ncleg.gov/enactedlegislation/sessionlaws/pdf/2021-2022/sl2021-110.pdf>.

¹³⁶ North Carolina Department of Health and Human Services, North Carolina State Health Director's Standing Order for Oral and Transdermal Self-Administered Combined Hormonal and Progestin-Only Contraceptives (April 4, 2023), available at <https://www.dph.ncdhs.gov/docs/HormonalContraceptiveStandingOrder-appendices.pdf>.

¹³⁷ 45 C.F.R. § 164.522(b)(ii).

¹³⁸ Centers for Medicare & Medicaid Services, SHO #16-008 Medicaid Family Planning Services and Supplies (June 14, 2016), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>.

- ¹³⁹ State Medicaid programs and managed care plans are “covered entities” under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.
- ¹⁴⁰ Centers for Medicare & Medicaid Services, SHO #16-008 Medicaid Family Planning Services and Supplies (June 14, 2016), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>.
- ¹⁴¹ Loretta Gavin, Susan Moskosky, Marion Carter, et al., *Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report*, Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population Affairs (April 25, 2014), available at <https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>.
- ¹⁴² American College of Obstetricians and Gynecologists, Counseling Adolescents About Contraception (August 2017), available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/counseling-adolescents-about-contraception>.
- ¹⁴³ Liza Fuentes, Meghan Ingerick, Rachel K. Jones & Laura D. Lindberg, *Guttmacher Institute*, Adolescents’ and Young Adults’ Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services (November 2017), available at <https://www.guttmacher.org/article/2017/11/adolescents-and-young-adults-reports-barriers-confidential-health-care-and-receipt>.
- ¹⁴⁴ Loretta Gavin, Susan Moskosky, Marion Carter, et al., *Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report*, Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population Affairs (April 25, 2014), available at <https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>.
- ¹⁴⁵ Jamille Fields, Amanda Bakowski, Amy Rosenberg, Katie Garfield & Robert Greenwald, *Center for Health Law and Policy Innovation*, Confidentiality & Explanation of Benefits: Protecting Patient Information in Third-Party Billing (August 2016), available at https://www.chlpi.org/wp-content/uploads/2013/12/Confidentiality-and-Explanation-of-Benefits_issue-brief_August-2016.pdf.
- ¹⁴⁶ National Cancer Institute, HPV and Cancer (April 4, 2023), available at <https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-and-cancer#cancers-caused>.
- ¹⁴⁷ American College of Obstetricians and Gynecologists, Counseling Adolescents About Contraception (August 2017), available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/counseling-adolescents-about-contraception>.
- ¹⁴⁸ Marina J. Chabot, Sandy Navarro, Diane Swann, Philip Darney & Heike Thiel de Bocanegra, *American Journal of Public Health*, Association of Access to Publicly Funded Family Planning Services With Adolescent Birthrates in California Counties (February 2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4011102/>.
- ¹⁴⁹ Social Security Act § 1902(a)(23).
- ¹⁵⁰ Centers for Medicare & Medicaid Services, SMD # 16-005 Clarifying “Free Choice of Provider” Requirement in Conjunction with State Authority to Take Action against Medicaid Providers (April 19, 2016), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf>.
- ¹⁵¹ “Reasonable access” is defined as at least one health center or provider that provides the full range of contraceptive methods for every 1,000 women in need of publicly funded contraception. For additional information, see: Power to Decide, Contraceptive Deserts, available at <https://powertodecide.org/contraceptive-deserts>.
- ¹⁵² Centers for Medicare & Medicaid Services, Access Monitoring Review Plans, available at <https://www.medicaid.gov/medicaid/access-care/access-monitoring-review-plans/index.html>.
- ¹⁵³ California Department Of Health Care Services Office Of Family Planning, Family Pact Program Report Fiscal Year 2017–2018 And Fiscal Year 2018–2019, available at https://familyfact.org/wp-content/uploads/2022/04/FPACT-Program-Report-FY17-18-and-FY18-19-_published.pdf.
- ¹⁵⁴ Minnesota Department of Human Services, The Minnesota Family Planning Program (July 1, 2022), available at <https://edocs.dhs.state.mn.us/lfserver/public/DHS-4750-ENG>.
- ¹⁵⁵ Centers for Medicare & Medicaid Services, State Medicaid & CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of Telehealth COVID-19 Version, available at <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>.

¹⁵⁶ *Id.*

¹⁵⁷ Lavanya Rao, Alison B. Comfort, S. Sei Dojiri, et al., *Women's Health Issues*, Telehealth for Contraceptive Services During the COVID-19 Pandemic: Provider Perspectives (September–October 2022), available at <https://www.sciencedirect.com/science/article/pii/S1049386722000500>.

¹⁵⁸ Bianca M. Stifani, Tessa Madden, Elizabeth Micks, et al., *Contraception*, Society of Family Planning Clinical Recommendations: Contraceptive Care in the Context of Pandemic Response (September 2022), available at <https://www.sciencedirect.com/science/article/pii/S001078242200138X>.

¹⁵⁹ Centers for Medicare & Medicaid Services, Telehealth, available at <https://www.medicare.gov/medicaid/benefits/telehealth/index.html>.

¹⁶⁰ Allison Orris, Gayle Mauser, Deborah Bachrach & April Grady, Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States, Manatt Health (May 2019), available at <https://www.manatt.com/getattachment/4dfc897e-6f05-42dd-b82b-a0bbc8725c52/attachment.aspx>.

¹⁶¹ 42 C.F.R. § 435.214.

¹⁶² CMS initially noted in SMD #10-013 (issued July 2010) that one example of a family planning-related service would be a family planning visit for men but subsequently clarified in SMDL #14-003 (April 2014) that this should be considered a family planning service eligible for 90% FMAP reimbursement rather than a family planning-related service.

¹⁶³ Individuals were classified as being enrolled in a Medicaid family planning program in a given year if they had a “restricted benefits code” equal to “6” at any point in the calendar year per guidance issued by CMS; see: Centers for Medicare & Medicaid Services, TAF Technical Documentation: Annual Demographic & Eligibility (DE) File (April 2022), available at <https://resdac.org/TAF-data-quality-resources/TAFTechDoc-DEF>.

¹⁶⁴ For example, in California, individuals with income up to 138% FPL are eligible for Medicaid coverage, and individuals with income up to 205% FPL are eligible for family planning program enrollment, so we classified individuals with FPL between 138% and 205% FPL as being potentially eligible for family planning enrollment.

¹⁶⁵ Bradley Corallo & Sophia Moreno, Kaiser Family Foundation, Analysis of Recent National Trends in Medicaid and CHIP Enrollment (April 4, 2023), available at <https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicare-and-chip-enrollment/>.

¹⁶⁶ Ceci A. Villa Ross, Hyon B. Shin & Matthew C. Marlay, United States Census Bureau, Pandemic Impact on 2020 American Community Survey 1-Year Data (October 27, 2021), available at <https://www.census.gov/newsroom/blogs/random-samplings/2021/10/pandemic-impact-on-2020-ac-s-1-year-data.html>.

¹⁶⁷ Allison Orris, Gayle Mauser, Deborah Bachrach & April Grady, Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States (May 2019), available at <https://www.manatt.com/getattachment/4dfc897e-6f05-42dd-b82b-a0bbc8725c52/attachment.aspx>.

manatt

Albany

Boston

Chicago

Los Angeles

New York

Orange County

Sacramento

San Francisco

Silicon Valley

Washington, D.C.