DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO # 16-008

Re: Medicaid Family Planning Services and Supplies

June 14, 2016

Dear State Health Official:

The purpose of this letter is to clarify previous guidance on the delivery of family planning services and supplies to all Medicaid beneficiaries, as well as to highlight approaches states may take to ensure timely access to this benefit. Specifically, this letter provides guidance on family planning services provided under both fee-for-service and managed care delivery systems; clarifies the purpose of the family planning visit; offers strategies to reduce barriers to receiving family planning services and supplies; and suggests ways to increase access to contraceptive methods. The guidance in this letter is effective immediately.

Background

Under section 1905(a)(4)(C) of the Social Security Act (the Act), family planning services and supplies must be included in the standard Medicaid benefit package and in alternative benefit plans (ABPs). The mandatory family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, a medical visit to change the method of contraception, and (at the state's option) infertility treatment. For expenditures for family planning services and supplies, states receive an enhanced Federal Financial Participation (FFP) of 90 percent.

In addition, section 1902(a)(10)(G) of the Act, as amended by section 2303(a)(3) of the Affordable Care Act, added an optional family planning eligibility group. While full benefit Medicaid eligible individuals receive a wide array of care under other Medicaid coverage categories, individuals in this optional eligibility group are covered only for family planning services and family planning *related* services. Family planning *related* services are medical, diagnostic, and treatment services provided pursuant to a family planning visit that address an individual's medical condition and may be provided for a variety of reasons including, but not limited to: treatment of medical conditions routinely diagnosed during a family planning visit, such as treatment for urinary tract infections or sexually transmitted infection; preventive services routinely provided during a family planning visit, such as the HPV vaccine; or treatment of a major medical complication resulting from a family planning visit. Expenditures for family planning *related* services are matched at the states' regular Federal Medical Assistance Percentage (FMAP). The clarifications in this letter supplement all earlier guidance.

The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Directors letter on July 2, 2010 (SMDL #10-013), which provided guidance on the new optional family planning state plan eligibility group created by section 2303 of the Affordable Care Act. In a subsequent

letter issued on April 16, 2014 (SMDL #14-003), CMS provided additional clarification on coverage of family planning-related services provided to individuals eligible under the new optional family planning state plan group.

Applying Family Planning Policy to Fee-for-Service and Managed Care

In accordance with section 1902(a)(23)(B) of the Act, an individual has free choice of a family planning provider regardless of the state's delivery system (i.e., fee-for-service or managed care) and cannot be required to obtain a referral prior to choosing a provider for family planning services. In managed care, enrollees can select any qualified family planning provider from in-network or out-of-network without referral.

In addition to a beneficiary's free choice of provider, beneficiaries are free to choose the method of family planning as provided for in 42 C.F.R. § 441.20. States must provide that individuals are free from coercion or mental pressure and free to choose the method of family planning to be used. States cannot have requirements that would place an undue burden, coercion, or mental pressure that would impinge on access to family planning services.

While states and managed care plans have the ability to apply medical necessity or utilization control criteria for a beneficiary's request for family planning services, such processes cannot interfere with a beneficiary's freedom to choose the method of family planning or the services or counseling associated with choosing the method. For example, a state or managed care plan cannot require that a particular method be used first (e.g., step therapy) or have in place policies that restrict a change in method (which may involve removal of an implanted or inserted method). The only permissible prior authorization requirement would be the determination that the method is medically necessary and appropriate for the individual, using criteria that may include considerations such as severity of side effects, clinical effectiveness, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service. States and managed care plans should avoid practices that delay the provision of a preferred method or that impose medically inappropriate quantity limits, such as allowing only one long acting reversible contraceptive (LARC) insertion every five years, even when an earlier LARC was expelled or removed. To the extent that states elect to employ utilization practices, they should pursue only those practices that ensure beneficiaries choice in family planning providers and method of contraception.

Clarification of the Purpose of the Family Planning Visit

CMS is clarifying that, when family planning services and supplies are delivered during a medical visit in which family planning and non-family planning services are furnished, expenditures for such family planning services and supplies are eligible for 90 percent FFP. Therefore, 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 percent FFP. The family planning purpose must be for the purpose of preventing or delaying pregnancy (or at the state's option, for treating infertility). In order for the state to claim the 90 percent FFP for that family planning service, states must ensure that

provider claims are appropriately documented to reflect the provision of family planning services and supplies.

Assuring Access to Family Planning Services and Supplies

Coverage of specific family planning services and supplies is one key to ensuring access to family planning for Medicaid beneficiaries. However, family planning benefit requirements differ depending on whether a beneficiary has coverage under the traditional state plan benefit package or under an Alternative Benefit Plan (ABP.)[1] In general, ABPs allow states flexibility in defining benefit packages that are different from the Medicaid state plan. ABPs must include all Essential Health Benefits (EHBs). Under the Preventive Services EHB category, coverage must include all U.S. Food and Drug Administration (FDA) approved methods of contraception prescribed for women by a health care practitioner. ABPs must cover at least one form of contraception within each method approved by the FDA. For a list of approved methods, see FDA Office of Women's Health Birth Control Guide available at http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf.

For Medicaid beneficiaries whose coverage is governed by the state plan rather than the ABP's, states may determine the specific services and supplies that will be covered as Medicaid family planning services and supplies so long as those services are sufficient in amount, duration, and scope to reasonably achieve the purpose of preventing or delaying pregnancy and permit beneficiary choice of the method of family planning. Although it is not required, CMS recommends that states cover all FDA-identified contraceptive methods for beneficiaries, including both prescription and non-prescription methods. Because not all forms of contraception are appropriate for all beneficiaries, in the absence of contraindications, patient choice and efficacy should be the principal factors used in choosing one method of contraception over another. One pathway for states to accomplish this would be to align ABP and state plan coverage for these services.

Under both ABP and state plan coverage, whether provided through a fee-for-service or a managed care delivery system, family planning services and supplies, including contraceptives and pharmaceuticals, must be provided without cost sharing pursuant to 42 C.F.R. §447.56(a)(2)(ii) and 42 C.F.R. §438.108. Additionally, existing timely claims payment provisions specified in 42 C.F.R. §447.45 and §447.46 apply to claims for family planning services and supplies. For managed care plans, these provisions apply to claims from in-network and out-of-network providers, unless a mutually agreed to alternative payment schedule is in place.

Other confidentiality requirements protect individuals seeking family planning services. State Medicaid programs and managed care plans are "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Under 45 C.F.R. §164.522(b)(ii), the

[1] States are required to provide Medicaid benefits through an ABP for the Medicaid expansion population. The state has the option of providing benefits through an ABP for other populations, otherwise individuals receive traditional state plan benefits.

state Medicaid program and managed care plans must accommodate a beneficiary's reasonable request to receive communications, including explanation of benefits, by alternative means or at an alternative location when the individual clearly states that disclosure could endanger the individual. For example, a beneficiary may request that a plan communicate with her/him via cell phone instead of paper mail. States and managed care plans are responsible for ensuring that beneficiaries are informed of this option. In addition, under 45 C.F.R. §164.522(b)(i), health care providers must accommodate an individual's reasonable request for alternative means of communication in all circumstances. All states and Medicaid managed care plans (and health care providers) should already be ensuring confidentiality as part of their compliance with the HIPAA Privacy Rule.

Strategies for Improving Access to Long Acting Reversible Contraceptives (LARCs)

LARCs, including IUDs and contraceptive implants, are an extremely effective form of contraception. LARCs are administered by physicians and other providers who may administer them within their scope of practice. LARCs may also be cost effective (and when expenditures are federally matched at the 90 percent rate, the costs to states are extremely low). For Medicaid eligible individuals, 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. CMS issued an informational bulletin on April 8, 2016, highlighting emerging payment approaches that several state Medicaid agencies have used to optimize access to and use of LARCs.[2]

States may cover LARCs through their pharmacy benefit. Covering LARCs through the pharmacy benefit means that dispensing pharmacies bill the state for the LARCs and applicable dispensing fees, then deliver the LARCs to providers for insertion or administration. The provider then bills the state for the furnished insertion or implantation service. These steps may present barriers to access since this process requires the woman to see the provider twice: once to obtain the LARC prescription and then again for insertion or administration. Another challenge is that, absent permissible state policies or prior manufacturer arrangements, providers may not return un-inserted or un-administered LARCs, resulting in waste and financial loss for the state.

Issues have also arisen when states cover LARCs through the medical benefit. In these states, providers can stock the array of LARCs and implant or administer the most appropriate one during the patient's visit, which helps improve access by reducing the need for a second visit. It could also reduce the waste from unused LARCs. High upfront costs required to maintain a stock of LARCs, however, may deter providers from implementing this approach, resulting in barriers to access due to a potential unwillingness of providers to furnish LARCs.

CMS encourages states to explore and pursue the following models, some of which are already being used by states, to overcome administrative and logistical barriers to the provision of LARCs:

[2] State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. April 8, 2016. https://medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf

First, states are encouraged to implement measures that facilitate immediate postpartum LARC insertion, when a woman chooses this option. As a result of the global or bundled pregnancy and delivery payment arrangements, some states have established policies of not covering additional services provided immediately following delivery. These policies have the effect of deterring providers from inserting LARCs immediately after delivery. In addition, when multiple procedures are performed during a single hospital stay and submitted as a single inpatient claim, if those costs attributable to family planning services are separately identified, the state can receive federal matching funds at the 90 percent rate. To the extent that there are shared costs between family planning services and other services, the state should develop a methodology for allocating these costs. CMS strongly recommends that states establish payment policies that, when a woman chooses, permit and encourage insertion of LARCs immediately following a vaginal delivery or surgical procedure as a separately identified service that is eligible for the 90 percent FFP. CMS also recommends similar policies with respect to coverage of free standing birth center services, which are generally reimbursed at the state's regular FMAP unless the free standing birth center provides family planning services. These services would then be eligible for the 90 percent FFP.

Another approach to ensure same-day access, to the extent permissible, is for publicly funded providers of family planning services who also serve Medicaid patients to pre-purchase and stock their inventories with LARC methods and bill Medicaid or the pertinent third-party payer for the LARC when it is used.

Additionally, states are encouraged to direct pharmacies and providers to utilize programs already established by manufacturers that facilitate stocking providers with LARCs for medical benefit coverage, as well as those that facilitate the return of, and reimbursement by manufacturers to states for unused LARCs dispensed under the pharmacy benefit. Or states can seek to establish new arrangements with LARC manufacturers to increase Medicaid beneficiary access to their LARCs. In one such arrangement piloted in a number of states, the LARC manufacturer proactively furnishes providers with its LARCs without upfront costs. At a reasonable time post-implantation or administration, the manufacturer bills the provider for the cost of the LARC to ensure providers have had the time to be reimbursed by third party payers, including state Medicaid programs. With this approach, providers can be stocked with a supply of LARCs without incurring upfront costs. Providers' funds which would otherwise be invested in inventory could be used in other ways to improve the range and quality of services provided. Beneficiaries would also receive LARCs in a more timely and efficient manner. Lastly, providers may be able to focus more on the provision of healthcare and not the administrative duties related to stocking and being reimbursed for LARCs. This approach is consistent with existing Medicaid policy, including the availability of manufacturer rebates on the drugs.

CMS is also interested in exploring with states the use of section 1115(a) demonstration authority to make available administrative funding at the 90 percent federal matching (authorized by section 1903(a)(5) of the Social Security Act) for states to maintain an inventory of LARCs for providers who furnish covered medical assistance for eligible individuals. The 90 percent federal matching is available for costs related to the state's administration of family planning services and supplies. CMS envisions that, under a section 1115(a) demonstration, the state would incur an administrative expense to purchase a stock for a Medicaid provider for use by

Medicaid beneficiaries. Once the entire stock is used, the state Medicaid agency would re-stock the provider with the same number of LARCs. To be a reasonable administrative cost, the stock would be expected to be used in the course of a period of time, such as a month, and would be replenished as a stock consisting of the same number of items. To account for the costs, states would claim the cost of the stock as a family planning administrative cost, make the stock available without cost to providers, prohibit any further claim by the provider for the cost of LARCs taken from stock for Medicaid use (the provider would bill for insertion or removal of the LARC, but not for the LARC itself), and provide for replenishment of the stock when LARCs are used. CMS will consider other state ideas like this, related to all types of family planning services, subject to the regular process for review, approval, and evaluation of section 1115(a) demonstrations.

Clarifying Policies Regarding Sterilization and Delivery

Federal funds are available for sterilizations as a family planning service, including when the sterilization is provided immediately following delivery with the informed consent of the patient as an add-on procedure. When provided with the informed consent of the patient, postpartum sterilization is an effective form of contraception that provides convenience for the woman, reduces costs, and reduces unplanned pregnancies. All sterilization services require informed consent in accordance with 42 C.F.R., Part 441, Subpart F. The Federally required consent form, without alteration, must be used and consent must be obtained at least 30 days before the sterilization, but not more than 180 days before the date of the sterilization. The only exception is in the case of procedures performed post-premature delivery or following emergency abdominal surgery. Under those exceptions, the informed consent must be given no less than 72 hours prior to the sterilization and, in the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

CMS encourages states to develop appropriate policies and procedures that eliminate barriers to requested postpartum sterilization while ensuring informed consent. Providers should be encouraged to discuss postpartum sterilization with interested patients early in the course of treatment to ensure that the requirements for informed consent and for completion of the consent form are met pursuant to 42 C.F.R., Part 441, Subpart F, to avoid payment disallowances. When a postpartum sterilization is performed that does not comply with the requirements for informed consent described in 42 C.F.R., Part 441, Subpart F, FFP is not available for costs related to the sterilization.

CMS is committed to assuring that all Medicaid beneficiaries have access to and receive vital family planning services and supplies without limitations on their choice of provider or their choice of contraception method. CMS hopes that states find the information and clarifications provided within this letter useful in administering the Medicaid family planning benefit. If you have any questions regarding this information, please contact, Kirsten Jensen, Director, Division of Benefits and Coverage, at 410-786-8146.

Sincerely,
/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

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