Congress of the United States
Washington, DC 20515

October 21, 2024

The Honorable Gene L. Dodaro
Comptroller General of the United States
U.S. Government Accountability Office
441 G Street, NW
Washington, D.C. 20548

Dear Mr. Dodaro,

We are writing to request information on federal resources and inventory stocking of contraception options for women through Federally Qualified Health Centers (FQHCs), specifically Community Health Centers (CHCs). In 2020, more than 12,000 FQHCs provided care for over 28 million people, many of them women of reproductive age.[1] While millions of women continue to pursue care through FQHCs, there are significant discrepancies in access to specific forms of contraception at each facility, many of which are associated with a lack of provider training.[2]

Section 330 of the Public Health Service Act, which authorizes the CHC program, requires centers provide, "voluntary family planning services." However, the law and regulations do not define or restrict the exact scope of "voluntary planning services" that must be provided, and community health centers are given significant leeway to determine the precise mix and scope of the required family planning services that are offered. This may include counseling on contraception methods including, but not limited to, oral hormonal contraception, implants, injectables, patches, vaginal rings, intra uterine devices (IUD), and condoms, but there is limited data on the methods available to women at CHCs and associated provider training.

Increased access to family planning services has proven to reduce the rate of unintended pregnancies, reduce the spread of sexually transmitted diseases, and reduce rates of infertility and maternal mortality.[3] The limited information that is available also indicates that women in rural communities are facing a significant lack of access.[4] With millions of women in the United States living in areas with limited contraceptive access, it's imperative we understand the deficiencies and why they exist.[5]

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[1] Gourevitch RA, Hatfield LA. Changes in prenatal care and birth outcomes after federally qualified health center expansion. Health Serv Res. 2023 Apr;58(2):489-497. doi: 10.1111/1475-6773.14099. Epub 2022 Nov 14. PMID: 36342016; PMCID: PMC10012219.
[2] https://www.kff.org/report-section/community-health-centers-and-family-planning-in-an-era-of-policy-uncertainty-report/
[3] https://www.ncbi.nlm.nih.gov/books/NBK215219/
[4] Bornstein M, Carter M, Zapata L, Gavin L, Moskosky S. Access to long-acting reversible contraception among US publicly funded health centers. Contraception. 2018 May;97(5):405-410. doi: 10.1016/j.contraception.2017.12.010. Epub 2017 Dec 15. PMID: 29253581; PMCID: PMC6750753.
[5] Kreitzer RJ, Smith CW, Kane KA, Saunders TM. Affordable but Inaccessible? Contraception Deserts in the US States. J Health Polit Policy Law. 2021 Apr 1;46(2):277-304. doi: 10.1215/03616878-8802186. PMID: 32955562.

Based on data from 2017, just 24 percent of all CHCs in the country provide a comprehensive list of contraception options for patients to review on-site, while close to half participate in mail-order prescription programs. Adding to inventory challenges, many CHCs do not have a provider on staff trained on IUD or implant insertion procedures. Smaller health centers, specifically those located in rural or suburban areas, are less likely to offer IUDs or implant devices due to training barriers. In fact, 27 percent of rural or suburban CHCs report staff training as a barrier in providing additional contraception options on-site, in contrast to 10 percent of CHCs located in urban areas.[6]

We request GAO identify the following for Fiscal Years 2017-2024:

1. Itemized inventory stocking of available contraception methods i.e., percentage of FQHCs offering oral contraceptives versus implant versus IUD. Analysis should also include:
    - Data separation by products or devices prescribed as a prophylactic contraception method and those used as emergency contraception or abortifacient.
    - Average number of FQHC providers trained on insertion of applicable IUD or arm implant device.
    - Training averages within each category of FQHCs, including health center "look-alikes."[7]
2. Annual disbursements and expenditures of federal funds to FQHCs for reimbursement of contraception methods including, but not limited to, oral hormonal contraception, implants, injectables, patches, vaginal rings, IUDs, and condoms.
    - Analysis should specify funding stream i.e., Medicaid, Medicare, federal grant, self-pay, and clarify specific use of Title X funds.
3. Annual family planning counseling appointment requests, which should include rate of return after an initial visit with a FQHC provider.
4. Financial resources and contraceptive options offered by FQHCs that do not receive Title X funding.
5. Any additional barriers to FQHC providers who wish to provide a wider range of contraceptive methods to patients, including geographic barriers.

Kindly provide a response on or before November 11, 2024.

Sincerely,

Joni K. Ernst
United States Senator

Ashley Hinson
Member of Congress

[6] https://www.kff.org/report-section/community-health-centers-and-family-planning-in-an-era-of-policy-uncertainty-report/
[7] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FQHC-Text-Only-Factsheet.pdf/