

National
Family Planning
& Reproductive Health Association

TO: Interested Parties
FROM: Robin Summers, JD, Senior Policy Director, National Family Planning & Reproductive Health Association
SUBJECT: Access to and Reimbursement of Family Planning Services in Medicaid Managed Care, Including Payment for Out-of-Network Services
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The right to freely choose to receive family planning services from any qualified participating Medicaid provider is an essential protection designed to ensure that Medicaid beneficiaries have ready access to the health services they need when they need them, and from a provider they trust. Federal law guarantees that Medicaid beneficiaries can receive family planning services from any qualified Medicaid provider, even if that provider is outside of the beneficiary's Medicaid managed care network; this principle is referred to as "freedom of choice" (42 U.S.C. § 1396a(a)(23); 42 U.S.C. § 1396n(b)). Managed care organizations must provide direct access to women's health providers (42 C.F.R. § 438.206(b)(2)). Beneficiaries have the right to receive family planning services and supplies from both in- and out-of-network providers, without restrictions as to their choice of provider or contraceptive method (42 USC § 1396(a)(23)(B); 42 C.F.R. § 441.20), and without additional costs to beneficiaries for family planning services received out-of-network (42 U.S.C. §§ 1396o(a)(2)(D) and (b)(2)(D); 42 C.F.R. § 447.56(a)(2)(ii); 42 U.S.C. § 1396u-2(b)(6)(C)).

Furthermore, the state is responsible for ensuring that individuals can access family planning services through the Medicaid provider of their choice, and for ensuring payment for such services provided (42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51; CMS State Medicaid Manual, Sections 2088.5 and 2100; *see also* CMS, [Special Terms and Conditions, Iowa Marketplace Choice Plan, July 31, 2015](#) ("Family planning services that the QHP considers to be out-of-network, subject to all third party liability rules, will be ensured by the state Medicaid program to be paid at state plan rates")). States have three choices for ensuring payment: 1) they can require a managed care plan to pay for family planning services provided to beneficiaries enrolled in such plan (even though the services were provided outside of that plan's network); 2) they can reimburse out-of-network providers directly; or 3) they can cover all family planning services and supplies directly (whether provided in-network or out-of-network) on a fee-for-service basis (CMS State Medicaid Manual, Section 2088.5).

In relevant part, federal law and guidance provides:

[42 U.S.C. § 1396a\(a\)\(23\)](#) [Social Security Act (SSA) § 1902(a)(23)]: "(A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a [M]edicaid managed care organization, or a similar entity shall not restrict the choice of the qualified

person from whom the individual may receive services under section 1396d(a)(4)(C) of this title. . . .”

[42 U.S.C. § 1396d\(a\)\(4\)\(C\)](#) [SSA § 1905(a)(4)(C)]: “[F]amily planning services and supplies” must be “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.”

[42 U.S.C. § 1396n\(b\)](#) [SSA § 1915(b)]: Freedom of choice can be waived in managed care, except with regard to family planning: “No waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title.”

[42 U.S.C. §§ 1396o\(a\)\(2\)\(D\) and \(b\)\(2\)\(D\)](#) [SSA § 1916(a)(2)(D) and (b)(2)(D)]: “[N]o deduction, cost sharing[,], or similar charge will be imposed under the plan with respect to . . . family planning services and supplies described in section 1396d(a)(4)(C) of this title.”

[42 U.S.C. § 1396u-2\(b\)\(6\)\(C\)](#) [SSA § 1932(b)(6)(C)]: “Each [M]edicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the organization may not be held liable . . . for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.”

[42 C.F.R. § 431.51\(a\) - \(c\)](#):

(a) Provides the statutory basis for the regulation, including:

“(1) Section 1902(a)(23) of the Act provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

(2) Section 1915(a) of the Act provides that a State shall not be found out of compliance with section 1902(a)(23) solely because it imposes certain specified allowable restrictions on freedom of choice.

(3) Section 1915(b) of the Act authorizes waiver of the section 1902(a)(23) freedom of choice of providers requirement in certain specified circumstances, but not with respect to providers of family planning services.

(4) Section 1902(a)(23) of the Act provides that a beneficiary enrolled in a primary care case management system or Medicaid managed care organization (MCO) may not be denied freedom of choice of qualified providers of family planning services.

(5) Section 1902(e)(2) of the Act provides that an enrollee who, while completing a minimum enrollment period, is deemed eligible only for services furnished by or through the MCO or PCCM, may, as an exception to the deemed limitation, seek family planning services from any qualified provider.

(6) Section 1932(a) of the Act permits a State to restrict the freedom of choice required by section 1902(a)(23), under specified circumstances, for all services except family planning services.”

- (b) A state plan must provide that a “beneficiary may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is (i) Qualified to furnish the services; and (ii) Willing to furnish them to that particular beneficiary.”

Further, the state plan must provide that a “beneficiary enrolled in a primary care case–management system, a Medicaid MCO, or other similar entity will not be restricted in freedom of choice of providers of family planning services.”

- (c) Provides that § 431.51(b) “does not prohibit the agency” from “(1) Establishing the fees it will pay providers for Medicaid services; (2) Setting reasonable standards relating to the qualifications of providers; or (3) Subject to paragraph (b)(2) of this section, restricting beneficiaries' free choice of providers in accordance with one or more of the exceptions set forth in § 431.54, or under a waiver as provided in § 431.55.”

[42 C.F.R. § 438.206\(b\)\(2\)](#): “The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services . . . [p]rovides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.”

[42 C.F.R. § 441.20](#): “For beneficiaries eligible under the plan for family planning services, the plan must provide that each beneficiary is free from coercion or mental pressure and free to choose the method of family planning to be used.”

[42 C.F.R. § 447.56\(a\)\(2\)\(ii\)](#): “The agency may not impose cost sharing for . . . [f]amily planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.”

[CMS State Medicaid Manual](#), **Section 2088.5, Freedom of Choice for Family Planning Services**: “Sections 1902(a)(23)(B) and 1905(a)(4)(C) of the Act and 42 CFR 431.51(b) require that a person's enrollment in [a Health Maintenance Organization (HMO)] does not restrict the choice of the provider from whom the person may receive family planning services and supplies. You must cover family planning supplies and services provided by any qualified provider, even though the individual is enrolled in an HMO and the provider does not contract with the HMO. This means that the recipient may obtain family planning

services and supplies from outside of the HMO without an HMO referral, even if the HMO contracts with Medicaid to provide the same services. For the family planning services and supplies provided outside the HMO, you have three options. You may hold the HMO responsible for covering such services by making FFS payments to non-plan providers. You may cover out-of-plan services while the HMO covers in-plan services. Or, you may cover all family planning services directly on a FFS basis. In all three cases, adjust the HMO's capitation payments accordingly.”

[CMS State Medicaid Manual](#), Section 2100, Free Choice of Providers – General: “The purpose of the free choice provision is to allow title XIX recipients the same opportunities to choose among available providers of covered health care and services as are normally offered to the general population. This means that title XIX recipients are subject to the same reasonable limitations in exercising such choice as are nonrecipients.

Under §1902(a)(23) of the Social Security Act, a State plan for medical assistance under title XIX must provide that any individual eligible for medical assistance (including drugs) under the plan may obtain the services available under the plan from any institution, agency, community pharmacy, or practitioner qualified to perform the services required, who undertakes to provide him these services, including an organization which provides such services or arranges for their availability on a prepayment basis. This requirement does not apply in the case of Puerto Rico, the Virgin Islands, and Guam. The agency is not prohibited from:

- imposing reasonable and objective qualification standards for provider eligibility,
- establishing the fees which will be paid to providers for furnishing medical and remedial care under the plan, or
- restricting the free choice of providers in accordance with one or more of the exceptions provided for under §1915(a) or under a waiver as provided for under §1915(b).

This provision is implemented in regulations at 42 CFR 431.51.

Section 2175 of Public Law 97-35 added §1915 to the Social Security Act. Section 1915 allows exceptions to and waivers of the freedom of choice provision as described in §§2103 and 2104.”