DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

CMCS Informational Bulletin

DATE: August 8, 2024

FROM: Daniel Tsai, Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: Medicaid Family Planning Services and Supplies: Requirements and Best Practices

The Center for Medicaid and the Children's Health Insurance Program (CHIP) Services (CMCS) at the Centers for Medicare & Medicaid Services (CMS) is issuing this CMCS Informational Bulletin (CIB) to summarize state obligations related to Medicaid coverage of family planning services and supplies and state options for helping to ensure timely access to these services. Specifically, this CIB provides states with guidance on requirements for the coverage of family planning services and supplies, strategies to reduce barriers and increase access to contraception, confidentiality protections for those seeking family planning services and supplies, and information on quality measures.

Together, Medicaid and CHIP are the largest health coverage programs in the country. A critical piece of this health coverage is equitable access to quality family planning services and supplies. Ensuring access to contraception is especially important in the wake of the Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health Organization*.

Medicaid Coverage of Family Planning Services and Supplies under Fee for Service (FFS) and Managed Care

In 2016, CMS issued a State Health Official (SHO) letter on "Medicaid Family Planning Services and Supplies" ("Family Planning SHO") that included guidance on Medicaid coverage of family planning services and supplies.[1] As discussed in the Family Planning SHO, under section 1905(a)(4)(C) of the Social Security Act (the Act), family planning services and supplies must be included in the standard Medicaid benefit package. Family planning services in alternative benefit plans (ABPs) are required to be covered to the same extent as in the standard benefit package under the state plan.[2] The mandatory family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, a medical

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf
[2] See also section 1937(b)(7) of the Act. Additional coverage requirements may also apply under the requirement for ABPs to provide at least the essential health benefits under section 1302(b) of the Affordable Care Act. See section 1937(b)(5) of the Act and implementing regulations at 42 CFR 440.347.

visit to change the method of contraception, and (at the state's option) infertility treatment. For expenditures for family planning services and supplies, states receive an enhanced Federal Financial Participation (FFP) matching rate of 90 percent.[3]

CMS reminds states and managed care plans that there is a freedom of choice protection for family planning services and supplies in section 1902(a)(23)(B) of the Act that allows Medicaid managed care enrollees and beneficiaries whose freedom of choice is restricted under other specified authority to obtain family planning services and supplies from out-of-network providers of their choice. This critical protection prohibits managed care plans from restricting an enrollee from obtaining family planning services and supplies from a provider of their choosing; moreover, a plan cannot require an enrollee to obtain a referral before choosing a family planning provider. Additionally, in accordance with 42 C.F.R. § 438.210(a)(4), a managed care plan must ensure that family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used, and as discussed further below, free from coercion or mental pressure.

Regardless of whether states utilize fee-for-service or managed care delivery systems, beneficiaries are free to choose the method of family planning as provided for in 42 C.F.R. § 441.20. States must provide that individuals are free from coercion or mental pressure, and free to choose the method of family planning to be used. While states and managed care plans have the ability to apply appropriate limits on a service, including utilization control criteria, such processes cannot interfere with a beneficiary's freedom to choose the covered method of family planning, services, or counseling associated with choosing the method. For example, a state or managed care plan cannot require that a particular method be used first (e.g., step therapy) or have in place policies that restrict a change in method (which may involve removal of an implanted or inserted method). The only permissible prior authorization requirement for covered family planning services would be the determination that the method is medically necessary and appropriate for the individual, using criteria that may include considerations such as severity of side effects and clinical effectiveness. States and managed care plans should avoid practices that delay the provision of an enrollee's preferred method or that impose medically inappropriate quantity limits, such as allowing only one Long-Acting Reversible Contraception (LARC) insertion every five years, even when an earlier LARC was expelled or removed. To the extent that states elect to employ utilization control practices, they should pursue only those practices that ensure beneficiaries' choice in family planning providers and method of contraception.

We remind states that under both ABP and state plan coverage, whether provided through a fee-for-service or a managed care delivery system, family planning services and supplies, including contraceptives and pharmaceuticals, must be provided without cost sharing pursuant to 42 C.F.R. § 447.56(a)(2)(ii) and 42 C.F.R. § 438.108.

[3] On August 10, 2023, CMS issued SMD 23-005 regarding the use of claiming methodologies for Medicaid managed care, including for claiming FFP for the 90 percent family planning match rate.

Best Practices for Helping to Assure Access to Family Planning Services and Supplies

FFS and Managed Care Best Practices
There are many actions states can take to strengthen access to Medicaid- and CHIP-covered family planning services and supplies across delivery systems. States are encouraged to utilize the following best practices:

1. Allow for the prescription or provision of 6- to 12-months of contraception supplies.[4]
2. Provide timely, patient-centered, comprehensive coverage of contraceptive services (e.g., contraception counseling; insertion, removal, replacement, or reinsertion of LARC or other contraceptive devices) for individuals of reproductive age.
3. Improve access to over-the-counter (OTC) contraception by issuing statewide protocols or standing prescription orders for an OTC drug, so that pharmacists can issue prescriptions for an OTC drug to Medicaid enrollees directly at the point of sale.[5]
4. Pay directly for immediate postpartum LARC insertion and unbundle payment for this service from labor and delivery services.[6]
5. Remove administrative and logistical barriers for supply management of LARC devices (e.g., addressing supply chain, acquisition, inventory, stocking cost and disposal cost issues; allowing for billing office visits and LARC procedures on the same day; removing preauthorization requirements).[7]
6. Pay for replacement or reinsertion of expelled IUDs, including those placed immediately postpartum, as well as removal upon request.
7. Include language in managed care contracts that cover family planning services and supplies that reinforces the requirement to cover the full range of covered family planning services and supplies without cost sharing and with freedom of choice of providers.
8. Include language in managed care contracts requiring plan networks to include essential community providers for family planning services.

As a reminder, federal Medicaid matching funds at a 90 percent federal match rate are available for state expenditures attributable to the offering, arranging, and furnishing of family planning services and supplies.[8] CMS also reminds states that it is a statutory requirement under section 1902(a)(30)(A) of the Act to ensure that "payments are consistent with efficiency, economy, and

---

[4] https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/combined.html#packs
[5] States may have statewide standing orders for classes of drugs that may include some OTC products. If a state has a statewide standing order that allows pharmacists to prescribe certain drugs, that statewide standing order could apply to OTC drugs.
[6] For more information about state Medicaid payment approaches to improve access to LARCs, please see this 2016 CMS informational bulletin: https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf. More information about Medicaid Family Planning Services and Supplies is included in this 2016 SHO: https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf
[7] See discussion at pages 5 through 6 of SHO #16-008: https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf
[8] As is true for all Medicaid services, the State Medicaid agency and provider must maintain auditable documentation of services to support claims for FFP. See regulations at 42 C.F.R § 431.107 and 42 C.F.R. § 433.32for more information.

quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." This includes payments to providers for administering covered family planning services, including clinically administered drugs, LARCs, and medroxyprogesterone or contraceptive devices.

Read more about improving access to LARCs in the 2016 CIB, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception."[9]

Postpartum Coverage Best Practices

Medicaid is the largest single payer of pregnancy-related services and covers over 41 percent of births nationally.[10] CHIP also covers pregnant adolescents and, in some states, other low-income pregnant individuals with income over the Medicaid income limit. Together, Medicaid and CHIP play a critical role in ensuring access to care for pregnant and postpartum individuals, improving the quality of maternal health care, and addressing disparities in health outcomes and pregnant and postpartum care. The American Rescue Plan Act of 2021 (ARP) gave states a new option to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP. Under the Consolidated Appropriations Act of 2023, this option was made permanent. As of July 16, 2024, 46 states and the District of Columbia have chosen to extend postpartum coverage to 12 months.

Family planning is a part of high quality, comprehensive postpartum care. As such, states are encouraged to adopt the following best practices to further improve their postpartum care coverage:

1. Produce provider bulletins with prenatal care standards that include anticipatory guidance during the prenatal period on planning for contraceptive care after delivery.
2. Pay for LARC device and insertion unbundled from the global maternity care bundle.
3. Implement measures that facilitate immediate postpartum LARC insertion, when a person chooses this option, and increase provider awareness of postpartum LARC policies.
4. Allow same-day orders to facilitate access to LARCs immediately postpartum, without requirements to order LARCs before a birth.
5. Pay for counseling and education on all contraception options in the prenatal and postpartum periods.
6. Submit a state plan amendment (SPA) or section 1115 demonstration to expand eligibility for Medicaid family planning services and supplies for individuals who are no longer eligible for Medicaid coverage.

Read more about improving postpartum care in Medicaid and CHIP in the 2023 toolkit: "Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP: A Toolkit for State Medicaid and CHIP Agencies."[11]

[9] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB040816.pdf
[10] https://www.medicaid.gov/media/154791
[11] https://www.medicaid.gov/sites/default/files/2023-08/ppc-for-state-and-medicaid-toolkit.pdf

OTC Drug Best Practices

There are steps that states can take to ensure Medicaid and CHIP enrollees have access to covered OTC drugs, including oral contraception and emergency contraception. To make it easy for Medicaid enrollees to obtain OTC drugs, states may issue statewide protocols or standing prescription orders for an OTC drug, so that pharmacists can issue prescriptions for an OTC drug to Medicaid enrollees directly at the point of sale. As family planning services and supplies described in 1905(a)(4)(C) of the Act, OTC oral contraception and emergency contraception must be provided under Medicaid with no cost sharing, per sections 1916(a)(2)(D), 1916(b)(2)(D), and 1916A(b)(3)(B)(vii) of the Act, and 42 C.F.R. § 447.56(a)(2)(ii) and 42 C.F.R. § 438.108.

In its definition of the authorized scope of practice for pharmacists, a state can specify that pharmacists can dispense certain drugs 1) after independently prescribing them, 2) after entering into collaborative practice agreements (CPA) with another licensed practitioner with prescribing authority under which the pharmacist can dispense the medication pursuant to the terms of the CPA 3) under "standing orders" issued by the state, or 4) based on some other predetermined state authorized protocols. These flexibilities can be used to improve access to OTC drugs, including oral contraception and emergency contraception.

Confidentiality for Individuals Seeking Family Planning Services

CMS reminds states and managed care plans that they are required to comply with applicable federal and state laws and regulations governing the confidentiality, privacy, and security of applicants' and beneficiaries' information under Medicaid and CHIP, including information concerning individuals seeking family planning services and supplies.[12]

Section 1902(a)(7) of the Act and implementing regulations at 42 C.F.R. part 431, subpart F, require state Medicaid agencies to provide safeguards that restrict the use or disclosure of information concerning Medicaid applicants and beneficiaries to purposes that are directly connected with the administration of the Medicaid state plan. The same requirements also apply to state CHIP agencies through a cross reference at 42 C.F.R. § 457.1110(b) and to Medicaid managed care plans and CHIP managed care entities through cross references at §§ 438.224 and 457.1233(e), respectively.

The regulation at 42 C.F.R. § 431.302 provides that purposes directly related to Medicaid and CHIP state plan administration include: establishing eligibility, determining the amount of medical or child health assistance, providing services for beneficiaries, and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan. By contrast, use or disclosure of applicants' or beneficiaries' family planning services and supplies data or other information for a purpose not directly connected with the administration of the state plan is prohibited under section 1902(a)(7) of the Act and the

[12] At the federal level, these laws include, but are not limited to: section 1902(a)(7) of the Act and its implementing regulations at 42 C.F.R. part 431, subpart F; 42 C.F.R. § 457.1110(b) (for CHIP), and 42 C.F.R. § 438.224 (for Medicaid managed care); the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104-191) and its implementing regulations at 45 C.F.R. parts 160, 162, and 164; and 42 C.F.R. part 2 (governing confidentiality of substance use disorder patient records).

regulations at 42 C.F.R. part 431, subpart F. Examples of prohibited use or disclosure of data regarding Medicaid or CHIP applicants' or beneficiaries' information include release of information to support criminal investigations or pursuit of charges or civil penalties that are not directly related to the administration of the state plan.

The regulation at § 431.306 includes various requirements governing the release of information concerning a Medicaid or CHIP applicant or beneficiary. Under § 431.306(b), the state Medicaid or CHIP agency or managed care plan or managed care entity must restrict access to information concerning applicants and beneficiaries to persons or agency representatives that are subject to standards of confidentiality that are comparable to those of the state Medicaid or CHIP agency. Accordingly, if the state Medicaid or CHIP agency or managed care plan or managed care entity provides another individual, agency, or organization or entity (a recipient) with applicant or beneficiary information, then the confidentiality standards in section 1902(a)(7) of the Act and the implementing regulations at 42 C.F.R. part 431, subpart F apply to that recipient's use and disclosure of the information.

CMS highlights a few of these requirements here for states to consider. However, this description of these requirements is non-exhaustive and states should refer directly to, and comply with, the applicable law and regulations. Under § 431.306(d), the state Medicaid or CHIP agency or managed care plan or managed care entity must generally obtain permission from applicants, beneficiaries, or an applicant or beneficiary's personal representative whenever possible before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility, or the amount of medical assistance payment in accordance with section 1137 of the Act and 42 C.F.R. § 435.940 through § 435.965. Under § 431.306(e), the state Medicaid or CHIP agency's or managed care plan's or managed care entity's policies must apply to all requests for information from outside sources, including governmental bodies, the courts or law enforcement officers.

Additionally, state Medicaid and CHIP programs and managed care plans are "covered entities" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. Under 45 C.F.R. §164.522(b)(ii), the state Medicaid and CHIP programs and managed care plans must accommodate a beneficiary's reasonable request to receive communications, including explanation of benefits, by alternative means or at an alternative location when the individual clearly states that disclosure could endanger the individual. For example, a beneficiary may request that a plan communicate via cell phone instead of paper mail. States and managed care plans are responsible for ensuring that beneficiaries are informed of this option. In addition, under 45 C.F.R. §164.522(b)(i), health care providers must accommodate an individual's reasonable request for alternative means of communication in all circumstances. All states, Medicaid managed care plans, and CHIP managed care entities (and health care providers) should already be ensuring confidentiality as part of their compliance with the HIPAA Privacy Rule.

Read more about recent amendments to the HIPAA Privacy Rule in the 2024 final rule: "HIPAA Privacy Rule to Support Reproductive Health Care Privacy."[13]

[13] https://www.hhs.gov/about/news/2024/04/22/biden-harris-administration-issues-new-rule-support-reproductive-health-care-privacy-under-hipaa.html

Quality of Care

Child and Adult Core Sets
CMS partners with states to share best practices and provide technical assistance to improve access to and the quality of care for Medicaid and CHIP beneficiaries. As part of this effort, the Act requires the Secretary of Health and Human Services to identify and publish core sets of quality measures for children in Medicaid and CHIP and adults in Medicaid. Beginning with state reporting in 2024, state reporting on the Child Core Set and the behavioral health measures on the Adult Core Set is mandatory.

The Core Sets are a foundational tool to understand the quality of healthcare provided in Medicaid and CHIP, help CMS and states assess the access to and quality of health care being provided to beneficiaries, and identify and improve understanding of any health disparities experienced by beneficiaries. CMS encourages states to use Core Set data to identify disparities in care and to develop targeted quality improvement efforts to advance health equity.

Both the Child and Adult Core Sets include measures of contraceptive care:

- Child Core Set: Contraceptive Care – Postpartum Women Ages 15 to 20
- Child Core Set: Contraceptive Care – All Women Ages 15 to 20
- Adult Core Set: Contraceptive Care – Postpartum Women Ages 21 to 44
- Adult Core Set: Contraceptive Care – All Women Ages 21 to 44

The contraceptive care measures on the Child and Adult Core Sets track how many people were provided with a method of contraception. These measures are helpful for CMS, states, and external partners to understand the prevalence of contraceptives delivered to individuals with Medicaid and CHIP coverage. These specific measures, however, are not designed to be incentive metrics for value-based care payments (VBP). The measures are not appropriate for VBP because a specific benchmark has not been set for them, and the measure steward (the U.S. Department of Health and Human Services (HHS) Office of Population Affairs) does not expect or intend for the measure rate to reach 100%, as some women will make informed decisions not to use contraception or to choose methods in the lower tier of efficacy even when offered the full range of methods.[14] The goal of offering and providing contraception should never be to promote any one method or class of methods over women's individual choices.

Other Measures of Contraceptive Care
To be considered as part of the annual review process[15] for inclusion in the Child and Adult Core Sets, measures must meet several minimum technical feasibility criteria, including being tested or in use by at least one state Medicaid and CHIP agency and relying on data that are readily available for state-level reporting. Many measures go through years of development and testing at the practice or health-plan level before they meet these criteria. CMS is aware of a few additional measures of contraceptive care that do not yet meet these criteria, but that states or managed care plans could consider including in a robust set of measures to assess whether individuals are receiving respectful care and the family planning services and supplies they want

[14] https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures
[15] https://www.medicaid.gov/medicaid/quality-of-care/downloads/annual-core-set-review-11102022.pdf

for themselves and their families.

For example, the Person-Centered Contraceptive Counseling (PCCC) measure uses a survey tool to evaluate patient experience of contraceptive care, and particularly how well health care providers are supporting individuals during the contraceptive decision-making process.[16] [17] The PCCC is intended to be given to patients following a contraceptive counseling visit.

Another emerging measure, Self-Identified Need for Contraception (SINC), was created to give providers an easy-to-use, patient-centered reproductive health screening tool.[18] SINC is calculated using standardized data elements in electronic health records (EHR) and can be used in conjunction with electronic clinical quality measures (eCQMs) of contraceptive use. SINC asks patients what reproductive health services they are interested in at the time of their appointment. There are several answer options that can help providers in documenting and addressing health needs.

More information on how to develop a quality measurement and improvement approach, such as one to support improvement in quality and equity of contraceptive care, can be found in Section V of the 2023 toolkit: "Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP: A Toolkit for State Medicaid and CHIP Agencies."[19]

Conclusion

CMS is committed to ensuring that all Medicaid and CHIP beneficiaries have coverage of, and access to, vital family planning services and supplies without limitations on their choice of provider or their choice of covered contraception method. CMS hopes that states find the information within this CIB useful in administering the Medicaid family planning benefit and strengthening access to family planning services and supplies. If you have any questions regarding this information, please contact CMCS_familyplanning@cms.hhs.gov.

---

[16] The PCCC measure was developed by the Person-Centered Reproductive Health Program (PCRHP), at the University of California, San Francisco. https://pcccmeasure.ucsf.edu/

[17] This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[18] https://pcrhp.ucsf.edu/SINC#:~:text=The%20Self%2DIdentified%20Need%20for,their%20needs%20for%20contraceptive%20care

[19] https://www.medicaid.gov/sites/default/files/2023-08/ppc-for-state-and-medicaid-toolkit.pdf