M2 Health Care Consulting

Key Considerations in Estimating the Budgetary Effects of Restricting Federal Funds to Certain Family Planning Providers in Medicaid

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A recent Congressional Budget Office (CBO) cost estimate[1] for eliminating Federal Payments to Prohibited Entities does not appear to include the substantially higher rates that FQHCs receive compared to the providers who will be considered prohibited from delivering basic family planning services in its estimates of budgetary effects. Based on a comparison M2 performed of a sample of state Medicaid rates for FQHCs vs. family planning providers, it appears the CBO estimate did not consider that FQHCs are reimbursed at rates from 72% to 894% higher for the most common family planning services. A more detailed analysis from CBO should be sought to better estimate the budgetary effect of this provision as it appears Medicaid spending could increase substantially relative to the CBO cost estimates published in May 2025.

Background

Estimating the budgetary effects of changes to Medicaid provider types necessitates an understanding of the different reimbursement methodologies used by states. If patients are to receive family planning services in an FQHC setting, those reimbursement amounts will almost always be higher than if the patient receives the same service in a clinic setting. As such, the federal funding outlay will be higher if patients receive care in the higher priced setting. Below is brief explanation of the two reimbursement methodologies of importance to the CBO's cost estimate related to family planning services.

FQHC Reimbursement Methodology

Federally-qualified health centers (FQHCs) are reimbursed for services provided to Medicaid-eligible individuals under a Prospective Payment System (PPS) methodology consistent with requirements of The Budget Improvement and Protection Act of 2001 (BIPA).[2] FQHC services are a required Medicaid service and states may not pay less than the PPS rate. A CMS Dear State Health Official and State Medicaid Director Letter explaining the BIPA requirements states that BIPA "includes an option for a state and an FQHC…to agree to an alternative payment methodology (APM) that provides for payment of at least the same amount as would otherwise be required under the PPS."[3] The payment methodology applies to health centers regardless of whether they are paid directly by their state Medicaid programs on an encounter basis or through participation in managed care arrangements."

The BIPA methodology is based on FQHCs' 1999-2000 cost reports and is trended forward annually by an inflator tied to the medical economic index (MEI). The unified payment is made on an encounter (i.e., bundled procedures) basis, not per service or procedure. As the Centers for Medicare & Medicaid Services (CMS) clarified in a State Health Official sub-regulatory guidance in February 2010, "Unlike a cost-based reimbursement system, a PPS establishes a provider's

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[1] CBO. "Estimated Budgetary Effects of a Bill to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, the One Big Beautiful Bill Act," May 20, 2025. https://www.cbo.gov/publication/61420

[2] 42 U.S.C. §1396a(bb)(2-6)

[3] CMS. State Health Official Letter SHO #16-006. "FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care." April 26, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16006.pdf

payment rate for a service before the service is delivered; the rate is not dependent on the provider's actual costs or the amount charged for the service."[4] This payment methodology essentially sets a federal floor for FQHCs.[5]

What does this mean in practice? At an FQHC, a patient visit that includes the examination of a rash, a sore throat and a health care provider answering questions about the side effects of a medication, would, under most circumstances be reimbursed at a flat rate (either the PPS or an APM of at least the PPS amount). In other words, the simplest office visit pays at the same rate as a much more complex visit. Payment for some items, though very few, are outside the set reimbursement rate, for example, drugs and devices are often paid separately. In most states, that same patient visit at a family planning clinic would be reimbursed based on each service provided according to a fee schedule (fee-for-service) published by the relevant state agency. Published rates for a simple office visit to prescribe contraceptives are far below the PPS rate for an FQHC.

Family Planning Services in Medicaid

Federal law requires state Medicaid programs to cover "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies."[6] Further, family planning is a required service of all FQHCs, as per §330 of the Public Health Service Act.[7] Although the term "family planning services and supplies" is not defined in federal statute or regulation, CMS has routinely identified birth control drugs and devices, including oral contraceptives and long-acting reversible contraceptives (LARCs), for example, intrauterine devices (IUDs) and implants, as family planning services and supplies.[8] While contraception is a primary service of family planning, state Medicaid programs may also choose to cover what CMS calls "related family planning services", for example health education and promotion or testing and treatment for sexually transmitted infections, if they are provided in the context of a family planning visit.[9]

In a national survey of more than 1,800 women of childbearing age in 19 community health centers across the U.S., the Jacobs Institute of Women's Health and the Geiger Gibson/RCHN Community Health Foundation Research Collaborative, both part of the Milken Institute School of Public Health at the George Washington University, highlighted the most common family planning services sought by women in Medicaid (see Table 1).[10]

[4] CMS. State Health Official Letter SHO #10-004. "Prospective Payment System for FQHCs and RHCs." February 10, 2010. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO10004.pdf

[5] Shin, P et al., Geiger Gibson RCHN Community Health Foundation Issue Brief #45, "Community Health Centers and Medicaid Payment Reform: Emerging Lessons from Medicaid Expansion States," October 11, 2016. http://www.rchnfoundation.org/wp-content/uploads/2016/10/GG-CMWF-Brief-45-Final-for-10-11-16-release-JS-SR.pdf

[6] 42 U.S.C. § 1936d(a)(4)(C); 42 U.S.C. 1396u-7(b)(7) (extending coverage of family planning services and supplies to the new adult (Medicaid expansion) group).

[7] 42 U.S.C. §254b(b)(1)(A)(i)(gg)

[8] CMS. State Medicaid Manual § 4270(B)(1).

[9] CMS. State Medicaid Director Letter SMDL #14-003. "Re: Family Planning and Family Planning Related Services Clarification," April 16, 2014. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf

[10] Wood, S et al., Geiger Gibson RCHN Community Health Foundation Issue Paper 63, "Patient Experiences With Family Planning in Community Health Centers," February 2015. http://hsrc.himmelfarb.gwu.edu/sphhs_policy_ggrchn/63

Table 1. Most commonly received family planning services

Service	Percent of women receiving service
Pap smear or pelvic exam	87.54%
Pregnancy test	75.32%
Contraceptive visit	67.99%
Testing for a sexually transmitted disease	63.51%
Counseling on birth control methods	56.10%

What this means operationally is a fairly narrow set of Current Procedural Terminology (CPT®) codes - the code set used to bill outpatient and office procedures – account for many of the family planning and family planning related services provided in Medicaid.

Comparing State Medicaid Reimbursement Rates for Family Planning

State Medicaid programs have flexibility in defining both family planning services and can offer different levels of benefits for different populations.[11] Additionally, service volume and FQHC rates are not always public information. As such, we did not attempt to estimate total cost differences either nationally or by state. This memo aims to highlight illustrative examples of differences in Medicaid reimbursement for typical family planning CPT® codes between family planning providers and FQHCs. These examples could serve to request additional analysis by CBO, especially since this information is possible to retrieve directly from state Medicaid agencies or from reports made to CMS.

Methodology

Choosing the appropriate diagnosis and billing code for services delivered to patients is the responsibility of the health care provider, but there are typical CPT® codes for health care services, and in many cases, state Medicaid agencies establish a specific set of CPT® codes that can be reimbursed. For family planning services, the most commonly used codes (which does not include lab tests or drugs or devices, for example) are for evaluation and management (E&M) problem-oriented office visits,[12] preventive visits or visits for the insertion or removal of a long-acting contraceptive. For this comparison, we chose two E&M codes, two preventive codes, and two codes used for insertion of implants and IUDs. (See Appendix 1 for the six CPT® codes we chose as common examples of family planning service codes).

To examine illustrative differences in Medicaid reimbursement rates between family planning providers and FQHCs, M2 searched for publicly available reimbursement rate information in more than 30 states. In many states we reviewed, FQHC rates were not publicly available. This analysis includes 10 states where we could find current Medicaid reimbursement rates for both family planning providers and FQHCs. Those states are: California, Florida, Georgia, Illinois, Missouri, New York, North Carolina, Oklahoma, Texas and Washington.

[11] Ranji, U et al., "Medicaid and Family Planning: Background and Implications of the ACA," Kaiser Family Foundation Issue Brief. February 3, 2016. http://kff.org/report-section/medicaid-and-family-planning-future-challenges/

[12] E&M visits can be for new or established patients and can have varying levels of complexity. The CPT® codes run from 99203 to 99215. We chose one new patient code and one established patient code as examples for this analysis.

For the two E&M codes and the two preventive codes, the comparison was relatively straight-forward. The published Medicaid reimbursement rate for these four codes for the family planning category of provider was copied into an Excel file. Since FQHC rates vary by health center, we copied all available rates for FQHC in the state and calculated an average rate. In Oklahoma, there were 178 FQHC rates comprising the calculated average; in California, by contrast, more than 2,000 FQHC rates were averaged; The completed analysis for all states and codes reviewed appears in Appendix 2. An example of the reimbursement rates compared for the first four codes for Illinois is seen below in Table 2.

Table 2. Illinois Rate Comparison – E&M and Preventive Visit Codes

CPT Code	CPT Code Description	Physician Family Planning Rate	FQHC Rate (Averaged)
99203	Office Visit, New	$54.44	$191.16
99213	Office Visit, Established	$43.46	$191.16
99385	Preventive Visit, New	$64.61	$191.16
99395	Preventive Visit, Established	$41.36	$191.16

For the two CPT® codes typically used to bill for the insertion of a long-acting contraceptive[13], the analysis required an additional step. For these two codes we multiplied the average FQHC reimbursement rate we calculated by two because it is often the case that either the FQHC requires a second visit for the patient to obtain her chosen method of an implant or IUD, or the state Medicaid agency allows the FQ to be reimbursed for both their PPS rate **and** the fee-for-service rate for the LARC insertion.[14] With regards to the second visit, research shows health care providers do not always offer the full-range of long-acting methods.[15,16,17] Reasons differ for why a provider might not offer all LARC methods, but this lack of access can be due to inadequate provider training, lack of provider knowledge on latest evidence-based protocols, or practice inability to afford stocking of a wide range of LARC devices.[18,19,20,21] A study examining FQHCs specifically found, "only 19% of FQHCs report that they make all method categories available on-site through prescription and delivery, insertion and/or dispensing."[22] In fact, in some states like

[13] Medicaid also pays for the cost of the implant or IUD device, however, it is uncommon for family planning providers and FQHCs to be paid differently for the device. As such, this analysis assumes there is no substantial cost difference to be considered in the estimation of budgetary effects of defunding Planned Parenthood.
[14] For state examples, see CMS Informational Bulletin "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," April 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf
[15] Beeson T, et al. Accessibility of long-acting reversible contraceptives (LARCs) in Federally Qualified Health Centers (FQHCs). Contraception 2014; 89(2): 91-96.
[16] White K, et al. The impact of reproductive health legislation on family planning clinic services in Texas. Contraception 2013; 88: 445.
[17] Wood S, et al. Scope of family planning services available in federally qualified health centers. Contraception 2014; 89: 85-90.
[18] Vaaler M, et al. Urban–rural differences in attitudes and practices toward long-acting reversible contraceptives among family planning providers in Texas. Women's Health Issues 2012; 22(2): e157-e162.
[19] ACOG Committee on Adolescent Health, Long-Acting Reversible Contraception Work Group. Committee Opinion No. 539: Adolescents and long-acting reversible contraception: implants and intrauterine devices. Obstetrics & Gynecology 2012; 120(4): pp. 983–988.
[20] ACOG Committee on Gynecologic Practice. Increasing use of contraceptive implants and intrauterine devices to reduce pregnancy. ACOG 2009.
[21] Dehlendorf C, et al. Health care providers' knowledge about contraceptive evidence: a barrier to quality family planning care? Contraception 2010; 81(4): 292-298.
[22] Wood, S et al. Scope of family planning services available in Federally Qualified Health Centers. Contraception 2014; 89(2): 85-90.

Illinois, FQHC's bill LARCs separately, outside of the encounter rate (i.e., the FFS rate) since LARC's are such a unique reimbursement.

An example of the reimbursement rates compared of the two LARC insertion codes for Missouri is seen below in Table 3.

Table 3. Missouri Rate Comparison - LARCs

CPT Code	CPT Code Description	Physician Family Planning Rate	FQHC Rate (Averaged and Doubled)
58300	Insertion of intrauterine device (IUD)	$29.95	$297.76
11981	Insertion, non-biodegradable drug delivery implant	$79.39	$297.76

A family planning provider that is able to provide the full-range of contraceptive choices to patients the same-day the patient visits the health center, for example, Planned Parenthood, substantially reduces the cost of providing this particular service to the Medicaid program, if the patient has to return to the FQHC for care, or if the state has a reimbursement methodology that provides payment to the FQHC for the long acting contraceptive insertion *in addition to* the PPS or APM rate.

Discussion

Based on a comparison of Medicaid family planning service rates to FQHC rates in a sample of states across the U.S., M2 estimates that for those people who continue to receive Medicaid family planning services from FQHCs, there would be a substantial increase in Medicaid spending given the higher, cost-based rate structures set in federal law for FQHCs.

Proponents of prohibiting federal funding from being made available to Planned Parenthood often argue these patients can easily be served by the nearly 1,500 community health center grantees located across the U.S. Based on the rate comparison we conducted, it is clear the Medicaid reimbursement per service for common family planning services is most frequently substantially higher at FQHCs in these states compared to other family planning service sites given the unique way that FQHCs are reimbursed per longstanding federal law and reiterated under multiple administrations from both political parties. If, in fact, Planned Parenthood patients do seek care at community health centers as proponents argue they will, it seems unlikely this would **not** increase Medicaid costs.

To properly determine the estimated budgetary effects of prohibiting certain entities, we encourage a request be made of CBO for additional analysis of Medicaid reimbursement differentials for typical family planning codes across provider types, especially FQHCs.

APPENDIX 1. Description of CPT Codes[23]

Detailed description of Current Procedural Terminology (CPT®) codes used for this analysis.

CPT Code	Detailed Description
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years.
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years.
58300	Insertion of intrauterine device (IUD)
11981	Insertion, non-biodegradable drug delivery implant

[23] AMA. CPT® Code/Relative Value Search.
https://apps.amaassn.org/CptSearch/user/search/cptSearchSubmit.do?locality=1&keyword=99203

APPENDIX 2. Medicaid family planning reimbursement rates vs. FQHC rates – 10 state sample

State	CPT Code	CPT Code Description	Medicaid FP Rate (Fee for Service)	Medicaid FQHC Rate Per Visit (Average)	# of Visits	Total FQHC Rate	Increased Cost Per Service	% Increase In Cost Per Service
CA	99203	Office Visit, New	$101.27	$281.13	1	$281.13	$179.86	177.6%
	99213	Office Visit, Established	$82.02	$281.13	1	$281.13	$199.11	242.8%
	99385	Preventive Visit, New	$144.10	$281.13	1	$281.13	$137.03	95.1%
	99395	Preventive Visit, Est	$129.90	$281.13	1	$281.13	$151.23	116.4%
	58300	Insert Intrauterine Device	$168.22	$281.13	2	$562.26	$394.04	234.2%
	11981	Implant Insertion	$208.86	$281.13	2	$562.26	$353.40	169.2%
FL	99203	Office Visit, New	$86.04	$164.02	1	$164.02	$77.98	90.6%
	99213	Office Visit, Established	$34.29	$164.02	1	$164.02	$129.73	378.3%
	99385	Preventive Visit, New	$95.13	$164.02	1	$164.02	$68.89	72.4%
	99395	Preventive Visit, Est	$89.87	$164.02	1	$164.02	$74.15	82.5%
	58300	Insert Intrauterine Device	$80.84	$164.02	2	$328.04	$247.20	305.8%
	11981	Implant Insertion	$77.36	$164.02	2	$328.04	$250.68	324.0%
GA	99203	Office Visit, New	$76.53	$141.36	1	$141.36	$64.83	84.7%
	99213	Office Visit, Established	$82.05	$141.36	1	$141.36	$59.31	72.3%
	99385	Preventive Visit, New	$75.38	$141.36	1	$141.36	$65.98	87.5%
	99395	Preventive Visit, Est	$75.38	$141.36	1	$141.36	$65.98	87.5%
	58300	Insert Intrauterine Device	$62.48	$141.36	2	$282.72	$220.24	352.5%
	11981	Implant Insertion	$100.90	$141.36	2	$282.72	$181.82	180.2%
IL	99203	Office Visit, New	$54.44	$191.16	1	$191.16	$136.72	251.1%
	99213	Office Visit, Established	$43.46	$191.16	1	$191.16	$147.70	339.9%
	99385	Preventive Visit, New	$64.61	$191.16	1	$191.16	$126.55	195.9%
	99395	Preventive Visit, Est	$41.36	$191.16	1	$191.16	$149.80	362.2%
	58300	Insert Intrauterine Device	$85.62	$191.16	2	$382.32	$296.70	346.5%
	11981	Implant Insertion	$60.67	$191.16	2	$382.32	$321.65	530.2%
MO	99203	Office Visit, New	$82.91	$148.88	1	$148.88	$65.97	79.6%
	99213	Office Visit, Established	$75.21	$148.88	1	$148.88	$73.67	98.0%
	99385	Preventive Visit, New	$52.42	$148.88	1	$148.88	$96.46	184.0%
	99395	Preventive Visit, Est	$38.71	$148.88	1	$148.88	$110.17	284.6%
	58300	Insert Intrauterine Device	$29.95	$148.88	2	$297.76	$267.81	894.2%
	11981	Implant Insertion	$79.39	$148.88	2	$297.76	$218.37	275.1%

State	CPT Code	CPT Code Description	Medicaid FP Rate (Fee for Service)	Medicaid FQHC Rate Per Visit (Average)	# of Visits	Total FQHC Rate	Increased Cost Per Service	Percent Increase In Cost Per Service
NC	99203	Office Visit, New	$80.86	$165.07	1	$165.07	$84.21	104.1%
	99213	Office Visit, Established	$54.26	$165.07	1	$165.07	$110.81	204.2%
	99385	Preventive Visit, New	$93.93	$165.07	1	$165.07	$71.14	75.7%
	99395	Preventive Visit, Est	$81.61	$165.07	1	$165.07	$83.46	102.3%
	58300	Insert Intrauterine Device	$59.14	$165.07	2	$330.14	$271.00	458.2%
	11981	Implant Insertion	$98.81	$165.07	2	$330.14	$231.33	234.1%
NY	99203	Office Visit, New	$99.74	$223.56	1	$223.56	$123.82	124.1%
	99213	Office Visit, Established	$80.06	$223.56	1	$223.56	$143.50	179.2%
	99385	Preventive Visit, New	$65.52	$223.56	1	$223.56	$158.04	241.2%
	99395	Preventive Visit, Est	$55.32	$223.56	1	$223.56	$168.24	304.1%
	58300	Insert Intrauterine Device	$49.49	$223.56	2	$447.12	$397.63	803.5%
	11981	Implant Insertion	$92.91	$223.56	2	$447.12	$354.21	381.2%
OK	99203	Office Visit, New	$98.08	$241.78	1	$241.78	$143.70	146.5%
	99213	Office Visit, Established	$79.99	$241.78	1	$241.78	$161.79	202.3%
	99385	Preventive Visit, New	$113.70	$241.78	1	$241.78	$128.08	112.6%
	99395	Preventive Visit, Est	$102.60	$241.78	1	$241.78	$139.18	135.7%
	58300	Insert Intrauterine Device	$95.11	$241.78	2	$483.56	$388.45	408.4%
	11981	Implant Insertion	$87.51	$241.78	2	$483.56	$396.05	452.6%
TX	99203	Office Visit, New	$48.28	$270.71	1	$270.71	$222.43	460.7%
	99213	Office Visit, Established	$29.52	$270.71	1	$270.71	$241.19	817.0%
	99385	Preventive Visit, New	$85.29	$270.71	1	$270.71	$185.42	217.4%
	99395	Preventive Visit, Est	$74.02	$270.71	1	$270.71	$196.69	265.7%
	58300	Insert Intrauterine Device	$110.18	$270.71	2	$541.42	$431.24	391.4%
	11981	Implant Insertion	$85.04	$270.71	2	$541.42	$456.38	536.7%
WA	99203	Office Visit, New	$51.36	$385.85	1	$385.85	$334.49	651.3%
	99213	Office Visit, Established	$42.01	$385.85	1	$385.85	$343.84	818.5%
	99385	Preventive Visit, New	$91.31	$385.85	1	$385.85	$294.54	322.6%
	99395	Preventive Visit, Est	$82.43	$385.85	1	$385.85	$303.42	368.1%
	58300	Insert Intrauterine Device	$363.72	$385.85	2	$771.70	$407.98	112.2%
	11981	Implant Insertion	$357.37	$385.85	2	$771.70	$414.33	115.9%