

TO: Interested Parties
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SUBJECT: CMS Advancements in Medicaid Family Planning
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Between April and June 2016, the Centers for Medicare & Medicaid Services (CMS) issued important regulations and sub-regulatory guidance that clarify and strengthen existing requirements governing the provision of family planning services and supplies under Medicaid, and also implement important new requirements designed to improve the quality of and access to family planning care.

The prioritization of Medicaid family planning by CMS and the agency's Center for Medicaid & CHIP Services (CMCS) has been a welcome and important step in strengthening policies governing coverage of and reimbursement for family planning services and supplies. Collectively, the Medicaid managed care regulations and the three pieces of sub-regulatory guidance provide states with a clear indication of CMS's support for improved and expanded access to high-quality family planning services and supplies in Medicaid, and a roadmap of requirements and recommendations for states to follow in implementing policies to achieve these goals.

This memo highlights some of the key provisions contained in the recent regulations and guidance that may be of significant benefit to family planning providers and their patients.

Freedom of Choice of Providers

Family planning services and supplies have long been required services under the Medicaid program.¹ Family 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."² Federal law provides for an enhanced federal match rate of 90%³ for "the offering, arranging, and furnishing (directly or on a contract basis)

¹ 42 U.S.C. § 1396d(a)(4)(C).

² Ibid.

³ 42 U.S.C. § 1396b(a)(5); 42 CFR § 433.10(c)(1).

KEY CMS REGULATIONS AND SUB-REGULATORY GUIDANCE

April 8: Informational Bulletin
on state Medicaid payment approaches to improving long-acting reversible contraception (LARC) access.

April 19: State Medicaid Director letter clarifying Medicaid's "free choice of provider" requirement in conjunction with state actions against Medicaid providers.

April 25: Final rule on managed care for Medicaid and the Children's Health Insurance Program (CHIP). The rule, while broadly affecting family planning services and providers, includes specific policy enhancements and updates to program rules specific to family planning services and supplies.

June 14: State Health Officials letter providing guidance on family planning services provided under both fee-for-service and managed care delivery systems.

of family planning services and supplies.”⁴ 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” or “free choice of provider.”⁵

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. However, since 2015, a growing number of states have moved to bar certain family planning providers from state Medicaid programs, despite long-standing federal law.

In response to recent state actions, the April 19 State Medicaid Director letter makes clear that states are prohibited from establishing qualification standards, or taking certain actions against a provider (such as barring a provider from Medicaid), unless those standards or actions are related to the provider’s fitness to provide covered services or to appropriately bill for such services.⁶ States must provide “supporting evidence of the provider’s failure to meet the state’s reasonable provider standards,” and may not target “disfavored providers” for state action simply because they provide the “full range of legally permissible gynecological and obstetric care, including abortion services (not funded by federal Medicaid dollars, consistent with the federal prohibition), as part of their scope of practice.”⁷

The final Medicaid managed care rule provides additional clarifications and requirements concerning beneficiary access to the provider of their choice. The right of Medicaid beneficiaries to access family planning services from the provider of their choice means little if beneficiaries are not informed of that right and/or how they can obtain these benefits. Under the final rule, managed care plans are required to provide information to enrollees detailing “the extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers,” including an explanation that the plans cannot require enrollees to obtain a referral before choosing a family planning provider.⁸ Further, when a managed care plan refuses to cover a counseling or referral service because of moral or religious objections, the plan is required to inform enrollees both that the service is not covered and how enrollees can obtain information from the state about how to access the service.⁹

Freedom of Choice of Services and Methods

Under long-standing federal law, Medicaid beneficiaries not only have the freedom to choose their family planning provider, but also the freedom to choose their method of family planning. States must ensure that beneficiaries are “free from coercion or mental pressure and free to choose the method of family planning to be used,”¹⁰ and family planning must be provided without patient co-pays or other

⁴ 42 U.S.C. § 1396b(a)(5).

⁵ 42 U.S.C. § 1396a(a)(23); 42 U.S.C. § 1396n(b).

⁶ US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, State Medicaid Director letter, “Clarifying ‘Free Choice of Provider’ Requirement in Conjunction with State Authority to Take Action against Medicaid Providers,” April 19, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf>.

⁷ Ibid.

⁸ 42 C.F.R. § 438.10(g)(2)(vii).

⁹ 42 C.F.R. § 438.10(g)(2)(ii)(A) and (B).

¹⁰ 42 C.F.R. § 441.20.

cost sharing.¹¹ However, federal law does not define what constitutes “family planning” under a state Medicaid plan, meaning that states have some flexibility in determining what services and supplies they cover in their state Medicaid plans, “so long as those services are sufficient in amount, duration, and scope to reasonably achieve the purpose of preventing or delaying pregnancy” (or treating infertility, if the state chooses to include infertility treatment in its definition of family planning) and “permit beneficiary choice in the method of family planning.”¹² States and managed care plans have also had flexibility in applying medical necessity or utilization control criteria to family planning services and supplies, which has created barriers for beneficiaries in accessing care.

The final Medicaid managed care rule and the June 14 State Health Officials letter take significant steps toward eliminating such barriers. Together, the rule and guidance severely curtail the ability of states and managed care plans to apply policies that interfere with a Medicaid beneficiary’s ability to freely choose their “method of family planning or the services or counseling associated with choosing the method.”¹³ For example, states and managed care plans are expressly prohibited from utilizing policies that require a particular method be used before another (step therapy) or that restrict a change in method.¹⁴ Prior authorization is only permissible in the narrow context of assessing medical necessity and appropriateness for an individual (e.g. side effects, clinical effectiveness, etc.).¹⁵ Medically inappropriate quantity limits (such as allowing only one insertion of a long-acting reversible contraceptive (LARC) every five years even when the earlier LARC was expelled or removed) and other practices that delay the provision of a preferred method of contraception are discouraged.¹⁶

In the June 14 State Health Officials letter, CMS also recommends states cover all methods of contraception approved by the US Food and Drug Administration (FDA), including non-prescription methods (e.g. emergency contraception), for all Medicaid beneficiaries.¹⁷ Although, as discussed earlier, federal law does not define family planning for state Medicaid plan beneficiaries, the Affordable Care Act (ACA) requires that Alternative Benefit Plans (ABPs) cover the women’s preventive health services benefit, which includes coverage of all FDA-approved methods of contraception. Thus, family planning requirements can and do differ within states, depending on whether a Medicaid beneficiary is enrolled in state plan Medicaid or an ABP. CMS’ recommendation would help states better align their ABP and state plan coverage, providing more uniformity in family planning services across state Medicaid programs and better ensuring access to care for all beneficiaries.¹⁸

¹¹ 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)).

¹² US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, State Health Officials letter, “Medicaid Family Planning Services and Supplies,” June 14, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>. See also 42 U.S.C. § 1396b(a)(5); Centers for Medicare & Medicaid Services, *State Medicaid Manual*, § 4270, <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

¹³ State Health Officials letter, June 14, 2016. See also US Department of Health and Human Services, Centers for Medicare & Medicaid Services, “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability,” *Federal Register* 81, no. 88 (May 6, 2016): 27498, <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. Note: The final managed care rule was released on April 25 but was not formally published in the *Federal Register* until May 6.

¹⁴ State Health Officials letter, June 14, 2016.

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ *Ibid.*

¹⁸ *Ibid.*

Access to and Reimbursement for Family Planning Providers

CMS has also strengthened requirements governing in-network access to family planning providers and reimbursement both in network and out of network. Federal law requires states to ensure that Medicaid managed care plans provide “female enrollees with direct access to a women’s health specialist within the provider 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.”¹⁹ The preamble language of the final managed care rule clarifies that “female enrollees” includes minor females, and that “routine and preventive health care services” includes (but is not limited to) “initial and follow-up visits for services unique to women such as prenatal care, mammograms, pap smears, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted diseases.”²⁰

The final managed care rule clarifies that states are responsible for ensuring all services covered under a state’s Medicaid plan are available and accessible to managed care plan enrollees in a timely manner.²¹ The rule also adds a new provision specific to the adequacy of family planning networks, in recognition that even though freedom of choice is a critical protection, it is not an adequate substitute for the in-network inclusion of family planning providers. The new provision requires that states include a provision in its contracts with all managed care plans that requires the plan to demonstrate “that its network includes sufficient family planning providers to ensure timely access to covered services.”²²

The June 14 State Health Officials letter also makes improvements in the timely reimbursement of family planning providers. The letter clarifies that existing timely claims payment regulations, which set the requirements for both states and managed care plans to follow in the payment of provider claims,²³ apply to claims for family planning services and supplies.²⁴ For managed care plans, the timely claims payment provisions apply to claims from both in- and out-of-network providers, “unless a mutually agreed to alternative payment schedule is in place” — meaning managed care plans are responsible for paying claims to out-of-network providers unless the plan has an agreement (either with the provider or the state) in place that the state will pay such claims.²⁵

Confidentiality and Access to Services

Medicaid has long maintained confidentiality protections for Medicaid beneficiaries.²⁶ However, access to family planning and other sensitive services present unique challenges, which can result in explanation of benefits (EOBs) and other Medicaid-related communications that may inadvertently violate a patient’s confidentiality depending on who has access to the communications and what information they contain. The June 14 State Health Officials letter clarifies that state Medicaid programs and managed care plans

¹⁹ 42 C.F.R. § 438.206(b)(2).

²⁰ “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability,” May 6, 2016.

²¹ 42 C.F.R. § 438.206(a).

²² 42 C.F.R. § 438.206(b)(7).

²³ 42 C.F.R. §§ 447.45 and 447.46.

²⁴ State Health Officials letter, June 14, 2016.

²⁵ *Ibid.*

²⁶ 42 U.S.C. § 1396a(a)(7). *See also* 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 441.20.

are required to accommodate reasonable requests of Medicaid beneficiaries to receive communications (including EOBs) by alternative means or at an alternative location.²⁷ Both states and managed care plans bear responsibility for ensuring that beneficiaries are informed of this option.²⁸ Additionally, providers are required to accommodate a beneficiary's reasonable request for alternative communications in all circumstances.²⁹

The June 14 State Health Officials letter also clarifies that family planning services and supplies provided during the course of a medical visit are eligible for the enhanced 90% match rate for family planning, regardless of the purpose of the medical visit in which such services or supplies are provided.³⁰ This language comes in the wake of audit findings in recent years by the federal Office of Inspector General (OIG) related to the provision of family planning services and supplies in state Medicaid programs and state receipt of the enhanced 90% match rate for such services and supplies. In several of the audits, OIG has recommended that states return to the federal government millions of dollars for certain services that OIG deemed ineligible for the enhanced 90% match rate because the primary purpose of the visit was not family planning. The June 14 letter clarifies that "if an individual presents at a medical visit for any reason, such as an annual physical exam, and obtains a family planning service or supply for a family planning purpose during that visit, an expenditure for the family planning service or supply, if properly identified on the claim, is eligible for the [90% match]."³¹ The letter further states that the "family planning purpose" of the services and supplies must be for the purpose of preventing or delaying pregnancy (or treating infertility, if the state has chosen to include such treatment in its definition of family planning).³² States are required to ensure provider claims are "appropriately documented to reflect the provision of family planning services and supplies."³³

Finally, CMS is encouraging states to improve beneficiary access to LARCs, and has provided a number of strategies for states to consider implementing and clarifications of current requirements and policies related to reimbursement. In July 2014, CMCS launched a Maternal and Infant Health Initiative to improve maternal and infant health outcomes. The April 8 Informational Bulletin stems directly from that work, and identifies five broad categories of strategies that can be used by states to improve LARC access: providing timely, patient-centered comprehensive coverage for the provision of contraceptive services for women of reproductive age; raising payment rates to providers; reimbursing for immediate postpartum LARC insertion by unbundling LARC payments from other labor and delivery services; removing logistical barriers for supply management; and removing administrative barriers for the provision of LARC.³⁴

The June 14 State Health Officials letter details further approaches that can be used by states to improve LARC access, such as utilizing manufacturer programs that facilitate stocking of LARCs as well as the

²⁷ State Health Officials letter, June 14, 2016. *See also* 45 C.F.R. § 164.522(b)(ii).

²⁸ State Health Officials letter, June 14, 2016.

²⁹ *Ibid.* *See also* 45 C.F.R. § 164.522(b)(i).

³⁰ State Health Officials letter, June 14, 2016.

³¹ *Ibid.*

³² *Ibid.*

³³ *Ibid.*

³⁴ US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, CMCS Informational Bulletin, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," April 8, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf>.

return of and reimbursement for unused LARCs, and utilizing Section 1115(a) demonstration waiver authority to make 90% match funding available to states for administrative costs associated with maintaining an inventory of LARCs for Medicaid providers.³⁵ The letter also specifies that Medicaid reimbursement to providers for LARCs should be reasonable and must include “not only the insertion and removal of the LARC, but also the LARC itself, even if the service and device are billed and paid separately.”³⁶

Conclusion

As is often the case with federal rules and guidance, much about the success of any policy or requirement is dependent upon their implementation. Although much of the Medicaid managed care final rule and the three pieces of sub-regulatory guidance is already effective, it will take time for states to modify their policies in response to required changes, make decisions about recommended changes, and for such policies to be implemented in a way that affects family planning providers and patients. However, understanding some of the key provisions of recent regulations and guidance should help family planning providers and advocates bring new policies to fruition in meaningful ways in their states.

CMS’s promulgation of regulation and sub-regulatory guidance specific to the needs of family planning providers and patients is a welcome advancement in improving access to family planning services and supplies in Medicaid. NFPRHA is working on additional tools to assist family planning providers and administrators in navigating these new policies and in helping state officials in their implementation efforts.

³⁵ State Health Officials letter, June 14, 2016.

³⁶ Ibid.