DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Frequently Asked Questions (FAQs)
Medicaid Family Planning Services and Supplies
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These FAQs provide additional information and address questions raised from previous guidance regarding the delivery of family planning services and supplies to Medicaid beneficiaries.

Family Planning Related Services in the Optional Family Planning Eligibility Group

Q1: Are states required to cover drugs for the treatment of sexually transmitted diseases (STD)/sexually transmitted infections (STI) if diagnosed during the regular family planning visit for individuals eligible through the optional family planning eligibility group? What Federal Medical Assistance Percentage (FMAP) rate applies?

A1: Treatment of STDs/STIs may be covered as a family planning related service pursuant to a family planning visit at state option. If a state decides to cover treatment for STD/STIs as a family planning related service, then drugs for the treatment for STD/STIs would be required. Further, such drugs would be subject to the requirements of the Medicaid drug rebate program under section 1927 of the Act to the extent that they are covered outpatient drugs from manufacturers that have Medicaid drug rebate agreements. As with other family planning related services, federal funding would be available at the state's regular Federal Medical Assistance Percentage (FMAP) rate.

Coding

Q2: Will CMS provide a list of codes for family planning services and supplies and family planning related services?

A2: No. This is a state operational matter, and as such states should develop criteria so that claims for FFP at the 90 percent rate for family planning services and supplies are documented with codes that indicate that the underlying item or service was a family planning service or supply. For claims with multiple services and codes, the enhanced Federal match rate applies only to the family planning services and codes.

Informed consent and patient choice

Q3: If a provider performs a postpartum sterilization that does not comply with the informed consent requirements, how can the provider be reimbursed for the allowable portions of the claim?

A3: When a postpartum sterilization is performed that does not comply with the requirements for informed consent described in 42 C.F.R, Part 441, Subpart F—Sterilizations, Federal Financial Participation (FFP) is not available for costs related to the sterilization. This applies to both the hospital-related costs as well as the provider's costs. States must reduce payment for

the inpatient stay by the amount that would have been paid for the sterilization alone. Since the majority of non-postpartum sterilizations are performed on an outpatient basis, that amount would be the Medicaid outpatient rate. In SHO #16-008, CMS identified ways states can ensure informed consent.

Q4: How can states adopt policies that encourage the use of long acting reversible contraception (LARCs) while still maintaining patient choice?

A4: Longstanding Medicaid regulations at 42 CFR 441.20 specifically require that beneficiaries must be free to choose the method of family planning to be used and must be free from coercion or mental pressure in making that choice. This requirement applies to all aspects of an individual's decision, including the decision to start or insert a method and the decision to stop or remove a method. Additionally, states must ensure an individual's decision to use any contraceptive method does not impact their ability to access other medical services.

Dual Eligibles

Q5: When treating dually eligible individuals (those with both Medicare and Medicaid), do providers first need to obtain a Medicare denial before seeking Medicaid coverage of long-acting reversible contraceptives (LARCs – e.g., IUDs and contraceptive implants)?

A5: No. Medicare does not allow payment for contraceptive devices. Because these items and services are non-coverable by Medicare, when a Medicaid-participating provider provides a LARC to a full-benefit dually-eligible individual, Qualified Medicare Beneficiary (QMB) Plus, or Specified Low-Income Medicare (SLMB) Plus beneficiary, the provider may submit a claim to Medicaid or otherwise seek Medicaid coverage without first obtaining a Medicare denial. Because LARCs are not covered by Medicare, Medicaid claims processing system should note the absence of coverage under Medicare and not apply standard claims processing edits relating to third party coverage of dually eligible individuals.