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# Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States

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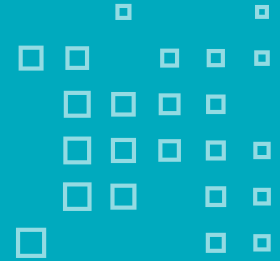
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# Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States



## Toolkit Purpose and Overview

Important aspects of family planning coverage—including eligibility levels, benefits, and payment policies—vary by state. This toolkit provides an overview of the issues that most affect access to family planning services and supplies, and the policy options available to state Medicaid agencies to enhance access. To enable evaluation of the current family planning landscape and monitor progress toward improved access, this toolkit also provides an inventory of data analyses.

Background . . . . .	5
<b>Part I: Policy Options . . . . .</b>	<b>9</b>
Eligibility and Enrollment . . . . .	9
Expand Medicaid Eligibility for Family Planning Services Through a State Plan Amendment or Waiver . . . . .	9
Include Family Planning Questions on Medicaid Applications and Create a Family Planning-Only Application. . . . .	11
Implement Presumptive Eligibility to Enable Timely Access to Family Planning Services . . . . .	11
Family Planning Benefits . . . . .	12
Increase Contraceptive Dispensing Limits . . . . .	13
Increase Access to Over-the-Counter Contraceptives . . . . .	14
Financing Family Planning Services . . . . .	15
Appropriately Claim Federal Medicaid Funding for Eligible Family Planning Services. . . . .	15
Utilize the Children’s Health Insurance Program “Unborn Child” Option . . . . .	16
Use Children’s Health Insurance Program Health Services Initiative Funding . . . . .	16
Confidentiality . . . . .	17
Exclude Family Planning Services From Explanations of Benefits. . . . .	17
Implement Good-Cause Exceptions to Third-Party Liability . . . . .	17

---

Reimbursement . . . . .	18
Ensure Payment Levels Do Not Impede Access . . . . .	18
Consider Reimbursing Outpatient Contraceptive Care on a Per-Service Basis . . . . .	19
Reimburse Providers for Family Planning Services Delivered via Telehealth. . . . .	19
Long-Acting Reversible Contraceptives . . . . .	20
Implement Device Reimbursement Policies That Enable Providers to Stock Long-Acting Reversible Contraception . . . . .	21
Separate Reimbursement for Postpartum Long-Acting Reversible Contraception Insertion From Reimbursement for Labor and Delivery . . . . .	24
Reimburse Providers for Long-Acting Reversible Contraception Removal. . . . .	24
Issue Provider Guidance Describing Long-Acting Reversible Contraception Reimbursement Options . . . . .	25
Medicaid Managed Care . . . . .	25
Develop Managed Care Organization Contract Requirements That Assure Family Planning Access . . . . .	26
Communicating and Implementing State Family Planning Policies . . . . .	30
Partner With Provider Champions to Amplify Policy Changes . . . . .	30
Offer “Boots on the Ground” Provider Supports . . . . .	31
Provide Education on Best Practices to Promote Patient Autonomy and Choice . . . . .	31
<b>Part II: Data Inventory . . . . .</b>	<b>32</b>
Family Planning Providers . . . . .	32
Measure the Number and Characteristics of Participating Providers . . . . .	32
Examine Provider Supply in Relation to Population Need. . . . .	33
Measure Time and Distance to Family Planning Providers . . . . .	33
Service Use and Spending . . . . .	35
Examine Patterns of Care Among Enrollees. . . . .	35
Use National Contraceptive Care Quality Measures. . . . .	35
Examine Provider Payment and Other Spending Issues of Interest. . . . .	36
Pregnancies and Birth . . . . .	37
Examine Measures Over Time . . . . .	37
<b>Appendix A: Relevant Federal Statutes, Regulations, and Guidance . . . . .</b>	<b>39</b>
<b>Appendix B: State Resources . . . . .</b>	<b>44</b>
<b>Appendix C: Provider Resource . . . . .</b>	<b>47</b>

# Background

Medicaid is the primary source of family planning coverage in the United States, accounting for 75 percent of total public expenditures for family planning services; Title X and state and local governments also play an important role, including by financing family planning services for individuals who otherwise lack coverage.<sup>1</sup>

This toolkit reviews the policy options available to state Medicaid agencies seeking to ensure that Medicaid enrollees have access to the full range of family planning services and supplies. Before turning to these policy options, this introduction sets out baseline information about the efficacy of family planning and the importance of assuring that enrollees have free choice about whether to use contraception and the method(s) they use.

## Importance of Family Planning

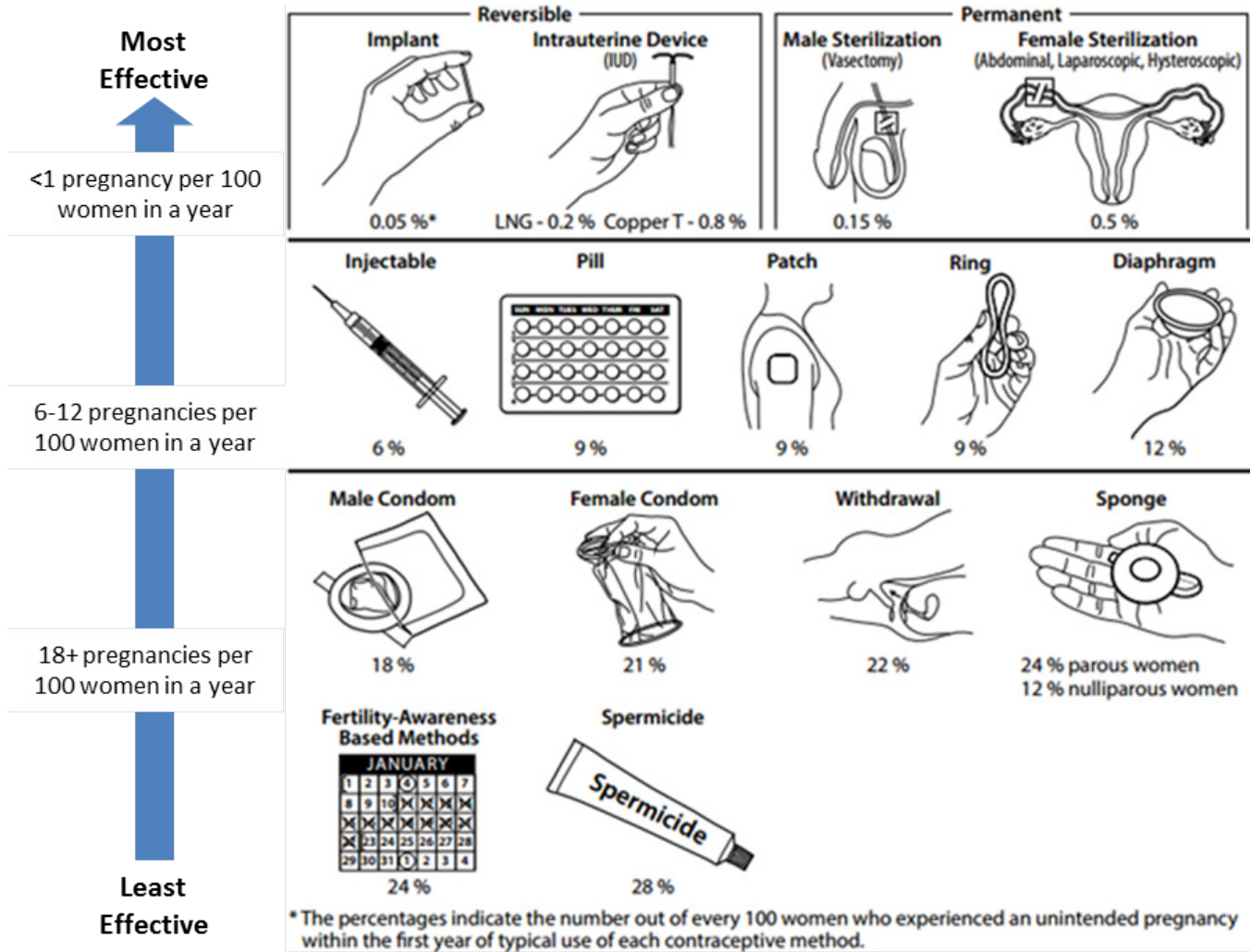
According to Healthy People 2020, family planning is one of the 10 great public health achievements of the 20th century, allowing individuals to achieve desired birth spacing and family size, and contributing to improved health outcomes for infants, children, women, and families.<sup>2</sup> Healthy birth spacing, for example, helps reduce the number of babies born prematurely, at low birth weight, or small for their gestational age.<sup>3</sup> In addition to maternal and infant health benefits, family planning has social and economic benefits. For example, research shows that contraception allows women to complete their educations and pursue careers, resulting in contributions to the economy and reducing public expenditures related to unintended pregnancies.<sup>4</sup>

Family planning also serves an important role in connecting women to healthcare. For many women, a family planning provider is their entry point into the healthcare system and their usual source of care.<sup>5</sup>

## Contraceptive Options

Over time, the number and types of contraception available to women in the United States have grown—and the effectiveness of the options available to women has increased. The reasons that individuals choose some methods over others vary, and are impacted by multiple factors including age, partnership or relationship status, fertility desires, and insurance coverage. Research demonstrates that most women rely on multiple contraceptive methods throughout the course of their lives,<sup>6</sup> and that women have diverse and strong preferences when selecting a particular method of contraception.<sup>7</sup> For some women, effectiveness of a method is a primary concern. Figure 1 below categorizes the range of available contraceptive methods by level of effectiveness. Depending on the method, contraceptive effectiveness ranges from 18 or more pregnancies per 100 women in a year (for methods like withdrawal and the sponge) to less than one pregnancy per 100 women in a year (for methods like intrauterine devices (IUDs) and the contraceptive implant—collectively referred to as long-acting reversible contraceptives (LARCs)).

**Figure 1. Effectiveness of Family Planning Methods**



Source: Centers for Disease Control and Prevention.<sup>8</sup>

Contraceptive effectiveness is not the only, or always the most important, feature that women consider when selecting a method.<sup>9</sup> For example, one study found that, on average, women reported 11 contraceptive features that were important to them when selecting a particular method, including whether the method is very effective at preventing pregnancy, is easy to use, and has few or no side effects, and whether the woman has control over when and whether to use the method.<sup>10</sup> Moreover, women’s family planning preferences may be different at different stages of life, reinforcing the importance of ongoing communication between providers and patients. Medicaid agencies will want to consider the best ways to provide balanced communication and information about contraceptive effectiveness, while ensuring that providers give

Medicaid enrollees complete and accurate information they need to make informed, autonomous decisions about their healthcare. State Medicaid policies can support consistent and effective contraceptive use by fostering individuals' ability to choose among contraceptive methods as their needs and desires change.

### **Patient Choice and Autonomy**

In crafting family planning policies and determining policy priorities, policymakers should be cognizant of the history of coercion related to contraceptive use for low-income women, women of color, and other historically marginalized communities, especially Black women. That history and its legacy continue to inform women's understanding and beliefs about family planning policies today. For example, in the 1990s, state legislatures considered measures to require and/or provide incentives to women receiving public assistance to obtain the contraceptive implant, and judges in several states upheld rulings that a woman must accept implant insertion as a criminal sentencing requirement.<sup>i</sup> The effort was revisited in 2015 when legislators in Arkansas introduced a bill offering a one-time payment of \$2,500 to unmarried mothers receiving Medicaid in exchange for using a LARC method.<sup>11</sup> Although none of these bills were enacted, evidence continues to emerge that penal sentencing has been tied to contraception and sterilization mandates at the judicial level. As recently as 2013, women in California prisons underwent coerced sterilization, with improper or no consent.<sup>12</sup> Many of those impacted were women of color and/or low-income women. This not-so-distant history of policymakers and providers engaging in practices that coerce women to be sterilized or to use specific contraceptive methods (typically LARCs) continues to drive mistrust in low-income communities and among women of color.

For more information about the history of reproductive coercion, see:

- In Our Own Voice, National Black Women's Reproductive Justice Agenda, "Contraceptive Equity: Fact Sheet."
- The Jacobs Institute of Women's Health, "Long-Acting Reversible Contraception: Overview of Research & Policy in the United States" (the "LARC Methods and Reproductive Injustice" section begins on page 30 of the Jacobs Institute publication).
- The Guttmacher Institute, "Guarding Against Coercion While Ensuring Access: A Delicate Balance."

Efforts to expand access to, and use of, LARC methods have contributed to increased concerns about contraceptive decision making and the risks of coercion. For example, recent research demonstrates that some providers may make assumptions about which patients should use LARCs based on their race/ethnicity

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<sup>i</sup> Among the most infamous cases is the story of Darlene Johnson, a Black mother of four. Johnson was given a choice between a seven-year prison sentence or only one year in prison (plus three years on probation) if she received the contraceptive implant. Johnson agreed to the terms of the probation and later unsuccessfully appealed the court's decision. See "Demand Increases for Mandatory Norplant Sentences," *Family Plan World* 1, no. 2 (1991): 5–16, <https://www.ncbi.nlm.nih.gov/pubmed/12284518>.

and socioeconomic status,<sup>13</sup> and may resist removing LARCs upon patients' request.<sup>14</sup> Women of color, young women, and low-income women report experiences of discrimination, bias, and coercion during interactions with healthcare providers more frequently than other groups do.<sup>15,16</sup>

Policymakers committed to ensuring that women have access to the full range of contraception, including LARC methods, will want to evaluate their policy priorities and subsequent decisions with consideration of the historical and cultural framework in which women receive reproductive healthcare. This means promoting patient autonomy and choice, assuring that decisions about whether or not to use contraception, which method to use, and when and from whom to seek care rest with the individual woman.

Resources about best practices for promoting patient autonomy and choice include:

- The “[Joint Statement of Principles on LARCs](#),” created by Sister Song and the National Women’s Health Network. This publication articulates the practices that public health agencies, clinicians, professional associations, and other stakeholders can adopt to prevent coercion and promote patient choice and autonomy.
- “[Setting the Standard for Holistic Care of and for Black Women](#),” created by the Black Mamas Matter Alliance.



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# Part I: Policy Options

## Eligibility and Enrollment

**OBJECTIVE:** Extend Medicaid family planning benefits to populations not otherwise eligible for Medicaid and support timely enrollment.

### Expand Medicaid Eligibility for Family Planning Services Through a State Plan Amendment or Waiver

States must provide family planning services and supplies to Medicaid-eligible “individuals of child-bearing age (including minors who can be considered to be sexually active).”<sup>17</sup> As with access to healthcare generally, lack of coverage impedes access to family planning services. Notably, 21 percent of uninsured women between the ages of 15 and 44 have incomes below the federal poverty level (FPL).<sup>18</sup> States have long used Section 1115 demonstration (or waiver) authority to expand Medicaid coverage for family planning services to populations not otherwise eligible for Medicaid. The Affordable Care Act (ACA) created a new optional Medicaid family planning eligibility group that authorized states to offer family planning benefits to certain individuals using a more straightforward State Plan Amendment (SPA), rather than a waiver.<sup>19</sup> Twenty-five states have received federal approval to offer family planning services through a waiver (10 states) or SPA (15 states).<sup>20</sup> Throughout this toolkit, we refer to individuals covered by the SPA as the “optional family planning eligibility group.”

Family planning waivers and SPAs have the greatest impact in states that have not expanded their Medicaid programs under the ACA to include all adults under 138 percent of the FPL. For these non-expansion states, family planning waivers and SPAs are important tools to provide access to affordable reproductive healthcare for uninsured individuals whose incomes are below the FPL and who do not have access to Marketplace subsidies, or who have income over 100 percent of the FPL but forgo private coverage.<sup>21</sup> In expansion states, family planning waivers and SPAs help promote access to services among people whose incomes are above 138 percent of the FPL and who forgo private coverage (for example, because they find Marketplace premiums to be unaffordable, despite federal subsidies). Family planning waivers and SPAs also serve an important role for individuals with private insurance. Such individuals—such as teenagers or individuals experiencing intimate partner violence—may use Medicaid’s family planning programs to preserve the confidentiality of their use of reproductive healthcare (for further discussion, see page 17). Others may use these programs to access providers outside of their private insurance networks.

Waivers and SPAs present different opportunities for states to expand access to reproductive healthcare. Key differences are summarized in Figure 2 below.

**Figure 2. Comparison of Using Section 1115 Waivers and SPAs to Offer Family Planning-Only Benefits**

	1115 Waivers	SPAs
<b>Eligibility Conditions for Potential Enrollees</b>		
<b>Age</b>	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) <sup>ii</sup>
<b>Gender</b>	May be limited at state's discretion	Men and women are both eligible
<b>Income Limit</b>	Defined at state's discretion	Defined by the state up to the limit for: <sup>iii</sup> <ul style="list-style-type: none"> <li>• Pregnant women under Medicaid or</li> <li>• Pregnant women under the Children's Health Insurance Program (CHIP)</li> </ul>
<b>Covered Services</b>		
<b>Family Planning Services/Supplies</b>	Must be covered	Must be covered
<b>Other Services</b>	At state discretion and subject to budget neutrality	Family planning-related services <sup>iv</sup> must be covered (state has discretion over which related services to provide)
<b>Administrative Requirements and Considerations</b>		
<b>Public Notice and Transparency Rules</b>	Must follow Section 1115 public process rules	States establish public notice requirements, which CMS approves
<b>Approval Timeframe</b>	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)
<b>Duration of Approval</b>	5-year initial term, followed by periodic renewals	Permanent (a state can end or modify coverage with another SPA)
<b>Monitoring and Evaluation</b>	Required	Not required
<b>Budget Neutrality</b>	Required	Not required

<sup>ii</sup> CMS has indicated that states may not limit eligibility for the optional family planning eligibility group on the basis of age. See: CMS, *Family Planning Services Option and New Benefit Rules for Benchmark Plans*, SMDL #10-013, ACA #4 (Baltimore, MD: CMS, July 2010), <https://downloads.cms.gov/cmssgov/archived-downloads/smdl/downloads/smdl10013.pdf>. Therefore, states may not set an upper age limit tied to typical reproductive age. However, states may choose to limit coverage under this group to specific populations described in SSA § 1905(a). SSA § 1902(a)(10)(A)(ii) describes most optional Medicaid eligibility groups and § 1905(a) describes the specific populations that may be covered in an eligibility group. Together, these provisions allow states to target an optional group to a specific population, such as individuals under age 21 (or under age 20, 19, or 18). See: under *Eligibility and Administration SPA Tools, Eligibility and Administration SPA Implementation Guide: "Medicaid SPA Processing Tools for States,"* CMS, <https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/medicaid-spa-toolkit/index.html>.

<sup>iii</sup> States have flexibility to apply different income standards and calculation methods for the family planning eligibility group than they use for other groups, and may apply varying approaches within the family planning group. For example, the income calculation for the family planning group may include all household members in the individual's MAGI-based household, but count only the individual's income when determining total household income; or may include only the individual in the MAGI-based household and count only the individual's income when determining total household income. This flexibility is particularly important to promote access for individuals under the age of 21, for example. See: under *Eligibility and Administration SPA Tools, Eligibility and Administration SPA Implementation Guide: "Medicaid SPA Processing Tools for States,"* CMS, <https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/medicaid-spa-toolkit/index.html>.

<sup>iv</sup> Medical, diagnosis, and treatment services provided pursuant to a family planning visit. For further details, see page 12 of this toolkit.

## **Include Family Planning Questions on Medicaid Applications and Create a Family Planning-Only Application**

Medicaid and Marketplaces use a “single, streamlined application,” which facilitates enrollment into comprehensive coverage by assuring that applicants can be assessed for and enrolled in coverage they qualify for, regardless of where they apply. Some states that have adopted optional family planning-only coverage (through either a waiver or the family planning eligibility group) include an additional question on their single, streamlined applications, asking applicants if they wish to be assessed for the limited family planning benefit program, thereby ensuring that they are aware of the option. To further facilitate access to family planning coverage, some states have created short, family planning-only applications. These applications may appeal to individuals who have other coverage but are also interested in applying for Medicaid family planning coverage (for example, to access their provider of choice and/or to protect their confidentiality). Similarly, in states that have not expanded Medicaid, childless adults may have little interest in completing a Medicaid application, knowing they do not qualify; however, they might be interested in applying for family planning coverage, especially if the application is tailored to the one program for which the individual might be eligible. States with or interested in optional family planning programs should discuss with CMS the best approach to designing their family planning application process. States must request CMS approval to use a family planning-specific application.

**STATE EXAMPLE – SOUTH CAROLINA:** South Carolina’s single, streamlined **application** asks applicants whether they would like to apply for family planning benefits, noting that “Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventive screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.” In addition, the state created a targeted family planning-only **application** that individuals interested in applying only for family planning coverage may use.

## **Implement Presumptive Eligibility to Enable Timely Access to Family Planning Services**

Presumptive eligibility (PE) allows individuals to obtain Medicaid-covered care immediately, before a full eligibility determination is complete. This approach ensures that providers are paid for any services they deliver during the PE period, even if the individual is not subsequently determined to be Medicaid-eligible. States that cover the optional family planning eligibility group can implement PE for this population via a SPA, provided the state has PE in place for pregnant women and/or children.<sup>22</sup> Of the 15 states that have an optional family planning eligibility group, six states had implemented PE for the group as of January 2019.<sup>23</sup> States also have the option to expand PE to parents and other adults, provided that states have PE in place for pregnant women or children.<sup>24</sup> Implementing PE for these populations could also help promote access to family planning services.

States have substantial flexibility when designating qualified entities to conduct PE determinations.<sup>25</sup> To make maximum use of PE with respect to family planning, states may want to extend PE authority to the following providers: healthcare providers (such as federally qualified health centers (FQHCs) or family planning clinics), schools, community-based organizations, and agencies that determine eligibility for health or social services programs.<sup>26</sup>

For CMS guidance about the optional Medicaid family planning eligibility group, including the option to adopt PE for this group, see CMS State Medicaid Director Letter #10-013.

**STATE EXAMPLE – CONNECTICUT:** Connecticut has used PE for its family planning program since it first adopted the optional family planning Medicaid eligibility group in 2012. Trained providers submit a condensed application online for individuals who appear eligible for family planning services. Individuals obtain coverage beyond the PE period by applying through the state-based Marketplace, where they can be evaluated for full-scope Medicaid, Marketplace coverage, or the family planning plan. As reported by the Kaiser Family Foundation in 2017, over 90 percent of Connecticut’s family planning program participants enrolled via PE at one Planned Parenthood affiliate.

## Family Planning Benefits

**OBJECTIVE:** Cover the full range of family planning and family planning-related services.

States receive a 90 percent federal matching rate for family planning services and supplies.<sup>27</sup> States may offer different family planning benefits to different eligibility groups as follows:

- Enrollees in the adult expansion population receive an “Alternative Benefit Plan” (ABP) that includes all the “Essential Health Benefits” (EHBs) that are available to individuals who receive Marketplace coverage; states may extend ABP coverage to other groups. The ABP includes the full range of Food and Drug Administration (FDA)-approved contraceptives as well as screening services and counseling.<sup>28</sup>
- For other eligibility groups, enrollees receive family planning services and supplies as enumerated by the state in the state plan.<sup>29</sup> Family planning services and supplies are services and supplies intended to prevent or delay pregnancy and can include prescription contraceptives, “education and counseling on the method of contraception desired or currently in use by the individual, a medical visit to change the method of contraception, and (at the state’s option) infertility treatment.”<sup>30</sup> Thus, a state could determine to provide somewhat fewer family planning services and supplies than would be provided under an ABP.

- Individuals enrolled in the optional family planning eligibility group are only eligible for family planning and family planning-related services, which are medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting.<sup>31</sup> Family planning-related services include treatment for urinary tract infections or sexually transmitted infections (STIs), preventive services routinely provided in family planning settings (such as human papillomavirus vaccines), and/or treatment for medical complications that result from a family planning visit (such as a perforated uterus following the insertion of an IUD).<sup>32</sup> States must provide family planning-related services, but can choose which services to provide. Unlike family planning services, family planning-related services are matched at the state’s regular matching rate.<sup>v</sup>

The Kaiser Family Foundation published a report, “[Medicaid Coverage of Family Planning Benefits: Results from a State Survey](#),” that describes how states’ fee-for-service family planning coverage policies vary.

For CMS policy on family planning-related benefits, see State Medicaid Director Letters #10-013 and #14-003, State Health Official Letter #16-008, and [Frequently Asked Questions about Medicaid Family Planning Services and Supplies](#).

## Increase Contraceptive Dispensing Limits

Medicaid may cover and enrollees may receive 12-month supplies of prescription contraceptives (for oral contraceptives, up to 13 cycles)<sup>vi</sup> when prescribed by a qualified prescriber. Authorizing yearlong supplies of prescription contraceptives at one time—rather than the typical 30- to 90-day supply—can decrease gaps in contraceptive use, and as a result, reduce the rate of unintended pregnancies.<sup>33</sup> However, covering extended supplies of prescription drugs may mean that some of the dispensed contraceptives are never used, resulting in unnecessary or duplicative costs. For example, an enrollee may switch from one drug to another after experiencing negative side effects from the first prescription. To balance concerns about gaps in use with concerns about duplicate costs, state Medicaid agencies may authorize an extended supply of contraceptives only after an initial trial period (e.g., 30 to 90 days).

<sup>v</sup> The family planning-related benefit distinction is relevant only to the family planning eligibility group; items that are considered family planning-related are available to full-scope Medicaid populations under the state plan as part of a standard Medicaid package and are reimbursed at the state’s regular matching rate. Some family planning-related services may be eligible for other special matching rates; for example, states that cover—without cost-sharing—a full list of specified preventive services and adult vaccines (e.g., the human papillomavirus vaccine) qualify for a 1 percentage point increase in the Federal Medical Assistance Percentage (FMAP). For more information, see: CMS, *Affordable Care Act Section 4106 (Preventive Services)*, SMDL #13-002, ACA #25 (Baltimore, MD: CMS, February 2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-002.pdf>.

<sup>vi</sup> The Centers for Disease Control and Prevention indicates that “the more pill packs given up to 13 cycles, the higher the continuation rates.” See: *Number of Pill Packs that Should be Provided at Initial and Return Visits: “U.S. Selected Practice Recommendations for Contraceptive Use,”* Centers for Disease Control and Prevention, 2016, <https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/combined.html>.

**STATE EXAMPLE – WASHINGTON, D.C.:** Washington, D.C. law requires Medicaid (and other insurers) to cover up to a 12-month supply of prescription contraception at one time, consistent with the prescribed supply; this provider [guidance](#) provides additional information.

### Increase Access to Over-the-Counter Contraceptives

As noted above, the ABP includes all EHBs and, under the Preventive Services EHB category, coverage must include all FDA-approved methods of female contraception prescribed for women<sup>vii</sup> by a healthcare provider.<sup>34</sup> This means that the ABP covers over-the-counter (OTC) contraceptive methods, including “barrier methods” (such as female condoms and spermicide) and one form of emergency contraception (levonorgestrel, or Plan B<sup>®</sup>)<sup>viii</sup> **when prescribed for women by a healthcare provider**. States also can determine to cover OTC items under the regular state plan. By extending coverage to OTC, all Medicaid enrollees can receive the same comprehensive family planning benefit at no out-of-pocket cost.<sup>35</sup>

Once a state determines to cover OTC contraceptives, it will want to address barriers that may prevent women from accessing them:

- **Cover OTC contraceptives without a prescription.** By definition, OTC contraceptives may be accessed without a prescription. States seeking to improve access to OTC contraceptives while assuring that federal Medicaid match is available for these supplies **without a prescription** will want to engage CMS to determine their options for claiming federal match. Prescription requirements may be necessary only for states to claim federal match for supplies that are not “drugs.” New York seeks federal reimbursement when a pharmacist dispenses emergency contraception pursuant to a qualified provider’s prescription, but uses state-only funds to cover emergency contraception when a pharmacist dispenses the drug **without a prescription**.<sup>36</sup> Michigan’s approved state plan generally requires that covered family planning supplies be prescribed by a physician and purchased at a pharmacy, but an exception exists for “condoms and similar supplies which do not require a prescription.”<sup>37</sup>
- **Permit pharmacists to prescribe OTC contraceptive supplies and emergency contraception.** States can permit pharmacists to prescribe OTC contraception and reimburse them for their time spent counseling patients to whom they prescribe. In recent years, a handful of states have taken this policy further, permitting pharmacists to prescribe all forms of self-administered contraception (such as the pill and the patch, and not just OTC contraceptives).<sup>ix</sup>

<sup>vii</sup> The inclusion of contraceptives as an EHB derives from a requirement to cover women’s preventive services, and the current federal interpretation of this provision excludes male condoms (as well as male sterilization).

<sup>viii</sup> There are three forms of emergency contraception: levonorgestrel, or Plan B<sup>®</sup>; ulipristal acetate, or Ella<sup>®</sup>; and the copper intrauterine device, or ParaGard<sup>®</sup>. Levonorgestrel is the only method of emergency contraception FDA-approved for OTC use.

<sup>ix</sup> CMS guidance outlines the options states have to expand pharmacists’ scope of practice, including through “collaborative practice agreements” wherein pharmacists operate under authority delegated by another licensed practitioner with prescribing authority; under “standing orders” issued by the state; and alternative state methods. See:

#### STATE EXAMPLES:

- **New York** permits Medicaid enrollees to obtain OTC emergency contraception, male condoms, and female condoms at Medicaid-participating pharmacies. Pharmacies are required to submit “fiscal orders” (which contain the same information as a prescription) for male condoms and female condoms, but not for emergency contraception (which is available without a prescription or fiscal order and covered using state-only funds).
- **Maryland** legislation enacted in 2018 authorizes qualified pharmacists to prescribe FDA-approved contraceptive medications and self-administered contraceptive devices, and requires Medicaid/CHIP to cover pharmacist-prescribed contraceptives. Maryland pharmacists and pharmacies may enroll with Maryland Medicaid as a Pharmacist Prescriber provider type and, once enrolled, may bill for patient assessments to prescribe contraceptives. (For more information, see pages 2–3 of this Maryland [guidance](#) and this Maryland Department of Health [informational page](#).)

## Financing Family Planning Services

**OBJECTIVE:** Use available financing for family planning.

### Appropriately Claim Federal Medicaid Funding for Eligible Family Planning Services

As of 2016, five out of 31 managed care states responding to a survey reported that they did not claim the 90 percent federal matching rate available for family planning services provided through their Medicaid managed care plans.<sup>38</sup> States not currently obtaining the enhanced federal match can use their own data to determine the extent to which appropriate claiming can offset costs that are otherwise borne by the state. Additionally, while Medicaid has long been the largest payer of publicly funded family planning services,<sup>39</sup> in 2017, uninsured individuals accounted for 38 and 51 percent of family planning users at Title X clinics in Medicaid expansion and non-expansion states, respectively.<sup>40</sup> For individuals who may be Medicaid-eligible but unenrolled, states can encourage Title X sites to use data on the characteristics of their patients to estimate the potential for increased Medicaid take-up and revenues; they can also work collaboratively with sites to facilitate Medicaid enrollment and billing while maintaining patient confidentiality.<sup>41</sup>

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CMS, *State Flexibility to Facilitate Time Access to Drug Therapy by Expanding the Scope of Pharmacy Practice using Collaborative Practice Agreements, Standing Orders or Other Predetermined Protocols*, CMCS Informational Bulletin (Baltimore, MD: CMS, January 2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib011717.pdf>.

### Utilize the Children’s Health Insurance Program “Unborn Child” Option

Under the Children’s Health Insurance Program (CHIP) “unborn child” option, states may cover prenatal care for women who do not otherwise qualify for Medicaid or CHIP, so long as their income does not exceed CHIP eligibility levels.<sup>42</sup> For states that do not fully exhaust their CHIP allotments on other CHIP spending, this option provides a source of federal funding—at the enhanced CHIP matching rate.<sup>x</sup> With respect to family planning, this option enables states to cover LARCs administered immediately postpartum, so long as payment is made through a prepaid bundled “global fee.”<sup>43</sup>

### Use Children’s Health Insurance Program Health Services Initiative Funding

States can leverage CHIP Health Services Initiative (HSI) funding to draw down federal matching funds at the enhanced CHIP rate for certain non-coverage expenditures for children under 19 years of age.<sup>44</sup> HSIs are “activities that protect the public health, protect the health of individuals, improve or promote a State’s capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children.”<sup>45</sup> States use HSIs to address a range of health priorities,<sup>46</sup> including family planning (see examples below).<sup>xi</sup> States implement HSI programs by submitting a CHIP SPA and claiming funding through the usual CHIP administrative cost claiming process. Because there are no statewideness requirements for CHIP or CHIP HSIs, states are permitted to target programs to specific communities and children with the greatest needs.

**STATE EXAMPLE — MASSACHUSETTS:** Massachusetts employs the HSI option for children under 19 years old who receive services through eight state programs, including its Family Planning Program. The Family Planning Program provides comprehensive family planning services, including diagnosis and treatment of STIs; contraceptive supplies, including emergency contraception; pregnancy testing; pre-conception care; and individual health education and counseling (among other services).

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<sup>x</sup> Each state’s enhanced match for CHIP ranges from 65 percent to 85 percent, and the Affordable Care Act increased this matching rate by 23 percentage points (not to exceed 100 percent). The 23 percent “bump” will be phased down (to 11.5 percent) in federal fiscal year 2020, and eliminated thereafter. See: SSA § 2105(b).

<sup>xi</sup> If the HSI is not exclusively focused on children and/or serves a broader population, the state may claim CHIP reimbursement only for services provided to children under 19 years of age. See: “Frequently Asked Questions: Health Services Initiative,” CMS, January 2017, <https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf>.



## Confidentiality

**OBJECTIVE:** Protect enrollees' privacy.

Patient confidentiality is always critical; reproductive healthcare presents unique confidentiality issues that Medicaid policies should address. Of particular concern are insurance communications (such as Explanations of Benefits (EOBs)) that are directed to the policy holder (for example, a parent or spouse). By informing third parties about the family planning services accessed by the patient, these communications could unintentionally breach the patient's privacy. Particularly for adolescents and individuals experiencing intimate partner violence, assurances of confidentiality are often a gating issue, determining whether enrollees will seek required care.

Some states have enacted legislation to enhance privacy protections for these populations; for example, 13 states have established laws to protect the confidentiality of individuals insured as dependents.<sup>47</sup> Many states also have established laws related to minors' privacy and authority to consent to healthcare,<sup>48</sup> and courts also have affirmed minors' right to receive Medicaid-funded services in the absence of parental consent.<sup>49</sup> In addition to ensuring that providers and managed care entities comply with federal and state confidentiality and privacy laws, state Medicaid agencies can establish Medicaid-specific policies and procedures to protect the privacy of enrollees seeking family planning benefits.

The Association of State and Territorial Health Officials provides an overview of "[State Efforts to Protect Confidentiality for Insured Individuals Accessing Contraception and Other Sensitive Healthcare Services](#)."

### Exclude Family Planning Services From Explanations of Benefits

Medicaid is not required to send EOBs to enrollees, but some Medicaid agencies send EOBs to fee-for-service enrollees and request that they verify receipt of services as a means of combating fraud.<sup>50</sup> States that send EOBs to Medicaid enrollees should consider excluding family planning services (and potentially other sensitive services, like STI, HIV, and substance use disorder treatment) from these communications.

### Implement Good-Cause Exceptions to Third-Party Liability

Some Medicaid enrollees may have another, non-Medicaid source of coverage (e.g., in addition to being enrolled in the state's optional family planning eligibility group, an enrollee may have full medical coverage from a private insurer). Under federal Medicaid Third Party Liability (TPL) rules, Medicaid is the "payer of last resort."<sup>51</sup> In most instances, providers must bill the non-Medicaid source of coverage before Medicaid will pay; the other insurer may send an EOB to the policy holder, potentially breaching the enrollee's

confidentiality and causing harm. States may waive TPL when an individual has “good cause.”<sup>52</sup> Good cause exists when following TPL rules would pose a risk of physical or emotional harm to the individual or other person. Good-cause determinations are made on a case-by-case basis and should be documented in the enrollee’s case file.<sup>53</sup> States should have a good-cause exception process in place and educate family planning providers about how to pursue such exceptions in appropriate cases.

**STATE EXAMPLE – NEW YORK:** New York issues good-cause exceptions to TPL rules where the state determines that billing an enrollee’s third-party health insurance could jeopardize the enrollee’s emotional or physical health, safety, and/or confidentiality and privacy. New York uses two approaches to identify individuals for good-cause exceptions:

- During enrollment – Section E of the state’s family planning benefit program **application** includes the question “If you are not the policy holder [of the identified third-party health insurance], do you have a reason the health insurance company should not be billed?”
- Based on a provider’s indication of good cause – The provider is required to call the New York Health Options Statewide Call Center to request a “good cause waiver authorization.”

(For more information, see question 4 in this [New York Frequently Asked Questions guide](#)).

## Reimbursement

**OBJECTIVE:** Ensure that Medicaid reimbursement levels and methodologies support access to the full range of contraceptives.

### Ensure Payment Levels Do Not Impede Access

States’ reimbursement rates for family planning services impact (1) private outpatient providers’ willingness to accept Medicaid patients and, accordingly, Medicaid enrollees’ access to care;<sup>xii</sup> and (2) the financial viability of safety net sites of care that are especially dependent on Medicaid revenue.<sup>54</sup>

<sup>xii</sup> In a 2013 Kaiser survey, 57 percent of Medicaid enrollees who had received a gynecological exam in the prior three years reported that the site of their most recent gynecological exam was a private doctor’s office or health maintenance organization. See: Alina Salganicoff, Usha Ranji, Adara Beamesderfer, and Nisha Kurani, *Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women’s Health Survey* (Kaiser Family Foundation, May 2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf>.

## Consider Reimbursing Outpatient Contraceptive Care on a Per-Service Basis

Where states use per-visit or bundled payment reimbursement methodologies, they will want to consider the impact that the selected methodology will have on family planning services and access. Reimbursing providers on a per-visit or bundled payment basis **without accounting for the specific services provided** during that visit may unintentionally incentivize providers to deliver services across multiple visits and, as a result, impede access to contraceptive counseling and same-visit access to contraception. For example, a provider seeing a patient for a well woman visit may be reluctant to also provide contraceptive counseling and, if desired, insert a LARC device in the same visit when such services will be separately reimbursed if the provider instead schedules a second visit.<sup>xiii,xiv</sup> Reimbursement methodologies that account for each of the following services provided during a single visit support contraceptive counseling and same-visit access to contraceptive care:

- Contraceptive counseling
- Administration of injectable (i.e., Depo-Provera)
- Same-visit insertion of LARCs
- LARC follow-up care
- LARC removal

**STATE EXAMPLE – ILLINOIS:** In 2014, Illinois began reimbursing outpatient providers for contraceptive counseling in addition to LARC insertion when both services are provided during the same visit. Illinois also separately reimburses outpatient providers for insertion, removal, and reinsertion of LARCs. (For more information, see Illinois' [provider notice](#).)

## Reimburse Providers for Family Planning Services Delivered via Telehealth

Many family planning services can be delivered via telemedicine, thereby reducing travel and time barriers to family planning services.<sup>55</sup> State laws related to reimbursement, licensure, and practice standards determine state Medicaid agencies' ability to reimburse providers for services provided via telemedicine.<sup>56</sup> Depending on the level of flexibility granted by state laws, Medicaid agencies should consider reimbursing family planning providers and pharmacies for services and supplies provided via telemedicine, including when they are provided through telehealth apps. These apps offer various services including virtual contraceptive

<sup>xiii</sup> Policies that eliminate reimbursement-related barriers to patient-centered contraceptive counseling are important; counseling is a critical component of quality family planning care that can help promote health equity and protect patients' choice and autonomy with respect to whether to use contraception, and which method(s) of contraception to select. See: Christine Dehlendorf, "Contraceptive Counseling and Selection for Women," UptoDate, April 2019, <https://www.uptodate.com/contents/contraceptive-counseling-and-selection-for-women>.

<sup>xiv</sup> While some practices may not be able to accommodate expanding the scope of an encounter in this manner, family planning-focused providers are increasingly identifying practice flow changes to accommodate longer appointments in an effort to minimize the need for return visits.

counseling, prescriptions for and mail delivery of birth control and emergency contraception, and testing and treatment for common health conditions (e.g., STIs and urinary tract infections). States can reimburse differently for the same service depending on whether it is delivered on-site or through telemedicine.<sup>xv</sup>

## Long-Acting Reversible Contraceptives

**OBJECTIVE:** Promote access to all forms of contraception, including LARCs.

LARCs have many benefits: LARC devices can last for up to 10 or more years, require little user effort (compared to, for example, taking a daily pill or receiving a quarterly injection), and are among the most effective forms of contraception available. In one study where women who desired contraception had access to all contraceptive options at no additional out-of-pocket cost, the majority of women chose to use a LARC method.<sup>xvi</sup> However, some patients who wish to use LARCs may not have easy access to the method. Many providers have difficulty purchasing and stocking LARCs given their cost—which is as much as \$1,000 or more per unit. Below we discuss some of the ways states may structure policies to overcome these cost barriers.

As with all family planning initiatives, policies to enhance access to LARCs should assure patient autonomy in contraceptive choice. Unlike contraceptive methods that are under the control of the user (e.g., taking a pill), LARC methods are provider-dependent—a clinician must insert and remove LARC devices, which poses a greater risk of coercion. State policymakers should be aware of these dynamics and provide patient and provider education on the importance of patient autonomy, and support contraceptive counseling to ensure that the patient is able to make an informed choice about whether to use contraception and what method to use.<sup>57</sup>

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<sup>xv</sup> Since decisions related to telemedicine are treated as reimbursement decisions by the states, the requirements of freedom of choice, comparability, and statewideness do not apply. States must ensure that there is adequate statewide access and freedom of choice with respect to the service—physician visits, for example—but not with respect to the mode for receiving the service. See: “Telemedicine,” Medicaid.gov, <https://www.medicaid.gov/medicaid/benefits/telemed/index.html>.

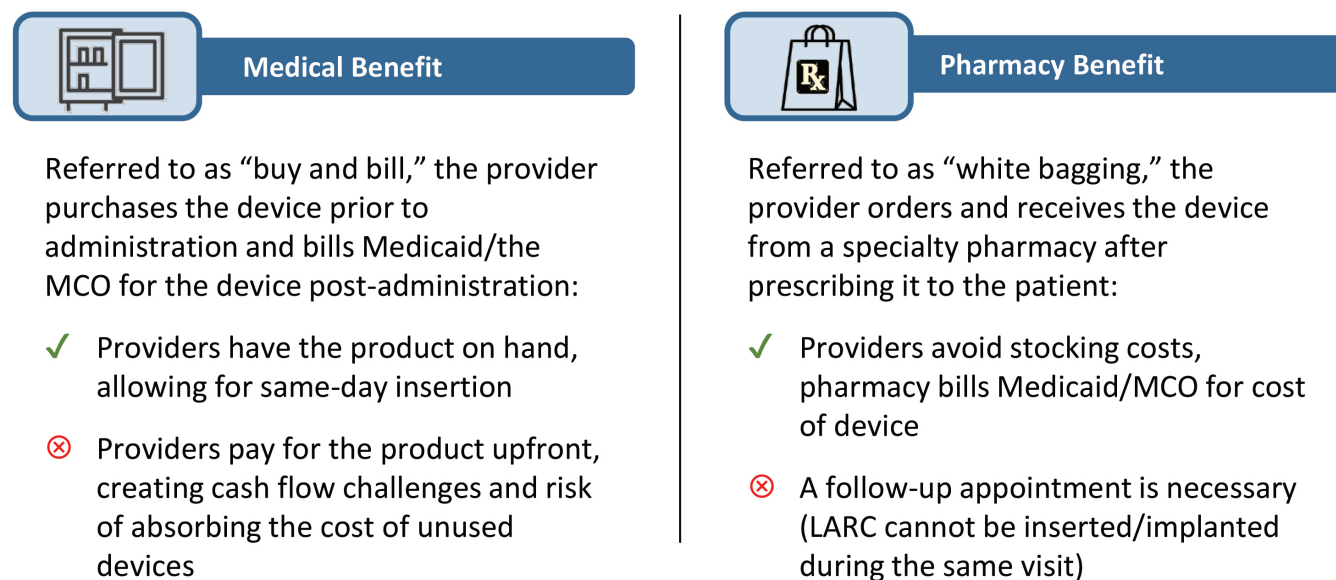
<sup>xvi</sup> In the Contraceptive CHOICE research project, a prospective cohort of 9,256 women between 14 and 45 years of age were offered their choice of contraceptive method without charge. Seventy-five percent of the cohort chose LARCs: 46 percent chose the LNG-IUD, 12 percent chose the copper IUD, and 17 percent chose the subdermal implant. See: Jeffrey Peipert, Tessa Madden, Jenifer Allsworth, and Gina Secura, “Preventing Unintended Pregnancies by Providing No-Cost Contraception,” *Obstetrics & Gynecology* 120, no. 6 (December 2012): 1291-297, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4000282/>.

## Implement Device Reimbursement Policies That Enable Providers to Stock Long-Acting Reversible Contraception

When providers have LARC devices on-site, they are able to offer patients same-day insertion (rather than requiring the patient return for another visit, which can create barriers to accessing care). The policies highlighted below support same-visit access to LARCs.

**Coverage of LARC Devices as a Medical or Pharmacy Benefit.** States cover LARC devices as a medical benefit or a pharmacy benefit, or both. When states cover LARC devices as a pharmacy benefit, providers order the device from a specialty pharmacy, for a specific patient; providers do not bear the cost of LARC devices. However, unless the pharmacy is on-site, this approach requires a return visit by the patient once the provider receives the device from the pharmacy. In theory, covering LARC devices as a medical benefit better enables same-visit access because providers can order and pay for devices that they then keep on hand, only billing Medicaid for the device post-insertion. However, in practice, many providers find the cost of stocking LARC devices to be prohibitive. Figure 3 below sets out the advantages and disadvantages of covering LARCs as a medical benefit versus a pharmacy benefit. Notably, many states cover LARC devices as a pharmacy benefit **and** a medical benefit, thereby leaving the choice of acquisition method to the provider.

**Figure 3. Advantages and Disadvantages of Covering LARCs as a Medical Benefit vs. Pharmacy Benefit**



To enable same-visit insertion, some providers are contracting with specialty pharmacies that place proprietary storage cabinets stocked with LARC devices in clinics or hospital labor and delivery units. The inventory is still “owned” by the specialty pharmacy and is dispensed from the cabinet for a specific patient. When a clinician fills a LARC prescription from the cabinet, the specialty pharmacy is notified of the change in inventory, and the specialty pharmacy bills Medicaid for the device.

The text box below provides examples of state policies designed to increase providers' ability to stock LARC devices.

#### STATE EXAMPLES:

- Texas **covers** LARCs as a medical and pharmacy benefit. FOHCs and providers that participate in its Family Planning Program use the “buy and bill” method; other Medicaid-participating providers may also stock LARCs using the buy and bill method, or they may use a specialty pharmacy to order the device.
- **Delaware** accelerated reimbursement for LARC device claims to help mitigate the upfront cost of LARC devices. Prompt state payment of claims allows providers to benefit from manufacturer/distributor 90-day “net terms” or “consignment” models, through which the provider receives an upfront inventory of LARC devices without charge. Post-insertion, the provider bills Medicaid, receives payment from the state, and uses that reimbursement to pay the manufacturer/distributor within a 90-day billing window.<sup>58</sup>
- **Illinois** **piloted** two payment models with manufacturers—the first was a consignment program and the second utilized a manufacturer’s proprietary storage cabinet to monitor and replenish inventory in real time.

**LARC Device Reimbursement Methodology.** The methodology that states use to reimburse providers for LARC devices often influences providers’ decisions about which devices to stock. Because there are multiple types of LARC devices, and a provider and patient may prefer a particular type of LARC (e.g., some individuals may prefer an implant over an IUD; a hormonal over a non-hormonal IUD; or a LARC device that can be used for a longer duration), states will want to be certain that their reimbursement methodology does not inadvertently incentivize providers to stock one device over another. For example, if a state’s fee schedule specifies that all IUDs are reimbursed at \$600/unit and a provider can purchase one type of IUD for \$550 and another type of IUD for \$300, the state may inadvertently be incentivizing the provider to stock only the \$300 device.

**340B Drug Discount Program Covered Entities.** The 340B Drug Discount Program (“340B program”) allows safety net providers (e.g., Disproportionate Share Hospitals, Title X clinics, and FOHCs) to purchase outpatient (but not inpatient) drugs/devices, including LARCs, at a discounted price.<sup>59</sup> 340B discounts may make the costs associated with purchasing and stocking LARC devices more tenable; whether or not providers can access these discounts depends on state policies. In states that allow 340B covered entities to use 340B drugs for Medicaid patients, providers can benefit from favorable 340B pricing when they purchase LARCs for Medicaid patients. (Some states do not permit providers to

The National Family Planning & Reproductive Health Association published “340B and Medicaid: An Explanation for Family Planning Providers.”

use 340B discounted drugs for Medicaid patients because they claim rebates for those drugs through the Medicaid Drug Rebate Program.)<sup>xvii</sup> In states that allow 340B covered entities to use 340B drugs for Medicaid patients, 340B hospitals can purchase LARC devices at 340B discounted prices, provided the state treats LARCs as outpatient drugs or devices when they are inserted immediately postpartum.

**STATE EXAMPLE – CONNECTICUT:** Connecticut requires hospitals to submit claims for LARC devices administered immediately postpartum on an **outpatient** claim, as described in its [SPA](#) and [guidance](#).

**Federally Qualified Health Centers/Rural Health Centers.** States must reimburse FQHCs and rural health centers (RHCs) for services provided to Medicaid enrollees on a per-visit basis. Given the relatively high price of LARC devices, providers may be unable or unwilling to “buy and bill” LARCs when reimbursement for the device is embedded in the per-visit rate. States have addressed this challenge by securing CMS approval to reimburse FQHCs and/or RHCs for the cost of the LARC device **outside** the per-visit payment. Under this arrangement, Medicaid pays the FQHC/RHC two fees for administering LARC devices: (1) the per-visit rate (including LARC insertion), and (2) reimbursement for the LARC device.

The National Institute for Reproductive Health published “[Enhancing LARC Uptake and Reimbursement at FQHCs: a Toolkit for States.](#)”

#### STATE EXAMPLES:

- **Delaware** and **Montana** received CMS approval to separately reimburse FQHCs/RHCs in the amount of the actual acquisition cost of LARC devices.
- **Georgia, Idaho, and Illinois** received CMS approval to separately reimburse FQHCs/RHCs in the amount of the actual acquisition cost when the FQHC/RHC purchases the device through the 340B program; if the device is not purchased through the 340B program, Medicaid pays the lesser of charges or the amount listed on the Medicaid fee schedule (whichever is applicable). (The National Academy for State Health Policy also highlights Georgia’s approach in [this report](#).)

<sup>xvii</sup> When a covered entity uses 340B drugs for its Medicaid patients, the drugs are described as being “carved in.” Conversely, when a covered entity does not use 340B drugs for its Medicaid patients, the drugs are described as being “carved out.” States may not claim Medicaid Drug Discount Program rebates on drugs purchased under the 340B program (referred to as “double dipping” or a “duplicate discount”). If states permit covered entities to use 340B drugs for their Medicaid patients, the covered entities must ensure that they are in compliance with 340B guidance governing the prevention of duplicate discounts, including indicating to the Medicaid agency that they are using 340B drugs for Medicaid patients.

## Separate Reimbursement for Postpartum Long-Acting Reversible Contraception Insertion From Reimbursement for Labor and Delivery

It is medically safe to insert an IUD or implant within minutes of childbirth. This timing has practical benefits; women are known not to be pregnant and it is likely that maternity care providers have already discussed birth spacing with their patients.<sup>60</sup> Until recently, most state Medicaid agencies did not pay for LARC devices and their insertion separate from the labor and delivery fee. This created barriers for accessing these methods of contraception because providers were not being reimbursed for the level of care provided once billed. To enable inpatient providers to offer their patients comprehensive contraception options, including LARCs, in the immediate postpartum period, states are increasingly “unbundling” payments for (1) labor and delivery; (2) the LARC device; and (3) the LARC insertion.

### STATE EXAMPLES:

- When a LARC device is inserted immediately postpartum, **Virginia** allows hospitals to submit two claims (one claim for the labor and delivery and one claim for the LARC device) and also allows physicians to submit a third claim for the insertion of the device.
- **Colorado** uses an All Patient Refined-Diagnosis Related Group (APR-DRG), which reflects the complexity of services provided, to reimburse for labor and delivery and LARC insertion. In 2017, the state decided to (pending CMS approval) carve LARC devices out of the APR-DRG. (See: 2016 guidance on page 9; 2017 guidance on page 13.)

The American College of Obstetricians & Gynecologists provides an [overview](#) of Medicaid reimbursement for postpartum LARC by state, including links to each state’s policy documents (last updated August 2018).

## Reimburse Providers for Long-Acting Reversible Contraception Removal

Individuals using LARC methods may desire discontinuation of their use at any time, for any reason. Accordingly, state Medicaid payment policies should always cover and reimburse for LARC removal, regardless of a patient’s length of use or reason for discontinuation, or whether another LARC device is inserted upon the old one’s removal. Imposing any limits on when or why LARC removal is covered limits patient choice and autonomy.<sup>61,62</sup> Provider training and education materials should reinforce this critical policy.

For more information about CMS policy on LARCs, see:

- [State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception](#), CMS Informational Bulletin, April 8, 2016.
- [Medicaid Family Planning Services and Supplies](#), State Health Official Letter #16-008, June 14, 2016.



## Issue Provider Guidance Describing Long-Acting Reversible Contraception Reimbursement Options

As state and Managed Care Organization (MCO) LARC policies change, states should issue guidance to providers about these reimbursement policies, including provider options for stocking LARCs, postpartum LARC insertion, and reimbursement for LARC removal. Such guidance also presents an opportunity for states to reinforce the importance of providing patient-centered contraception counseling and respecting patient choice.

**STATE EXAMPLE – LOUISIANA:** Louisiana issued a LARC **billing and ordering guide** that describes how inpatient and outpatient providers should bill Medicaid and Medicaid MCOs for LARC insertion and the cost of the device depending on (1) the enrollee’s source of coverage and (2) whether the provider “buys and bills” or orders the device from a specialty pharmacy.

## Medicaid Managed Care

**OBJECTIVE:** Ensure access to and the quality of family planning services for Medicaid managed care enrollees.

Over the past 30 years, managed care has become the dominant mode of Medicaid service delivery; in 2016, more than 80 percent of the Medicaid population nationwide was enrolled in managed care.<sup>63</sup> Thus, most Medicaid enrollees are now receiving most of their care through an MCO.<sup>xviii</sup> In recognition of the importance of family planning services and historical barriers to access, federal rules seek to assure that women enrolled in MCOs have access to the full range of family planning services and supplies. For example:

- **Free choice of providers:** Medicaid enrollees may receive family planning services from **any** Medicaid-enrolled provider. This protection applies to beneficiaries who receive services through fee-for-service or managed care and thus guarantees access to family planning providers regardless of whether providers are in the MCO’s network.<sup>64</sup> MCOs must include information in enrollee materials about enrollees’ freedom of choice.<sup>65</sup>

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<sup>xviii</sup> Family planning-only benefits (e.g., for the optional family planning eligibility group or for individuals enrolled in family planning waivers) are typically offered on a fee-for-service basis.

- **Network adequacy:** States must assure that Medicaid MCOs have a “sufficient” number of family planning providers in their networks to ensure “timely access to care” and that female enrollees have access to a women’s health specialist within the provider network, without first seeking a referral.<sup>66</sup> MCOs also must meet state-established time and distance standards for obstetricians and gynecologists (OB/GYNs).<sup>xix</sup>
- **Free choice of services:** Given the history of reproductive coercion and concerns about ongoing limitations on patient choice, Medicaid MCOs must provide that enrollees are “free from coercion or mental pressure and free to choose the method of family planning to be used.”<sup>67</sup>
- **Use of utilization controls:** Medical necessity and utilization control policies must support a beneficiary’s choice of method. For example, utilization control techniques such as step therapy or quantity limits are not consistent with the ability of beneficiaries to choose a method of contraception, but a prior authorization requirement that takes into account medical necessity for the individual beneficiary would be.<sup>68</sup>

### **Develop Managed Care Organization Contract Requirements That Assure Family Planning Access**

States can leverage their MCO contracts to enable family planning access; below we provide an overview of these types of contracting options.

**Provider Reimbursement for Family Planning Services.** The same provider reimbursement challenges described on page 18 pertain to family planning access for managed care enrollees. Therefore, states should consider whether to require MCOs to pay in-network family planning providers a minimum reimbursement rate (e.g., the fee-for-service rate paid by the Medicaid agency or a specified percentage of Medicare reimbursement rates), and/or require that MCOs use particular reimbursement methodologies (e.g., to separately pay for LARC devices, rather than paying for LARC devices in a bundled payment).

**MCO Policies Impacting LARC Access.** States should consider establishing standards in their MCO contracts and guidance to enable access to the full range of contraception, including LARC methods. For example, states can require MCOs to separate reimbursement for labor and delivery from reimbursement for immediate postpartum insertion of LARCs. States also can encourage MCOs to adopt approaches that address network providers’ LARC stocking challenges, such as the “Care Cart” example described in the text box below.

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<sup>xix</sup> 42 CFR § 438.68(b)(ii). CMS proposed changes to this regulation, which—if finalized—would permit states to adopt more flexible standards.

A Kaiser Family Foundation [report](#) describes one MCO that developed an innovative model to help providers stock LARC devices; the MCO pays the upfront cost to stock a “Care Cart” with LARC devices, and participating providers pay a low administration fee for use of the cart. Conversely, the report indicates that other MCOs did not pursue similar efforts because they had little financial incentive to increase access to LARC—particularly for women in non-expansion states who are eligible for Medicaid only on the basis of their pregnancy. These women typically lose Medicaid eligibility 60 days post-delivery and, thus, the MCO does not expect cost savings from preventing an unintended pregnancy. State leadership could help overcome MCO resistance to interventions that help providers stock LARC.

**Member Communications About Freedom of Choice.** MCO handbooks must include information about “the extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers” and advise enrollees that they are not required to obtain a referral before choosing a family planning provider.<sup>69</sup> Informing patients about their freedom of choice is particularly important when Medicaid MCOs or their network providers have “conscience” or religious objections to providing the full range of family planning services.

**Network Adequacy Requirements.** States seeking to improve access to family planning providers may wish to use their MCO contracts to strengthen family planning network adequacy requirements. As noted above, states must assure that Medicaid MCOs have a “sufficient” number of family planning providers in their networks to ensure “timely access to care” and that female enrollees have direct access to a women’s health specialist within the provider network. States also must establish specific time and distance standards for certain types of providers, including OB/GYNs. However, not all OB/GYNs offer family planning services and not all family planning providers are OB/GYNs. Therefore, to ensure that plans contract with a sufficient number of family planning providers—and not just OB/GYNs—state contracts with MCOs could establish network adequacy standards for family planning providers, including the number and types of providers with which an MCO must contract, travel time and distance to network providers, maximum wait times for appointments, geographical distribution of providers, and/or minimum family planning provider-to-enrollee ratios.<sup>xx</sup>

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<sup>xx</sup> In 2016, CMS finalized regulations requiring states to adopt time and distance standards to measure the adequacy of provider networks, which must specify time and distance standards for seven different provider types, including OB/GYN; see: 42 CFR § 438.68(b). In November 2018, CMS proposed revisions to the managed care regulations, but CMS has not yet finalized these revisions. If the proposed rule is finalized, states will not be required to impose “time and distance standards specifically,” and states may instead impose a “quantitative” standard (e.g., minimum provider-to-enrollee ratios), and may define “specialists” for whom network adequacy standards must apply; see: Medicaid Program; Medicaid and Children’s Health Insurance Plan (CHIP) Managed Care, 83 Fed. Reg. 57264 (Nov. 14, 2018), <https://www.federalregister.gov/documents/2018/11/14/2018-24626/medicaid-program-medicaid-and-childrens-health-insurance-planchip-managed-care>.

Medicaid freedom of choice requirements enhance family planning access, permitting enrollees to seek care from out-of-network providers. However, this flexibility can complicate MCO efforts to coordinate enrollees' care and to recruit family planning providers to their networks. To encourage MCOs to build strong family planning networks and to encourage providers to participate in those networks, states can require MCOs to pay family planning providers at or above minimum rates (e.g., fee-for-service rates or a specified percentage of Medicare reimbursement rates). At the same time, states may want to "charge back" to the MCO the costs of out-of-network family planning services reimbursed by the state (and included in the MCO's capitation rate). Taken together, these policies both encourage family planning providers to contract with MCOs and encourage MCOs to ensure in-network access to all required services, including family planning.

**STATE EXAMPLE – MASSACHUSETTS:** Massachusetts reimburses out-of-network family planning providers directly, and requires MCOs to cover the cost of family planning services through an end-of-year reconciliation process. The state calculates all fee-for-service family planning service payments it made during the contract year and subtracts that amount from a future capitation payment to the MCO.

**Pharmacy and Medical Utilization Management Criteria.** MCOs must ensure that enrollees are "free from coercion or mental pressure and free to choose the method of family planning to be used."<sup>70</sup> While MCOs may apply utilization control criteria to an enrollee's request for family planning services, MCOs are prohibited from using these techniques in a way that "interfere[s] with a beneficiary's freedom to choose the method of family planning or the services or counseling associated with choosing the method," including requiring that a particular contraceptive method be used first (i.e., "step therapy") or utilizing policies that restrict a change in contraceptive method.<sup>71</sup> States should assess MCOs' pharmacy formularies and utilization management criteria, and may also want to use External Quality Review Organizations (EQROs) or "secret shoppers" to monitor MCOs' compliance with these and any other state requirements.<sup>72</sup>

The National Health Law Program's "[Contraceptive Equity in Action: A Toolkit for State Implementation](#)" includes tips for designing secret shopper surveys (see page 48) and a model formulary tool (see page 57) that describes each unique FDA-approved contraceptive and any associated therapeutically equivalent generics.

**STATE EXAMPLE – ILLINOIS:** Illinois used its EQRO to develop a family planning readiness review tool and to review plans' family planning policies and procedures (see pages 18–20 of this [CMS informational bulletin](#) for more information).

**Pharmacy Dispensing Limits.** Above we note the benefits of increasing contraceptive dispensing limits (see page 13). However, MCOs may be reluctant to cover a yearlong supply of contraception if enrollees may not stay enrolled for the entire year. MCOs may also be concerned about redundant costs that could result if an enrollee receives an extended supply of contraception and thereafter discontinues use. Some states—like Nevada (see below)—have addressed these concerns by phasing in yearlong (or remainder of plan year) dispensing limit requirements after an initial, shorter-duration prescription.

**STATE EXAMPLE – NEVADA:** Nevada **legislation** requires pharmacists to dispense and certain plans (including Medicaid MCOs) to cover up to a 12-month supply of contraceptives, with certain exceptions:

- The initial prescription is dispensed for three months;
- The second prescription is dispensed for nine months **or any amount which covers the remainder of the plan year**; and
- For a refill in the plan year following the initial dispensing of the drug, up to a 12-month supply **or any amount which covers the remainder of the plan year** is dispensed.

**Confidentiality Protections.** Where required by state law or pursuant to MCO practice, MCOs send EOBs and other communications to the policy holder, who may not be the patient but rather the patient’s spouse or parent. States should consider requiring MCOs to exclude family planning services from member communications, including EOBs and notices of adverse actions as described on page 17.

**STATE EXAMPLE – NEW YORK:** New York requires MCOs to protect minors’ confidential information related to sensitive services, such as family planning services, STI testing and treatment, mental health services, and substance use disorder treatment. For such services, historically the state required MCOs to use nonspecific explanations on EOBs, suppress EOBs for all minors, and ensure written notices were addressed only to the minor. In 2016, New York **strengthened** these adolescent confidentiality policies by requiring MCOs to suppress **all** notices of action (and not just EOBs) with regard to specified sensitive services, including family planning services. The state requires MCOs with systems that cannot control notices based on these criteria to implement alternate approaches to prevent inadvertent disclosure of confidential health information, such as suppressing all EOBs regarding **any** services provided to minors (with some exceptions). MCOs also must establish certain requirements for participating providers; for example, providers must obtain consent from the enrollee to send notices to the enrollee’s home or to an alternate address specified by the enrollee.

**Quality Improvement.** States must develop written quality strategies to assess and improve the quality of care provided by Medicaid MCOs, and in turn, states must require MCOs to implement a quality assessment and performance improvement program (QAPI).<sup>73</sup> QAPIs must include performance improvement projects (PIPs) and state-identified standard performance measures. States can establish QAPI requirements that direct MCOs' focus on particular quality initiatives and priorities, including family planning.

As described on page 35, states and MCOs should be cautious about how they use contraceptive care measures, avoiding incentives for MCOs or providers to increase the use of specific contraceptive methods without considering individual patient preferences. However, when used to identify potential barriers to enrollees accessing contraceptive care, these measures can help states and MCOs target interventions to improve contraceptive access.

**STATE EXAMPLE – ILLINOIS:** Illinois's MCO model contract requires that MCOs specify in their QAPIs—which must be approved by the state—how they will assure that women have access to contraception and postpartum care. MCOs are also required to develop guidelines with respect to monitoring the use of family planning services, preventive healthcare for enrollees (such as mammography), and postpartum family planning services such as LARC.

## Communicating and Implementing State Family Planning Policies

**OBJECTIVE:** Translate policy changes into on-the-ground practices.

Any effort to improve access to family planning services starts with reviewing state policies and procedures. As with all policy changes, disseminating information about changes will be critical to their adoption by MCOs and providers. Adoption of family planning strategies, particularly those related to LARC access, may necessitate additional efforts to train providers regarding reproductive health counseling and promoting reproductive autonomy. To ensure that policies achieve these goals, states also should consider opportunities to engage with consumer advocates.

### Partner With Provider Champions to Amplify Policy Changes

Anecdotal experience and academic literature point to the importance of “provider champions” in promoting successful adoption of and adherence to revised family planning policies and best practices.<sup>74</sup> By relying on personal relationships and their established credibility within the facility, facility-level champions can drive on-the-ground changes. In addition to clinical champions, knowledgeable and committed organizational leadership and billing department/administrative staff also can help implement and sustain operational and cultural changes within organizations.

**STATE EXAMPLE – LOUISIANA:** Louisiana made several policy changes to increase access to LARC immediately postpartum. The state’s Medicaid medical director, who also was a practicing physician, served as a provider champion to promote these policies by working closely with academic medical center faculty and the Medicaid agency to implement reimbursement policy changes. She also conducted educational sessions for residents and other attending physicians about the importance and ease of immediate postpartum LARC placement. For more information, see this [article](#) about provider champions’ efforts in Iowa and Louisiana.

### **Offer “Boots on the Ground” Provider Supports**

States may wish to offer provider supports and in-office/facility trainings to family planning providers. Effective training strategies include providers who care for patients, as well as office administrative staff who implement billing and reimbursement and office workflow changes to facilitate same-visit access to family planning services. In partnership with Planned Parenthood, the University of California San Francisco tested its “Beyond the Pill” curriculum for training clinical teams about patient education and counseling on LARC.<sup>xxi</sup> The study found that women receiving care at trained clinics were more knowledgeable about contraceptive options, more likely to choose an IUD or implant, and half as likely to have an unintended pregnancy over the following year than women receiving care at clinics without such training.<sup>75</sup> Delaware, through its statewide Delaware Contraceptive Access Now (DE CAN) project, provides statewide contraceptive care training to all Title X health centers, the largest private outpatient providers, and five of Delaware’s six hospitals.<sup>76</sup> Provider training also presents an opportunity to reinforce state policies about LARC removal so that women who wish to have LARC removed—for any reason, at any time—do not encounter resistance.

### **Provide Education on Best Practices to Promote Patient Autonomy and Choice**

Patient choice is a critical element of any strategy to increase family planning access. And, as we have discussed above, all policies should be reviewed through the lens of patient choice and autonomy. In addition, states should consider partnering with professional organizations and stakeholder groups to develop resources for providers that speak to the importance of respecting patient choices and that call out the particular sensitivities with respect to LARC insertion and removal. Appendices B and C include examples of relevant resources for states and for providers.

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<sup>xxi</sup> The clinical team included clinicians, health educators, front desk staff, clinic managers, and billing experts.

## Part II: Data Inventory

Data is an important tool for states to use in assessing their existing Medicaid family planning programs, as well as measuring progress over time. For example, because family planning coverage may not translate into access if enrollees experience nonfinancial barriers—such as a lack of nearby providers offering a full range of services—data that quantify these issues can help states to identify areas for improvement and target policy efforts accordingly. Included in this section of the toolkit are specific examples of high-value family planning data analyses that states can undertake to gather baseline and ongoing information regarding successes and challenges, with a focus on:

- Family planning providers;
- Service use and spending; and
- Pregnancies and births.

### Family Planning Providers

**OBJECTIVE:** Assess access to providers offering a full range of family planning services and supplies.

#### Measure the Number and Characteristics of Participating Providers

States can use Medicaid claims data to examine a range of provider-related issues that may affect access to family planning services. For example, while clinics are an important source of care, national data indicate that more than half (57 percent) of women on Medicaid report that their most recent gynecologic exam was at a private doctor's office.<sup>77</sup> As such, states may find it valuable to analyze the number of participating family planning providers by various characteristics, which may inform their consideration of changes in reimbursement or other policies that can differ by provider type or setting.

In addition, understanding the extent to which certain providers may be more or less likely to offer specific types of care can help to target policy efforts. For example, Texas conducted a utilization review of its 2016 data to pinpoint which hospitals and other providers were using immediate postpartum LARC, and used this information to assess the effectiveness of immediate postpartum LARC policies through discussions with providers about what is working and what is not.<sup>78</sup>

Another area of interest for states may be the extent to which providers opt to participate in both Medicaid managed care and fee-for-service networks. While enrollees are guaranteed freedom of choice to see any family planning provider willing to accept Medicaid payment, continuity and coordination of care may be a concern for those who must go out of network to see their preferred provider.



### **Examine Provider Supply in Relation to Population Need**

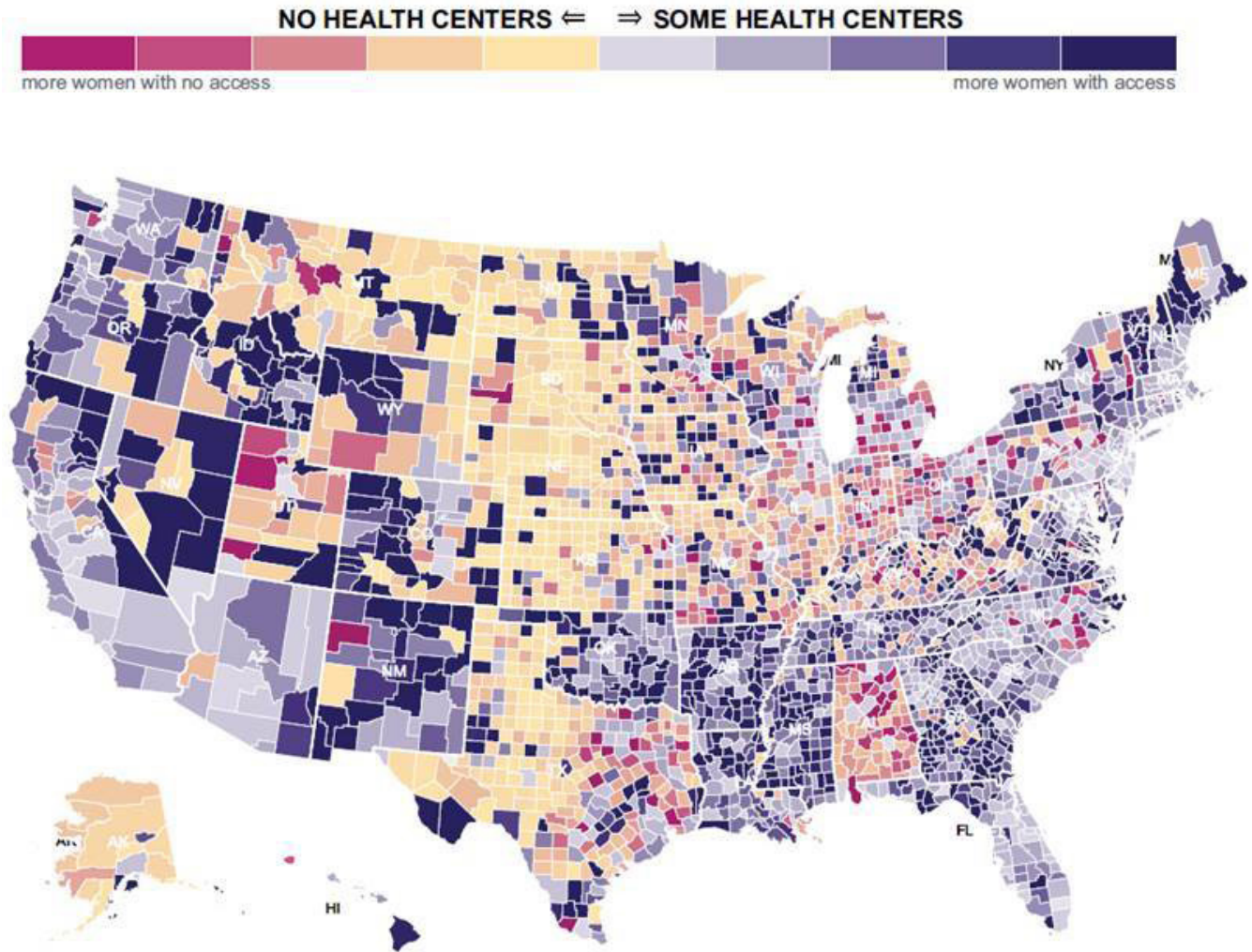
States may also find value in mapping the number of enrollees of reproductive age against the supply of Medicaid-participating providers in a given area, focusing on both enrollee and provider characteristics of interest. For example, Figure 4 demonstrates the extent to which women in need of publicly funded family planning services live in counties with clinics offering a full range of birth control methods.

Other analyses can identify areas where additional policy efforts may be warranted based on population characteristics such as teen birth rates. For example, California has developed an index that incorporates several measures and is used to determine subcounty areas most in need of adolescent pregnancy prevention resources,<sup>79</sup> including programs that partner with Medicaid family planning providers.<sup>80</sup>

### **Measure Time and Distance to Family Planning Providers**

Longer travel to family planning clinics is associated with lower utilization of Pap tests and other preventive health services,<sup>81</sup> suggesting that time and distance to receive care are important factors in assessing access. Under recent changes to federal Medicaid managed care regulations, states are required to establish time and distance standards for OB/GYNs and certain other provider types.<sup>82</sup> Although the requirement does not specifically apply to family planning providers as a separate category,<sup>83</sup> states can opt to develop benchmarks for measuring the extent to which Medicaid enrollees live in areas with an adequate family planning provider network. For example, using a 30-minute travel time threshold, a recent study found that 20 percent of North Carolina's population and 35 percent of Texas's population lacked or had poor access to the family planning services of a Title X-funded clinic.<sup>84</sup> In addition to measuring the ability to reach family planning providers offering any type of care, states may also wish to take into account the time and distance required to reach providers offering a full range of services (e.g., both oral contraceptives and LARC), given that not all are willing or able to do so.

Figure 4. Publicly Funded Clinics Offering a Full Range of Birth Control Methods, by County<sup>85</sup>



**Note:** Women in need of publicly funded contraception are defined as those who are low-income or under the age of 20. Counties in shades from yellow to dark pink have no publicly funded clinics, with the darkest reflecting those with the largest numbers of women in need. Counties in shades of purple have publicly funded clinics, with the darkest reflecting those with the highest ratios of providers to women in need.

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## Service Use and Spending

**OBJECTIVE:** Determine whether and which services are received by enrollees and how the state's resources are being invested.

### Examine Patterns of Care Among Enrollees

States can also use a range of claims-based measures to assess enrollees' receipt of care. For example, Alabama's evaluation of its Medicaid family planning Section 1115 waiver has employed several utilization monitoring metrics, including:

- Unduplicated number of enrollees with any claim by quarter (by key demographic characteristics such as age, gender, and income level);
- Utilization by primary method and age group;
- Total number of enrollees tested for any STI;
- Total number of female enrollees who obtained a cervical cancer screening; and
- Total number of female enrollees who received a clinical breast exam.

Alabama also tracks information on the use of moderately or highly effective contraceptive methods, reporting that nearly two-thirds of women in its Medicaid family planning program who used clinical services had a claim for one of these methods. While there are some differences in contraceptive claims submitted according to provider type (e.g., public versus private) and geographic residence, data indicate that women generally have access to the full range of contraceptive methods statewide. In contrast, there were notable differences in vasectomy procedure claims for men, with service use being higher in certain areas of the state.<sup>86</sup> Depending on a state's assessment of findings from its own analyses, areas of concern may be identified for further investigation.

### Use National Contraceptive Care Quality Measures

In 2016, the National Quality Forum (NQF) endorsed three contraceptive care measures that states can use to assess the degree to which women at risk of unintended pregnancy receive the most or moderately effective methods of contraception. These measures, which are typically calculated using claims data, are shown in Figure 5 below.<sup>87</sup> CMS added these contraceptive care measures to the CMS Adult and Child Core Measure Sets, which states currently can report on a voluntary basis.<sup>88</sup> States can use the national contraceptive care quality measures to assess the extent to which Medicaid enrollees are receiving contraception, identify potential barriers to contraception access, and prioritize strategies to improve access. For example, states may use these measures to identify providers with comparatively low LARC utilization rates and engage those providers to determine whether there are barriers to access preventing women who may desire LARC from receiving it in those provider settings. By targeting provider engagement in this way, states can prioritize strategies and policy solutions to promote improved access to contraception.

Importantly, national quality measures do not take into account whether an individual desired contraception and, if desired, the individual’s choice of contraceptive method—which may not be a most or moderately effective method. Setting any minimum performance standard suggests that a minimum number of women enrolled in Medicaid should be using the most or moderately effective contraception, and may create incentives for MCOs or providers to increase the use of these methods without appropriately considering individual patient preferences.<sup>xxii</sup> Indeed, the HHS Office of Population Affairs (OPA), which is responsible for maintaining the measure, indicates that a specific benchmark has **not** been set for the *Contraceptive Care – Most & Moderately Effective Methods* measure, “as some women will make informed decisions to choose methods in the lower tier of efficacy even when offered the full range of methods.” In regard to the *Contraceptive Care – Access to LARC* measure, OPA states that “the measure should **NOT** be used to encourage high rates of use, as this could lead to coercive practices related to contraception and sterilization, especially practices targeting racial/ethnic minorities and low-income individuals.”<sup>89</sup>

**Figure 5. Contraceptive Care Measures**

Measure	NQF Measure Description
NQF #2902 Contraceptive Care – Postpartum	Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1. A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2. A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.
NQF #2903 Contraceptive Care – Most & Moderately Effective Methods	The percentage of women aged 15–44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) methods of contraception.
NQF #2904 Contraceptive Care – Access to LARC	Percentage of women aged 15–44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS)).

**Note:** Different organizations treat these measures differently. For example, OPA does not treat NQF #2902 as a “composite” measure that assesses (1) use of the most or moderately effective methods of contraception **and** (2) use of LARC. Rather, OPA describes these two components as separate measures related to postpartum contraceptive care. Similarly, CMS combines NQF measures #2903 and #2904 into a single composite measure deemed “CCW-AD: Contraceptive Care – All Women.”

### Examine Provider Payment and Other Spending Issues of Interest

As noted earlier, states may wish to analyze data on provider participation in Medicaid managed care versus fee-for-service networks. To the extent that reimbursement differences are a potential concern, both fee-for-service and managed care payment levels can be examined to better understand what may be driving behavior. Additionally, if a state makes changes in reimbursement for particular provider or service types (e.g., postpartum LARC in hospital settings), it can use claims-based analyses to determine the impact on service volume and gross spending. States can also estimate net spending impacts by taking into account the potential savings from averted births that would otherwise result from unintended pregnancies;<sup>90</sup> this

<sup>xxii</sup> States may still wish to incorporate incentives for MCOs or providers to **report** these measures (e.g., via “pay for reporting” or “P4R” incentives) in lieu of incentives for a specific **performance** standard (e.g., “pay for quality” or “P4Q” incentives).

is commonly done for analyses of Medicaid family planning expansions under Section 1115 waivers, which must demonstrate that they are budget neutral to the federal government (i.e., that averted births and other savings outweigh the costs of providing coverage).

## Pregnancies and Births

**OBJECTIVE:** Understand trends in pregnancies and births that may be influenced by Medicaid family planning policies.

### Examine Measures Over Time

Ultimately, access to and use of family planning services are tied to outcomes that include pregnancies and birth—many of which are unintended and could be better timed or averted, based on the desires of women and their partners. Among the trends that states may wish to examine are the extent to which their populations have:

- Fewer unintended pregnancies;
- More timely connections to prenatal care for those who become pregnant;
- Healthier birth spacing; and
- Associated reductions in infant mortality, pre-term births, low birth weights, and other negative health outcomes.

Using data on New Jersey’s experience for illustrative purposes, measures for state tracking could include the following (see Figure 6 for data sources and additional examples):

- In New Jersey, 60 percent of the state’s women of reproductive age have a need for family planning services; of these women, more than 40 percent may be in need of publicly funded services because they are low-income or under the age of 20.<sup>xxiii</sup>
- Forty-seven percent of the state’s pregnancies are among women who wanted to be pregnant at a later date or not at all, while 28 percent of births are from these unintended pregnancies.
- The statewide teen birth rate is 10 per 1,000 population of females age 15–19, but county rates vary more than tenfold.<sup>91</sup>

Monitoring trends can help states understand the extent to which progress is being made. In New Jersey, for example, survey data indicate that the percentage of births from unintended pregnancies remained at or above 45 percent between 2012 and 2015 for women with prenatal Medicaid coverage, but decreased to 40 percent in 2016.<sup>92</sup> (In comparison, the 2016 figure for women with private coverage was 17 percent.) Ongoing tracking can reveal whether the decrease for this population is an anomaly or a true change in trajectory—particularly as the state is seeking to expand its eligibility for Medicaid family planning services.

<sup>xxiii</sup> While other criteria may be used, this definition of need for publicly funded care is commonly cited.

In Florida, the state is using Medicaid claims and eligibility information along with vital statistics birth certificate data to examine whether its family planning waiver has an impact on birth spacing.<sup>93</sup> Based on nationwide data, one recent analysis found that women living in states with family planning waivers were 10 percent less likely to have very short inter-pregnancy intervals (i.e., less than six months between a birth and subsequent pregnancy) compared to women in states without waivers,<sup>94</sup> an important finding in light of the negative health and other consequences of closely spaced births.

**Figure 6. Selected Contraceptive, Pregnancy, and Birth Measures, Using New Jersey Data for Illustrative Purposes**

Measure	Number	Percent or rate for specified population	
<b>Need for contraceptives</b>			
Women age 13–44	1,837,310		
In need of contraceptive services and supplies*	1,106,480	60%	of women age 13–44
In need of publicly supported**	455,260	41%	of those in need
Under age 20	114,120	25%	of those in need of publicly supported
Age 20+ and income < 250% FPL	341,140	75%	of those in need of publicly supported
<b>Use of contraceptives</b>			
Using contraception		72%	of women age 18–49 at risk of unintended pregnancy***
Relying on female sterilization		11%	of women age 18–49 at risk of unintended pregnancy***
Relying on male sterilization		2%	of women age 18–49 at risk of unintended pregnancy***
Relying on the contraceptive implant		3%	of women age 18–49 at risk of unintended pregnancy***
Relying on the IUD		8%	of women age 18–49 at risk of unintended pregnancy***
Relying on the pill		17%	of women age 18–49 at risk of unintended pregnancy***
Relying on other non-LARC hormonal methods		2%	of women age 18–49 at risk of unintended pregnancy***
Relying on condoms		24%	of women age 18–49 at risk of unintended pregnancy***
Relying on withdrawal		—	Estimate is statistically unreliable
Relying on other methods of contraception		4%	of women age 18–49 at risk of unintended pregnancy***
<b>Pregnancies and births by pregnancy desire/intention</b>			
Women age 15–44	1,724,147		
With pregnancies	169,690	10%	of women age 15–44
Wanted at time of pregnancy or sooner	73,691	43%	of pregnancies
Wanted later or unwanted	79,030	47%	of pregnancies
Ended in birth	27,661	35%	of pregnancies wanted later or unwanted
Ended in abortion	41,886	53%	of pregnancies wanted later or unwanted
Ended in fetal loss	9,484	12%	of pregnancies wanted later or unwanted
Wasn't sure about wanting	16,969	10%	of pregnancies
With births	101,081	60%	of pregnancies
Wanted at time of pregnancy or sooner	60,649	60%	of births
Wanted later or unwanted	27,292	27%	of births
Later	21,015	21%	of births
Unwanted	6,277	6%	of births
Wasn't sure about wanting	13,141	13%	of births
Women with births from unintended pregnancies		28%	of births
Received late or no prenatal care		22%	of births from unintended pregnancies
Used no prevention methods at conception		51%	of births from unintended pregnancies
Using pregnancy prevention method postpartum		73%	of births from unintended pregnancies
<b>Pregnancies and births among teens</b>			
Pregnancy rate among women age 15–19		36	per 1,000 women age 15–19
Birth rate among women age 15–19		10	per 1,000 women age 15–19
Births to women age 15–19	2,837		

**Notes:** Figures are for varying years from 2013 to 2017, and generally reflect Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring Surveillance System (PRAMS), or vital statistics data. See source references for details.

\* Those who are sexually active and able but do not wish to become pregnant.

\*\* Those who are in need of contraceptive services and supplies, and are either under age 20 or age 20+ with income at or below 250 percent of the FPL.

\*\*\* Those who are currently sexually active and able but do not wish to become pregnant.

**Source:** Manatt Health compilation.<sup>95</sup>

## Appendix A: Relevant Federal Statutes, Regulations, and Guidance

Resource	Description
<b>Statutes</b>	
<b>Title X Family Planning Program</b>	
<b>Public Health Service Act (PHSA), Title X 42 USC §§ 300 to 300a-6</b>	<ul style="list-style-type: none"> <li>Establishes the Title X Family Planning Program</li> <li>Authorizes federal grants to support the provision of voluntary family planning services at little or no cost to low-income individuals</li> <li>Specifies that grantees may provide family planning services directly or sub-award funding to public or nonprofit entities</li> <li>Prohibits the allocation of grant funds to programs where abortion is a family planning method</li> </ul>
<b>Medicaid and Family Planning</b>	
<b>Social Security Act (SSA) § 1902(a)(23)(B)</b>	<ul style="list-style-type: none"> <li>Gives Medicaid enrollees the right to obtain medical services from any qualified provider of their choice (often called the “free choice of provider” or “freedom of choice” requirement)</li> </ul>
<b>SSA § 1903(a)(5)</b>	<ul style="list-style-type: none"> <li>Establishes a 90 percent FMAP for family planning services and supplies in Medicaid</li> </ul>
<b>SSA § 1905(a)(4)(C)</b>	<ul style="list-style-type: none"> <li>Requires that Medicaid programs cover family planning services and supplies</li> </ul>
<b>SSA § 1916(a)(2)(D)</b>	<ul style="list-style-type: none"> <li>Exempts family planning services and supplies from cost-sharing</li> </ul>
<b>Optional Family Planning Eligibility Group</b>	
<b>SSA § 1902(a)(10)(A)(ii)(XXI)</b>	<ul style="list-style-type: none"> <li>Establishes an optional Medicaid eligibility group for the provision of family planning services</li> </ul>
<b>SSA § 1902(ii)</b>	<ul style="list-style-type: none"> <li>Defines eligibility conditions for the optional family planning group (individuals of any age who are not pregnant and who have incomes no more than the limit established by the state for pregnant women under Titles XIX or XXI)</li> </ul>
<b>SSA § 1902(a)(10)(G)(XVI)</b>	<ul style="list-style-type: none"> <li>Limits benefits under this option to family planning services and supplies and related medical diagnosis and treatment services</li> </ul>
<b>SSA § 1920C</b>	<ul style="list-style-type: none"> <li>Authorizes states that adopt the family planning eligibility option to provide coverage (at state option) to individuals during a PE period</li> </ul>
<b>Family Planning Services Through the Medicaid Expansion</b>	
<b>SSA § 1902(k)</b>	<ul style="list-style-type: none"> <li>Requires Medicaid to provide benchmark or benchmark-equivalent coverage to enrollees in state Medicaid expansion programs</li> </ul>
<b>SSA § 1937(b)(5)</b>	<ul style="list-style-type: none"> <li>Requires Medicaid benchmark or benchmark-equivalent plans to provide the 10 EHBs required under the ACA § 1302 (42 USC § 18022), including all contraceptive methods approved by the FDA</li> </ul>
<b>SSA § 1937(b)(7)</b>	<ul style="list-style-type: none"> <li>Expressly requires inclusion of family planning services and supplies in benchmark and benchmark-equivalent plans for expansion enrollees</li> </ul>
<b>Other Relevant Provisions</b>	
<b>42 USC § 18022</b>	<ul style="list-style-type: none"> <li>Establishes the benefits that must be covered as part of an EHB package, such as preventive health services</li> </ul>

Resource	Description
<b>PHSA § 2713(a)(4) (42 USC § 300gg-13)</b>	<ul style="list-style-type: none"> <li>Defines preventive services in the EHB category for non-grandfathered group health plans and individual health plans as including services identified by the Health Resources and Services Administration (HRSA)</li> <li>HRSA <a href="#">guidelines</a> recommend access to all FDA-approved contraceptive methods, effective family planning practices, sterilization procedures, and care that includes contraceptive counseling, initiation of contraceptive use, and follow-up care</li> </ul>
<b>Third Party Liability</b>	
<b>SSA § 1902(a)(25)</b>	<ul style="list-style-type: none"> <li>Requires Medicaid agencies to take all reasonable measures to ascertain the legal liability of third parties for healthcare services delivered to Medicaid enrollees</li> </ul>
<b>SSA § 1912(a)(1)(C)</b>	<ul style="list-style-type: none"> <li>Establishes an exception to Medicaid third party liability requirements with respect to individuals who have good cause for refusing to cooperate with the state in identifying and pursuing liable third parties</li> <li>The state Medicaid agency determines good causes based on an assessment of the best interests of the individuals involved</li> </ul>
<b>Rules and Regulations</b>	
<b>Title X Family Planning Program</b>	
<b>42 CFR Part 59, Subparts A and C</b>	<ul style="list-style-type: none"> <li>Under Subpart A, establishes requirements for receiving funds to support family planning services through the Title X grant program</li> <li>Under Subpart C, establishes requirements for receiving funds to support family planning-related training through the Title X grant program</li> <li>On March 4, 2019, HHS published a <a href="#">final rule</a> substantially changing these rules by, among other things, prohibiting Title X projects from referring patients for abortion services and requiring grantees to separate Title X projects physically and financially from any abortion-related activities funded by non-Title X dollars. As of May 2019, the revised rules have not been implemented due to pending legal challenges</li> </ul>
<b>Family Planning in Medicaid</b>	
<b>42 CFR § 431.51</b>	<ul style="list-style-type: none"> <li>Implements the free choice of provider guarantee to require that enrollees be permitted to obtain services from any qualified Medicaid provider willing to provide those services</li> <li>Extends this right to enrollees in Medicaid fee-for-service or managed care coverage (with certain limitations permitted for MCOs)</li> </ul>
<b>42 CFR § 433.32</b>	<ul style="list-style-type: none"> <li>Sets forth federal financial participation rates for certain services under Medicaid, including family planning services (90 percent)</li> </ul>
<b>42 CFR § 435.214</b>	<ul style="list-style-type: none"> <li>Implements the optional Medicaid family planning eligibility group</li> </ul>
<b>42 CFR § 435.603(k)</b>	<ul style="list-style-type: none"> <li>Specifies permitted methods for calculating income for the optional Medicaid family planning eligibility group</li> </ul>
<b>42 CFR §§ 435.1100-1110</b>	<ul style="list-style-type: none"> <li>Implements and sets forth requirements for PE programs</li> </ul>
<b>42 CFR § 440.210(a)(2)</b>	<ul style="list-style-type: none"> <li>Includes family planning services in the definition of pregnancy-related services, which are required for categorically needy enrollees</li> </ul>
<b>42 CFR § 440.250(c)</b>	<ul style="list-style-type: none"> <li>Limits family planning services and supplies to enrollees of childbearing age, including minors who can be considered sexually active and who desire such services and supplies</li> </ul>
<b>42 CFR § 441.20</b>	<ul style="list-style-type: none"> <li>Requires state plans to ensure that each enrollee is free to choose a family planning method without coercion or pressure</li> </ul>
<b>42 CFR § 447.56(a)(2)(ii)</b>	<ul style="list-style-type: none"> <li>Forbids states from imposing cost-sharing on enrollees for Medicaid family planning services and supplies</li> </ul>



Resource	Description
<b>Family Planning Services Through the Medicaid Expansion</b>	
42 CFR § 440.330	<ul style="list-style-type: none"> <li>• Outlines requirements for benchmark health coverage</li> </ul>
42 CFR § 440.335(b)(6)	<ul style="list-style-type: none"> <li>• Requires benchmark-equivalent health coverage to include family planning services and supplies and other appropriate preventive services</li> </ul>
42 CFR § 440.345(b)	<ul style="list-style-type: none"> <li>• Requires ABPs available to Medicaid expansion enrollees to include coverage for family planning services and supplies</li> </ul>
42 CFR § 440.347(a)(9)	<ul style="list-style-type: none"> <li>• Requires EHBs to include coverage of preventive services</li> </ul>
<b>Third Party Liability</b>	
42 CFR § 433.145-147	<ul style="list-style-type: none"> <li>• Provides that a Medicaid applicant may establish good cause for not cooperating with otherwise applicable TPL rules</li> </ul>
<b>Family Planning in Medicaid Managed Care</b>	
42 CFR § 438.10(g)(2)(vii)	<ul style="list-style-type: none"> <li>• Requires MCOs to inform enrollees that they may seek out-of-network family services and supplies pursuant to their “free choice of provider” right</li> </ul>
42 CFR § 438.12(a)	<ul style="list-style-type: none"> <li>• Prohibits plans from discriminating in the participation, reimbursement, or indemnification of providers acting within the scope of their license under applicable state law</li> </ul>
42 CFR § 438.108	<ul style="list-style-type: none"> <li>• Forbids states from imposing cost-sharing on enrollees for Medicaid family planning services and supplies</li> </ul>
42 CFR § 438.206(b)(7)	<ul style="list-style-type: none"> <li>• Requires states to ensure that MCO networks include sufficient family planning providers to ensure timely access to services</li> </ul>
42 CFR § 438.210(a)(4)	<ul style="list-style-type: none"> <li>• Permits MCOs to place appropriate limits on services, with special family planning protections</li> <li>• For family planning services, requires contracts between MCOs and states to ensure that enrollees are free from coercion and able to choose their method of family planning</li> </ul>
42 CFR § 438.68	<ul style="list-style-type: none"> <li>• Directs states to develop and enforce network adequacy standards, including for OB/GYNs</li> </ul>
<b>Sub-Regulatory Guidance</b>	
<p><b>Rescinding SMD #16-005 Clarifying “Free Choice of Provider” Requirement</b></p> <p>State Medicaid Director Letter (SMDL) #18-003</p> <p>January 19, 2018</p> <p><a href="#">Link</a></p>	<ul style="list-style-type: none"> <li>• Rescinds SMDL #16-005, citing concerns that prior guidance about the Medicaid “free choice of provider requirement” ran afoul of the Administrative Procedure Act</li> <li>• Refers states to SSA § 1902(a)(23) and 42 CFR § 431.51 for guidance</li> </ul>
<p><b>Medicaid Family Planning Services and Supplies</b></p> <p>Centers for Medicaid &amp; CHIP Services (CMCS) Frequently Asked Questions</p> <p>January 11, 2017</p> <p><a href="#">Link</a></p>	<ul style="list-style-type: none"> <li>• Classifies the treatment of STIs as a family planning-related service eligible for a state’s regular FMAP rate</li> <li>• Clarifies that states are responsible for developing family planning billing codes</li> <li>• Reinforces the importance of complying with informed consent requirements prior to performing a postpartum sterilization</li> <li>• Reiterates the right of enrollees to choose their family planning methods—including LARC—free of coercion or mental pressure</li> <li>• Clarifies how providers should approach dually eligible individuals seeking LARC</li> </ul>

Resource	Description
<p><b>Medicaid Family Planning Services and Supplies</b></p> <p>State Health Official Letter #16-008</p> <p>June 14, 2016</p> <p><a href="#">Link</a></p>	<ul style="list-style-type: none"> <li>• Provides guidance about family planning services provided under fee-for-service and managed care delivery systems</li> <li>• Defines family planning-related services as including, but not being limited to, the treatment of medical conditions routinely diagnosed during a family planning visit, such as treatment for urinary tract infections or STIs; preventive services routinely provided during a family planning visit, such as the human papillomavirus vaccine; or treatment of a major medical complication resulting from a family planning visit</li> <li>• Explains that, as part of the preventive services category of EHBs, ABPs must cover all FDA-approved methods of contraception</li> <li>• Asserts that enrollees' freedom of choice in family planning method cannot be limited by medical necessity or utilization control criteria set by states or MCOs</li> <li>• Clarifies that family planning services and supplies delivered during a medical visit will still be covered at the enhanced 90 percent FMAP</li> <li>• Clarifies that certain confidentiality protections apply to individuals seeking family planning services</li> <li>• Describes strategies to improve access to LARC, and assesses models of covering LARC through state pharmacy or medical benefits; calls for Section 1115 demonstrations and state ideas in this area</li> <li>• Clarifies policies regarding sterilization and delivery</li> </ul>
<p><b>Clarifying "Free Choice of Provider" Requirement in Conjunction with State Authority to Take Action against Medicaid Providers</b></p> <p>SMDL #16-005</p> <p>April 19, 2016</p> <p><a href="#">Link</a></p>	<ul style="list-style-type: none"> <li>• Provides guidance on compliance with the free choice of provider provisions in SSA § 1902(a)(23)—<b>rescinded by SMDL #18-003 (described above)</b></li> </ul>
<p><b>State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception</b></p> <p>CMCS Informational Bulletin</p> <p>April 8, 2016</p> <p><a href="#">Link</a></p>	<ul style="list-style-type: none"> <li>• Provides an overview of Medicaid payment strategies to improve access to LARC in 14 states</li> <li>• Profiles the strategies that three states—Illinois, Louisiana, and South Carolina—have pursued</li> </ul>
<p><b>Family Planning and Family Planning Related Services Clarification</b></p> <p>SMDL #14-003</p> <p>April 16, 2014</p> <p><a href="#">Link</a></p>	<ul style="list-style-type: none"> <li>• Clarifies the definition of family planning-related services to always include the diagnosis and treatment of an STI</li> <li>• Clarifies family planning services for men, noting that a visit for contraceptive counseling for men should be considered a family planning visit, not family planning-related</li> </ul>
<p><b>Family Planning Services Option and New Benefit Rules for Benchmark Plans</b></p> <p>SMDL #10-013</p> <p>July 2, 2010</p> <p><a href="#">Link</a></p>	<ul style="list-style-type: none"> <li>• Provides guidance on the new family planning eligibility group established by Section 2303 of the ACA, including information on benefits and PE</li> <li>• Defines family planning-related services</li> <li>• Describes the actions that states can take to convert existing Section 1115 family planning waivers to SPAs</li> </ul>

Resource	Description
<p><b>Implementation Guide: Medicaid State Plan Eligibility, Eligibility Groups – Options for Coverage, Individuals Eligible for Family Planning Services</b></p> <p>Medicaid SPA Processing Tools for States – Eligibility and Administration SPA Tools</p> <p>IG – S59</p> <p><a href="#">Link</a></p>	<ul style="list-style-type: none"> <li>• Provides guidance on the flexibilities states have when setting eligibility requirements for a family planning program</li> <li>• Specifies that individuals found to be ineligible for full-scope Medicaid cannot be required to complete a new application to be evaluated for the family planning program; individuals may be given the option to opt out of being considered for family planning coverage</li> <li>• Provides guidance on assembling and processing a SPA on the Medicaid and CHIP Program System</li> </ul>
<p><b>2019 Core Set of Adult Health Care Quality Measures; 2019 Core Set of Children’s Health Care Quality Measures</b></p> <p><a href="#">Link</a> to 2019 Adult Core Set</p> <p><a href="#">Link</a> to 2019 Child Core Set</p>	<ul style="list-style-type: none"> <li>• CMS annually updates two “core sets” of quality measures that states voluntarily report to CMS, one of which is the list of measures for adults and one of which is the list of measures for children</li> <li>• The 2019 Adult and Child Core Sets include measures related to several aspects of care, including contraception and prenatal and postnatal care delivery</li> </ul>

## Appendix B: State Resources

### General

- Association of State and Territorial Health Officials:
  - Increasing Access to Contraception Learning Community; information is available at: <http://www.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception/Learning-Community-Background/>, and a compilation of resources from states and partners is available at: <http://www.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception-Resources-from-States-Partners-and-ASTHO/>
  - (The Association of State and Territorial Health Officials also facilitated a LARC Immediately Postpartum Learning Community, linked under “Long-Acting Reversible Contraceptives” below)
- Power to Decide:
  - “Better Birth Control Framework,” September 2018, available at: [https://powertodecide.org/system/files/resources/primary-download/Better%20Birth%20Control\\_Framework\\_9-14-18.pdf](https://powertodecide.org/system/files/resources/primary-download/Better%20Birth%20Control_Framework_9-14-18.pdf)
  - “Key State Policies at a Glance,” January 2019, available at: <https://powertodecide.org/system/files/resources/primary-download/Key%20State%20Policies%20at%20a%20Glance.pdf>
  - “State Policies to Increase Information About and Access to Contraception,” July 2018, available at: <https://powertodecide.org/system/files/resources/primary-download/State%20Policies%20to%20Increase%20Information%20About%20and%20Access%20to%20Contraception.pdf>
- National Health Law Program:
  - “Contraceptive Equity in Action: A Toolkit for State Implementation,” March 2019, available at: <https://healthlaw.org/resource/contraceptive-equity-in-action-a-toolkit-for-state-implementation/>
  - “Model Contraceptive Equity Act: Legislative Language and Issue Brief,” January 2019, available at: <https://healthlaw.org/resource/model-contraceptive-equity-act-legislative-language-and-issue-brief/>
- Centers for Disease Control and Prevention 6|18 Initiative, “Prevent Unintended Pregnancy,” available at: <https://www.cdc.gov/sixteen/pregnancy/index.htm>

Federal statutes, regulations, and guidance are described in [Appendix A](#).

### Patient Choice and Autonomy

- Guttmacher Institute, “Guarding Against Coercion While Ensuring Access: A Delicate Balance,” 2014, available at: <https://www.guttmacher.org/gpr/2014/09/guarding-against-coercion-while-ensuring-access-delicate-balance>

- National Health Law Program, “Fact Sheet: Medicaid & Reproductive Justice,” available at: [https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/08/Joint-NHeLP\\_Medicaid-and-RJ.pdf](https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/08/Joint-NHeLP_Medicaid-and-RJ.pdf)
- Sister Song, “What is Reproductive Justice?,” available at: <https://www.sistersong.net/reproductive-justice>
- Black Mamas Matter Alliance, “Setting the Standard for Holistic Care of and for Black Women,” available at: [http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA\\_BlackPaper\\_April-2018.pdf](http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf)

## Confidentiality

- National Family Planning & Reproductive Health Association, “Protecting Patients’ Privacy in Health Insurance Billing & Claims: A Perspective from Six States,” available at: [https://www.nationalfamilyplanning.org/file/confidential--covered/State-Profiles-Overview\\_CC-1.pdf](https://www.nationalfamilyplanning.org/file/confidential--covered/State-Profiles-Overview_CC-1.pdf)
- Association of State and Territorial Health Officials, “State Efforts to Protect Confidentiality for Insured Individuals Accessing Contraception and Other Sensitive Healthcare Services,” available at: <http://www.astho.org/MCH/State-Efforts-to-Protect-Confidentiality-for-Insured-Individuals-Accessing-Contraception/>
- Guttmacher Institute, “Protecting Confidentiality for Individuals Insured as Dependents,” March 2019, available at: <https://www.guttmacher.org/state-policy/explore/protecting-confidentiality-individuals-insured-dependents>

## Long-Acting Reversible Contraceptives

- Association of State and Territorial Health Officials:
  - LARC Immediately Postpartum Learning Community (2014–2016); information is available at: <http://www.astho.org/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception/LARC-Immediately-Postpartum-Learning-Community-Background/>
  - “LARC Fact Sheet,” available at: <http://www.astho.org/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception/LARC-Fact-Sheet/>
  - “Obtaining and Managing Private Funding for Long-Acting Reversible Contraception Programs,” available at: <http://www.astho.org/Maternal-and-Child-Health/Best-Practices-for-Obtaining-and-Managing-Private-Funding-for-LARC-Programs/>
  - “Medicaid Policies, Codes, and Guidance,” available at: <http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Medicaid-Policies/>
  - “Strategies for Effective Patient Outreach on Long-Acting Reversible Contraception,” available at: <http://www.astho.org/Maternal-and-Child-Health/LARC-and-Patient-Outreach-Fact-Sheet/>
- George Washington University, Jacobs Institute of Women’s Health, *Bridging the Divide*:
  - “Long-Acting Reversible Contraception (LARC): State-Level and Regional Research on Reducing Barriers to Access,” available at: [https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/LARC\\_State\\_Research.pdf](https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/LARC_State_Research.pdf)

- “Long-Acting Reversible Contraception: Overview of Research & Policy in the United States,” available at: [https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/LARC\\_White\\_Paper\\_2016\\_1\\_0.pdf](https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/LARC_White_Paper_2016_1_0.pdf)
- “Access to Removal of Long-Acting Reversible Contraceptive Methods Is an Essential Component of High-Quality Contraceptive Care,” April 2017, available at: [https://www.whijournal.com/article/S1049-3867\(17\)30072-5/pdf](https://www.whijournal.com/article/S1049-3867(17)30072-5/pdf)
- Sister Song and the National Women’s Health Network “Joint Statement of Principles on LARC,” available at: <https://www.nwhn.org/nwhn-joins-statement-principles-larcs/>

## Provider Training/Education

- Association of State and Territorial Health Officials:
  - “Recommendations to Address Healthcare Providers’ Needs for Postpartum LARC Training,” available at: <http://www.astho.org/Maternal-and-Child-Health/Recommendations-to-Address-Healthcare-Providers-Needs-for-Postpartum-LARC-Training/>
  - “Guidance for Developing a Toolkit on Immediate Postpartum Long-Acting Reversible Contraception,” available at: <http://www.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception/Guidance-for-Developing-a-Toolkit-on-Immediate-Postpartum-LARC/>

## Appendix C: Provider Resources

### General

- Centers for Disease Control and Prevention, “Contraceptive Guidance for Health Care Providers,” available at: [https://www.cdc.gov/reproductivehealth/contraception/contraception\\_guidance.htm](https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm)
- National Coalition for Sexual Health, “Sexual Health and Your Patients: A Provider’s Guide,” available at: <https://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/document/ProviderGuide.pdf>
- Family Planning National Training Center
  - “Same-Visit Contraception: A Toolkit for Family Planning Providers,” available at: <https://www.fpntc.org/resources/same-visit-contraception-toolkit-family-planning-providers>
  - “Family Planning and Related Preventive Health Services Checklist,” available at: [https://www.fpntc.org/sites/default/files/resources/fpntc\\_fp\\_prvhlth\\_checklist.pdf](https://www.fpntc.org/sites/default/files/resources/fpntc_fp_prvhlth_checklist.pdf)
  - “Clinical Pathway for Family Planning Services for Women and Men of Reproductive Age,” available at: [https://www.fpntc.org/sites/default/files/resources/fpntc\\_clinical%20pathway2015.pdf](https://www.fpntc.org/sites/default/files/resources/fpntc_clinical%20pathway2015.pdf)
- National Health Law Program, “Contraceptive Equity in Action: A Toolkit for State Implementation” is available at <https://healthlaw.org/resource/contraceptive-equity-in-action-a-toolkit-for-state-implementation/> and includes a chapter specific to providers
- National Association of Community Health Centers, “Advancing Quality Family Planning Practices: A Guide for Health Centers,” available at: [http://www.nachc.org/wp-content/uploads/2017/06/NACHC\\_FPBooklet\\_FINAL-WEB-06-05-17.pdf](http://www.nachc.org/wp-content/uploads/2017/06/NACHC_FPBooklet_FINAL-WEB-06-05-17.pdf)
- Beyond the Pill and University of California San Francisco online training, available at: <https://beyondthepill.ucsf.edu/online-training>

### Confidentiality

- Confidential and Covered was a three-year research project funded by the U.S. Department of Health and Human Services’ Office of Population Affairs, designed to support Title X family planning providers’ ability to offer care that is confidential and receive payment without breaching privacy. More information is available at: <https://www.confidentialandcovered.com/>

### Contraceptive Counseling

- UptoDate, “Contraceptive Counseling and Selection for Women,” available at: <https://www.uptodate.com/contents/contraceptive-counseling-and-selection-for-women>
- American College of Obstetricians and Gynecologists, “Contraceptive Counseling Resource Digest,” available at: <https://www.acog.org/-/media/Departments/LARC/Contraceptive-Counseling-Replaceable.pdf?dmc=1&ts=20190306T2126139689>

- Family Planning National Training Center:
  - “Contraceptive Counseling Process Guide,” available at: [https://www.fpntc.org/sites/default/files/resources/fpntc\\_cc\\_counsel\\_guide2016.pdf](https://www.fpntc.org/sites/default/files/resources/fpntc_cc_counsel_guide2016.pdf)
  - “Providing Quality Contraceptive Counseling and Education: A Toolkit for Training Staff,” available at: <http://www.cardeaservices.org/resourcecenter/providing-quality-contraceptive-counseling-education-a-toolkit-for-training-staff>

## Long-Acting Reversible Contraceptives

- Sister Song and the National Women’s Health Network “Joint Statement of Principles on LARC,” available at: <https://www.nwhn.org/nwhn-joins-statement-principles-larcs/>
- Association of State and Territorial Health Officials:
  - “Medicaid Policies, Codes, and Guidance,” available at: <http://www.astho.org/Programs/Maternal-and-Child-Health/LOng-Acting-Reversible-Contraception-LARC/Medicaid-Policies/>
  - “Provider Education Resources,” available at: <http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Provider-Education/>



- <sup>1</sup> Kinsey Hasstedt, Adam Sonfield, and Rachel Benson Gold, *Public Funding for Family Planning and Abortion Services, FY 1980–2015* (New York: Guttmacher Institute, April 2017), [https://www.guttmacher.org/sites/default/files/report\\_pdf/public-funding-family-planning-abortion-services-fy-1980-2015.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-family-planning-abortion-services-fy-1980-2015.pdf).
- <sup>2</sup> “Healthy People 2020 Family Planning Overview,” Office of Disease Prevention and Health Promotion, Healthy People, <https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning>.
- <sup>3</sup> Megan L. Kavanaugh and Ragnar M. Anderson, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers* (New York: Guttmacher Institute, July 2013), [https://www.guttmacher.org/sites/default/files/report\\_pdf/health-benefits.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/health-benefits.pdf).
- <sup>4</sup> J.J. Frost and L. Lindberg, “Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics,” *Contraception* 87, no. 4 (April 2013): 465–472, <https://www.ncbi.nlm.nih.gov/pubmed/23021011>.
- <sup>5</sup> Jennifer J. Frost, *U.S. Women’s Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010* (New York: Guttmacher Institute, May 2013), [https://www.guttmacher.org/sites/default/files/report\\_pdf/sources-of-care-2013.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/sources-of-care-2013.pdf).
- <sup>6</sup> Adam Sonfield, “Why Family Planning Policy and Practice Must Guarantee a True Choice of Contraceptive Methods,” *Guttmacher Policy Review* 20 (October 2017): 103–107, [https://www.guttmacher.org/sites/default/files/article\\_files/gpr2010317.pdf](https://www.guttmacher.org/sites/default/files/article_files/gpr2010317.pdf).
- <sup>7</sup> A. Jackson, D. Karasek, C. Dehlendorf, and D. Greene Foster, “Racial and Ethnic Differences in Women’s Preferences for Features of Contraceptive Methods,” *Contraception* 93, no. 5 (May 2016): 406–411, [https://www.contraceptionjournal.org/article/S0010-7824\(15\)30046-9/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(15)30046-9/fulltext).
- <sup>8</sup> “Effectiveness of Family Planning Methods,” Centers for Disease Control and Prevention, [https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive\\_methods\\_508.pdf](https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf).
- <sup>9</sup> Anu Manchikanti Gomez, Emily S. Mann, and Vanessa Torres, “‘It would have control over me instead of me having control’: Intrauterine Devices and the Meaning of Reproductive Freedom,” *Critical Public Health* 28, no. 2 (2018): 190–200, <https://www.tandfonline.com/doi/full/10.1080/09581596.2017.1343935?scroll=top&needAccess=true>.
- <sup>10</sup> A. Jackson, D. Karasek, C. Dehlendorf, and D. Greene Foster, “Racial and Ethnic Differences in Women’s Preferences for Features of Contraceptive Methods,” *Contraception* 93, no. 5 (May 2016): 406–411, [https://www.contraceptionjournal.org/article/S0010-7824\(15\)30046-9/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(15)30046-9/fulltext).
- <sup>11</sup> An Act to Create a Contraception Incentive for Medicaid Beneficiaries; and for Other Purposes, AR-HR 1868, 90th General Assembly (2015), <ftp://www.arkleg.state.ar.us/Bills/2015/Public/HB1868.pdf>; Marci Manley, “Bill Considers Contraception Incentive for Unwed Mothers Receiving Medicaid,” KARK.com, March 2015, <https://www.kark.com/news/bill-considers-contraception-incentive-for-unwed-mothers-receiving-medicaid/164057553>.
- <sup>12</sup> Rachel Benson Gold, “Guarding Against Coercion While Ensuring Access: A Delicate Balance,” *Guttmacher Policy Review* 17, no. 3 (2014): 8–14, [https://www.guttmacher.org/sites/default/files/article\\_files/gpr170308.pdf](https://www.guttmacher.org/sites/default/files/article_files/gpr170308.pdf).
- <sup>13</sup> C. Dehlendorf, R. Ruskin, K. Grumbach, E. Vittinghoff, K. Bibbins-Domingo, D. Schillinger, and J. Steinauer, “Recommendations for Intrauterine Contraception: a Randomized Trial of the Effects of Patients’ Race/Ethnicity and Socioeconomic Status,” *American Journal of Obstetrics & Gynecology* 203, no. 4 (October 2010): 319.e1–319.e8, [https://www.ajog.org/article/S0002-9378\(10\)00578-8/fulltext](https://www.ajog.org/article/S0002-9378(10)00578-8/fulltext).
- <sup>14</sup> Jenny A. Higgins, Renee D. Kramer, and Kristin M. Ryder, “Provider Bias in Long-Acting Reversible Contraception (LARC) Promotion and Removal: Perceptions of Young Women,” *American Journal of Public Health* 106, no. 11 (November 2016): 1932–1937, <https://ajph.aphapublications.org/doi/10.2105/AJPH.2016.303393>.
- <sup>15</sup> L.M. Yee and M.A. Simon, “Perceptions of Coercion, Discrimination, and Other Negative Experiences in Postpartum Contraceptive Counseling for Low-Income Minority Women,” *Journal of Health Care for the Poor and Underserved* 22, no. 4 (November 2011): 1387–1400, <https://www.ncbi.nlm.nih.gov/pubmed/22080717>.
- <sup>16</sup> A.M. Gomez and M. Wapman, “Under (Implicit) Pressure: Young Black and Latina Women’s Perceptions of Contraceptive Care,” *Contraception* 96, no. 4 (October 2017): 221–226, <https://www.ncbi.nlm.nih.gov/pubmed/28756187>.

<sup>17</sup> SSA § 1905(a)(4)(C).

<sup>18</sup> “Fewer U.S. women of reproductive age were uninsured in 2017 than in 2013,” Guttmacher Institute, December 2018, <https://www.guttmacher.org/infographic/2018/fewer-us-women-reproductive-age-were-uninsured-2017-2013>. The Kaiser Family Foundation has found that approximately one in five women has postponed preventive care, skipped a recommended test or treatment, or missed or cut a prescription dose due to out-of-pocket costs. See also: Usha Ranji, Caroline Rosenzweig, and Alina Salganicoff, *Women’s Coverage, Access, and Affordability: Key Findings from the 2017 Kaiser Women’s Health Survey* (Kaiser Family Foundation, March 2018), <http://files.kff.org/attachment/Issue-Brief-Womens-Coverage-Access-and-Affordability-Key-Findings-from-the-2017-Kaiser-Womens-Health-Survey>.

<sup>19</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2303, 124 Stat. 119, 293–296 (2010) (codified at SSA § 1902(a)(A)(ii) (XXI) and 1902(ii)). See also: Usha Ranji, Yali Bai, and Alina Salganicoff, *Medicaid and Family Planning: Background and Implications of the ACA* (Kaiser Family Foundation, February 2016), <https://www.kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy>.

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