Medicaid Family Planning Program Policy Toolkit

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About ican!

Founded in 2020, ICAN! has worked to close the contraceptive gap in Illinois by de-siloing, de-stigmatizing, and normalizing birth control as basic health care. Today, ICAN! leverages the strategies honed, lessons learned, and resources developed in Illinois to guide states across the country to implement and enhance Medicaid Family Planning Programs (MFPPs). We serve as a "systems orchestrator", supporting providers, patients, payers, and policymakers to transform how contraceptive care is delivered, accessed, and paid for with a focus on equity and sustainability.



POLICY ANALYSIS AND IMPLEMENTATION

We identify opportunities to advance and strengthen on-the-books policies in order to maximize on-the-ground impact.



PROVIDER TRAINING AND TECHNICAL ASSISTANCE

We support safety-net providers to deliver and connect patients with person-centered contraceptive care and coverage.



PATIENT ENGAGEMENT

We empower patients to learn about their birth control options, find coverage, deliver feedback to providers, and to access timely and respectful care in their communities

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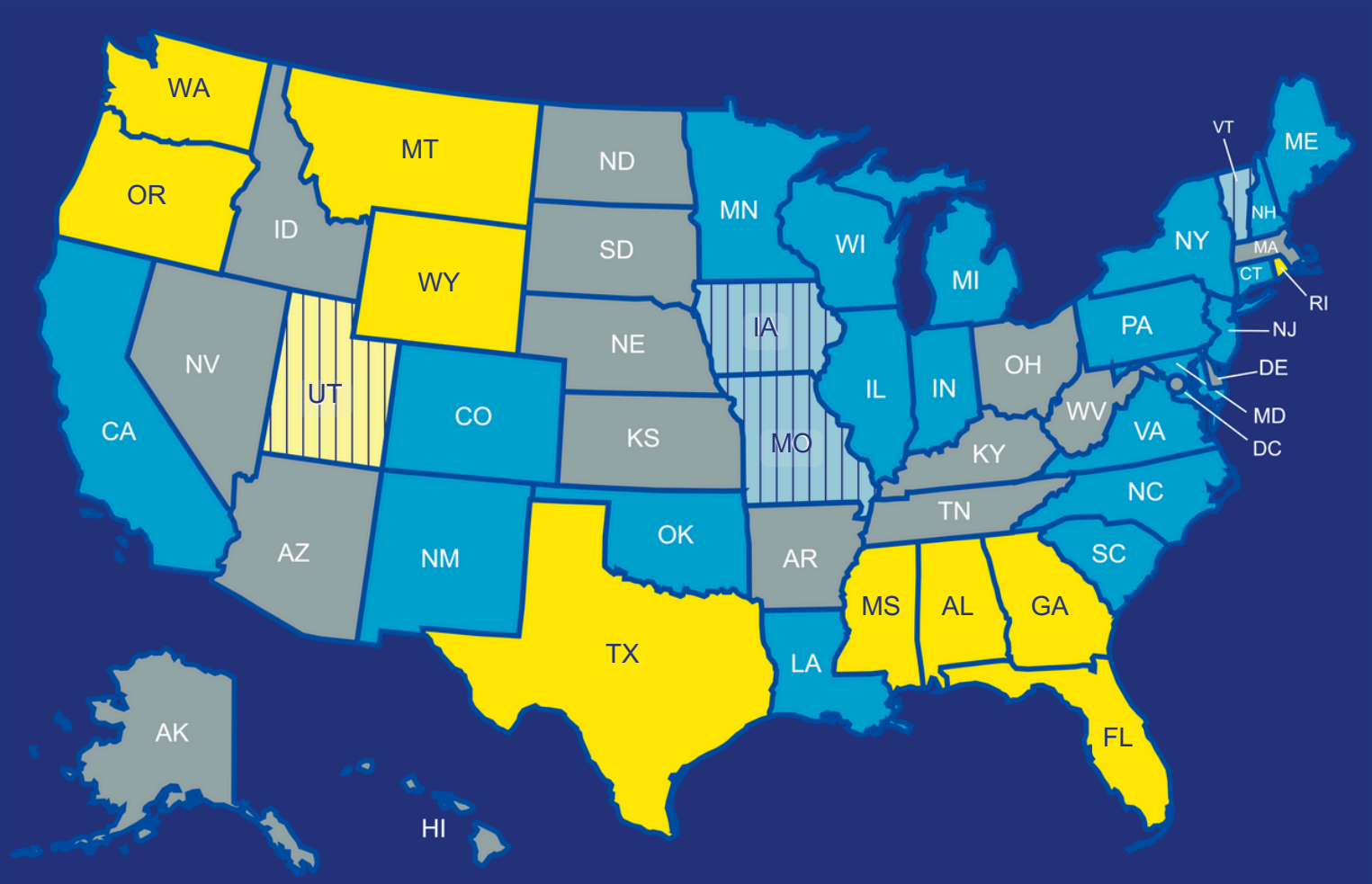
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Part I: Overview of Medicaid Family Planning Programs

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As of April 2025, 30+ states have Medicaid Family Planning Programs!



Medicaid SPA
Medicaid 1115 Waiver
Pending Waiver
State-funded program
No MFPP Expansion

Click here for more detail on each state's program or reach out to ICAN! to learn more!

What are Medicaid Family Planning Programs?

Medicaid Family Planning programs (MFPPs) allow people who are ineligible for full Medicaid coverage to access benefits for specified family planning and related services. They may be established through a permanent State Plan Amendment (SPA), or through a temporary demonstration project known as an 1115 Waiver.

SPA

- Permanent change to the state's Medicaid plan that creates a new eligibility group under the plan. Made possible by 42 USC § 1396a(a)(10)(A)(ii)(XXI).
- Coverage must be open to non-pregnant people of reproductive age of any gender with incomes that do not exceed a limit set by the state. The income eligibility limit cannot exceed the income eligibility limit for pregnant people under the state plan.
- CMS must approve, deny, or request additional information about a SPA within 90 days of a state's SPA application submission or the SPA is approved. CMS may only restart the 90-day clock by requesting additional information once.
- Cannot be unilaterally terminated by CMS.

1115 Waiver

- Temporary program intended for states to test new ideas and policies under the state's Medicaid program, made possible by § 1115 of the Social Security Act.
- The state, with approval from CMS, can determine eligibility criteria, including income limits. Some state waivers limit their family planning programs to people within a certain age range or extend coverage only to women.
- Waivers are not required to be approved or denied on any specific timeline and can be pending for years.
- Can be withdrawn or amended by CMS at any time if CMS determines the waiver is no longer in the public interest or would not promote the objectives of Medicaid.

The Application Process

State Medicaid agencies apply for MFPPs. To apply for a Family Planning SPA (FP SPA), the state Medicaid agency will submit an application to the Centers for Medicare & Medicaid Services (CMS) that allows the agency to make selections about income measure methodologies, presumptive eligibility, and other available options for building a FP SPA. States submitting Family Planning waiver applications to CMS must include a description of eligibility and scope of coverage, a showing of budget-neutrality for the federal government, and an agreement that the state will perform periodic review of implementation.

SPA APPLICATION TIMELINE

FP SPAs submitted to CMS are on a set timeline for approval. Once a state submits their complete application, CMS has 90 days to approve, deny, or request additional information on the application. If they do not, the SPA is automatically approved. If CMS submits a formal request for the state to provide it with additional information about the application, then the 90-day clock stops and a new 90-day clock begins on the date that the state submits its response to CMS's request for additional information. CMS can only stop the clock by requesting additional information once. Approved SPAs are effective from the first day of the quarter the SPA application was originally submitted.

Sources: 42 C.F.R. § 430.16 (2024); Social Security Act, 42 U.S.C. § 1915(f)(2). See also State Plan, MACPAC (Aug. 14, 2019), https://www.macpac.gov/subtopic/state-plan/#:~:text=Once%20approved%2C%20copies%20of%20each,posted%20to%20the%20CMS%20website.&text=States%20must%20also%20submit%20a,Medicaid%20state%20plan%20amendment%20process.



WAIVER APPLICATION TIMELINE

1115 Waivers do not have a set approval timeline and may sit pending for years. For example, Utah submitted an application for a FP 1115 Waiver in July of 2023 and it remains pending as of July 2025. Texas submitted a FP waiver application in 2017 that was not approved until 2020.

When approved, waivers must be renewed, usually every 3-5 years, but sometimes less. There is no set timeline for renewals, either and waiver coverage will end if waivers are not renewed or are allowed to expire pending renewal..

H.R. 1 and MFPPs

H.R. 1, often referred to as "The One Big Beautiful Bill," passed in July 2025 and changed Medicaid and access to healthcare in many ways. Here's what you need to know about how the new law affects Medicaid Family Planning Programs (MFPPs).

1. **MFPP enrollees will not be subject to eligibility redeterminations every 6 months.** H.R. 1 requires that individuals enrolled in Medicaid Expansion (primarily childless adults up to 138% FPL) have their eligibility determined every 6 months. This requirement **does not** apply to limited benefit programs like MFPPs. Redeterminations for MFPPs should take place once every 12 months.

2. **MFPP enrollees will not have work requirements.** H.R. 1 requires that, unless an exception applies, people enrolled in Medicaid Expansion report working or volunteering at least 80 hours per month to keep their coverage. This requirement **does not** apply to limited benefit programs like MFPPs.

3. **Beginning 10/1/2026, the categories of immigrants who qualify for MFPP coverage will be limited.** H.R. 1 limits the categories of immigrants and non-citizens who can qualify for Medicaid programs, including MFPPs, to legal permanent residents (green card holders) who have lived in the U.S. for 5+ years, Cuban and Haitian immigrants, and COFA migrants. Therefore, unless states use state-dollars to cover their care, refugees, asylees, and other humanitarian visa holders will soon be ineligible for MFPP coverage .

4. **Beginning 12/31/2026 MFPP enrollees will only be eligible for 2 months of retroactive coverage.** H.R. 1 reduces retroactive coverage from 3 months to 2 months for all covered populations except for the Expansion group. Expansion enrollees are only eligible for 1 month of retroactive coverage.

5. **H.R. 1 has a provision that temporarily prevents Medicaid payments, including MFPP dollars, from going to some providers that offer abortions, but this is not currently in effect.** H.R. 1 required that until July 2026, Medicaid dollars cannot go to nonprofit sexual and reproductive health providers who offer abortions and received more than $800,000 from Medicaid in FY 2023.

Note that states may apply for waivers to change these default rules for the MFPP in their state.

Benefits of a MFPP SPA

Both SPAs and waivers allow patients to access family planning and related care with no out-of-pocket costs, and both allow states to benefit from heightened federal match rates. However, SPAs are a more dependable and durable policy strategy to protect preventative healthcare, including reproductive care.

✓ **FP SPAs are on a set approval timeline:**

- Once a SPA application is submitted to the Centers for Medicare and Medicaid Services (CMS), CMS has 90 days to either approve, deny, or request additional information.
- If CMS takes no action, the SPA is established.
- CMS may only request additional information and restart the 90 day clock once. This 90-day clock restarts once a state has submitted the requested information.
- Waivers do not have a set timeline for approval and may sit pending for years.

✓ **FP SPAs are more difficult to deny on ideological grounds:**

- Federal requirements for SPAs are generally apolitical, making it difficult for CMS to deny SPA applications or withhold funding on ideological grounds. Denied SPAs can be appealed to the appropriate U.S. Circuit Court of Appeals.
- If a state submits an FP SPA application meeting statutory requirements and offering services in line with what 20 other states across the political spectrum have done, the SPA is unlikely to be denied. If it is, a Court of Appeals is unlikely to uphold that denial.

✓ **FP SPAs are more difficult to vacate or terminate on ideological grounds:**

- Waivers, unlike SPAs, can be unilaterally terminated or vacated by CMS if CMS determines the waiver no longer aligns with federal priorities for the Medicaid program.

✓ **FP SPAs preserve the capacity and resources of state Medicaid agencies:**

- Unlike Section 1115 Family Planning waivers, FP SPAs do not require states to conduct evaluations on the efficacy and success of the program nor make regular reports to CMS. This reduces administrative burdens.

✓ **FP SPAs reduce the amount of information about family planning and related care shared with the federal government:**

- FP SPAs, unlike waivers, do not require quarterly and annual reporting to the federal government on MFPP enrollment, utilization, cost, and other progress toward a state's goals. Thus, FP SPAs better protect information about family planning in the state from federal surveillance during a time when that information can put patients and state funding at risk.

✓ **FP SPAs safeguard against religious refusals of contraceptive coverage:**

- If the federal administration allows more types of employers to refuse to cover contraceptives on religious grounds, many individuals will need alternative coverage for birth control through FP SPAs.
- While waivers can also provide this alternative coverage, because they are more vulnerable to being terminated by CMS or not renewed, SPA coverage is more dependable.

In Summary:

	Waiver	SPA
Required timeline for approval	✗	✓
Cannot be unilaterally vacated by CMS	✗	✓
Does not require regular reporting to the federal government	✗	✓

Benefits of a MFPP Waiver

Waivers allow states to test innovations in coverage and eligibility. This flexibility can be used to make MFPP programs more generous in eligibility and scope of coverage than might be possible under a FP SPA.

FOR EXAMPLE, A STATE MAY USE A WAIVER TO:

- **Increase the FP income eligibility beyond the state's limit for pregnant people under the state plan.** This is particularly helpful in states like Idaho where the FPL limit for pregnancy Medicaid is 138%-- a waiver would allow Idaho to expand FP coverage beyond those who already are eligible for Expansion coverage.

- **Cover a more expansive set of services under the program.** While MFPPs can cover a broad range of primary and preventative care, waivers allow states the flexibility to cover services beyond what is considered family planning and family planning-related. For example, Alabama covers tobacco cessation under its FP waiver.



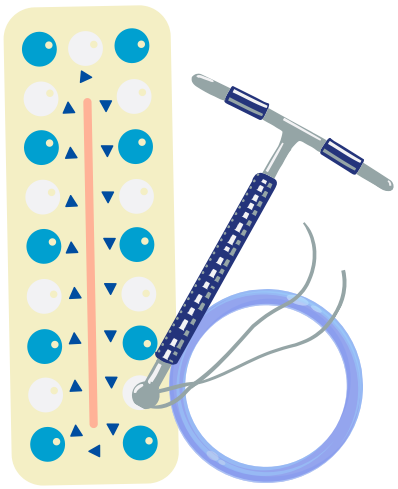
ICAN! SUPPORTS STATES IN DEVELOPING AND APPLYING FOR MFPP SPAS AND WAIVERS AND CAN HELP YOU DETERMINE WHICH IS BEST FOR YOUR STATE!

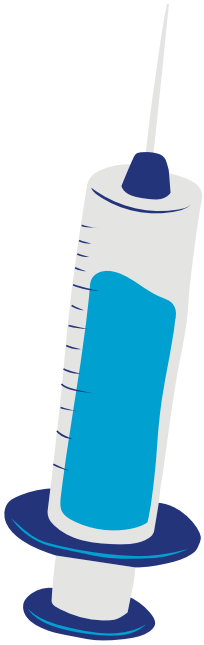
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What do MFPPs cover?

FAMILY PLANNING SERVICES

Family planning services and supplies are those intended 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 visit to change the method of contraception, and (at the state's option) infertility treatment."





FAMILY PLANNING-RELATED SERVICES

Family-planning related services "are medical, diagnostic, and treatment services provided pursuant to a family planning visit that address an individual's medical condition" and may include treatment for urinary tract infections or sexually transmitted infections, HPV vaccines, and preventative services routinely provided during family planning visits. This could include preconception care and support for patients looking to improve their health prior to pregnancy! States have flexibility in determining what family planning-related services to cover, allowing states to recognize the broad spectrum of care that relates to planning for healthy families and futures.

Family Planning Services are matched by the federal government at **90%**, leaving states responsible for just 10% of the costs of these services. **Family Planning- Related Services** are matched by the federal government at the state's regular FMAP (Federal Medical Assistance Percentage) rate. Find your state's FMAP rate here. Family planning services in MFPPs must be covered to the same extent as they are in the standard benefit package under your state plan.



SEE APPENDIX FOR A SAMPLE LIST OF COVERED SERVICES AND THEIR CODES

Source: CTRS. FOR MEDICARE & MEDICAID SERVS. SHO # 16-008, MEDICAID FAMILY PLANNING SERVICES AND SUPPLIES (2016) and §§ 1905(a)(4)(C) and 1937(b)(7) of the Social Security Act.

Part II: Building a Model MFPP

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Coverage for all genders and ages

CMS REQUIRES THAT FP SPAS BE OPEN TO PEOPLE OF ALL GENDERS AND AGES.

ALL GENDERS:

42 CFR § 435.214 Eligibility for Medicaid limited to family planning and related services.

(b) *Eligibility*

- (1) The agency may provide Medicaid limited to the services described in paragraph (d) of this section to individuals **(of any gender)** who --
  - (i) Are not pregnant; and
  - (ii) Meet the income eligibility requirements at paragraph (c) of this section.

ALL AGES:

"States must not restrict eligibility based on age. Under standard Medicaid rules, however, States may limit services based on medical necessity." However, states may not explicitly exclude individuals who have been sterilized.

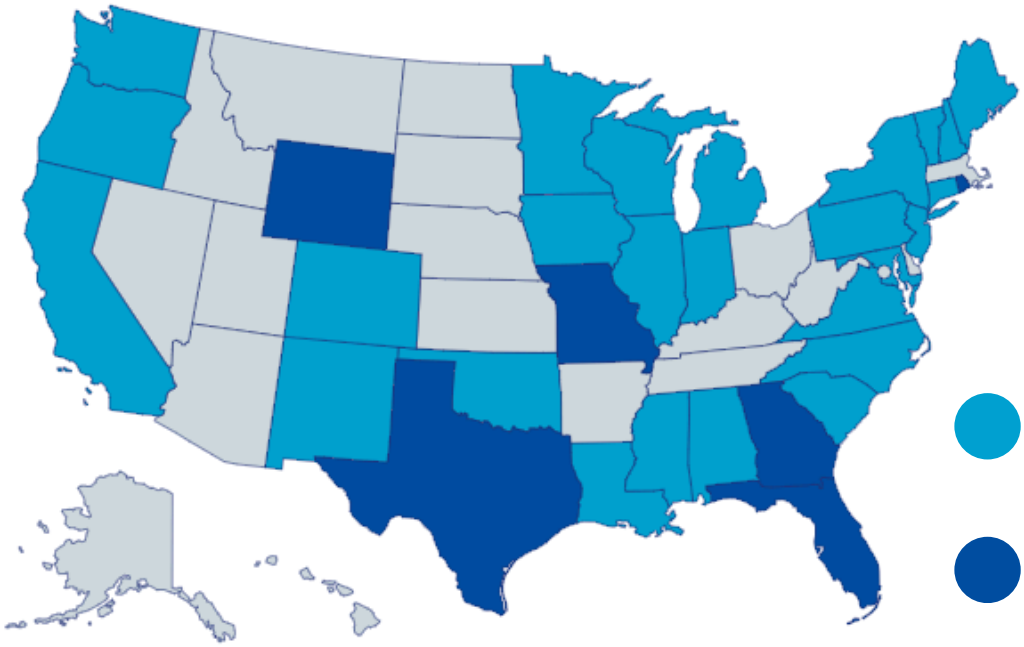
Sources: *State Medicaid Director Letter #10-013*, July 2, 2010 & Gold et al., *CMS Guidance on Family Planning State Plan Amendments*, Oct. 25, 2010.

WHY SHOULD A MODEL MFPP BE OPEN TO PEOPLE OF ALL GENDERS AND AGES?



Reproductive health is an important part of a person's health, regardless of their gender, and MFPPs offer more than just birth control! People of all genders, including men can benefit from MFPP coverage for their annual physical exam, STI testing and treatment including HIV prevention, vaccines, cancer prevention, and education.

ALL GENDERS



COVERS ALL GENDERS

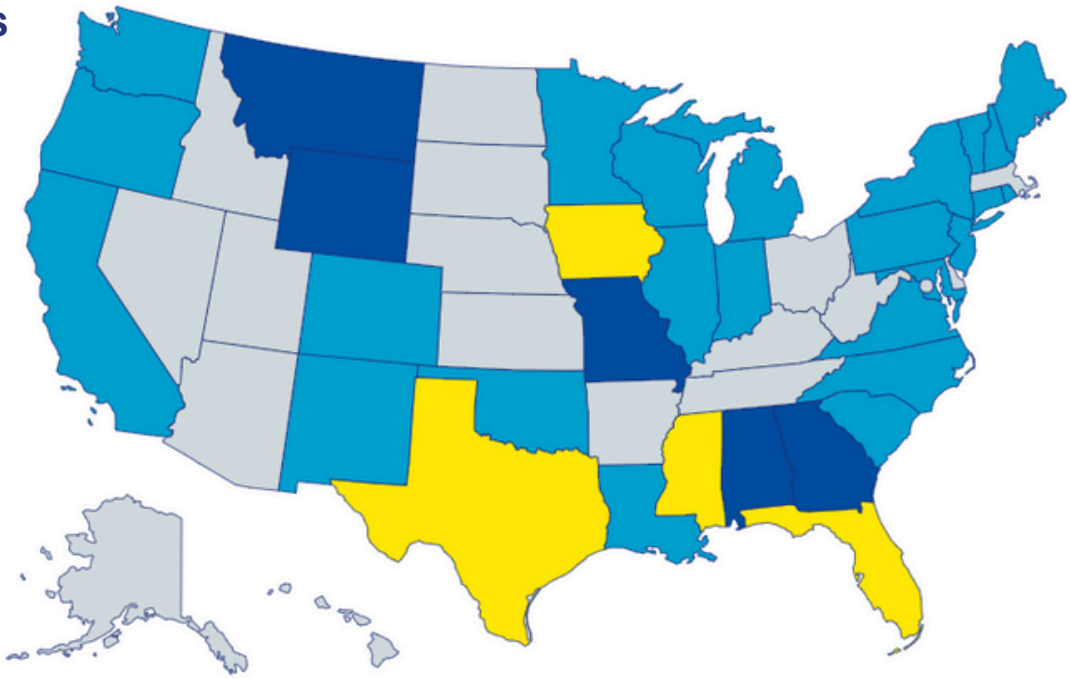
COVERS ONLY PEOPLE ASSIGNED FEMALE AT BIRTH

ALL AGES

COVERS ALL AGES

LIMITS AGES, COVERAGE FOR SOME PEOPLE UNDER 18

LIMITS AGES, NO COVERAGE FOR PEOPLE UNDER 18



Supplemental coverage for people with private insurance

Medicaid programs, like MFPPs, are typically the payer of last resort, however under a "good cause" exemption to the Third-Party Liability rule, people with confidentiality concerns, people with high out-of-pocket costs, or people whose insurance doesn't cover family planning and related care can enroll in MFPP coverage and Medicaid can be the primary payer.

CONFIDENTIALITY

SURVIVORS OF INTIMATE PARTNER VIOLENCE

People of reproductive age are the most likely to experience intimate partner violence. Abusive partners may perpetrate sexual violence or reproductive coercion, like preventing a partner from taking or using a birth control method or refusing to wear or breaking condoms. MFPP coverage allows survivors of intimate partner violence to get **confidential** coverage without their abusive partners being alerted to their care by an explanation of benefits.

TEENS AND YOUNG ADULTS

In most states, teens and young adults can consent to receiving birth control and STD testing. However, many young people may forego necessary reproductive and sexual healthcare for fear of using their parents' insurance. Because MFPPs can be open to people of all ages, including teens, they can ensure teens get the care they need without compromising their privacy.

HIGH OUT-OF-POCKET COSTS

People whose private insurance leaves them with high out-of-pocket costs or limits provider choice can benefit from MFPP coverage. For example, a person might want an IUD but can't afford it on their high deductible plan. If the person qualifies for MFPP, they could get their IUD for free! MFPPs can also support people on private plans with network limitations (i.e. HMOs) that prevent them from seeing their provider of choice unless they pay out of pocket. These patients' private plans can still be billed for any care not covered by the MFPP.

EXEMPTED PLANS

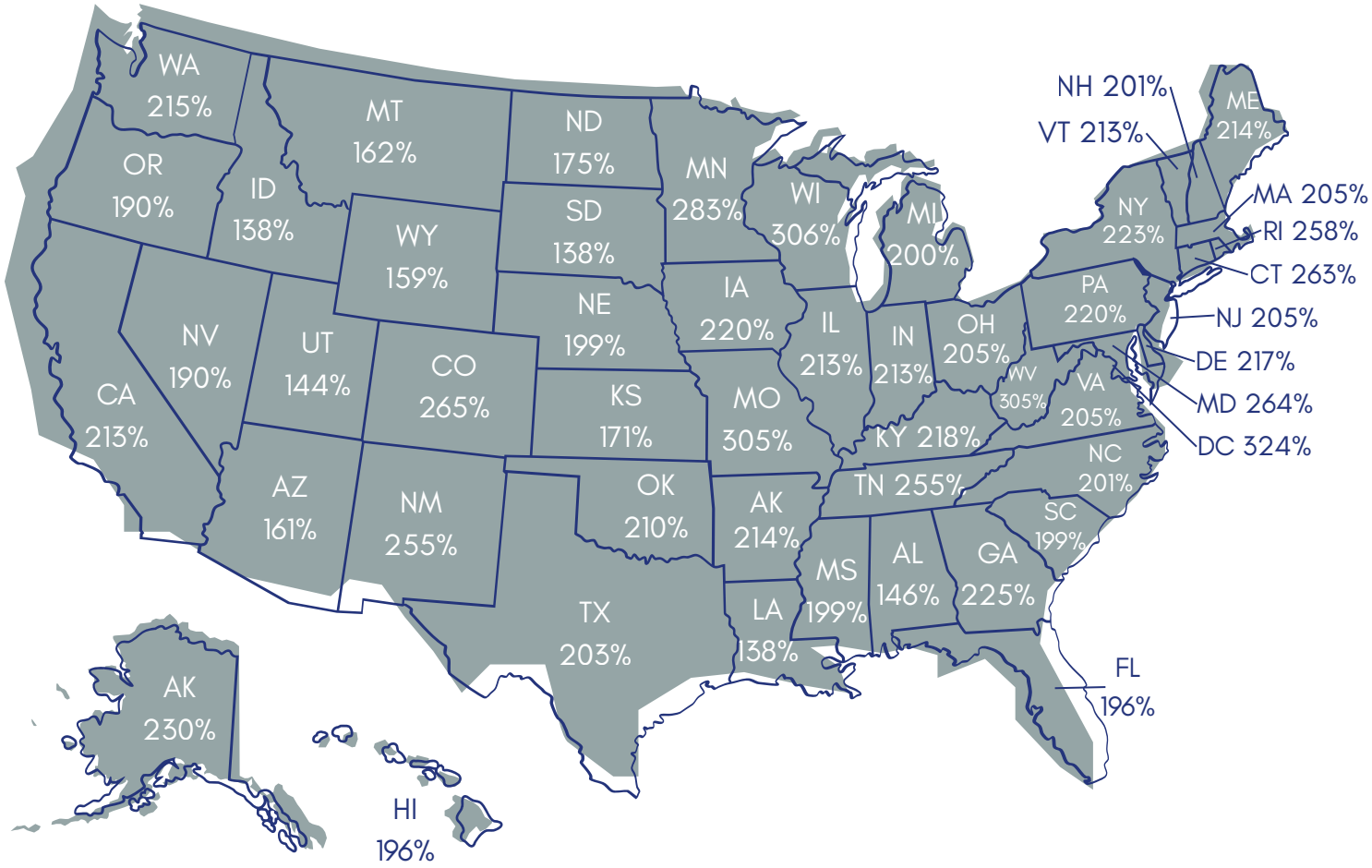
Employer-sponsored health plans at religiously-affiliated organizations and other exempted or grandfathered health plans may not cover family planning and related health care. MFPPs can fill coverage gaps for people on such plans.

Make sure your state's MFPP is open to people with private insurance and that there are systems in place to keep coverage confidential!

Determining income eligibility

Family planning SPAs are open to people with incomes up to the federal poverty level (FPL) limit set for pregnant people under the state's Medicaid or CHIP plan. In this way, FP SPAs are sister programs to pregnancy Medicaid programs, ensuring that people are cared for even when they're not pregnant. The map below shows states' FPL limits for pregnant people as of January 2025. Family planning waivers provide states with flexibility in determining the FPL limit for the program. Waivers do not require parity with pregnancy coverage limits and states may set more generous eligibility levels.

Source: *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level*, KFF.



Determining a household size

After identifying a FP SPA's maximum FPL limit, states can identify the household size they wish to use to determine eligibility.

1) INDIVIDUAL ONLY

States may choose to include only the individual when determining household size. Under this option, regardless of whether the applicant is married, has children, or other family members in their household, their application will always be considered as a household size of 1.

2) INCLUDE FAMILY MEMBERS

Alternatively, states may choose to measure the applicant's full household when determining household size. Under this methodology, the household size would increase if the applicant is living with a spouse or children under 19.

Next, the state can decide whether to increase the applicant's total family size by 1.

INCREASING HOUSEHOLD SIZE BY 1

Increasing the household size by 1 results in parity with a state's pregnancy Medicaid program. For example, a single woman who is pregnant in Michigan would qualify for Medicaid if she made less than 200% FPL based on a household size of 2, because her fetus is counted as part of the household. If a state with a family planning SPA did not increase family size by 1, then that same woman would not qualify for Family Planning SPA coverage to prevent her pregnancy. Adding 1 to family size ensures that people are able to access coverage both when they are pregnant and when they're trying to prevent pregnancy.

Source: 42 C.F.R. Section 435.603 (k)
Here's implementation guidance from CMS that explains more on page 3 and 4!

Counting income

Once a state has determined how to measure household size for the purposes of determining eligibility for a family planning SPA, they must choose whose income to consider.

1) APPLICANT ONLY

A state may opt to consider only the income of the applicant. This ensures that individuals are not prevented from receiving critical coverage because their spouse, children, or parents make too much money or because the applicant faces challenges in attempting to collect documentation of other household members' income (e.g. the applicant is a college student who doesn't live at home).

This is especially helpful for survivors of intimate partner violence and teens needing confidential services. A survivor of intimate partner violence may have a high-earning partner whose income would disqualify the survivor from FP SPA coverage if counted, and also be prevented from accessing the high-earning partner's income to pay for family planning care. If only the survivor's income is considered, the survivor can receive care to support their reproductive well-being and safety. Similarly, teens may have high-earning parents, but no income of their own. Considering only the teen's income ensures teens do not forego necessary care to avoid using their parents' insurance or because they can't use their family's income for reproductive healthcare without sacrificing confidentiality. A state can choose this option regardless of household size, but should certainly choose this if they measure household size as the individual or individual +1.

2) ALL FAMILY INCOME

A state may ask for the income of the applicant plus any additional family members when determining income eligibility. While this method is more commonly used for other MAGI (Modified Adjusted Gross Income) groups, it is less generous and less protective of applicants with a need for confidential services. States should not opt for this method if they consider only the individual or individual +1 as a household size. Doing so would make FP SPA coverage incredibly restrictive for applicants with families.

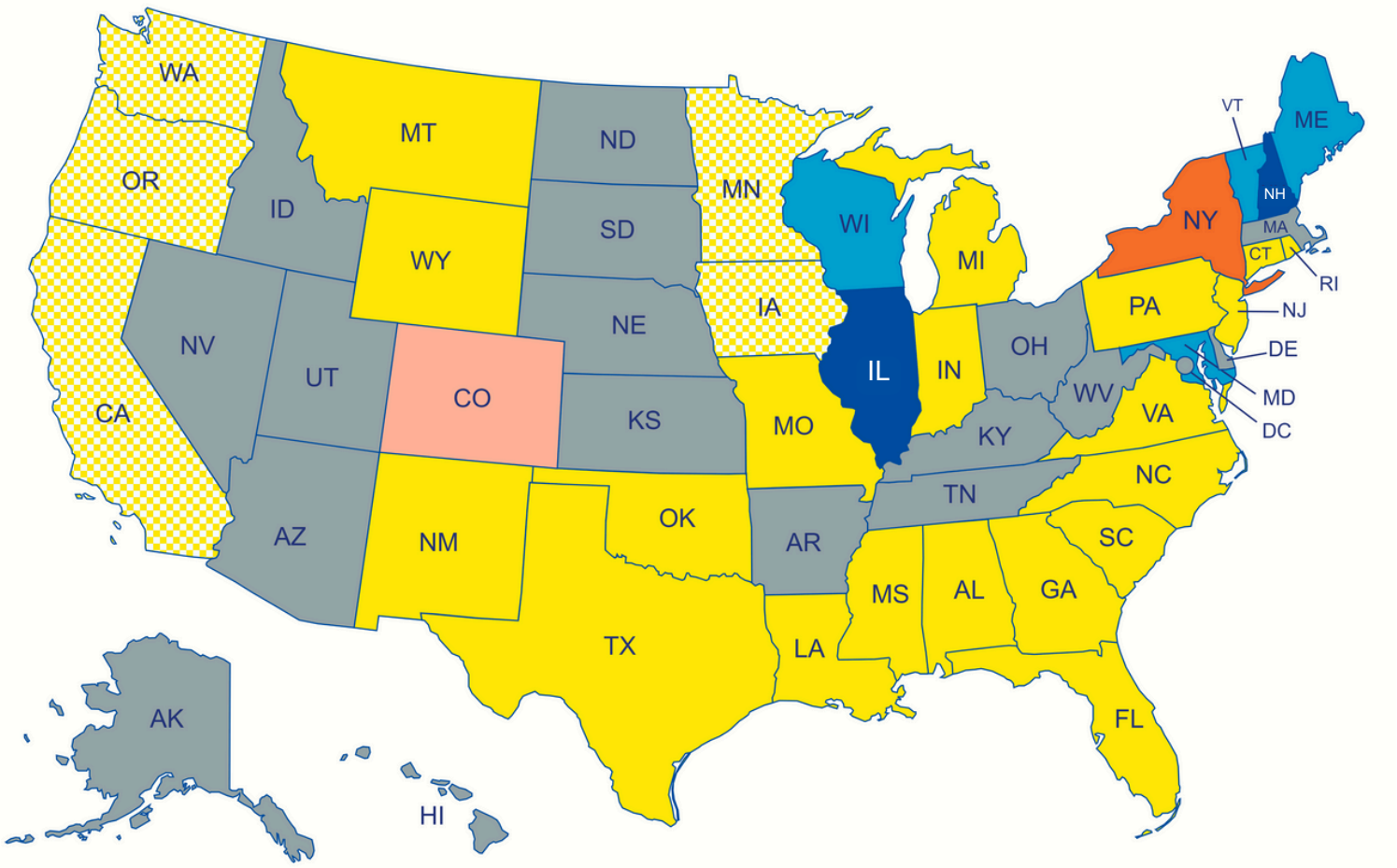
Putting it all together

The chart below is an example of the 2025 annual income eligibility limits based on different methods of measuring household and income. Update the income eligibility FPL percentage in the yellow box with the FPL limit for your state to see the potential income limits for a FP SPA (or waiver) in your state!

Income eligibility FPL	144%		How the size of the applicant's family is measured			
			Always household of 1	Always household of 2 (1+1)	Full household	Full household +1
Size of applicant's family	1		$22,536	$30,456	$22,536	$30,456
	2		$22,536	$30,456	$30,456	$38,376
	3		$22,536	$30,456	$38,376	$46,296
	4		$22,536	$30,456	$46,296	$54,216
	5		$22,536	$30,456	$54,216	$62,136
	6		$22,536	$30,456	$62,136	$70,056

Remember, each of these income eligibility limits can be based on individual income, or the income of every household member! More generous programs will consider only individual income.

Income eligibility methods by state



- HOUSEHOLD ALWAYS 1, APPLICANT'S INCOME ONLY
- HOUSEHOLD ALWAYS 2, APPLICANT'S INCOME ONLY
- FULL HOUSEHOLD SIZE, ALL HOUSEHOLD INCOME
- FULL HOUSEHOLD SIZE, ALL HOUSEHOLD INCOME; PARENTAL INCOME DISREGARDED FOR TEENS OR YOUNG ADULTS
- FULL HOUSEHOLD SIZE PLUS 1, ALL HOUSEHOLD INCOME
- FULL HOUSEHOLD SIZE PLUS 1, APPLICANT'S INCOME ONLY

Coverage for people of all immigration statuses

The same citizenship and immigration status requirements that apply under a state's Medicaid program apply for a MFPP. To be eligible for MFPP coverage, an individual must be a U.S. Citizen or a qualified immigrant.

H.R. 1 (known as President Trump's "Big Beautiful Bill") limited the immigration statuses that can qualify for Medicaid coverage, including MFPPs. Effective October 1, 2026, only immigrants falling under the bolded categories in the box to the right will be considered "qualified immigrants" for the purposes of Medicaid/ MFPP eligibility.

However, states may opt to use state-funds to offer MFPP coverage to non-citizens without a qualifying immigration status, including people who have not met the 5-year bar, those with Temporary Protected Status (TPS), and people who are undocumented.



Who is considered a qualified immigrant?

- **Lawful Permanent Residents/Green Card Holders***
- Asylees
- Refugees
- **Cuban/Haitian entrants**
- Paroled into U.S. for 1+ year*
- Conditional entrant granted before 1980*
- Battered non-citizens, spouses, children, or parents*
- Victims of trafficking and spouse, child, sibling, or parent, or individuals with a pending application for trafficking victim visa
- Granted withholding of deportation
- **Citizens of the Marshall Islands, Micronesia, and Palau who are living in a U.S. state or territory (COFA migrants)**

*Eligible after 5-years of having qualified immigration status. Not subject to the 5-year bar if entered the U.S. as asylees/refugee.

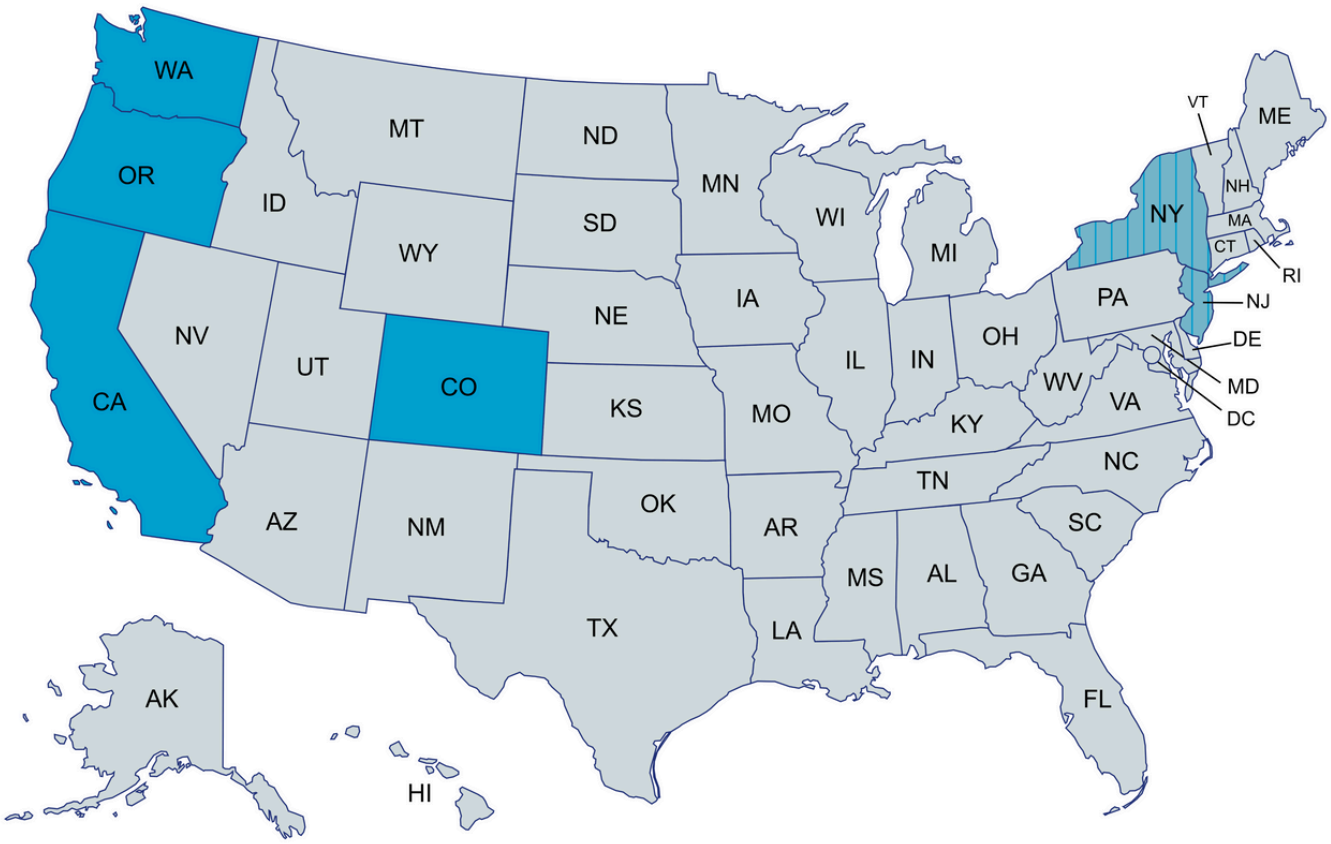
Sources: Akash Pillai et al., How States Verify Citizenship and Immigration Status in Medicaid, KFF, Apr. 16, 2025; Tanya Broder, Health Care Coverage (Maps), NAT'L IMMIGRATION L. CTR., Feb. 18, 2025 .

Coverage for people of all immigration statuses

Many states already use state dollars to provide Medicaid to pregnant people of any immigration status, and all states have Emergency Medicaid programs that will cover emergency hospital admissions, including labor and delivery, for people of any immigration status. Using state dollars to offer family planning coverage to people of all immigration statuses helps everyone be able to plan for healthy families!

STATE FUNDED FAMILY PLANNING COVERAGE FOR PEOPLE OF ALL IMMIGRATION STATUSES

LIMITED STATE-FUNDED FAMILY PLANNING COVERAGE FOR PEOPLE OF ALL IMMIGRATION STATUSES



* Some states may have other programs that provide full-scope Medicaid coverage, including coverage for family planning and related services, to people of all immigration statuses. (i.e. coverage for pregnant people or children of all immigration statuses).

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Immediate, temporary coverage through family planning presumptive eligibility (FPPE)

States have the option to provide patients with immediate, temporary coverage for family planning and related services through family planning presumptive eligibility (FPPE).

Presumptive eligibility allows patients to self-attest to their income, pregnancy status, and, at the state's option, state residency and immigration or citizenship status with a qualifying entity. Those whose self-attestations indicate they qualify for MFPP coverage can get immediate, temporary coverage that lasts until the last day of the month following the month they made their FPPE application, or until a determination on their application for 12 months of coverage is made. Even if an individual found presumptively eligible does not wind up being determined eligible for ongoing, 12-months of coverage, **any services rendered to them during the FPPE period are still covered.**

Authority for Family Planning PE comes from 42 U.S.C. 1396r-1c, 42 CFR § 435.1102(d)(1)(i), and § 435.1103(c)(1).

MANDATORY QUESTIONS

State Medicaid agencies **must** ask a FPPE applicant to self-attest to their individual or household income (depending on how the state measures income eligibility) and that the applicant is not pregnant. Pregnant individuals would be eligible for the state's Medicaid program for pregnant people, instead. 27 states and DC have presumptive eligibility for pregnant people to receive immediate, temporary Medicaid coverage.

1. **Income?**
2. **Pregnant?**

OPTIONAL QUESTIONS

State Medicaid agencies **may, but are not required to** ask a FPPE applicant (or someone who has reasonable knowledge of the applicant's status) to attest to their citizenship or satisfactory immigration status or state residency. *See* 42 CFR § 435.1102 (d)(1).

3. **State of residence?**
4. **Citizenship/immigration status?**

States may <u>not</u> require verification of citizenship, immigration, state residency, or income for FPPE determinations.

Immediate, temporary coverage through family planning presumptive eligibility (FPPE)

APPLICATION

The FPPE application should be streamlined to ensure that FPPE applications do not unnecessarily burden provider workflows nor add patient barriers. CMS provides states with flexibility in developing and administering PE processes and permit states to use verbal screening questions, written applications, or an online portal. FPPE applications should be available online and on paper. Online applications allow providers to submit the application on behalf of the patient and receive a real-time determination. Information input online can often be ported over to an application for 12-months of benefits by using an application number or the patient's social security number. This reduces patient barriers by simplifying the application process. Having paper applications available ensures that system failures or disruptions do not mean patients are preventing from accessing immediate, temporary coverage. Additionally, patients can work on paper applications while in the waiting room, saving providers' time by allowing them to enter the patient data without walking through the entirety of the application with the patient.

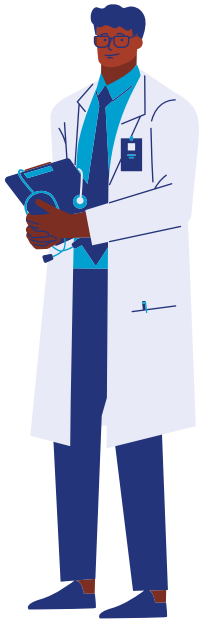
Applications should only include questions and information necessary for making a FPPE determination. Additional questions are burdensome to providers and patients, both.



Source: Implementation Guide: Medicaid State Plan Eligibility Presumptive Eligibility Individuals Eligible for Family Planning Services, available at hhttps://www.medicaid.gov/resources-for-states/downloads/macpro-ig-individuals-eligible-for-family-planning-services-presumptive-eligibility.pdf.

Immediate, temporary coverage through family planning presumptive eligibility (FPPE)

QUALIFIED PROVIDERS



PE is determined by qualified providers or qualified entities. Qualified providers/entities are those who participate in the state's Medicaid plan and who the state Medicaid agency determines are capable of making PE determinations. This often includes hospitals, Federally Qualified Health Centers (FQHCs), public health departments, Indian Health Services, and WIC offices. Best practices for identifying qualified entities/providers include allowing all providers in a certain provider type (e.g. FQHCs) automatic designation as a qualified entity, only instituting necessary training requirements (e.g. training on the PE application), and regular review of requests for status as a qualified provider.

DURATION



Presumptive eligibility can provide coverage for people while they wait for a determination to be made on their application for 12 months of coverage. If a person submits an application for ongoing, 12-months of coverage, then their PE will last until that determination is made. If no application is completed, then PE will end on the last day of the month following the month PE was determined. For example, if a person applies for PE on June 1 and does not apply for ongoing coverage, their PE will end on July 31. *See* 42 CFR § 435.1102 (b)(2)(iv).

FREQUENCY

Agencies "must adopt reasonable standards regarding the number of periods of presumptive eligibility" that are available to a person. *See* 42 CFR § 435.1102(c). PE that is available twice per 12 month period, beginning on the date that a PE application is completed or twice per calendar year best keeps people covered, especially since redeterminations for the Medicaid Expansion population will soon take place every 6 months. Illinois and Connecticut each offer FPPE 2x/year.

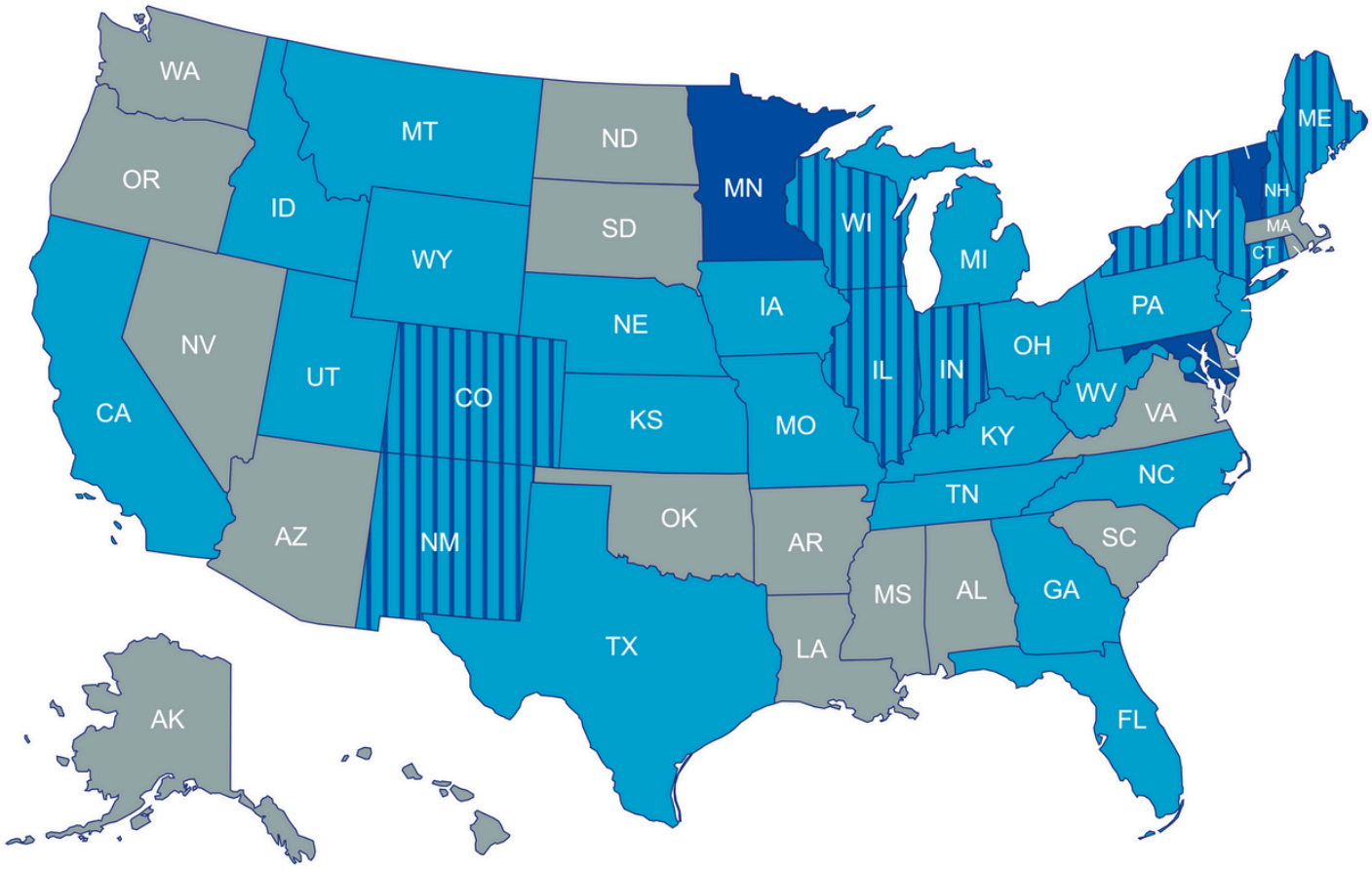


Immediate, temporary coverage through presumptive eligibility (PE)

STATES WITH FAMILY PLANNING PRESUMPTIVE ELIGIBILITY

STATES WITH MEDICAID PRESUMPTIVE ELIGIBILITY FOR PREGNANT PEOPLE

STATES WITH PRESUMPTIVE ELIGIBILITY FOR BOTH PREGNANT PEOPLE AND FAMILY PLANNING



ICAN! CAN HELP YOUR STATE BUILD A MODEL MFPP OR OPTIMIZE AN EXISTING MFPP THROUGH IMPLEMENTATION AND POLICY IMPROVEMENT!

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Model MFPP Checklist

A model MFPP checks all of the boxes in the list below. Use this list to identify opportunities to enhance your state's MFPP!

- ☐ Is established through a State Plan Amendment (SPA) or with an 1115 waiver that covers more people and services than a family planning SPA could cover
- ☐ Covers people of all ages
- ☐ Covers people of all genders
- ☐ Covers people with private insurance
- ☐ Add 1 to household size
- ☐ Eligibility based on applicant's income only
- ☐ Covers people of all immigration statuses
- ☐ Presumptive eligibility 2x/year
- ☐ Auto-enrollment for people who lose full-scope Medicaid coverage

Part III: Implementing your MFPP

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Optimizing Enrollment

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Integrating the MFPP Application

State Medicaid agencies should remove enrollment barriers by embedding the MFPP application into the state's application for full-coverage Medicaid. If a person applies for the state's Medical Assistance Program and is ineligible for full-scope coverage but is eligible for the state's MFPP, they should be enrolled in MFPP coverage and given the option to disenroll. An opt-out, rather than an opt-in system reduces the amount of steps a patient has to take to get enrolled. Additionally, it means more patients will go to the health center with coverage, already, preserving the capacity and resources of health center enrollment staff.

1. **Person applies for coverage using the state's Medical Assistance Application.**
2. **Applicant's eligibility for full-scope coverage programs (i.e. Medicaid Expansion, CHIP, Moms & Babies) is assessed.**
3. **Applicants eligible for full-scope programs are enrolled. Ineligible applicants are assessed for MFPP eligibility.**
4. **Applicants eligible for MFPP coverage are enrolled.**
5. **Enrollees are sent a letter explaining their benefits and how to disenroll if they prefer not to have MFPP coverage.**

Autoenrollment into MFPPs to Prevent Churning

State Medicaid agencies should auto-enroll eligible individuals into Family Planning Medicaid coverage instead of terminating their coverage to ensure continuity of coverage.

✓ **Federal Regulations require states to auto-enroll eligible individuals into Family Planning Medicaid programs during redetermination:**

- Federal Regulations require state Medicaid agencies to redetermine enrollees' eligibility based on reliable information available to the agency, when possible. This process is often called *ex parte* redetermination. 42 CFR § 435.916(b).
- Before terminating an ineligible enrollee's current coverage, the agency must check their eligibility for other coverage groups, including Family Planning, and enroll them there when eligible. 42 CFR § 435.916(d), State Medicaid Director Letter #10-013.

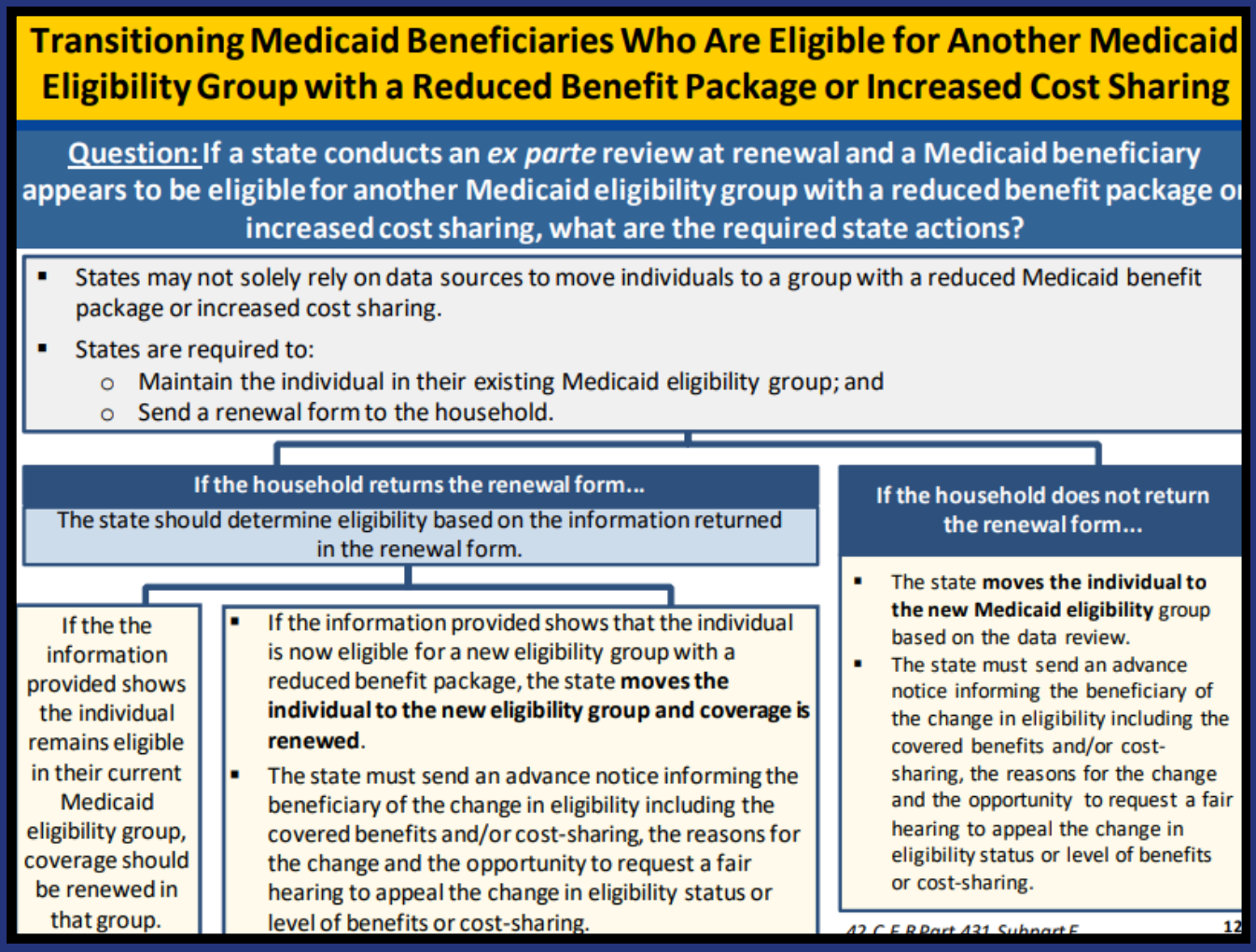
✓ **Auto-enrollment into MFPP coverage prevents people from becoming uninsured:**

- The income threshold for Family Planning coverage is often the same as the threshold for pregnant and postpartum people. Therefore, most individuals rolling off of postpartum Medicaid can be auto-enrolled into Family Planning coverage and **retain coverage** for critical preventative and reproductive healthcare.
- Procedural obstacles are often the reason that people lose their coverage. Auto-enrollment removes procedural obstacles, keeping people covered and improving health outcomes.

THE AUTO-ENROLLMENT PROCESS

1. A state Medicaid agency conducts an *ex parte* redetermination of eligibility.
2. The agency finds the individual is no longer eligible for their current coverage but is eligible for Family Planning coverage.
3. The agency keeps the individual in their current coverage group and sends them a renewal form.
4. If the form is not returned, the agency enrolls the individual in family planning coverage. If it is returned, the agency reviews it and determines whether the individual should keep their existing coverage or be enrolled in Family Planning.

CMS Guidance on Autoenrollment



Graphic Source: CMS Training, "Transitioning Individuals Within Medicaid Eligibility Groups and Between Medicaid and Chip at Renewal," slide 12.

Provider Training and Patient Engagement

Provider training and patient engagement are two critical components of MFPP implementation. Providers should be trained on MFPP eligibility, covered services, and enrollment processes to equip them to support patients in accessing no-cost family planning and related care. States should engage in public awareness campaigns to increase patient understanding of MFPP coverage and availability.

ICAN! has developed a suite of over 20 trainings and resources for specific provider audiences, including postpartum home visitors, family case managers, enrollment assisters, community health workers, and healthcare providers at safety net health centers along with digital and print culturally affirming patient-facing materials.

For Providers

- Tailored front end tools to assist with new patient capture and increasing coverage (i.e. phone scripts, sliding fee scales, patient simulation feedback).
- Coverage and eligibility fact sheets/assets (available in multiple languages and on request).
- Access to back-end resources to support workflow and revenue efficiency (i.e. documentation, coding, and buy &bill of devices).
- Collaborate with peer network to optimize patient outcomes.



For Patients

- Marketing campaign messaging and creative assets.
- Digital platform including tools such as:
  - Screening eligibility quiz.
  - Enrollment site directory.
  - Consumer FAQs.
- Flyers and postcards to distribute at health centers.

See the appendix for sample resources that can be adapted for your state's MFPP. Contact ICAN! for no cost resources and support tailored to the needs of your state.

Operationalizing MFPPs at the Health Center

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Reimbursement for FQHCs

States determine how to reimburse providers for Medicaid-covered services. Many states reimburse their community health centers (FQHCs, Look Alikes, and Rural Health Centers) with a per visit flat encounter rate based on a prospective payment system rate (PPS). States should ensure safety net primary care providers can bill the encounter rate or have a reimbursement model that fully compensates the care of preventative services provided under a MFPP.

Reimbursing FQHCs their encounter rate for MFPP care simplifies billing processes for MFPPs, ensuring that a patient will have the cost of their visit covered and the health center will be reimbursed so long as there is a qualifying, covered diagnosis code. Covering the cost of a patient's visit will help get patients through the door and engaging with a medical provider, leading to better outcomes, for all.

When programs bill MFPPs as fee-for-service, claims often get denied when during a qualifying visit, a provider discovers or a patient discloses an issue for which care is not covered under the MFPP. Including a non-covered code might result in the visit no longer being considered a "family planning" visit, and the cost of the visit is billed to the patient. This does not support patient-centered care. A patient should be able to visit a provider for a qualifying family planning visit and share information about their whole health without worrying that the discovery of additional conditions will result in them paying for the cost of their visit.



Of course, even under an encounter rate system, patients will still have to pay for non-covered services (e.g. the cost of an asthma inhaler refill at the pharmacy). The important benefit of an encounter-rate reimbursement methodology, however, is that patients can get the cost of their visit covered which significantly reduces patient financial barriers.

T1015 IS THE ALL-INCLUSIVE ENCOUNTER RATE HCPCS CODE!

Routine Screening for Contraceptive Needs and Desires

In many states, in order for a visit to be covered under a MFPP, the provider must include a family planning code or Family Planning (FP) modifier. The code for routine screening for contraceptive needs and desires can be a qualifying family planning code that ensures a visit is covered under an MFPP! Routine screening ensures that patients with MFPP coverage pay less (or nothing!) out of pocket and provides sustainable revenue for safety net health clinics by allowing providers to recoup the cost of their visit. See the appendix for screening questions!

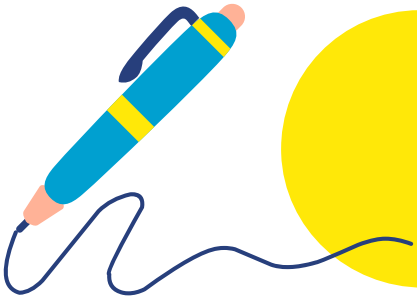
EXAMPLES

A patient is enrolled in State's MFPP. She visits a community health center for her annual physical exam. Her doctor screens her for contraceptive needs and desires and documents Z30.09, the code for general contraceptive management. With MFPP coverage, the annual exam is billable by the health center and the patient doesn't have financial barriers to basic preventative care.



A patient comes to the health center wanting STI testing and hasn't seen a primary care doctor in years. She gets her STI testing, gets screened for her contraceptive needs and desires and receives a recommended pap test for cervical cancer. Her provider enrolls her in her state's MFPP through presumptive eligibility and she is able to receive immediate, temporary coverage that covers the cost of her care. She completes an application for 12-months of MFPP coverage and schedules her next annual exam, knowing that the cost of her visit will be covered under the MFPP program.

Even a patient has to pay out-of-pocket for services or supplies not covered under a MFPP, out-of-pocket costs are minimized and health centers are reimbursed for the care provided because of routine screening and MFPP coverage. With MFPP coverage, health centers write off fewer costs and preserve limited grant dollars that go toward serving uninsured patients.



Document Z30.09 (general contraceptive screening) or Z30.XX (birth control method specific code) to capture revenue under your state's MFPP.

Ensuring Sustainability

Medicaid Family Planning Programs provide sustainable solutions to improve sexual and reproductive care.

MFPP coverage is Medicaid coverage, so it can be billed for qualifying services without a cap. This means health centers can be confident that they will be compensated for the care they provide without drawing down on limited grant dollars. Instead, those grant dollars can go to providing care to uninsured individuals with no coverage options. The steady and reliable stream of funding available through MFPPs can help health centers stay open and provide a vast scope of care, providing patients with an expansive network of places to access care.

Sustainability is maximized by reimbursing health centers at their encounter rate and covering a robust set of services. Reimbursing health centers their encounter rate means that health centers are adequately reimbursed for qualifying visits, and covering a robust set of services means that more visits qualify for coverage under the state's MFPP. This helps health centers connect their patients to whole person care without drawing down on limited grant dollars or writing off patient balances. Further, the more services that an MFPP covers, the more incentivized health centers are to enroll patients in coverage. When health centers enroll more folks in coverage, they become partners in lowering the uninsured rate in your state and improving state health outcomes!



WHY IT MATTERS

Sustainable coverage for preventative and primary care, including family planning and related services, is critical in this moment. Federal grant programs for family planning care are under attack and being frozen, cut dramatically, or completely terminated. Especially in difficult budget environments, states may not have the resources to backfill these lost federal grant dollars. MFPPs provide a sustainable solution to the family planning funding crisis by allowing states to preserve state dollars and take advantage of federal dollars through the federal match for family planning and related care. Further, MFPPs give providers a payment mechanism that, unlike a grant, is not capped nor subject to being cut, frozen, or terminated each budget cycle.



Part IV: Complementary Policies to Maximize the Impact of Your MFPP

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12-Month Supply of Contraception in a Single Pick Up

Patient outcomes are improved when a patient is dispensed a 12-month supply of their contraceptive method at the pharmacy in a single pick up. 12-month supplies reduce a patient's need to request numerous refills and support a patient's continuous use of their contraception. States should ensure patients can receive 12-months supply by requiring insurance, including Medicaid programs, to cover 12-months supply.

12-MONTHS SUPPLY REDUCES PATIENT BARRIERS TO CARE

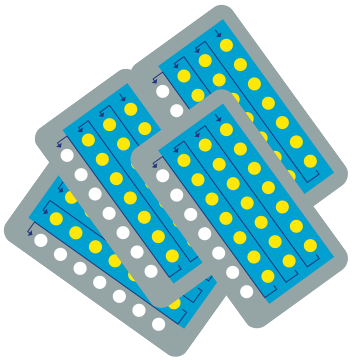
Providing patients with a 12-month supply of contraception means fewer trips to the pharmacy. For many patients, this means saving costs on gas and childcare and less time spent off of work. These time and costs can add up, especially when a patient has to visit the pharmacy once every 1-3 months for a refill. Further, 12-months supply is especially beneficial for patients who receive immediate, temporary coverage through presumptive eligibility, but don't go on to apply for or do not qualify for 12-months of MFPP coverage. 12-months supply ensures these patients' coverage can go further with fewer barriers for the patient.



12-MONTHS SUPPLY SUPPORTS CONTINUOUS USE OF CONTRACEPTION

Women dispensed 12-months supply of contraception experience fewer gaps in use over the course of a year than women dispensed 3-months at a time. 43% of women who only got a three month supply experienced a usage gap of at least a week. Further, people receiving 12-months supply were far more likely to refill their prescription more than a year after receiving their initial prescription, and receiving more packages of contraception is associated with a higher rate of continuation of the method at 6 months.

12-MONTHS SUPPLY REDUCES UNINTENDED PREGNANCY AND SAVES STATE DOLLARS



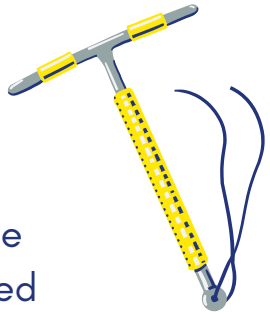
Supplying individuals with 12-months of contraception at one pharmacy visit decreases the likelihood of unintended pregnancy by 30%. When people are able to avoid pregnancies and births they did not intend or did not intend, yet, the state saves costs on maternity and infant care services. A study-from the VA found $87.12 in savings per woman who went from receiving 3-months supply to 12-months supply, and Washington found an average savings of $226 per woman who received 12-months supply as opposed to 1-month.

Sources: Judge-Golden, *et al.*, *Financial Implications of 12-Month Dispensing of Oral Contraceptive Pills in the Veterans Affairs Health Care System*, 179 JAMA INTERN. MED., (2019); Foster, *et al.*, *Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies*, 117 OBSTET. & GYNECOL., (2011); Fan *et al.*, *The Effect of Dispensing One-Year Supply of Oral Contraceptive Pills: Findings from Washington State*, DEP'T SOCIAL & HEALTH SERVS. (2018); White & Westhoff, *The Effect of Pack Supply on Oral Contraceptive Pill Continuation A Randomized Controlled Trial*, 118 OBSTET. & GYNECOL., (2011).

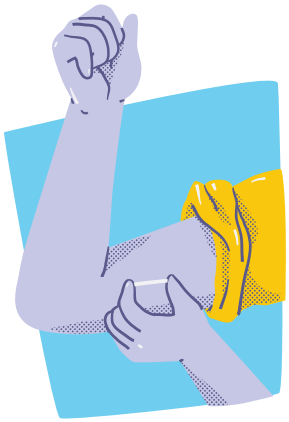
Carveouts from PPS Rate

Long-Acting Reversible Contraceptives (LARCs) are intrauterine devices (IUDs) and the contraceptive arm implant, hassle- free birth control method of choice for many people. However, many safety-net clinics are hesitant to cover the upfront cost of purchasing LARC devices (which can range from $100-$1,000 per unit) because there is no carve out of these devices from the encounter rate. Consequently, many providers opt to have patients pick up their devices via pharmacy, which means a separate visit which is not consistent with Quality Family Planning standard of same day insertion. States can help expand the availability of LARCs for those who want them by adopting a LARC carveout that allows providers to bill Medicaid for the cost of the device separately from the procedure code and/or encounter rate.

FOR EXAMPLE:



A FQHC buys a Liletta IUD at the 340B price. A provider inserts the device for a patient on Medicaid. The provider bills Medicaid for the clinic's encounter rate and for the Liletta IUD. The clinic is reimbursed its encounter rate plus the actual acquisition cost for the IUD.



States can adopt a LARC carveout for Medicaid programs, including Medicaid FPPs through a State Plan Amendment! Many states have separate reimbursement for LARC devices including for immediate placement postpartum, but broadening the carveout to cover all LARC devices to all people expands access to care and improves reproductive equity!

Similarly, at many clinics the encounter rate is not high enough to cover the one time permanent procedure of vasectomy services. States can also carve out vasectomy procedure (CPT code 55250) to expand access points for vasectomy and ensure all people can access their contraceptive method of choice.

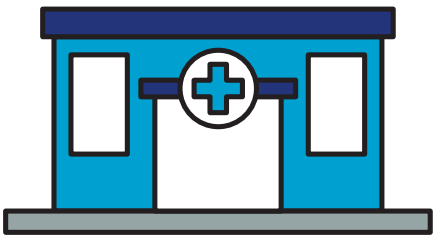
Reimbursing Enrollment

The federal government will provide federal match dollars for Mediaid enrollment that happens at community sites including disproportionate share hospitals, community health centers, and other sites that provide care to potentially eligible pregnant women and children. State Medicaid agencies should establish outstation enrollment sites at a broad range of community sites and support the sites in receiving reimbursement for the enrollment support they provide.

BENEFITS OF REIMBURSING ENROLLMENT

PROMOTES HEALTH CENTER SUSTAINABILITY

Enrolling patients in coverage requires staff time and resources. With a steady stream of funding for providing enrollment support, health centers are incentivized to continue providing that assistance.





INCREASES PATIENT ACCESS TO CARE

When more health centers are incentivized to offer enrollment support, patients have more pathways to getting coverage. When patients have coverage, they're more likely to engage with a healthcare provider to manage their health!

HELPS LOWER YOUR STATE'S UNINSURED RATE

State uninsured rates will decrease as patients transition from self-pay to a coverage program with enrollment assistance from their local health center. Strengthening enrollment in MFPPs helps your state maximize federal match dollars for providing care, which is especially valuable considering the generous federal match rate of 90% for family planning.



Source for federal requirements on outstationed enrollment: 42 CFR § 435.904.

ICAN! CAN WORK WITH YOUR STATE TO IDENTIFY COMPLEMENTARY POLICIES TO EXPAND ACCESS TO FAMILY PLANNING COVERAGE AND CARE!

Appendix

Reproductive Justice Aligned MFPP Checklist

Applying a Reproductive Justice lens to your state's MFPP is a critical part of ensuring that your state's MFPP is best serving patients. MFPPs should be patient-centered and connect people to care and coverage without coercion.

ELEMENTS OF A RJ-ALIGNED MFPP:

- ✓ **Connects individuals to whole-person health care** that supports reproductive well-being across the lifespan by allowing for encounter rate clinics to bill at the encounter rate as long as the visit includes a covered service code.
- ✓ **Creates the conditions for a person to make informed decisions** about their own sexual and reproductive health rather than directing an individual toward a particular reproductive health outcome or birth control method. RJ-aligned MFPPs should cover all methods of contraception and contraceptive counseling and management, regardless of if a patient chooses to use a method.
- ✓ **Promotes a TRUER** (Trauma-informed, Respectful, Unconscious bias aware, Evidence-based, and Reproductive well-being centered) **approach** to contraceptive care.
- ✓ **Evaluates impact without making assumptions** about patients' reproductive goals by measuring patient-reported experiences about person-centered contraceptive care instead of measuring impact based on increased use of a specific contraceptive method.

A RJ-ALIGNED MFPP SHOULD NOT:

- ✗ **Condition coverage on the patients' use of a contraceptive method.**
  People can use MFPP coverage to keep themselves healthy and plan for a healthy pregnancy as well as use the coverage for pregnancy prevention!
- ✗ **Deny coverage for MFPP covered services because a non-covered service was billed.**
  In these instances, the visit and covered service should be covered by the MFPP program. Non-covered services can be billed to the patient, separately. This ensures patients and their doctors do not delay or avoid necessary treatment to ensure payment through MFPP coverage.
- ✗ **Center around averting Medicaid-paid births.**

  MFPPs help people get primary and preventative care, including contraception. The goal of MFPPS should not be to save state dollars by averting Medicaid-paid births, but to help people access coverage for the care they need. Many may choose to use the coverage to prevent pregnancies that otherwise would have been covered by Medicaid, but others may use it to plan for healthy pregnancies or ensure they can get necessary cancer screenings and vaccines. However a patient uses this coverage, covering people keeps your state healthier!



Sample Patient and Provider Outreach Materials

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Get coverage for your visit!

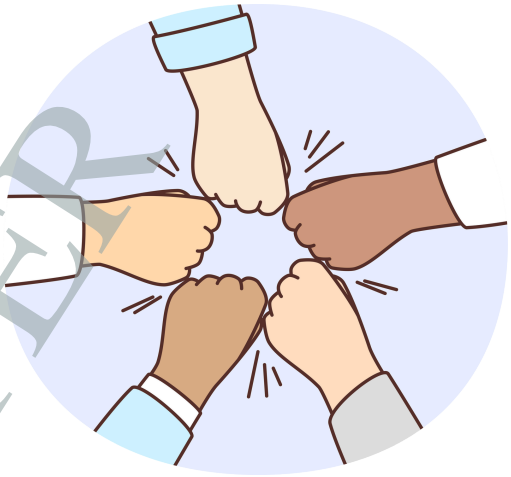
People of any age and gender can apply for ***immediate, temporary coverage*** in just 5 minutes!

You are eligible to enroll if:

- You live in Illinois.
- You make $3,754 or less a month ($45,048 a year) before taxes.
- You are not already enrolled in Medicaid.

In addition to your visit being free, you can also get any of the following services and medications at no cost:

- Physical exam
- STI testing/treatment and condoms
- HIV testing, PEP, and PrEP
- COVID, HPV, Hepatitis, and mpox vaccines
- Preconception care, counseling, and labs
- Birth control (pill, patch, ring, Depo, implant, IUD)
- Emergency contraception
- Tubal ligation or vasectomy
- Mammograms, pap smears/pap follow-up
- Treatment for genital/urinary infections



Enroll with a registered provider to apply for same-day coverage and care. Scan the QR code to find a provider near you!

- Say " I would like to enroll in FPPE coverage". Your temporary coverage will begin immediately and last through the end of the following month.
- No proof of income or citizenship required - does not count toward public charge. Coverage is confidential - no bill will be sent.
- Ask your provider if you're eligible to enroll for ongoing 12-month coverage or when you're eligible to reapply for temporary coverage.

Locate a health center

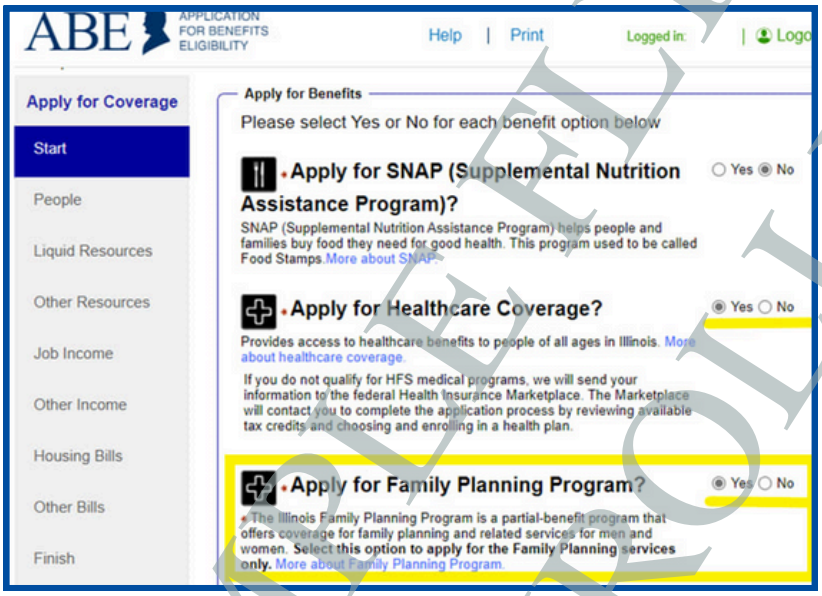
SAMPLE PATIENT FLYER

CHECK "YES" FOR FAMILY PLANNING

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HFS Family Planning Program (HFS FPP)

There are an estimated 1.2 million Illinoisans newly eligible for this alternative Medicaid benefits program covering primary and preventive services including all birth control methods. This coverage is open to individuals of any gender or age who (1) reside in Illinois (2) make ≤$3500 a month (3) are not already be enrolled in a public benefits program.



Check "YES" for family planning to ensure your client gets coverage for some preventive services if they don't qualify for full Medicaid benefits. Clients can apply even if they have private insurance they don't want to use (i.e. confidentiality concerns, high out-of-pocket costs, etc).*7*.

For individuals applying for Medicaid via ABE, check "yes" for family planning under *Apply for Benefits.*

For individuals going through the redeterminations process, check "yes" for family planning on *question 17*.

Covered services

- All FDA-approved birth control: condoms, emergency contraception, IUD, implant, pill, patch, ring, Depo shot, tubal ligation and vasectomy.
- STI testing and treatment: screening for chlamydia, gonorrhea, syphilis, etc.
- HIV testing & prevention: PEP & PrEP.
- Screening for breast (mammogram), cervical (pap), and testicular cancer.
- Follow up for abnormal pap smears.
- Treatment for genital & urinary infection.
- HPV and hepatitis vaccines.
- Basic infertility counseling.

Presumptive Family Planning Application from the *Provider Portal Landing Page*

In addition to ongoing coverage through the HFS FPP, clients can apply for **immediate, temporary coverage** (up to two months) by self-attesting to their income and residency with a qualifying presumptive eligibility provider (**FPPE**). No proof of documentation/citizenship requested when applying for FPPE and does not count toward public charge.

To become a FPPE provider, email: HFS.MPE.FPproviders@illinois.gov .

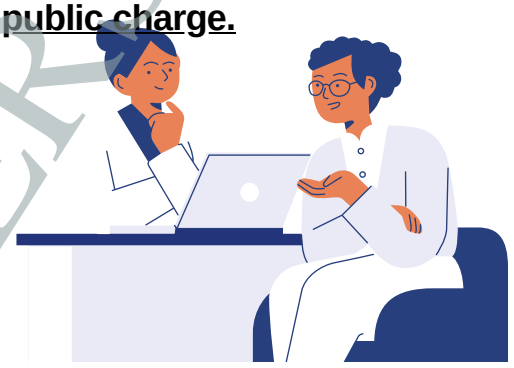
SAMPLE FLYER FOR ENROLLMENT ASSISTORS

Immediate, Temporary Coverage for Preventive Care Services

see if you qualify

Family Planning Presumptive Eligibility (FPPE)

There are an estimated 1.2 million Illinoisans newly eligible for an alternative Medicaid benefits program covering primary and preventive services including all birth control methods. **Regardless of immigration status, people of all genders and ages can apply for immediate, temporary coverage (**~31-60 days) by self-attesting their income is ≤$3600 a month, residing in Illinois, and not already being enrolled in Medicaid. Individuals can enroll with a qualifying provider and can apply for FPPE 2x per calendar year. **No proof of documentation/citizenship required when applying for FPPE and does not count toward public charge.**



Covered services

- Annual wellness exams/physicals
- HIV testing & prevention (PEP & PrEP)
- Treatment for reproductive, genital & urinary concerns
- HPV and hepatitis vaccines
- All FDA-approved birth control: condoms, emergency contraception, IUD, implant, pill, patch, ring, Depo shot, tubal ligation, vasectomy, and fertility awareness methods
- STI testing and treatment: screening for chlamydia, gonorrhea, syphilis, etc.
- Cervical cancer screening (Pap) and treatment for abnormal pap smears (colposcopy)
- Screening for breast cancer (mammogram) and BRCA testing
- COVID-19 Vaccine

HFS Family Planning Program (HFS FPP)

US Citizens and individuals who have lawfully lived in the U.S. for more than 5 years are also eligible for 12 months of coverage and can apply through ABE by checking YES for family planning.

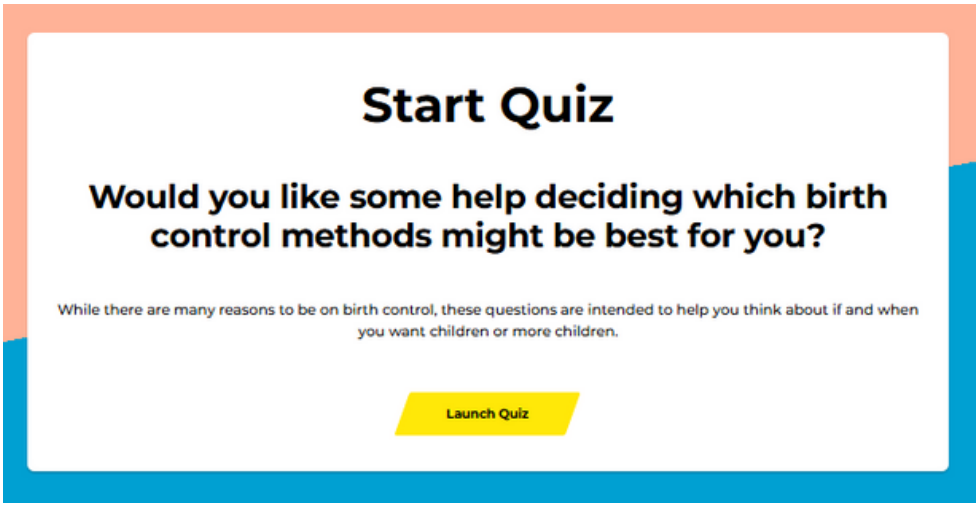
Additional Information

- For more information on public charge: https://docs.google.com/document/d/1JX6r9Ye2h3vT1ti_R2ba4DMczGyaEVIv/edit
- To learn more or become a member of the ICAN! health center network or be an FPPE provider email ican4all@alliancechicago.org.

SAMPLE FLYER FOR PROVIDERS

Sample Patient Tools

Click here for a Birth Control Options Quiz

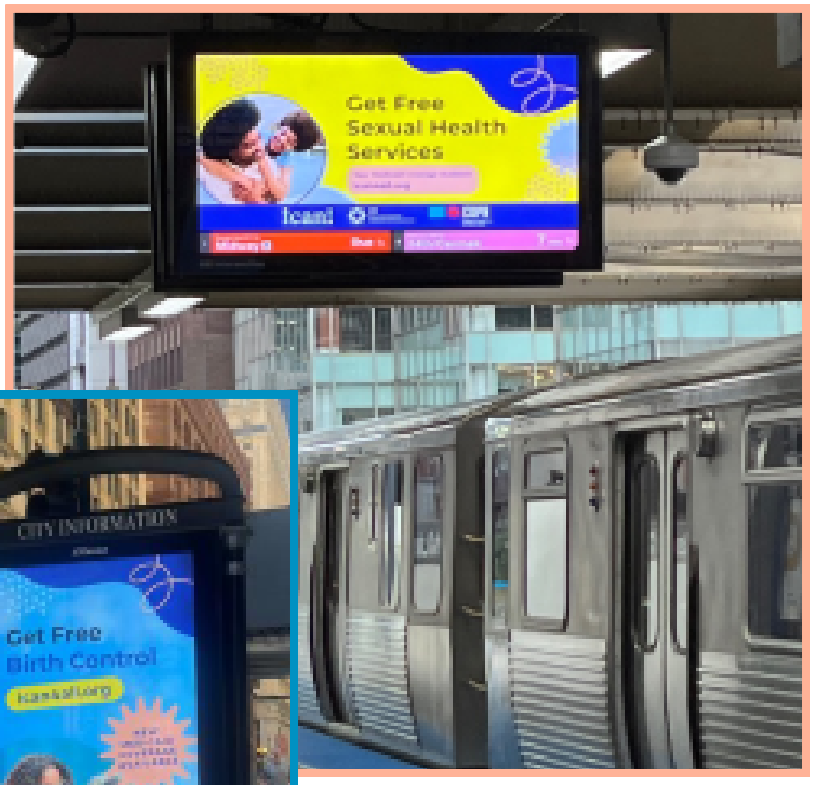


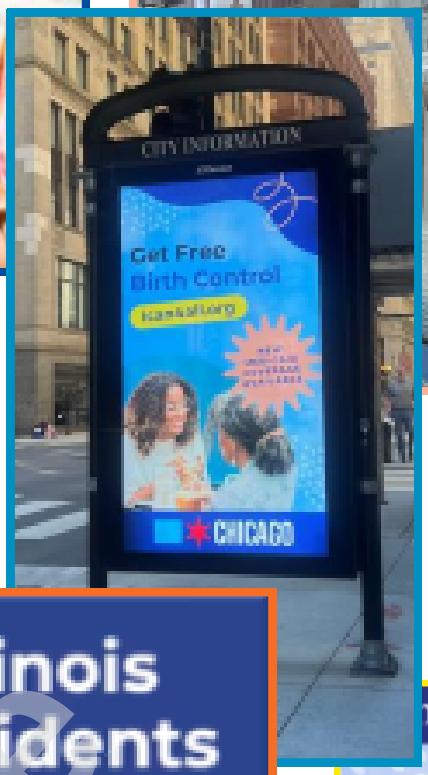
Click here for a sample MFPP Eligibility Quiz



Sample Digital and Out-of-Home MFPP Ads











Sample

Screening Questions for Contraceptive Needs and Desires

Patients of reproductive age should be screened for contraceptive needs and desires alongside STI and HIV education and prevention during primary care visits. Screening all patients, regardless of gender, helps destigmatize and normalize thinking of birth control as basic health care.

SCREENING QUESTIONS

PATH (PARENTHOOD/PREGNANCY ATTITUDE, TIMING, AND IMPORTANCE)

Do you think you might like to have (more) children at some point?

When do you think that might be?

How important is it to you to prevent pregnancy (until then)?

✓ **Gender-neutral**

OKQ (ONE KEY QUESTION)

Would you like to become pregnant within the next year?

SINC (SELF-IDENTIFIED NEED FOR CONTRACEPTION)

Do you want to talk about contraception or pregnancy prevention during your visit today?

✓ **Gender-neutral** ✓ **Open-ended questions**



Sample Covered Services and Codes

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These sample covered codes are those codes covered under Illinois' HFS Family Planning Program.

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MFPP Billing and Coding Job Aid

Method	CPT: *the WHAT*	ICD-10: the *WHY*		Supply/Med
		Initial	Surveillance	
Screening & counseling	E/M	Z30.09	Z30.09	Usually no Rxing
Pills	E/M	Z30.011	Z30.41	S4993
Depo Shot	96372 injection	Z30.013	Z30.42	J1050 150 units (IM) 104 units (SQ)
Vaginal Ring	E/M	Z30.015	Z30.44	J7295-monthly J7294-yearly
Patch	E/M	Z30.016	Z30.45	J7304- monthly
Barrier Methods	E/M	Z30.018	Z30.49	A4267 -external, "male" A4268 -internal. "female" A4266 - cap / diaphragm
Natural Family Planning	E/M	Z30.02	Z30.02	
Procreative counselling	E/M	Z31.61	Z31.69	
Procedural Visits				
IUD	Insertion-58300 Removal- 58301 Remove & Reinsert- 58301 + 58300 + 51 or 59	Z30.430 Z30.432 Z30.433	Z30.431	J7296-Kyleena J7297-Liletta* J7298-Mirena* J7300-Paragard* J7301-Skyla
IUD for EC*	58300, note ICD-10 for EC*	Z30.012*		
Implant	Insertion-11981 Remove-11982 Remove & Reinsert 11983	Z30.017 Z30.46 Z30.46	Z30.46	J7307- Nexplanon
Vasectomy	55250	Z30.2	Z98.52	Counseling & Medicaid consent signed (HFS 2189) = E/M visit prior to procedure (Z30.09)
Tubal Ligation	58600	Z30.2	Z98.51	
Practice Pearls				
EC Pills: Rx in advance, if > 165 lbs- Rx Ella		Z30.012	Z30.012	S4993

For Pills/Patch/ Ring: Prescribe one year supply for single pick up (#13 or #15 if continuous use)

Screen for STI per guidelines and offer or Rx ext/int condoms (#30 per month covered by Medicaid)

COMMON MODIFIERS

22: Unusual surgical procedure (longer or more complicated than usual)

25: Significant & separate procedure/services (annual & problem E/M, problem E/M and procedure)

***5*1: >1 procedure** (IUD insert & remove)

53: Discontinued (vasovagal)

59: Distinct procedural service (not bundled)

95: Telehealth – real time video and audio

GOOD TO KNOW

76830: Transvaginal ultrasound (TV u/s) guidance for IUD placement

76817: TV u/s, non-pregnant uterus

N92.4: Excessive menstrual bleeding

N92.6: Irregular menstrual bleeding

N94.6: Painful menstrual bleeding

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Sample covered service codes

Code/Description of Service
00851 - Anesthesia, for procedures of the lower abdomen
00940 - Anesthesia for vaginal procedures
00952 - Anesthesia, procedures for the perineum
01965 - Intrathecal/epidural catheter insertion, anesthesia for obstetric procedure
01966 - Anesthesia services for induced abortion procedure
11976 - Removal of implantable contraceptive capsules or pellets
11981 - Insertion, non-biodegradable drug implant
11982 - Removal, non-biodegradable drug implant
11983 - Removal and reinsertion of non-biodegradable drug implant
17000 - Destruction, premalignant lesions
49320 - Laparoscopic abdominal diagnostic procedure
54050 - Destruction of lesion(s), penis (laser surgery, electrosurgery, cryosurgery, chemosurgery, or surgical curettement)
54056 - Destruction of lesions on the penis (cryosurgery)
54065- Destruction of lesion on the penis when the destruction is extensive
54100 - Biopsy of the penis
55250 - Unilateral or bilateral vasectomy including post op semen exam
56420 - Bartholin's gland, incision and drainage
56440 - Marsupialization of a Bartholin's gland cyst
56501 -Destruction of lesion(s) Vulva or perineum (simple)
56515 - Destruction of lesion(s), Vulva or perineum lesion destruction (extensive)
56605 - Biopsy of the vulva or perineum, specifically for one lesion
56805 - Repair procedure of the vulva, perineum and introitus; clitoroplasty, a surgical procedure aiming to reshape or reduce the size of the clitoris
57061 - Destruction of small or simple vaginal lesions
57065 - Destruction of multiple vaginal growths/lesions
57160 - Fitting and insertion of a pessary or other intravaginal support device
57170 - Fitting for diaphragm or cervical cap
57410 - Pelvic examination done under anesthesia
57420- Colposcopy of the entire vagina, including the cervix
57452 - Colposcopy of the cervix including upper/ adjacent vagina
57454 - Colposcopy of the cervix including upper/adjacent vagina with biopsy of the cervix and endocervical curettage
57455 - Colposcopy of the cervix including upper/adjacent vagina with biopsy(s) of the cervix
57456 - Colposcopy of the cervix with endocervical curettage

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Code/Description of Service
57460 - Colposcopy of the cervix with loop electrode biopsy(s) of the cervix (LEEP)
57461 - Colposcopy of the cervix including upper/adjacent vagina with loop electrode conization of the cervix (LEEP)
57500 - Removal of a lesion such as a polyp on the cervix or performs biopsy(s) of the cervix with or without high frequency electric current (fulguration)
57505 -Endocervical curettage to collect tissue samples with a curette, not part of D&C procedure
57510 - Excision procedures on the cervix uteri using electric current or thermal cautery to destroy cervical lesions
57511 - Excision procedures on the cervix/freezing destruction of the cervix
57520 - Conization of the cervix using a scalpel or a laser and may use electrical current, fulguration, dilation and curettage or repair
57522 - Conization of the cervix without using a colposcope
58100 - Endometrial biopsy without dilating the cervix
58110 - Endometrial sampling or biopsy performed during a colposcopy
58120 - Diagnostic and/or therapeutic non-obstetrical dilation and curettage (D&C) procedures
58300 - Insertion of an intrauertine deivce (IUD)
58301 - Removal of an intrauterine device (IUD)
58340 - Catheterization and introduction of substances for selective fallopian tube catheterization, including imaging
58555 - Diagnostic hysteroscopy to examine uterine cavity
58558 - Diagnostic hysteroscopy with endometrial sampling/D&C/polypectomy
58562- Surgical hysteroscopy that removes an impacted foreign body, such as an intrauterine device (IUD)
58565 - Laparoscopic/hysteroscopic procedure with bilateral fallopian tube cannulation to induce occulsion by placement of permanent implants
58600 - Ligation or transection of fallopian tube(s), abdominal or vaginal approach
58605 - Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum during same hospitalization as delivery
58611 - Ligation or transection of fallopain tube(s) done at time of cesarean delivery or intra-abdominal surgery
58615 - Occlusion of fallopian tube by device (band, clip or ring) at cesarean delivery or intra-abdominal surgery.
58661 - Laparoscopic surgical with removal of adnexal (partial or total oopherectomy and /or salpingectomy)
58670 - Laparoscopic surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58671 - Laparoscopic surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58673 - Laparoscopic surgical procedures involving the creation of a new opening at the end of the fallopian tube, used for unilateral procedures only.
58700 - Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
59812 - Surgical management of an incomplete abortion, used to report the D&C
59820 - Treatment of a missed abortion, surgically, first trimester
59821 - Treament of a missed abortion, surgically second trimester
59830 - Surgical treatment of septic abortion, removing POC
59840 - Abortion procedure by dilation and curettage (D&C), prior to 14 weeks
59841 - Induced abortion by dilation and evacuation, after 14 weeks and 0 days
59850 - Induced abortion using one or more intra-amniotic injections to cause fetal demise and initiate labor process

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Code/Description of Service
59851 -Induced abortion using one or more intra-amniotic injections, typical >14 wks, includes hospital admission
59855 - Induced abortion by one or more vaginal suppositories with or w/o cervical dilation
59856 - Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria)
59857 - Induced abortion, surgical, by 1 or more vaginal suppositories
74018 - X-ray examination of abdomen with one view
74740 - Hysterosalpingography, x-ray procedure to evaluate the uterus and fallopian tubes with selective contrast catheterization of fallopian tube(s)
76376 - 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision
76830 - Ultrasound, transvaginal
76856 - Ultrasound, complete evaluation of the pelvic structures (nonobstetric), real-time with image documentation; limited
76857 - Ultrasound, pelvic (nonobstetric), limited to assess one or more pelvic organs (bladder, uterus, ovaries, or prostate)
76998 - Ultrasound guidance, intraoperative
77046 - Magnetic resonance imaging (MRI), breast, without contrast material; unilateral
77047 - Magnetic resonance imaging (MRI), breast, without contrast material; bilateral
77048 - Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77049 - Magnetic resonance imaging (MRI) procedure of the breast that includes both contrast and non-contrast imaging, along with computer-aided detection (CAD)
Screening digital breast tomosynthesis (3D); bilateral
78800 - Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area, for a single planar imaging session alone
77065 - Diagnostic mammography code for unilateral breast imaging, including computer aided detection (CAD)
77066 - Diagnostic mammography code used for bilateral breast imaging, including computer aided detection (CAD)
77067 - Screening mammogram for both breasts including computer aided detection (CAD)
80048 - Basic metabolic panel (BMP) : calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen.
80061 - Lipid panel
80076- Hepatic function panel: total protein, albumin, alkaline phosphatase, bilirubin, both total and direct, and liver enzymes
81000 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81001 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002 - Urinalysis, non-automated without microscopy (dipstick)
81003 - Urinanalysis, automated without microscopy
81005 - Urinalysis, qualitative or semi-quantitative, except immunoassays
81007 - Urinalysis, bacteriruria screen, by non-culture, commercial ki
81015 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; reagent strip, microscopic only
81025 - Urine pregnancy test, by visual color comparison methods
81162 - Genetic analysis of the BRCA1 and BRCA2 genes, covers full sequence analysis and full duplication/deletion of both genes.

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Code/Description of Service
81163 - BRCA1 and BRCA2 gene analysis using full sequence analysis
81164 - BRCA1 and BRCA2 gene analysis, specifically for full duplication/deletion analysis
81432 - Genomic sequencing procedures and other molecular multianalyte assays, specifically for hereditary breast cancer-related disorders
82270 - Blood occult test, feces, 1-3 simultaneous determinations, qualitative test that indicates presence of blood in stool (FIT or FOBT)
82570 - Creatine, urine
82670 - Estradiol, total
82947 - Glucose; quantitative, blood (except reagent strip)
83001 - Follicle stimulating hormone (FSH)
83002 - Luteinizing hormone (LH)
83020 - Hemoglobin fractionation and quantitation
83021 - Hemoglobin; electrophoresis or hgb identification, also use to identify thalassemia anemia
83026 - Hemoglobin; glycosylated (A1c)
83036 - Hemoglobin A1c lab test use dto measure and monitor blood sugar levels
83520 - Anti-Müllerian hormone (AMH)
84144 - Procedural code for measuring the level of progesterone, a reproductive hormone
84146 - Prolactin level testing useful for detecting prolactin secreting pituatary tumors and other conditions that affect the hypothalamus or pituitary gland.
84155 - Protein, total, serum
84156 - Protein, total, urine
84402 - Testosterone, free (direct), serum
84403 - Testosterone; total levels, serum
84702 - Human chorionic gonadotropin (HCG), quantitative measurement, serum
84703 - Human chorionic gonadotropin (HCG), b-subunite, qualitative, serum
85013 - Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count)
85014 - Complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count), red blood cell concentration measurement
85018 - Hemoglobin levels in a whole blood sample
85025 - Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count)
85027 - Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count); CBC without a differential
86592 - Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
86593 - Syphilis test, non-treponemal antibody; quantitative
86628 - Qualitative or semiquantitative immunoassays for analysis for antibody to candida (yeast)
86631 - Antibody; Chlamydia trachomatis
86632 - Antibody IgM; Chlamydia trachomatis, with reflex to confirmation, serum

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Code/Description of Service
86689 - Antibody; HTLV or HIV antibody, confirmatory test (Western Blot)
86694 - Antibodies to non specific type of herpes simplex virus (HSV), serum
86695 - Antibody, qualitative or semiquantitative immunoassays, testing for HSV1 or IgG antibodies
86696 - Antibodies to type 2 herpes simplex (HSV-2), immunoassays procedure, serum or CSF
86701 - Antibody HIV-1 test
86702 - Antibodies to HIV-2, serum
86703 - Antibody to HIV-1 and HIV-2 virus
86780 - Antibody to treponema pallidum (bacterium that causes syphilis)
86787 - Antibodies to varicella -zoster (chickenpox and shingles), serum or CSF
87086 - Bacterial culture, urine; quantitative colony count, urine
87088 - Bacterial culture, urine; with isolation and presumptive identification of non-urinary pathogens including antimicrobial sensitivity when performed
87110 - Culture, typing; Chlamydia
87184 - Suspectibility studies by disk metho or urine culture isolates, 12 or fewer agents
87186 - Suspectiblity studies by the MIC (minimum inhibitory concentration) technique on urine culture isolates for sensitivity studies
87210 - Smear, wet mount for infectious agents (bacteria, fungi, or cell types)
87270 - Infectious agent antigen detection by immunofluorescent technique, Chlamydia trachomatis
87273 - Infectious agent antigen detection by immunofluorescent technique for Herpes Simples Virus 2 (HSV 2, genital herpes)
87285 - lab analyst to detect antigens of Treponema pallidum bacteria using immunofluorescent antibody stain and fluorescence microscopy
87320 - Infectious agent antigen detection by enzyme immunoassay technique for Chlamydia
87389 - Infectious agent antibody test for HIV-1, antigen detection for HIV 1 and HIV-2 (single result)
87390 - Infectious agent antigen detection of HIV-1 by enzyme immunoassay without the inclusion of HIV-2 antibodies
87391 - Infectious agent antigen detection of HIV-2 by enzyme immunoassay technique
87485 - Infectious agent detection by nucleic acid (DNA or RNA) with direct probe technique to detect t+D140:D143he presence of chlamydia pneumoniae
87490 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87491 - Infectious agent detection by nucleic acid amplification techniques (DNA or RNA); Chlamydia trachomatis, quantification
87492 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
87510 - Laboratory test to detect the presence of Gardnerella vaginalis with direct nucleic acid probe technique
87511 - Amplified nucleic acid probe technique to identify the presence of Gardnerella vaginalis
87512 - Detection of Gardnerella vaginalis, a bacteria associated with bacterial vaginosis; quantification using nucleic acid probe technique
87528 - Infectious agent detection by nucleic acid (DNA or RNA); amplified probe technique, Herpes simplex virus (HSV)
87529 - Infectious agent detection by nucleic acid (DNA or RNA); amplified probe technique, differentiates HSV-1 and HSV-2
87530 -Infectious agent detection by nucleic acid (DNA sequences by PCR); quantification, amplified probe technique, HSV-1 and HSV-2
87590 - Infectious agent detection by nucleic acid (DNA or RNA); detection test for Neisseria gonorrhoeae

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Code/Description of Service
87591 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhae amplified probe technique
87592 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae quantification
87623 - Infectious agent detection by nucleic acid (DNA or RNA); specifically for detecting low risk types of Human Papillomavirus (HPV) such as 6, 11, 43, 43, and 44
87624 - Infectious agent detection by nucleic acid (DNA or RNA); detection of high risk types of Human Papillomavirus (HPV), causative agent of cervical dysplasia and carcinoma.
87625 - Infectious agent detection by nucleic acid (DNA or RNA); HPV types 16, 18, and 45
87660 - Direct probe technique used to detect the presence of Trichomonas vaginalis, a protozoan parasite in a primary specimen
87661 - Detection of Trichomonas vaginalis
87806 - Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen[s], with HIV-1 and HIV-2 antibodies
87808 - Infectious agent antigen detection of Trichomonas vaginalis by immunoassay with direct optical observation
87810 - Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis
87850 - Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhea
87899 - Infectious agent antigen detection by immunoassay with direct optical observation; multiple step method and specific infectious organism is NOT identified by another code
88141 - Cytopathology, in situ hybridization (eg, FISH), cervical or vaginal (any reporting system), usually through a pap smear or liquid based cytology
88142 - Cytopathology, in situ hybridization (eg, FISH), cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, manual screening under physician supervision
88143 - Cytopathology, in situ hybridization (eg, FISH), manual screening and rescreening under physician supervision , used for liquid based specimens.
88147 - Cytopathology smears, cervical or vaginal using an automated system under physician supervision. Code is for one screening session
88148 - Cytopathology smears, cervical or vaginal, screened by automated system with manual rescreening under physician supervision
88150 - Cytopathology screening procedure ,cervical or vagina manually under a physician's supervision
88152 - Cytopathology, selective cellular enhancement technique/computer-assisted rescreening, with interpretation and report (eg, liquid based slide preparation method)
88153 - Cytopathology, cervical/vaginal pap smear, selective cellular enhancement technique with manual screening and rescreening under physician supervision
88155 - Cytopathology screening procedures, used to report physician interpretation of a cervical or vaginal specimen.
88160 - Cytopathology smears, lab analyst performs the technical steps to analyze a cytopathology specimen smeared on a slide.
88161 - Pathology and laboratory cytopathology screening exam of specimen cells. Can be used for tumor immunohistochemistry.
88162 - Cytopathology smears with extended study, analyzing over 5 slides or multiple stains
88164 - Cytopathology, manual screening of cervical or vaginal slide by a lab analyst under the supervision of a physician.
88165 - Cytopathology, slides, cervical or vaginal; manual screening with rescreening under physician supervision
88166 - Cytopathology, slides, cervical or vaginal; with manual screening and rescreening by computer assisted system under physician supervision
88167 - Cytopathology, slides, cervical or vaginal; with manual screening by automated system under physician supervision using the Bethesda System
88174 - Cytopathology, preservative fluid, cervical or vaginal; screening by automated system, with further review by physician
88175 - Cytopathology, preservative fluid, cervical or vaginal; with automated thin layer preparation, followed by screening with automated system and manual rescreening under physician supervision. Bethesda or non-Bethesda reporting system
88305 - Surgical pathology, gross and microscopic examination (code endometrial curettings, biopsies and polyps for gynecological specimens

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Code/Description of Service
88307 - Surgical pathology, gross and microscopic examination of tissue with moderately high complexity. Applied to ovary with or w/o tube, neoplastic, or excision of lesion requiring microscopic evaluation of surgical margins.
88331 - First block of the frozen section specimen- surgical pathology examination)
88332 - Pathology consultation during surgery, each additional tissue block with frozen section.
88342 - Initial single antibody stain performed on a tissue specimen
89300 - Semen analysis for presence and/or motility of sperm and a Huhner test
89310 - Semen analysis procedure to analyze semen for motility and count
89321 - Semen analysis including the presence and motility of sperm, use for post-vasectomy
90611 - Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use
90651 -Human Papillomavirus (HPV) vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use. This vaccine is typically administered to prevent HPV infection, which can lead to cervical cancer, genital warts, and other cancers.
90744 - Hepatitis B vaccine, adolescent or pediatric dosage (3 dose schedule), for intramuscular use.
90746 - Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use.
96372 - Therapeutic, prophylactic, and diagnostic substance by subcutaneous or intramuscular injections
99070 - Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered.
99152 - Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer.
99202 - Office or other outpatient visit for the evaluation and management (E/M) of a new patient with straightforward medical decision making and/or 11-20 minutes of patient encounter time
99203 - Office or other outpatient visit for the evaluation and management (E/M) of a new patient, low medical decision making and/or 30 to 44 minutes
99204 - Office or other outpatient visit for the evaluation and management of a new patient, moderate complexity, 45-59 minutes.
99205 - Office or other outpatient visit for the evaluation and management of a new patient, comprehensive, high complexity, 60-74 minutes
99211 - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.
99212 - Office or other outpatient visit for the evaluation and management of an established patient, straightforward, typically last 10-19 minutes
99213 - Office or other outpatient visit for the evaluation and management of an established patient, low complexity, 20-29 minutes
99214 - Office or other outpatient visit for the evaluation and management of an established patient, moderate complexity, 30-39 minutes
99215 - Office or other outpatient visit for the evaluation and management of an established patient, comprehensive, high complexity, 40+ minutes
99221 - Initial hospital care, low complexity.
99222 - Initial hospital care, moderate complexity.
99223 - Initial hospital care, high complexity.
99231 - Subsequent hospital care, minimal.
99232 - Subsequent hospital care, low complexity.
99233 - Subsequent hospital care, moderate complexity.
99238 - Hospital discharge day management; 30 minutes or less.
99239 - Hospital discharge day management; more than 30 minutes.

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Code/Description of Service
99242 - Office consultation for a new or established patient, low complexity.
99243 - Office consultation for a new or established patient, moderate complexity.
99244 - Office consultation for a new or established patient, high complexity.
99245 - Office consultation for a new or established patient, comprehensive.
99252 - Prolonged service in the office or other outpatient setting, requiring direct patient contact beyond the usual service, first hour.
99253 - Prolonged service in the office or other outpatient setting, requiring direct patient contact beyond the usual service, first hour.
99254 - Prolonged service in the office or other outpatient setting, requiring direct patient contact beyond the usual service, each additional 30 minutes.
99255 - Prolonged service in the office or other outpatient setting, requiring direct patient contact beyond the usual service, each additional 30 minutes.
99383 - Initial preventive visit, new patient, age 5-11 years
99384 - Initial preventive visit, new patient, age 12-17 years
99385 - Initial preventive visit, new patient, age 18-39 years
99386 - Initial preventive visit, new patient, 40-64 years
99387 - Initial preventive visit, new patient, 65 years and older
99393 - Periodic comprehensive preventive medicine reevaluation and management, 5-11 years
99394 - Periodic comprehensive preventive medicine reevaluation and management, 12-17 years
99395 - Periodic comprehensive preventive medicine reevaluation and management, 18-39 years
99396 - Periodic comprehensive preventive medicine reevaluation and management, 40-64 years
99397 - Periodic comprehensive preventive medicine reevaluation and management, 65 years and older
99401 - Preventive medicine counseling and/or risk factor reduction; approximately 15 minutes.
A4267 - Contraceptive supply, condom, male, each
A4268 -Contraceptive supply, condom, female, each
A4269 - Contraceptive supply spermicide (foam, gel), each
G0101 - Cervical or vaginal cancer screening; pelvic and clinical breast examination.
G0123 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by cytotechnologist under physician supervision.
G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision.
G0279 - Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)
G0432 - Infectious agent antibody detection by enzyme immune assay (EIA) technique, qualitative or semi quantitative, multiple step method, HIV-1 or HIV-2 screening
G0433 - Infectious agent antibody by enzyme linked immunosorbent assay (ELISA) technique , HIV-1 and/or HIV-2
G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2 screening or just "oral HIV-1/HIV-2 screen"
G0475 - HIV antigen/antibody combination assay screening
J0694 - Injection, Cefuroxime sodium, 1 gm
J0696 - Injection, Ceftriaxone sodium, per 250 mg

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Code/Description of Service
J0698 - Injection, Ceftriaxone sodium
J1050 - Injection, Medroxyprogesterone acetate, 1 mg
J3490 - Unspecified drug, injection(must bill with NDC numbers, drug name/dosage/route (EC Pills)
J7294 - Segesterone acetate and ethinyl estradiol per 24 hours, yearly vaginal system each (Annovera)
J7295 - Ethinyl estradiol and etonogestrel per 24 hours, monthly vagina ring, each (Eluryng/Nuvaring)
J7296 - Levonorgestrel-releasing intrauterine contraceptive system, 19.5 mg (Kyleena)
J7297 - Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Liletta)
J7298 - Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)
J7300 - Intrauterine copper contraceptive (Paragard)
J7301 - Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg (Skyla)
J7304 - Contraceptive supply, hormone containing patch, each (Xuland, Zafemy, Twirla)
J7307 - Etonogestrel contraceptive implant system, including implant and supplies (Nexplanon)
J8499 - Prescription drug, oral, non-chemotherapeutic, NOS.
Q0111 - Wet mounts including preparations of vaginal, cervical or skin specimens
S0190 - Mifepristone, oral, 200 mg
S0191 - Misoprostol, oral, 200 mcg
S0199 - medically induced abortion by oral ingestion of medication including all associated services and supplies
S4993 - Contraceptive pills for birth control
T1015 - All inclusive clinic visit code used to identify service provided in a FQHC or Community Health Center.
58600 - Female sterilization
55250 - Vasectomy
0102U - BreastNext® test from Ambry Genetics®, which is a genomic sequence analysis panel of 17 genes associated with hereditary breast cancer-related disorders.
0103U - OvaNext® test from Ambry Genetics®, which is a genomic sequence analysis panel of 25 genes associated with hereditary ovarian cancer.
0129U - BRCAplus™ test developed by Ambry Genetics®, which is a genomic sequence analysis and deletion/duplication analysis to assess genetic predispositions to hereditary breast cancer-related disorders, including hereditary breast cancer, ovarian cancer, and endometrial cancer.
0131U - +RNAinsight™ for BreastNext® test from Ambry Genetics, which is a targeted mRNA sequence analysis panel of 13 genes to improve variant classification of genes implicated in various hereditary breast cancer-related disorders.
0132U - +RNAinsight™ for OvaNext® test from Ambry Genetics, which is a targeted mRNA sequence analysis panel of 17 genes to improve variant classification of genes implicated in various hereditary ovarian cancer-related disorders.
01325U - +RNAinsight™ for OvaNext® test from Ambry Genetics, which is a targeted mRNA sequence analysis panel of 17 genes to improve variant classification of genes implicated in various hereditary ovarian cancer-related disorders.
0238U - Genomic Unity® Lynch Syndrome Analysis uses a blood or saliva specimen processed using a PCR free whole genome sequencing (WGS) platform with algorithmic data analysis to evaluate the five genes listed in the code for variants relevant to Lynch syndrome, also called hereditary non-polyposis colorectal cancer (HNPCC)

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Any procedure code highlighted in grey must have a documented family planning service code to be covered and reimbursed by the program. Qualifying codes include:

Z30.XX - Family planning
Z31.XX - Preconception care
A50-A64, A74.9, Z11.3 - STI
Z01.419/Z01.411: Annual gynecological exam
Z00.00/Z00.01: General adult medical exam
Z12.4: Screening for cervical neoplasm
R87.619: Unspecified abnormal cytology findings in specimen from cervix uteri

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Medicaid Family Planning Program Policy Toolkit

September 2025

All maps in this toolkit were created with mapchart.net
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