

Exploring Network Barriers to Accessing Contraception for Illinois Medicaid Recipients

ACLU Illinois

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The University of Chicago Medicine
Department of Family Medicine

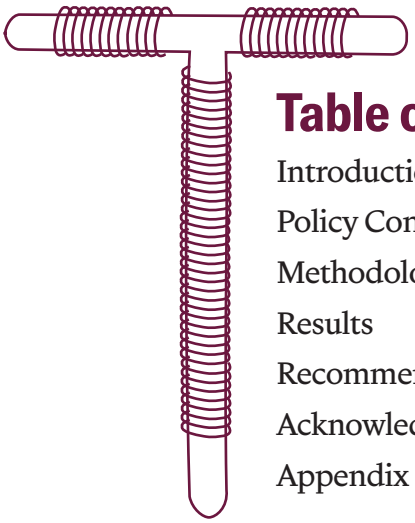


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Introduction

Of the 3.2 million Illinois residents enrolled in Medicaid, more than 417,000 are "women of childbearing age."[1] In some respects, Illinois is a leader nationwide in expanding access to family planning services for these Medicaid beneficiaries. The Illinois Public Aid Code requires the Illinois Department of Healthcare and Family Services (HFS) to provide coverage for all reproductive health care that is lawful in the state of Illinois.[2] This includes all FDA-approved methods of contraception, including oral contraceptive pills, long-acting reversible contraceptives (LARCs), Depo-Provera, contraceptive rings and patches, and emergency contraception, at no cost.[3] Further, HFS administers two pathways to coverage for reproductive health services to individuals who do not otherwise qualify for comprehensive Medicaid: Family Planning Presumptive Eligibility, which provides immediate, temporary medical coverage for reproductive health and family planning services, and the HFS Family Planning Program, which provides ongoing coverage for all eligible Illinois residents specifically for family planning services.[4]

Yet despite these efforts, Illinois women of childbearing age access contraceptive services through Medicaid at a rate 11.5 percent lower than that of the average U.S. state. Illinois lags behind even more significantly in providing access to LARCs, like intrauterine devices (IUDs) and contraceptive implants; the rate of access to LARC services is 23.6 percent lower for Illinois Medicaid beneficiaries than the average U.S. state.

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[1] "Women of childbearing age" is typically defined as females ages 15 to 44. Census data for 2024 reflects 416,669 Illinois females ages 19 to 44 with public health insurance. *See* U.S. Census Bureau, Table B27003: Public Health Insurance Status by Sex by Age, https://data.census.gov/table/ACSDT1Y2024.B27003?q=Health+Insurance&t=Age+and+Sex&g=040XX00US17 (last visited Aug. 24, 2026); *see also* Ill. Dep't of Healthcare & Family Servs., *Medical Assistance Program 2025 Annual Report 1* (Apr. 2026), https://hfs.illinois.gov/content/dam/soi/en/web/hfs/info/reports/annual/fy25hfsannualreport.pdf (last visited Aug. 25, 2026) (reporting 3,263,822 total Medicaid enrollees for FY 2025).

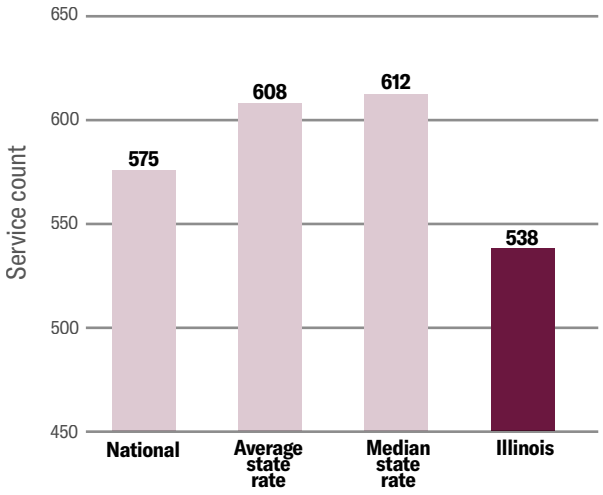
[2] 305 Ill. Comp. Stat. 5/5-5.

[3] Ill. Dep't of Healthcare & Family Servs., *HFS Family Planning Program Covered Services*, https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/familyplanningcoveredservices.pdf (last visited Aug. 21, 2026).

[4] Ill. Dep't of Healthcare & Family Servs., *Family Planning & Birth Control*, https://hfs.illinois.gov/medicalclients/familyplanning.html (last visited Aug. 21, 2026).

Figure 1.

Contraception services per 1,000 female Medicaid/CHIP beneficiaries, ages 15-44 (2022)

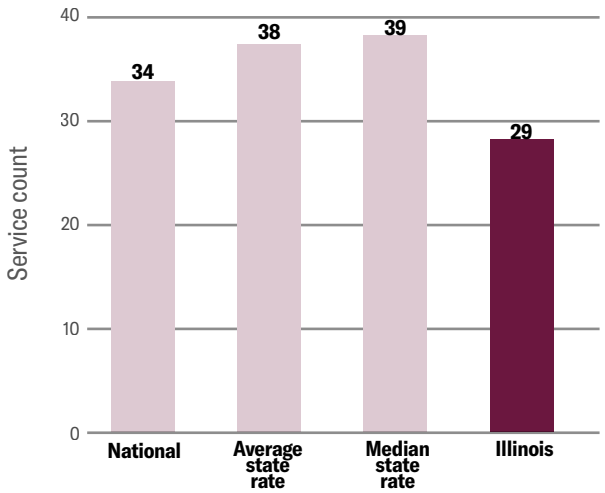


Source: U.S. Centers for Medicaid and Medicare Services, "Contraceptive Care Services Provided to Medicaid and CHIP Beneficiaries ages 15 to 44."
Available at: https://healthdata.gov/CMS/Contraceptive-Care-Services-Provided-to-Medicaid-a/9aic-28dc/about_data

Note: The metrics used in this dataset are based on data from CMS' T-MSIS Analytic Files. The analysis exludes Arkansas due to data quality concerns and includes Washington, D.C.

Figure 2.

Long-acting reversible contraceptive (LARC) services per 1,000 female Medicaid/CHIP beneficiaries, ages 15-44 (2022)



Source: U.S. Centers for Medicaid and Medicare Services, "Contraceptive Care Services Provided to Medicaid and CHIP Beneficiaries ages 15 to 44."
Available at: https://healthdata.gov/CMS/Contraceptive-Care-Services-Provided-to-Medicaid-a/9aic-28dc/about_data

Note: The metrics used in this dataset are based on data from CMS' T-MSIS Analytic Files. The analysis exludes Arkansas due to data quality concerns and includes Washington, D.C.

This report asks, "why?"

One reason could be the labyrinthine obstacles those on public insurance must overcome in order to actually access care. During a series of patient simulation calls conducted in 2025 to providers identified by each Illinois Medicaid Managed Care Organization as being in their networks, our hypothetical Medicaid patients were turned away for myriad reasons:

Some of the providers were closed or were no longer accepting Medicaid patients.

Some providers listed as OB/GYN or family planning clinicians were in fact pulmonology, urology, cardiology, pediatric orthopedics, oncology, gastroenterology, addiction medicine, urgent care, or occupational health providers.

For some of the providers listed, the phone number was out of service. Other numbers routed to a billing company, an HR service center, a private individual, or providers in Texas and North Carolina.

One provider only schedules Medicaid appointments on the first of the month, with more than a six-month wait for some contraceptive services.

And some providers do not offer contraceptive services or only provide natural family planning services due to the religious affiliation of their facilities – including the University of Illinois College of Medicine providers operating out of OSF Saint Francis Medical Center in Peoria.

To truly be a leader in providing contraceptive care to Medicaid beneficiaries, Illinois needs to address these barriers to practical access.

Policy Context & Background

The Medicaid Act requires states to make medical assistance – including "family planning services and supplies" – available to all eligible individuals.[5] Because Illinois has opted to contract with Managed Care Organizations (MCOs) to carry out these obligations, federal regulations require the State to ensure that each MCO "demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services."[6]

This is true even though Medicaid beneficiaries may access family planning services out of network without a referral. In its response to public comment on the network adequacy provision of this regulation, CMS noted that "[u]se of network providers facilitates claims payment, helps enrollees locate providers more easily, and improves care coordination," and therefore the right to choose an out-of-network provider does not "negate[ ] a managed care plan's responsibility to ensure timely access within its network."[7]

As required by federal regulations, HFS retains an external quality review organization, the Health Services Advisory Group (HSAG), to conduct an annual evaluation of each MCO's compliance with federal quality assessment and performance improvement standards – including the standards for network adequacy. The most recent annual report was published in April 2025 and concludes that each of Illinois' MCOs contracts with a sufficient number of required provider types within each service region to comply with their statutory obligations.[8]

The 2025 HSAG report conducted an audit of the MCOs' own efforts to ensure their compliance with network requirements, as well as an independent "time and distance" study to evaluate whether the MCO networks included sufficient providers within the required time and distance from member residences. Under state standards, MCOs must ensure Medicaid enrollees have access to at least two OB/GYN providers within a 30-mile radius or 30-minute drive of their residence in "urban" areas, and at least one OB/GYN provider within a 60-mile radius or 60-minute drive of their residence in "rural" areas.[9] But as HSAG recognized, the time and distance results do not consider or account for other issues impacting access, such as the overall availability of providers at an office location, whether a given provider is accepting new Medicaid patients at a specific location, or whether a provider has appointments available within a reasonable timeframe.[10] The MCOs likewise did not identify, and the State and HSAG did not ask, which OB/GYN or family planning providers offer comprehensive family planning services, which providers do not offer contraceptive services for the purpose of pregnancy prevention, and which providers offer only certain methods of contraception.

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[5] 42 U.S.C. § 1396a(a)(10)(A).

[6] 42 C.F.R. § 438.206(b)(7).

[7] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,498, 27,667 (May 6, 2016).

[8] Health Servs. Advisory Grp., Inc., *External Quality Review Annual Report*, at 34-36 (Ill. Dep't of Healthcare & Family Servs. 2025), https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/il2025eqrtechnicalreport.pdf (last visited Aug. 25, 2026) [hereinafter External Quality Review Annual Report].

[9] *See* Ill. Dep't of Healthcare & Family Servs., HealthChoice Illinois Contract Model Template § 5.8.1.1.3 (Aug. 2025), *available at* https://hfs.illinois.gov/medicalproviders/cc/managedcarecontracts.html (last visited Aug. 25, 2026) [hereinafter MCO Model Contract]. "Urban" areas refer to Illinois counties that are part of a metropolitan statistical area as defined by the U.S. Census Bureau and have a population equal to or greater than 60,000 residents. *Id.* § 1.1.198. "Rural" areas refer to counties that are not part of a metropolitan statistical area as defined by the U.S. Census Bureau, or are part of such an area but have a population of fewer than 60,000 residents. *Id.* § 1.1.176.

[10] External Quality Review Annual Report, *supra* note 8, at 34-36.

The Role of Religious Refusals

Provider refusals to provide contraception based on institutional and/or individual religious beliefs can result in barriers to care for patients. When seeking care in facilities with religious affiliations – particularly those that must follow the Ethical and Religious Directives for Catholic Health Services (ERDs) – patients can be denied a wide range of care, including family planning services, fertility treatments, abortion, and treatments for pregnancy complications.[11] In particular, research among providers working in Catholic health systems suggests that often providing any type of contraception is prohibited, unless it can be shown that it was used to treat some other condition besides preventing pregnancy.[12]

Patients may seek care from religious facilities because they are included in their insurance networks, located in their communities, referred to by family and friends who may not have encountered restrictions, and/or are employers of trusted individual providers.[13] Patients are often unaware when a health care facility has a religious affiliation or that its services may be restricted as a result.[14] Providers working within such facilities have described how obstacles to desired care burdened patients, especially those with social and financial constraints, and resulted in delayed or lower quality care.[15] Patients of such facilities have expressed frustration when turned away from receiving care, and described how facing religious restrictions led to feelings of stigma and judgment, which could impact a patient's motivation to seek out care elsewhere.[16]

In Illinois, both health care facilities and individual providers are protected from liability or professional discipline when they refuse to provide care for conscience-based reasons under the Illinois Health Care Right of Conscience Act.[17]

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[11] U.S. Conf. of Cath. Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (7th ed. 2025), https://www.usccb.org/resources/ERDs-7th-ed-Approved_2025-11-12.pdf (last visited Aug. 25, 2026).

[12] Yuan Liu et al., *"Am I Going to Be in Trouble for What I'm Doing?": Providing Contraceptive Care in Religious Health Care Systems,* 51 Persp. on Sexual & Reprod. Health 193, 193–99 (2019); Zoey J. Wong et al., *What You Don't Know Can Hurt You: Patient and Provider Perspectives on Postpartum Contraceptive Care in Illinois Catholic Hospitals*, 107 Contraception 62, 62–67 (2022).

[13] Tess Solomon et al., *Bigger and Bigger: The Growth of Catholic Health Systems* (Cmty. Catalyst 2020), https://www.communitycatalyst.org/wp-content/uploads/2022/11/2020-Cath-Hosp-Report-2020-31.pdf (last visited Aug. 25, 2026); Rebecca Gieseker et al., *Family Planning Service Provision in Illinois Religious Hospitals: Racial/Ethnic Variation in Access to Non-Religious Hospitals for Publicly Insured Women*, 100 Contraception 296, 296–98 (2019); Wong, *supra* note 12, 62–67.

[14] Jocelyn M. Wascher et al., *Do Women Know Whether Their Hospital Is Catholic? Results from a National Survey*, 98 Contraception 498, 500 (2018); Debra B. Stulberg et al., *Women's Expectation of Receiving Reproductive Health Care at Catholic and Non-Catholic Hospitals*, 51 Persp. on Sexual & Reprod. Health 135, 138 (2019); Jocelyn M. Wascher et al., *Restrictions on Reproductive Care at Catholic Hospitals: A Qualitative Study of Patient Experiences and Perspectives*, 11 AJOB Empirical Bioethics 257, 260 (2020).

[15] Liu, *supra* note 12, at 193-199.

[16] Wong, *supra* note 12, at 62-67.

[17] 745 Ill. Comp. Stat. 70/1 *et seq*.

Methodology

In 2025, interns from the American Civil Liberties Union of Illinois (ACLU-IL) conducted patient simulation calls to providers identified as in-network by each of the five statewide Illinois MCOs contracted with HFS at the time – Aetna Better Health, Blue Cross Community Health, Meridian Health, Molina Healthcare, and YouthCare – inquiring about the availability of contraceptive services, to assess the practical ability of a Medicaid beneficiary to access care.

We submitted a request for public records to HFS pursuant to the Illinois Freedom of Information Act, seeking the provider data submitted by each MCO which formed the basis for HSAG's assessment of its network adequacy. We chose one "urban" (Peoria) and one "rural" (Effingham) location as our survey sites, and approximated the respective county seat as a single geographic point to represent the residence of a hypothetical Medicaid patient in that area. We filtered the provider lists from the MCOs by OB/GYN and family planning provider types, then used mapping software to geocode the provider addresses and identify all those located within 35 miles of the Peoria location and 65 miles of the Effingham location.[18]

Some of the provider entries submitted by the MCOs were missing key details, like facility name or phone number. Where possible, we aimed to fill in those blanks based on publicly available information.

The datasets provided by the MCOs included many instances where multiple providers were associated with the same address and telephone number – e.g., the main line for a clinic or office location with more than one provider participating in the MCO network. Because this patient simulation exercise was targeted at identifying the availability of appointments for a hypothetical Medicaid patient, in those instances we included only one provider entry for each distinct address and phone number combination, and we instructed our callers to inquire about appointment availability with any in-network provider at that clinic or location.

Similarly, sometimes a single telephone number was associated with providers located at multiple different street addresses – e.g., a main reception or scheduling line serving multiple locations of the same clinic or health system. In these instances, we instructed our callers to place a single call to the shared telephone number to inquire about appointment availability with any in-network provider at any location associated with that telephone number. As discussed further below, our results therefore sometimes reflect multiple identical outcomes resulting from a single patient simulation call.

Between January and October 2025, the ACLU-IL interns attempted to call each provider identified to ask the same series of questions about the availability of an appointment for the insertion of Paragard, the brand name of a non-hormonal copper IUD.

We chose this form of contraception because we wanted to explore why Illinois trails the average U.S. state in providing access to LARCs. And we chose to ask about Paragard, specifically, because while it is one of the most effective forms of contraception, it is only used for purposes of pregnancy prevention. Paragard is therefore unlikely to be available at facilities that offer only limited reproductive health care services due to religious affiliation.

The standard questions asked in each call were:

- Is the provider in-network for this MCO?
- Does the provider have an appointment available within two weeks?
- If not, how soon is the next available appointment?
- Does the provider offer Paragard?
- If not, does the provider offer other IUDs or LARCs?

[18] Although the Illinois access standards require MCOs to ensure network adequacy within 30 miles of urban area patient residences and 60 miles of rural area patient residences, we included a 5-mile "buffer" for each. We also estimated drive times under conditions of no traffic, rush hour, or normal traffic and confirmed that even the most optimistic drive times resulted in fewer providers within the required radius. We therefore proceeded with the more inclusive list of providers, using distance rather than drive time.

Results

Our goal in conducting the patient simulation calls was to capture the experience of a Medicaid patient seeking to use their insurance coverage to access a specific method of contraception.

We analyzed the results of the calls to determine whether a phone call to each OB/GYN or family planning provider identified as in-network by the MCO's data would result in an appointment providing timely access to the requested method of contraception (Paragard). We categorized each phone call based on whether it resulted in full access, limited access, or no access, or reflected bad information about the MCO network.

Figures 3 and 4 summarize the results of our analysis of the patient simulation calls, and a more detailed breakdown of the results is provided in the Appendix. Overall, these findings reveal significant barriers to contraceptive access for all of the MCO networks that we assessed in both the Peoria and Effingham regions.

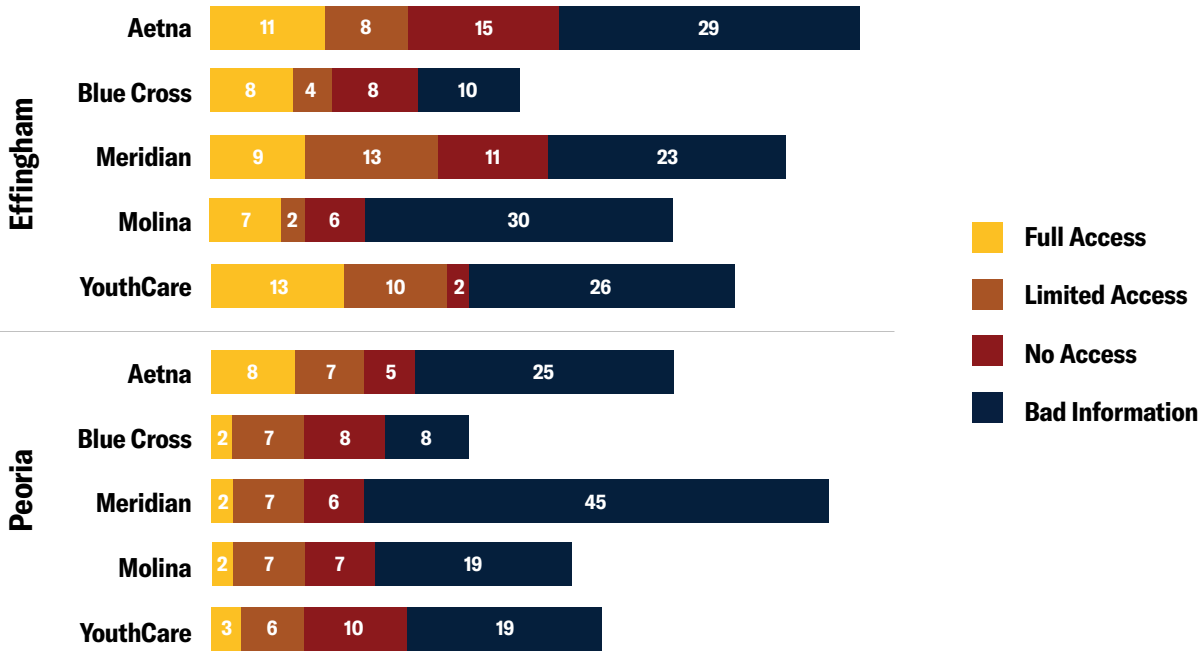
Full Access: Provider offered an appointment for placement of the particular method sought – Paragard – within five weeks.

Limited Access: Provider offered an appointment for Paragard more than five weeks away; or provider offered an appointment for other contraceptive methods.

No Access: Provider reported being unable to provide birth control for contraceptive purposes or only offering natural family planning; provider referred or redirected the caller to other providers; provider reported not taking new Medicaid patients, or new patients in general; or caller was unable to obtain the information sought about the availability of an appointment to use their insurance coverage to access Paragard.

Bad Information: Provider not an OB/GYN generalist or other family planning provider; provider reported not actually being in the MCO's network; another change in status such as an office closure or disaffiliation of a particular provider from a practice; or listed phone number was incorrect or disconnected, or calls to the number went unanswered.

Figure 3.
Outcomes of Patient Simulation Calls by Region & MCO



To begin with, the provider data that we received from HFS was littered with inaccuracies. Between 32% to a whopping 75% of the provider entries in each of the MCO networks that we analyzed contained bad information for one of the following reasons: (1) the identified provider was not an OB/GYN generalist or other family planning provider; (2) the identified provider reported not being in the MCO's network; (3) there was another change in status such as an office closure or disaffiliation of a particular provider from a practice; or (4) we were unable to contact the identified provider because the listed phone number was incorrect or disconnected, or calls to the number went unanswered. This sort of bad information accounted for at least 50% of the provider entries in four of five MCO networks in the Peoria region and two of five MCO networks in the Effingham region.

Even when the provider data that we received from HFS was technically accurate, a significant number of our patient simulation calls within each MCO network still did not result in access to contraceptive services. We categorized calls as resulting in no access for any of the following reasons: (1) the identified provider reported being unable to provide birth control for contraceptive purposes or only offering natural family planning; (2) the identified provider referred or redirected the caller to other providers; (3) the identified provider reported not taking new Medicaid patients, or new patients in general; or (4) the caller was unable to obtain the information they sought about the availability of an appointment to use their insurance coverage to access the specific method of contraception sought. The prevalence of this outcome varied considerably among the MCOs we analyzed. Depending on the MCO network, anywhere between 3% and 32% of provider entries resulted in no access for one of these reasons, with no access being the result of at least 20% or more of the calls for half of the MCOs. Of note, in seven of the ten MCO networks analyzed, at least one provider reported being unable to provide birth control for contraceptive purposes or only offering natural family planning.

For the patient simulation calls that resulted in at least some access to contraceptive services, we distinguished between those that offered full access to an appointment for placement of the particular method sought – Paragard – within five weeks,[19] and those that only offered limited access either because they offered an appointment for Paragard more than five weeks away or did not provide Paragard but offered an appointment for other contraceptive methods. In terms of full access to an appointment for Paragard within five weeks, between a paltry 3% and 27% of the provider entries resulted in such full access depending on the MCO network. In the Peoria region in particular, less than 10% of the provider entries in four of the five MCO networks that we analyzed resulted in full access. In terms of limited access, between 4% and 28% of the provider entries resulted in limited access depending on the MCO network.[20]

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[19] We distinguished between those providers offering an appointment within five weeks and those offering an appointment for more than five weeks away because under Illinois standards MCOs are required to ensure that appointments for routine preventative care services (like contraception) are available within 5 weeks of the date of request. *See* MCO Model Contract, *supra* note 9, at § 5.8.3.

[20] As discussed above, when there was a single phone number associated with providers located at multiple different addresses, we only called that number one time to inquire about the availability of an appointment with any in-network provider at any of the associated addresses. Because each of the distinct addresses reflected a separate provider entry in our analysis of the call results, we applied the same analysis to each provider entry associated with that phone number based on the results of that single phone call. For example, in situations where there were five separate locations associated with the same phone number and a call to that number resulted in full access in our analysis, it was counted as full access five separate times in the final analysis results for the particular MCO network. However, it is possible that in some circumstances not all of the different addresses associated with that phone number would actually provide the same level of access (i.e., only two of five clinic locations associated with that phone number actually provide appointments for Paragard), and thus our results may be overestimating the actual degree of access in that MCO network.

Figure 4.
Access to Desired Contraceptive Care Across Regions & MCOs



Only 1 in 7 provider contacts resulted in access to the contraceptive method of choice within 5 weeks.

The Impact of Religious Refusals

The patient simulation calls revealed that religious refusals to provide care are one of the factors impacting access to comprehensive contraceptive care for Medicaid MCO members, with at least one provider in the majority of MCO networks being unable to provide birth control for contraceptive purposes or only offering natural family planning. However, this may be an undercount of the number of providers in the respective MCO networks whose provision of care is restricted by current or past religious affiliation.

This information about restrictions on care was only elicited because the patient simulation calls asked about an appointment for a method of contraception which can only be used for the purpose of preventing pregnancy and not to treat any other conditions, and some providers chose to explain their inability to offer that appointment in terms of not offering contraception for pregnancy prevention. The patient simulation calls did not explicitly ask the providers contacted whether they had any religious affiliation or whether there were any forms of care they would not provide due to religious reasons, which may have revealed an even broader saturation of religiously affiliated providers following restrictions that could impact access to contraceptive care across the MCO networks.

For example, one study of Medicaid MCO plans available to residents of Cook County found that between 36% and 55% of the in-network Cook County hospitals with labor and delivery units were Catholic-affiliated.[21] In addition, often when a religiously-affiliated health system sells a hospital facility to or merges with a secular system, the conditions of sale or merger include adhering to religious restrictions on care in hospitals run by the secular system.[22] However, without a formal religious affiliation any longer, those answering the phone at a facility may not know or be able to communicate precisely why a particular method of contraception is not available, only that it is not offered.

[21] Gieseker, *supra* note 13, at 296-298.

[22] Elizabeth Sepper, *Zombie Religious Institutions*, 112 Nw. U. L. Rev. 929, 929–88 (2018).

Recommendations

The patient simulation calls to reported in-network OB/GYN and family planning providers revealed a very high amount of inaccurate or outdated information, many providers not taking new patients or otherwise not facilitating appointments at the office contacted, some providers who reported not offering any birth control services for contraceptive reasons, and the inability to obtain all forms of FDA-approved contraceptives and/or timely access to Paragard even at many providers that offered appointments.

To address these barriers to care, we recommend Illinois take the following actions to improve Medicaid enrollees' access to timely, high-quality contraceptive care.

1. **Add "contraception for pregnancy prevention" as a subspecialty in IMPACT and require MCOs to include provider subspecialty information in their searchable provider directories.**

Illinois providers must enroll in IMPACT (Illinois Medicaid Program Advanced Cloud Technology) to participate as a Medicaid provider and receive reimbursement. As part of the enrollment process, providers select their provider type (e.g., Physician), specialty (e.g., Family Medicine, Obstetrics and Gynecology), and any applicable subspecialties. Providers revalidate this information at least every five years. Although providers may currently select specialties or subspecialties related to gynecologic care, IMPACT does not include a designation to identify providers who offer comprehensive contraceptive services. Under the existing specialty and subspecialty options neither patients, Illinois HFS, nor MCOs can readily determine which providers offer the full range of hormonal and nonhormonal contraceptive care versus those who do not provide contraception for the purposes of pregnancy prevention. Thus, current assessments of network adequacy cannot meaningfully assess actual access to comprehensive family planning.

HFS should add "contraception for pregnancy prevention" as a subspecialty option in IMPACT for providers who select primary care specialties,[23] and require MCOs to display provider subspecialties in their searchable, public-facing provider directories. This information would allow Illinois to assess network adequacy for family planning services more accurately, identify geographic gaps in contraceptive access, and facilitate targeted network development and resource allocation. Because providers revalidate their IMPACT information every five years, this subspecialty information could be kept up to date through existing information maintenance processes.

Hospitals and facilities (FAOs) must also enroll in IMPACT. HFS should include "contraception for pregnancy prevention" as a subspecialty option for the following FAO provider types: Ambulatory Surgical Treatment Centers, Birthing Centers, Clinics, and Hospitals. This additional information would help identify where patients could access care like tubal ligation or vasectomy or immediate post-partum birth control methods (like LARCs).

Making this information publicly available would improve patients' ability to locate their desired care without unnecessary barriers like multiple phone calls to providers or attending appointments to find and confirm family planning service availability. Rather, a patient seeking contraception could search for in-network providers or FAOs who have

[23] Including Family Medicine, Family Medicine Obstetrics, Family Practice, Internal Medicine, Obstetrics and Gynecology, Pediatrics, and Preventative Medicine.

identified themselves as offering contraceptive services by filtering by subspecialty or determine whether their existing provider offers the care they need prior to making an appointment. Because this information is based on a provider's self-attestation about the care they provide, patients can get specific, provider or site-level confirmation of available care rather than generalized information about care usually offered by a provider type or facility.

Additionally, publicly displaying contraception-related subspecialty designations would assist care coordinators, community-based organizations, and health center staff providing referrals in directing patients to providers who offer comprehensive contraceptive care and provide MCOs with more precise information to support their efforts to build and maintain an adequate network of family planning providers.

2. Update MCO contracts to require that members be notified of their free choice of family planning provider in member handbooks, prohibit coercive or directive counseling, and include additional quality measures.

Contracts between MCOs and HFS for the provision of Medicaid services should be updated to require that contractors include plain language in member handbooks to inform members that they have free choice of family planning providers without prior authorization and can access family planning care even at out-of-network providers. This language would help patients understand their options for accessing care when, for example, their usual provider offers limited or no access to the contraceptive method of their choice.[24]

In addition, while access to LARCs is an important consideration given statewide trends suggesting decreased access, strategies to improve access must at the same time preserve patient-centered decision-making. Thus, HFS should also remove any MCO contract language that encourages or requires coercive or directive counseling toward a particular contraceptive method. For example, Section 3.1.3.2 of the August 2025 HealthChoice Illinois Contract Model Template requires contractors to provide education and counseling on "all safe, effective and clinically appropriate contraceptive methods, with emphasis on the most effective methods first and encourage use of long-acting reversible contraceptives (LARCS), such as IUDs and implants when clinically appropriate and consistent with FDA approved product information label."[25] This language directing patients toward LARC methods is not in line with promoting patient-centered decision-making.

Finally, HFS should update MCO contracts to require MCOs to measure additional performance indicators for method mix, timeliness, and patient experience. These measures, in addition to the already-adopted Contraceptive Care for Women (CCW) measure that requires reporting the percentage of women ages 15–44 at risk of unintended pregnancy who were provided either a most or moderately effective method of contraception, or a long-acting reversible method of contraception (LARC), would provide a clearer picture of the providers offering quality, comprehensive contraceptive care to Illinois Medicaid enrollees. Specifically, a timeliness measure would reveal access capacity, highlighting where MCOs need to bolster their provider

[24] Further, HFS should update their billing manual to include clear billing guidance for providers on how to bill for family planning services provided out-of-network pursuant to the patient's right to free choice.

[25] MCO Model Contract, *supra* note 9, at § 3.1.3.2

network. A method mix measure would provide insight into why Illinois falls behind national averages for LARC provision by identifying which providers could use more support offering LARC devices or where there may be concerns with coercive contraceptive counseling. Finally, a patient reported experience measure would supplement information gathered through "secret shopper" surveys and identify gaps in care and quality that are best revealed through hearing from patients.[26]

3. Make contraceptive care quality measures publicly available.

Illinois should make contraceptive quality measures, like the CCW data and any new quality measures adopted, publicly available and create a map showing the data by provider location. This additional transparency maximizes the usefulness of quality measures by improving HFS's understanding of access and allowing members to locate proficient, timely, and high-quality providers of most and moderately effective methods of birth control. Additional transparency also incentivizes providers to provide high-quality, comprehensive contraceptive care to patients because the data may influence a patient's choice about where to receive their care. This can improve quality without the need for performance improvement plans.

4. Include a question inquiring about the scope of available family planning services in "secret shopper" surveys assessing MCO network adequacy, when relevant.

Federal rules scheduled to take effect in 2027 and 2028 will require states to conduct annual "secret shopper" surveys to assess network adequacy and verify information in an MCO's provider directory. These rules will require states to confirm that a provider is active in-network and taking new Medicaid patients, and that their physical address and phone number are correct. States can use "secret shopper" surveys to verify additional information, and HFS should incorporate a question inquiring about the availability of family planning services into these surveys, when relevant. The state may choose to vary this question from year to year – for example, inquiring about whether the provider offers Paragard, like the patient simulation calls conducted for this report; whether the provider has any appointments for family planning open in the next month; or an alternative question designed to assess method availability, timeliness, or the accuracy of provider directory information about family planning. This additional question would provide a consistent, statewide mechanism for evaluating the accuracy of provider directory data about the availability of family planning care. Because it can be incorporated into existing calls soon to be required under federal rules, it provides a lower lift, high impact strategy for assessing network adequacy.

[26] HFS should require MCOs to evaluate patient experience using a validated and reliable tool like the Patient Centered Contraceptive Counseling (PCCC) retrospective survey, which measures the quality of patient-centered care offered by providers using four simple questions: "Overall, how do you think the member(s) of the healthcare team(s) did – (1) respecting me as a person, (2) letting me say what mattered to me about my birth control, (3) taking my preferences about my birth control seriously, and (4) giving me enough information to make the best decision about my birth control method." *See* Person-Centered Reprod. Health Program, UCSF, *The Retrospective PCCC*, https://pcccmeasure.ucsf.edu/retrospective-pccc (last visited Aug. 24, 2026).

Acknowledgments

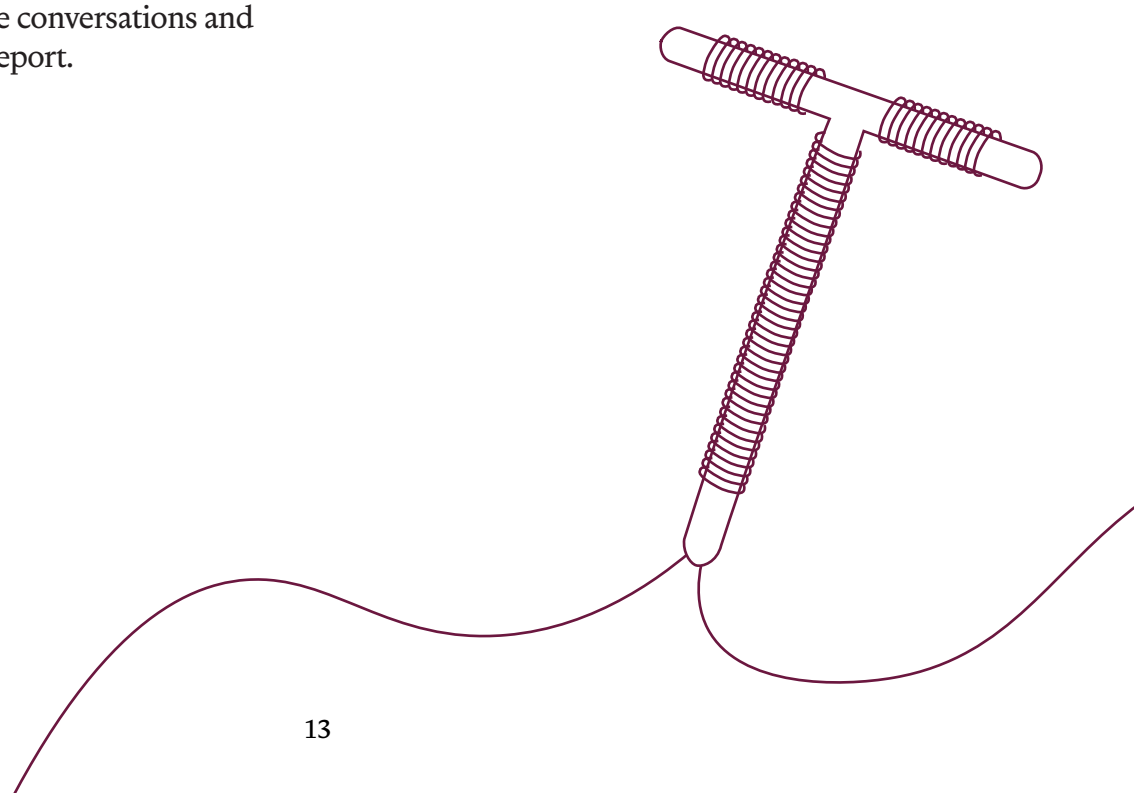
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Appendix

EFFINGHAM

Effingham – Aetna Better Health

Total Providers	n=63
Full Access	**11 (17.5%)**
Offered appointment for Paragard placement – within 5 weeks	11
Limited Access	**8 (12.7%)**
Offered appointment for Paragard placement – more than 5 weeks out	6
Offered appointment for other contraceptive method(s)	2
No Access	**15 (23.8%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	0
Referred/redirected to other provider(s)	1
Reported not taking new Medicaid patients/new patients in general	7
Unable to obtain information sought/helpful information	7
Bad Information	**29 (46.0%)**
Not an OB/GYN Generalist or Family Planning provider	14
Reported not being in MCO network	3
Reported other change in status – office closure, disaffiliation, etc.	4
Unable to contact/wrong number/did not exist	8

Effingham – Blue Cross Community Health

Total Providers	n=30
Full Access	**8 (26.7%)**
Offered appointment for Paragard placement – within 5 weeks	8
Limited Access	**4 (13.3%)**
Offered appointment for Paragard placement – more than 5 weeks out	2
Offered appointment for other contraceptive method(s)	2
No Access	**8 (26.7%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	0
Referred/redirected to other provider(s)	0
Reported not taking new Medicaid patients/new patients in general	3
Unable to obtain information sought/helpful information	5
Bad Information	**10 (33.3%)**
Not an OB/GYN Generalist or Family Planning provider	6
Reported not being in MCO network	2
Reported other change in status – office closure, disaffiliation, etc.	2
Unable to contact/wrong number/did not exist	0

Effingham – Meridian Health

Total Providers	n=56
Full Access	**9 (16.1%)**
Offered appointment for Paragard placement – within 5 weeks	9
Limited Access	**13 (23.2%)**
Offered appointment for Paragard placement – more than 5 weeks out	12
Offered appointment for other contraceptive method(s)	1
No Access	**11 (19.6%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	1
Referred/redirected to other provider(s)	5
Reported not taking new Medicaid patients/new patients in general	1
Unable to obtain information sought/helpful information	4
Bad Information	**23 (41.1%)**
Not an OB/GYN Generalist or Family Planning provider	16
Reported not being in MCO network	2
Reported other change in status – office closure, disaffiliation, etc.	0
Unable to contact/wrong number/did not exist	5

Effingham – Molina Health Care

Total Providers	n=45
Full Access	**7 (15.6%)**
Offered appointment for Paragard placement – within 5 weeks	7
Limited Access	**2 (4.4%)**
Offered appointment for Paragard placement – more than 5 weeks out	2
Offered appointment for other contraceptive method(s)	0
No Access	**6 (13.3%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	1
Referred/redirected to other provider(s)	1
Reported not taking new Medicaid patients/new patients in general	0
Unable to obtain information sought/helpful information	4
Bad Information	**30 (66.7%)**
Not an OB/GYN Generalist or Family Planning provider	7
Reported not being in MCO network	14
Reported other change in status – office closure, disaffiliation, etc.	2
Unable to contact/wrong number/did not exist	7

Effingham – YouthCare

Total Providers	n=51
Full Access	**13 (25.5%)**
Offered appointment for Paragard placement – within 5 weeks	13
Limited Access	**10 (19.6%)**
Offered appointment for Paragard placement – more than 5 weeks out	7
Offered appointment for other contraceptive method(s)	3
No Access	**2 (3.9%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	1
Referred/redirected to other provider(s)	0
Reported not taking new Medicaid patients/new patients in general	1
Unable to obtain information sought/helpful information	0
Bad Information	**26 (51.0%)**
Not an OB/GYN Generalist or Family Planning provider	12
Reported not being in MCO network	1
Reported other change in status – office closure, disaffiliation, etc.	2
Unable to contact/wrong number/did not exist	11

PEORIA

Peoria – Aetna Better Health

Total Providers	n=45
Full Access	**8 (17.8%)**
Offered appointment for Paragard placement – within 5 weeks	8
Limited Access	**7 (15.6%)**
Offered appointment for Paragard placement – more than 5 weeks out	4
Offered appointment for other contraceptive method(s)	3
No Access	**5 (11.1%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	2
Referred/redirected to other provider(s)	3
Reported not taking new Medicaid patients/new patients in general	0
Unable to obtain information sought/helpful information	0
Bad Information	**25 (55.6%)**
Not an OB/GYN Generalist or Family Planning provider	6
Reported not being in MCO network	7
Reported other change in status – office closure, disaffiliation, etc.	5
Unable to contact/wrong number/did not exist	7

Peoria – Blue Cross Community Health

Total Providers	n=25
Full Access	**2 (8.0%)**
Offered appointment for Paragard placement – within 5 weeks	2
Limited Access	**7 (28.0%)**
Offered appointment for Paragard placement – more than 5 weeks out	0
Offered appointment for other contraceptive method(s)	7
No Access	**8 (32.0%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	1
Referred/redirected to other provider(s)	2
Reported not taking new Medicaid patients/new patients in general	3
Unable to obtain information sought/helpful information	2
Bad Information	**8 (32.0%)**
Not an OB/GYN Generalist or Family Planning provider	3
Reported not being in MCO network	3
Reported other change in status – office closure, disaffiliation, etc.	0
Unable to contact/wrong number/did not exist	2

Peoria – Meridian Health

Total Providers	n=60
Full Access	**2 (3.3%)**
Offered appointment for Paragard placement – within 5 weeks	2
Limited Access	**7 (11.7%)**
Offered appointment for Paragard placement – more than 5 weeks out	1
Offered appointment for other contraceptive method(s)	6
No Access	**6 (10.0)%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	2
Referred/redirected to other provider(s)	1
Reported not taking new Medicaid patients/new patients in general	2
Unable to obtain information sought/helpful information	1
Bad Information	**45 (75.0%)**
Not an OB/GYN Generalist or Family Planning provider	25
Reported not being in MCO network	7
Reported other change in status – office closure, disaffiliation, etc.	2
Unable to contact/wrong number/did not exist	11

Peoria – Molina Health Care

Total Providers	n=35
Full Access	**2 (5.7)%)**
Offered appointment for Paragard placement – within 5 weeks	2
Limited Access	**7 (20.0%)**
Offered appointment for Paragard placement – more than 5 weeks out	0
Offered appointment for other contraceptive method(s)	7
No Access	**7 (20.0%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	0
Referred/redirected to other provider(s)	0
Reported not taking new Medicaid patients/new patients in general	3
Unable to obtain information sought/helpful information	4
Bad Information	**19 (54.2%)**
Not an OB/GYN Generalist or Family Planning provider	10
Reported not being in MCO network	4
Reported other change in status – office closure, disaffiliation, etc.	1
Unable to contact/wrong number/did not exist	4

Peoria – YouthCare

Total Providers	n=38
Full Access	**3 (7.9%)**
Offered appointment for Paragard placement – within 5 weeks	3
Limited Access	**6 (15.8%)**
Offered appointment for Paragard placement – more than 5 weeks out	1
Offered appointment for other contraceptive method(s)	5
No Access	**10 (28.6%)**
Reported being unable to provide birth control for contraceptive reasons or only offering natural family planning	1
Referred/redirected to other provider(s)	1
Reported not taking new Medicaid patients/new patients in general	3
Unable to obtain information sought/helpful information	5
Bad Information	**19 (50.0%)**
Not an OB/GYN Generalist or Family Planning provider	7
Reported not being in MCO network	1
Reported other change in status – office closure, disaffiliation, etc.	2
Unable to contact/wrong number/did not exist	9

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