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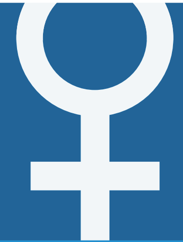
REPORT



April 2017

Medicaid Managed Care and the Provision of Family Planning Services

Prepared by:

Caroline Rosenzweig, Laurie Sobel, and Alina Salganicoff
Kaiser Family Foundation

and

Jennifer E. Moore and Ashley A. Hernandez Gray
Institute for Medicaid Innovation

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Executive Summary

Overview

Since the 1990's, managed care has had an increasingly significant role in the delivery of health care services to Medicaid beneficiaries. With the passage of the Affordable Care Act (ACA), more individuals qualified for Medicaid than ever before, and the majority of those beneficiaries are enrolled in managed care arrangements. Regardless of the outcome of efforts to repeal or replace the ACA or cap Medicaid spending, managed care is likely to remain the dominant care arrangement for Medicaid beneficiaries across the nation. With three quarters of women of reproductive age in Medicaid enrolled in care arrangements through managed care organizations (MCOs), the effective provision of family planning services is an essential element of needed care for women and is critical to reduce unintended pregnancies among this population. The findings presented in this report are based on information collected from both a national survey and focus groups of leaders from Medicaid MCOs across the country who represented a cross-section of plans in terms of geographic region and the number of enrolled Medicaid beneficiaries. They were asked to address a variety of topics related to the provision of family planning services to low-income women including billing and reimbursement, provider recruitment and network adequacy, scope of benefits, member education, provider training, quality measurement, and state policy constraints.

Key Findings

Plans rely on clinics, including Federally Qualified Health Centers (FQHCs) and family planning clinics, to provide a wide range of comprehensive health care, including family planning services, to their members. Plans did not report having problems developing an adequate network. In fact, they report that they contract with the majority of FQHCs in the area they serve. They maintained that the importance of these health centers derives from their ability to provide a broad suite of health services, including family planning care. In addition, these centers are already embedded in the enrollees' communities; therefore, the plan may ensure access to care through the providers their members are most likely to seek out. Many also reported that they have contracts with free-standing family planning providers, like Planned Parenthood, to provide family planning services to their enrollees.

The types of contraceptives covered by plans closely follow state policies; and some plans have policies that offer contraceptive coverage options that exceed what is available under fee-for-service programs. Plans felt that enrollees were not always aware of these options. Most plans reported covering all forms of emergency contraception, including Plan B®, ella®, and the copper intrauterine device (IUD), ParaGard®. Although ella® is required to be covered for ACA Medicaid expansion populations, some plans reported challenges with coverage of the drug, attributed to problems with formularies. While there is evidence that providing women who use oral contraceptives with six to twelve cycles of pills reduces unintended pregnancy rates,[1,2] most plans in the study only cover one or three months of oral contraceptives at one time. Only one plan reported covering a 12-month supply, even though plans have the leeway to cover more cycles of oral contraceptives than the state does under fee-for-service. Almost all plans reported requiring a prescription for over-the-counter (OTC) contraception, such as Plan B ® emergency contraceptive pills and male condoms, and some plans also covered spermicides, sponges, and female condoms, but noted that enrollees could pay out of pocket for these items if they did not pay at the pharmacy counter. Plans reported that requiring a prescription is the only way for them to track utilization and pay for claims directly, but noted that members may not be aware of the requirements for over-the-counter contraceptive coverage.

The expense of stocking of IUDs and implants remains key challenge in ensuring access to Long Acting Reversible Contraceptives (LARC), such as IUDs and implants. LARC devices are usually reimbursed after insertion, requiring providers to take on a significant financial risk to cover the high upfront stocking expenses of devices that can cost as much as $1,000. Plans recognized that limited availability of on-hand LARC devices is often due to the prohibitive expense of stocking. This barrier may limit a beneficiary's ability to obtain one the same day she requests it, an element of high qualify family planning care according to the Centers for Disease Control and Prevention (CDC). Some health plans reported that they have negotiated with local pharmacies to stock IUDs in order to improve the availability of LARCs to their members.

Plans suggested that state payment and reimbursement methodologies that bundle pregnancy services act as a barrier to care, particularly in the provision of post-partum LARC. Plans reported they largely follow the payment methodologies set by their state Medicaid agency. While plans may reimburse providers above the fee-for-service rates determined by the state, most said they do not due to the administrative burden of reconfiguring their claims systems. This has become particularly salient when the state pays for prenatal and obstetrics care with a global fee or bundled payment, as it has important implications for access to post-partum LARC such as IUDs or implants which most states still include in the bundled rate for pregnancy care. They noted that hospitals have little incentive to provide expensive LARC devices to Medicaid beneficiaries if the plan does not pay them for the devices separately. In response, plans noted that some states have changed their policy to reimburse for LARC services separately, outside of the global fee for pregnancy. In addition, plans expressed concerns that bundling pregnancy care into one payment does not enable them to see details in the encounter data, limiting their plans ability to customize care and education for their members based on the care they access.

Frequent eligibility changes and churn among members can create a disincentive for plans to provide LARC to their enrollees. State-specific changes in eligibility among Medicaid enrollees depend on the expansion status of the state. In non-expansion states, pregnant women typically lose eligibility 60 days post-delivery. Therefore, plans in these states reported little financial incentive to promote expensive methods of LARC to prevent unintended pregnancy when the new mother will likely lose her Medicaid eligibility and, thus, the plan will likely not receive the expected cost savings from their use. In addition, frequent churning between plans, even in states that have expanded Medicaid, was raised as a disincentive for plans to provide long-acting forms of contraception to members that may soon be enrolled in another MCO.

Some plans expressed concern about the issue of coercion in the promotion of LARC to Medicaid populations. Medicaid populations have a history of being subjected to coercive practices surrounding sterilization and certain methods of contraception. With many states' heightened interest in the promotion of LARC due to its effectiveness in preventing unintended pregnancies, plans were concerned about the perceived or actual coercion of Medicaid beneficiaries to adopt LARC methods. They wanted to ensure that beneficiaries had access to these methods, but did not want their members to feel coerced into making the choice. While there is awareness of the potential of problems, most plans did not report this as a major issue that they have encountered.

Plans identified provider training as crucial to the education of members and their access to the full-range of contraceptive care; however, they did not report the implementation of any programs to train providers in their network. Some of the barriers reported by plans regarding access

to LARC included the lack of provider knowledge about the appropriate use of IUDs, especially for post-partum women and among minors or women who have not had children. There was also a reported lack of providers trained in the insertion and removal of LARC methods. Nonetheless, no participating plan reported having implemented a program to train providers in this area nor any attempts to partner with academic institutions or clinician professional associations to ensure that physicians, nurse practitioners, and nurse midwives are receiving this training.

Plans did not report any specific policies to assure that in-network faith-based providers with religious objections to contraception do not limit access to family planning and reproductive health services for Medicaid enrollees. Many plans contract with religious providers that have objections to contraception—even though family planning is a mandatory benefit under Medicaid. Plan members may not be aware of the restrictions placed on their care before seeing one of these providers or that they are able to go out of network to the participating family planning provider of their choice to get contraceptive services. Plans did not report any policies to identify providers with religious or conscience objections that would make it possible proactively to provide referrals for care that might be denied to members. Plans also did not have a consistent method to inform members of their rights to seek care elsewhere if a service is denied by their provider.

Plans reported that they do not measure or evaluate the quality of family planning services. While plans do collect data on the standard state and federally required Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the National Quality Forum (NQF) endorsed measures, these systems have few quality measures focused on family planning care. Plans do not report collecting internal data on family planning services, nor do they measure if their providers are offering the full-range of contraceptive care. NQF has recently endorsed a new contraceptive measure, so this policy may change in the future as plans adopt the new measure.

Conclusion

Over the past two decades, managed care has transformed the way Medicaid beneficiaries receive essential health care services such as family planning and reproductive health care. States and managed care plans play a central role in shaping access to quality family planning and reproductive health services for millions of low-income women across the nation. The findings of this study highlight the unique challenges that Medicaid plans face in assuring their members have access, and reveals areas where plans can work to strengthen their networks and policies to improve care. The Trump Administration has signaled their willingness to put more decisions about Medicaid benefits, eligibility, and financing in the hands of state policymakers, and this will likely have implications for how plans provide family planning services to their members and the types of clinics they can contract with as part of their provider network. Looking forward, the state and federal programmatic decisions will undoubtedly shape Medicaid plan choices regarding the scope of services, the network of participating providers, and the policies that Medicaid plans will use to provide low-income women with access to high quality family planning services.

Introduction

Overview

The Medicaid program is jointly administered and financed by state governments and the Centers for Medicare and Medicaid Services (CMS), a federal agency within the U.S. Department of Health and Human Services (HHS). Established in 1965, it now provides health coverage to some 70 million low-income adults.[3] The program has been especially instrumental for women who were more likely than men to qualify for Medicaid because of their greater likelihood of having low incomes as well as meeting the pre-Affordable Care Act (ACA) categorical eligibility requirements as a pregnant woman, parent of a dependent child, senior, or an individual with a disability. With the passage of the ACA, states were given the option to extend eligibility to low-income adults without dependents for the first time. In states that chose to expand the program, federal regulations require states to cover this new category of nonelderly, childless adults at or below at least 138% of the Federal Poverty Level (FPL). These newly eligible adults include an estimated 13 million women who gained access to primary care and reproductive health services in 2016.[4] However, 19 states have not chosen to expand Medicaid.[5]

Given that women of reproductive age account for 70% of adult women enrolled in Medicaid,[6] the program's history of strong protections for family planning and reproductive health services are of particular importance.[7] Since 1972, the federal government has required Medicaid to cover family planning services as a mandatory benefit, matching state family planning expenditures at an enhanced Federal Medical Assistance Percentage (FMAP) of 90% in order to encourage states to expand access to these services.[8] Medicaid enrollees may not be charged cost-sharing for family planning services and are given freedom of choice of provider when it comes to family planning. Medicaid is the largest public payer for family planning care, financing about 75% of all publicly funded family planning services and supplies,[9] and remains a critical source of primary health care and family planning coverage for low-income women.

Family Planning in the Medicaid Managed Care Context

Over the past two decades, managed care has become the dominant mode of service delivery for Medicaid beneficiaries. In 2011, 77% of women insured by Medicaid were enrolled in managed care plans.[10] In the 1990s, there was a surge in Medicaid beneficiaries enrolled in managed care organizations (MCOs), as states shifted from traditional fee-for-service models to mandated MCO enrollment in order to cut costs and improve quality through coordinated care. Through these arrangements, state Medicaid offices contract with MCOs, paying them a capitated rate by the state for each Medicaid beneficiary enrolled in their plan. The MCO then assembles a network of providers to deliver services to their members. A key provision of the Medicaid program's family planning rules is that it allows enrollees the "freedom of choice" to select any participating provider for their family planning care. This rule also applies to those enrolled in a managed care arrangement, even if they are limited to the providers within the MCO network for other services. In other words, women on Medicaid may obtain family planning services out of network from the provider of their choice with full coverage by their managed care plan.

While the federal government issues broad guidelines governing managed care, the state Medicaid programs have extensive latitude to establish their own managed care regulations and negotiate contracts with MCOs. In addition, MCOs maintain flexibility in designing specific policies and reimbursement strategies that fall within

federal and state regulations. The result is a patchwork of policies across MCOs surrounding the provision of family planning services for Medicaid beneficiaries. In April 2016, CMS issued a new rule which strengthened federal managed care regulations including requirements for network adequacy standards for family planning providers, information provided to beneficiaries about their freedom of choice, as well as limitations on the use of utilization controls that may restrict a beneficiary's right to select the contraceptive method of their choice. Nonetheless, there is still considerable variation among policies affecting family planning services within the managed care system.

Regardless of the outcome of efforts to repeal or replace the ACA or cap Medicaid spending, managed care is likely to remain the dominant care arrangement for Medicaid beneficiaries across the nation. With three quarters of reproductive age women on Medicaid enrolled in managed care arrangements, the effective provision of these family planning services is an essential element of needed care for women and is critical to reduce unintended pregnancies among this population. This report provides insights from plan leaders on the current state of family planning services within Medicaid managed care arrangements and addresses a variety of topics related to the provision of family planning services to low-income women including billing and reimbursement, provider recruitment and network adequacy, scope of benefits, member education, provider training, quality measurement, and state policy constraints.

Methodology

This study serves as an environmental scan of Medicaid managed care and family planning services focusing on identifying gaps in knowledge, barriers to care, and current practices and policies in the coverage of family planning services offered by Medicaid managed care plans. The project was guided by a set of research questions about the provision of family planning benefits by MCOs to Medicaid populations:

- How does Medicaid managed care provide women's reproductive health benefits (e.g., family planning, contraception, prenatal and post-partum care)?
- What are the barriers that MCOs observe when coordinating care, providing access, and ensuring coverage to such benefits for their members? Are these barriers related to state or federal policies, providers, religious institutions, or personal and/or socioeconomic characteristics (e.g., transportation, health literacy)?
- What innovative programs are MCOs developing to overcome these barriers and improve care for women?
- What resources, policies, or tools would help MCOs to enable their patients to overcome barriers to accessing reproductive health care?

This report relies on information collected through two methods: a national survey and focus groups of Medicaid MCOs. A National Technical Advisory Committee (NTAC) of six experts, including Chief Medical Officers, Executive Directors, and Presidents of major Medicaid managed care organizations throughout the country, was assembled in March 2016 to serve as expert consultants in the development of the survey tool and interview guide for the focus groups. The survey then collected data on a wide variety of topics including billing and reimbursement, provider recruitment and network adequacy, benefits, member education, provider training, quality measurement, and state policy constraints. Due to the release of CMS managed care regulations in April 2016, the survey did not include questions about policies, such as utilization controls, that were prohibited by the new rule. The plans were selected based on the geographic region and the number of

lives covered. The survey was sent to 20 health plans in May 2016. Eight health plans responded to the questionnaire, including four multi-state plans.

Two in-person focus groups were conducted in September 2016. An interview guide was used to inquire about the same issues addressed in the survey. These focus groups consisted of seven additional plans that did not complete the survey, including six multi-state plans. In total, the report includes perspectives from 15 Medicaid managed care plans, representing more than 15.2 million beneficiaries. These groups were supplemented by follow-up discussions with three participants to clarify certain issues raised during the focus groups.

The survey tool is available upon request.

Key Findings

State Policy Constraints and Open Enrollment

While MCOs maintain authority to determine many of the specific policies that govern their beneficiary populations, they must abide by state Medicaid policies, which they reported sometimes constrain their ability to provide comprehensive family planning care.

Eligibility is focused on pregnancy in non-expansion states. In some non-expansion states, women must rely on the state's family planning waiver program, which provides access to family planning services for women living in low-income households who are not eligible for Medicaid. Otherwise, women are only covered during pregnancy, and do not qualify for family planning benefits outside of the six-week post-partum period. This was reported to limit a plan's ability to provide members with the comprehensive family planning care they need.

Some state Medicaid programs have mandated the reimbursement methodology for LARC in the hospital setting. As discussed earlier, plans generally follow the state Medicaid reimbursement schedule. There is little incentive for plans to set their own policies to reimburse separately for a LARC device, if the state methodology includes it in the bundled payment for delivery. Plans reported that the state methodology prevents them from creating a separate payment above the regular negotiated delivery rate that would incentivize LARC insertion immediately post-partum. Again, this may largely be a result of barriers related to the claims system configuration. However, a few states have changed their policies to allow for separate payment of LARC post-partum.

Changes in Medicaid eligibility and churn of enrollees among MCOs present challenges to MCOs in managing their members' care. One plan commented that once pregnant members give birth, they might be eligible for different types of Medicaid, and therefore might be moved from their plan. In addition, women in non-expansion states typically lose eligibility 60 days post-delivery. Plans reported that this instability in enrollment creates a disincentive for a plan to pay for LARC for a beneficiary that may soon not be a member of their plan. The cost savings that may incentivize a plan to promote post-partum LARC among their members is not fully realized if those members churn into another plan or are dropped from Medicaid shortly after their delivery and LARC placement.

Benefits

Despite its classification of family planning as a mandatory benefit, CMS has never formally defined what services and supplies must be included in that category. The Social Security Act authorizing Medicaid outlines the approved benefits as "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered sexually active) who are eligible under the state plan and who desire such services and supplies."[11] Without explicit federal guidance in the definition of family planning services, state Medicaid offices are able to design their own benefit packages as well as vary them across eligibility pathways, potentially omitting important services such as counseling services. In addition, coverage for abortion services is limited due to the Hyde Amendment which prohibits federal funding for abortions except in cases of rape, incest, or life endangerment of the mother. Only 15 states use their own funds to expand the circumstances in which abortion would be covered. The state Medicaid programs in Arizona and Illinois do not pay for abortions outside of circumstances permitted by Hyde despite court orders directing them to do so.

The HHS recently clarified that all 18 FDA-approved methods of contraception must be covered as prescribed under the ACA's no-cost preventive services, which affect Medicaid expansion populations (but not those who qualify through the traditional pre-ACA pathways). In addition, new guidelines released by CMS prohibited the use of certain utilization management techniques in the provision of family planning by MCOs.[12] Quantity limits and prior authorization are not permissible if used for any other purpose other than to determine medical necessity or appropriateness, and step-therapy, or the practice of requiring the use of a particular type of contraception before moving to a more expensive version, is not allowed. However, in most states plans retain authority to determine the coverage of over-the-counter (OTC) contraception, as well as the number of cycles of contraception dispensed at one time, absent any state regulations.[13]

Emergency Contraception and Dispensing Limits

Emergency contraception is intended to prevent unintended pregnancy after unprotected sex or contraceptive failure. There are three types of emergency contraception: progestin-based pills (e.g. Plan B®), ulipristal acetate (ella®), and copper IUDs. While ella® is available by prescription only, Plan B® and other generic progestin-based pills are available OTC without a prescription for women of all ages. The ACA requires that Medicaid expansion programs cover emergency contraceptives with a prescription. Therefore, while these programs must cover ella® for their expansion populations, they are only required to cover Plan B® with a prescription. Some states also limit the number of months of oral contraceptives dispensed at one time to a beneficiary.

Most plans reported covering all forms of emergency contraception, including Plan B®, ella®, and the copper IUD. Although ella® is required to be covered for expansion populations, some plans reported challenges with coverage of the drug. A consultant suggested this was most likely due to a problem with plan formularies.

Most of the plans surveyed cover one or three months of oral contraceptives at one time. Although managed care plans have the leeway to cover more cycles of oral contraceptives than the state does under fee-for-service, only one plan who participated in the survey reported covering a full 12-month supply.

Over-the-Counter Contraception

The ACA requires prescription contraceptive methods to be covered for Medicaid expansion populations, but this requirement does not apply to OTC methods, such as condoms, spermicide, and sponges, obtained without a prescription. As a result, some states require a prescription for coverage of OTC methods, most likely due to the reimbursement mechanism to pharmacies in place for prescription drugs. However, plans may determine their own requirements for OTC contraception.

Most plans reported covering Plan B® and male condoms over the counter. Some plans also covered spermicides, sponges, and female condoms. Plan representatives confirmed that a Medicaid enrollee could potentially pay out of pocket for these items, if they did not pay at the pharmacy counter. However, one plan stated that the amount their plan spends on the OTC benefit suggests that members are aware of and utilizing this benefit by obtaining OTC contraceptives through the pharmacy.

Almost all plans reported requiring a prescription for OTC contraception, though strategies vary. Some reported exceptions for Plan B®, or that they allow a pharmacist to produce the prescription. This is the only way for health plans to track utilization and pay for claims directly. Plans may cover it either as an OTC benefit or as a pharmacy benefit. However, one plan noted that a member would have to read the member benefits manual closely in order to know what is required for a drug or product to be covered, suggesting that members may not be aware this is an option for them.

Billing and Reimbursement

In a managed care arrangement, the state Medicaid program and the health plan enter into a contract in which the state pays the plan a negotiated capitated rate, a fixed fee per individual enrolled in the plan, in order to provide comprehensive coordinated health care services to its Medicaid beneficiaries. CMS regulations require "actuarially sound capitation rates" that must cover all "reasonable, appropriate, and attainable costs of providing services under the contract."[14]

The plan then pays its contracted providers for the services used by their members. Services can be reimbursed using various methodologies, such as a bundled payment or separate payments for each service. They might also be included in a capitated rate paid to a beneficiary's primary care provider. Bundled payments are a single fixed fee paid for a set of related services. For example, pregnancy-related services are often paid for in a bundle, referred to in this case as a global fee. This means a provider will receive a fixed negotiated amount to provide routine care throughout the entire pregnancy, regardless of the number of visits or services the patient utilizes. The purpose of a bundled payment is to incentivize providers to reduce costs associated with unnecessary care, while also easing the administrative burden of billing for each individual service. Alternatively, a plan could pay a provider for each service separately after it is rendered to the plan member. While rates are set by the state, a health plan can pay more to providers in order to recruit them into their network, especially if there are a limited number of providers in their area.

State and plan reimbursement methodologies are crucial to the effective provision of the full-range of family planning services and supplies for women insured by Medicaid. Providers may be less inclined to contract with health plans or provide certain services or supplies to Medicaid beneficiaries if their actual costs are higher than the reimbursable amount. Lower provider payments may compromise a member's right to see the family planning provider or use the method of contraception of their choice. In particular, out-of-network family

planning providers may not be willing to see Medicaid patients because the administrative burden of billing the plan may not be worth the low rates of reimbursement.

Payment Methodology

All plans reported that family planning services are paid for individually, rather than as a separate family planning bundle. While family planning is a required benefit, MCOs may choose how they pay for these services as long as they are in accordance with state regulations. All plans in the study reported that these services are paid for as separate line items outside of the capitated fee paid to a primary care provider for each enrollee. For example, providers are paid a separate fee for LARC device insertion or removal, in addition to the cost of the device itself. They do not have a separate family planning bundled rate for these services.

Pregnancy is paid for using a single global fee, which can limit access to post-partum LARC and tubal ligation. Plans reported that many providers prefer this method of payment because they are paid the same amount regardless of the number of times they see the patient, and they do not have the administrative burden of billing for each encounter. However, plans noted certain problems in the payment and provision of post-partum LARC. Hospitals often will not be reimbursed separately for LARC insertions post-delivery despite the use of their facilities. This creates an incentive for the provider to wait until the six-week post-partum visit to charge a separate reimbursement. This practice may pose a barrier for women who miss their follow-up appointment, and therefore do not receive their desired LARC method and then subsequently lose their Medicaid eligibility 60 days' post-partum.

Tubal ligation is also reimbursed as a separate payment outside of the global fee because Medicaid beneficiaries are required to sign an informed consent form at least 30 days prior to undergoing sterilization. Therefore, the procedure is essentially treated as a prior authorization, and paid for separately. Plans reported that billing for all pregnancy-related care as a single fee also prevents information about provider-patient encounters from being communicated to the plan in many cases until after the woman delivers, inhibiting their ability to customize and improve the coordination of their members' care. For example, a plan would not be aware if their enrollees are underutilizing their prenatal care benefits. One plan expressed that if they were able to see this information, they could provide their members with additional education about post-partum contraception and when to see their provider.

Challenges with LARC

In general, plans follow the state Medicaid fee schedule and reimbursement methodology for post-partum LARC. Plans may set their own policy in regards to payment for post-partum LARC, however, there is little incentive for plans to facilitate access to LARCs for their enrollees. Plans reported that because many women on Medicaid lose eligibility after delivery, the cost savings to the plan is essentially lost if a patient provided with post-partum LARC is likely to be dropped from the plan. Only two plans surveyed provided a supplemental payment for immediate post-partum LARC (device and insertion) in hospitals, and only one of those plans did so in other provider settings as well. Many of the plans stressed that the unbundling of services during pregnancy would facilitate access to LARC during hospitalization post-delivery.

Innovative Practice 1: Post-Partum LARC Pilot Program

In partnership with the state Medicaid program, one plan is currently working with a local hospital to test a new reimbursement methodology to pay separately for immediate post-partum LARC. The initiative seeks to identify and fix problems that may arise before expanding to the rest of the state. The plan noted that the primary barrier to implementing this policy change has been the configuration of claims system, which has not yet been set up to facilitate billing and reimbursement between the hospital and the plan for the separate payment of immediate post-partum LARC. In order for physicians to provide LARC devices immediately post-delivery, both the hospital and the plan must create and align the reimbursement codes for that service.

Plans cited reimbursement for LARC devices, especially for immediate post-partum insertion, as a top challenge in providing family planning services to women on Medicaid. The health plans reported variation across state markets in the reimbursement for in-patient post-partum LARC. In states without a mandate to pay separately, hospitals have no incentive to provide post-partum LARC because the bundled reimbursement they receive from the plan for the delivery is not enough to cover the cost of the device. Currently, 21 states mandate separate payment for post-partum LARC above the regular negotiated rate for delivery. Some of these states use a modifier code to increase the bundled payment for delivery to pay for post-partum LARC devices and insertions. The majority of the states retain the bundled payment for delivery, and instead apply the fee-for-service rate for LARC in an office setting to inpatient hospital settings, paying separately for either the device only, or both the device and insertion.[15]

The administrative and financial burden of maintaining a stock of IUD devices can be too great for many providers. Although most plans reported that they allow women to get same-day LARC insertion, they cited significant barriers due to the difficulty and expense of stocking LARC devices. Difficulty stocking LARC may limit a woman's ability to obtain an IUD the same day she requests it, requiring two appointments. For many women insured by Medicaid, it may be difficult to return for a second appointment, reducing the likelihood they will obtain their preferred method of contraception. Only one plan reported allowing providers to bill for the stocking of LARC.

Innovative Practice 2: Care Cart

One health plan has developed an innovative strategy to help providers stock LARC devices. In this model, the health plan pays the upfront costs to stock a "Care Cart," similar to a Pyxis® system, on site with LARC devices and insertion tools for a low administrative fee paid by the provider, primarily community health centers and school-based clinics with on-site pharmacies. The pharmacy then bills the plan for the restocking of LARC devices as needed. The Care Cart model allows providers to keep LARC on-hand to facilitate same-day insertions which improves adherence and access to this effective method of contraception.

Plans recognized the challenges around incentivizing the use of LARC due to concerns about the appearance of coercion, or encouraging the selection of LARC to avoid pregnancy when it may not align with the preference of the members. However, most plans did not report this as a major problem that their plan has encountered. One plan indicated that they requested guidance from CMS about how to handle the balance between encouraging access and educating members, and coercion.

Network Adequacy and Provider Recruitment

The Medicaid program requires states to establish network adequacy standards for beneficiaries enrolled in managed care plans. These standards include factors such as the number and type of providers, time and distance to travel to see a provider, wait-times for appointments, geographic distribution of providers between rural and urban areas, provider to enrollee ratios, and a provider's willingness to accept new patients. States have broad latitude to develop more specific network adequacy regulations, although they give MCOs significant leeway to create their own policies governing the recruitment and development of their network.

Network adequacy in the context of family planning providers is complicated by beneficiaries' right to seek care from out-of-network Medicaid participating providers for these services. CMS addressed this issue in their recent guidelines. Although family planning providers are exempted from the CMS time and distance standards, CMS stated that the freedom of choice provision, while important, does not negate the "plan's responsibility to ensure timely access within network."[16] CMS maintained that having sufficient family planning providers available within network would "facilitates claims payments, helps enrollees locate providers more easily and improves care coordination."[17]

In their new rule, CMS also noted the ability of MCOs to use telemedicine or e-visits to meet network adequacy requirements.[18] However, they provide no federal guidance other than encouraging states to create reimbursement methodologies to pay for services provided using telemedicine.[19] The state has the flexibility to determine the conditions under which they will cover telemedicine, if at all, including type of service, provider, and location of care, as well as reimbursement rates. They can also decide the level of control the individual managed care plan retains in setting these policies. MCOs may contract with religiously-affiliated providers with a conscience objection to family planning, an additional consideration in the establishment of adequate networks for family planning services. States may also contract with religiously-affiliated MCOs; however, this study did not include any MCOs of this type.

Recruitment

Plans considered a variety of factors when recruiting family planning providers for their networks. Surveyed plans reported the factors that weigh most heavily in their decisions are the average distance to see a provider, provider type, geographic distribution, and a provider's willingness to accept new patients. Plans participating in the focus groups reported that they do not focus narrowly on family planning providers when meeting access standards, but instead broadly recruit providers that offer a comprehensive range of services, including sexual and reproductive health care**.**

Plans contract with a majority of FQHCs in their area. They cited them as being particularly important because they are the providers their members are most likely to go to, and they provide a broad range of services, including family planning. Inclusion of other provider types such as school-based clinics, Planned Parenthood®, and state and local health departments varied by plan. No plans in the study reported problems developing an adequate network.

Some plans contract with specific providers that offer abortion services in non-Hyde states. Only 15 states use their own funds to pay for abortions outside of the Hyde exceptions of rape, incest, and life endangerment of the woman. However, even in those states, access to abortion counseling and services is often

constrained by many state abortion restrictions and regulations. In addition, the controversial nature of the issue of abortion has complicated contracting with Planned Parenthood® in certain states. For example, in Texas and Missouri, plans reported that Planned Parenthood® is no longer an approved Medicaid provider, and therefore cannot reimburse their providers with Medicaid funds. Two plans surveyed do not contract with Planned Parenthood®, though this may also be due to the lack of clinics in their area.

Plans do not report using telehealth for family planning services. Some focus group participants noted that contraceptive counseling may make sense in the telehealth context, but there was a perception that telehealth had "limited applicability" for family planning services. Plans maintained that in order to provide comprehensive reproductive health care providers need to see the patient in the office.

Plans noted some challenges to the implementation of the freedom of choice provision. In particular, there is administrative burden in the reimbursement of out-of-network providers. However, other plans noted that because of robust network adequacy requirements, there are few instances where a plan member would go out of network for services. Although in-network and out-of-network providers are paid the same state Medicaid rates, providers have an incentive to join the network to become eligible for rapid electronic payments and to establish a regular patient base. A member who receives services from an out-of-network provider is often a new enrollee who wishes to keep their current provider. In these continuity of care cases, the out-of-network provider will bill the plan, which must pay the provider at the rate they were receiving from the previous payer. Therefore, the rate paid to an out-of-network provider is member-specific, and in many instances, may be higher than the Medicaid rate if the new member was previously enrolled in a private commercial plan before losing coverage.

Religious Providers

There are a growing number of religiously-affiliated hospitals in the United States. This growth has raised concerns that the rise in the number of religiously-affiliated hospitals can limit patient access to reproductive health care due to the religious restrictions that govern the services they provide.[20] Some states, such as Texas, require plans to contract with religious providers who may have objections to family planning including contraception and abortion so that enrollees may choose to get their care at religious providers if they wish. However, Texas also includes provisions to ensure that the provider network is adequate for women who do not use those providers.

Religious providers may present a barrier to family planning care. In general, plans reported that they include Catholic hospitals and religiously-affiliated private provider offices in their networks. Catholic hospitals, in particular, were noted as presenting a barrier to family planning care for enrollees, especially for those hospitals located in rural areas or that do not have an unaffiliated clinic that provides these services. Plans reported that even in institutions located in urban areas that have implemented a work-around strategy to provide family planning care through another clinic, same-day access may be compromised. For example, a consultant cited the case of a religiously-affiliated academic medical institution on the East Coast that contracts with an FQHC to provide contraception in their university health center, but noted that the FQHC staff is only available on campus certain days of the week.

Plans reported that they do not have systems in place to notify enrollees of limits to care if they select a provider with "conscience" objections to family planning. Plans noted that the only way they

would know if a member could not access a specific service, such as contraception, sterilization, or abortion, is if the member calls the plan's member services or care coordinator/case manager to receive help finding access to those services elsewhere. This can act as a barrier to care for a member who may not know their provider is religious, and therefore is not counseling them on the full-range of family planning services. They may also not be informed about how to navigate the system in order to find a provider that will offer them the specific contraceptive services they desire.

Communication and Education

The Medicaid program's significant protections for beneficiaries' access to family planning services are only useful to the extent that enrollees are aware of them. Federal regulations require MCOs to inform their members of their right to go out of network for family planning services. CMS recently updated this rule, clarifying that enrollees must be informed that requiring a referral to see a family planning provider is not permitted.[21] In addition, CMS requires plans to post certain information on their public website including the member handbook, provider directory, and drug formulary, as well as provide the information in paper form in prevalent languages upon request. The rule also clarifies that plans may notify members of required information by email with enrollee consent or by "any other method that can reasonably be expected to result in the enrollee receiving" it, though both email and texting are prohibited from being used for cold-call marketing.[22] Beginning in July 2018, the new rule requires that plans implement a Beneficiary Support System (BSS) to assist enrollees in understanding their options within the managed care system such as enrollment and provider decisions. The BSS must be available via phone, internet, in-person, and auxiliary aids.[23]

Member Communication and Education

Plans reported that they rely heavily on providers to educate their members and communicate their health care options and rights to them. The plans also rely on care coordinators, member services, mailed paper notices, their website, and the member handbook for communication about the scope of reproductive health benefits and members' rights. One plan reported conducting in-person, on-site member health promotion workshops in community settings. However, contact information may be hard to obtain or may be incorrect. In particular, plans reported that they found that addresses for individuals in the Medicaid population often change frequently within short periods of time.

Plans reported having face-to-face care coordination visits during pregnancy. Pregnancy is a primary point of contact between plans and their members, especially for plans in states that have not expanded Medicaid. However, although one plan emphasized the particular strength of MCOs in coordinating care for their members, this type of episodic coverage limits their ability to address a member's general health or chronic conditions during the prenatal period alone.

Provider Education

In addition to effective communication strategies between plans and their members, the provision of family planning services requires trained providers skilled in addressing sensitive topics and educated in evidence-based family planning practices. While there are no federal regulations requiring MCOs to educate providers within their networks, the plans participating in this study acknowledged their important role with members but did not typically have formal programs in place to train in-network providers to educate members about family planning options.

Plans cited provider training and education in the provision of LARC as a top challenge in providing access to family planning services. One plan representative stressed that there is a lot of misinformation about LARC provision both for immediately post-partum and for young women and teens who have never given birth. Despite their reliance on providers as a key point of contact between the plan and the member, most plans report that they do not provide training for clinicians regarding enrollee education about post-partum contraception or sterilization. While some plans reported offering educational materials to providers to educate Medicaid enrollees about post-partum contraception or sterilization, the majority surveyed do not. One plan stated that many of their members are unaware of the need for a signed consent form and 30-day waiting period for sterilization.

Some plans and state Medicaid offices have implemented policies to educate providers on MCO plan policies. One plan sends email blasts to update providers on new plan policies. The New York state Medicaid office provides webinar and in-person seminars to train new Medicaid providers about billing practices, including those specific to managed care organizations, as well as instruct established providers about how to use the electronic claims system.[24]

Teen Outreach and Confidentiality

Although teen pregnancy and abortion rates are at all-time lows, they still remain an area of concern. Educating adolescents and minors about their rights to access family planning services, and communicating with them about their benefits requires targeted outreach strategies and confidentiality protections. Twenty-one states and the District of Columbia allow all minors to consent to contraceptive services, and 25 states allow minors who meet certain criteria to consent.[25] However, there are no federal regulations governing the confidentiality of these services or the promotion of effective outreach to young adult and teen populations.

Some plans reported strategies to target outreach to minors, but most did not have any overarching approach to target teens or specific policies to protect their confidentiality. Half of the surveyed plans reported using provider education as a strategy to protect enrollee confidentiality, and three out of the eight plans reported using this strategy specifically for assuring confidentiality for adolescents and other dependents. However, one plan reported that a top challenge they encounter in providing access to women's reproductive health and family planning services is providers' lack of commitment to addressing sexuality with minors, as well as difficulty coordinating with school-based clinics to gain access to medical records. Plans noted that quality care coordination is easier during pregnancy, however, healthy teens and young adults often do not come to the attention of care management. One plan recognized the need to perform outreach to contact that population of members, though they noted cultural and political barriers in some states hinder the implementation of innovative outreach strategies. Another plan stated that state regulations governing how they can communicate with their members, such as opt-in requirements for texting, restrict their ability to do outreach effectively. Still, one plan reported sending annual targeted mailings to adolescents on a variety of sexual health topics and confidentiality requirements.

Quality Measures and Data

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures used widely by health plans to evaluate the quality of the care they provide. Health plans are also required to report Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, a series of patient surveys

evaluating the quality of their health care experiences. However, few quality standards exist for family planning services, and most states do not collect data to evaluate utilization and quality. The National Quality Forum (NQF) recently endorsed new measures to enhance the service value and quality in family planning specifically in regard to post-partum contraceptive care, access to LARC, and the use of most and moderately effective methods.[26]

Overall, plans are not evaluating the performance of family planning services for the purposes of quality reporting. In general, plans do not collect performance measures for family planning services beyond the HEDIS and NQF measures, nor do they analyze the data they do collect. Only one plan reported measuring contraceptive rates, and another plan looks at performance measures for various aspects of pregnancy care including prenatal care, post-partum follow-up, and C-section rates. The lack of quality measurement for family planning services has implications for the provision of high-quality, patient-centered care. However, it was also noted that performance measures incentivize providers, which can be challenging especially when dealing with LARC due to the appearance of coercion.

Plans reported that they do not measure if providers are offering the full-range of contraceptive methods. Most plans participating in the focus groups reported that they are not conducting any analysis in this area. Only one plan mentioned a new initiative led by the New York City Department of Health that is analyzing plan data to determine preferred methods of birth control. Another plan discussed the benefits of creating a reimbursement code for contraceptive counseling and education in order to incentivize and track its use. However, the plan conceded it would be difficult to get providers to use the code and to validate the data provided to the health plan.

State implemented bundled payments for maternity care and pregnancy limits much of the information that is available through encounter data. Since providers are paid for the entire episode of care in one single payment, they are not required to file claims or encounters for every visit. Therefore, a health plan may not be aware of services being provided to a member until after a claim is made by the provider. In many instances, this may not be until the post-partum period. One plan noted that this had an impact on their "ability to communicate effectively with members and incentivize them to go to their individual visits." If members are underutilizing care, the plan's ability to educate that member about prenatal and post-partum care is limited.

Conclusion

Managed care organizations that coordinate members' health care to improve the quality of services provided and reduce unnecessary costs have become the primary care arrangement for women on Medicaid. Family planning has long been a mandated benefit under Medicaid and holds important protections such as freedom of choice of provider, an enhanced federal match, and a ban on cost sharing. However, the variability among state Medicaid policies at both the state and plan level leaves room for inconsistent coverage and access to family planning services and providers for MCO members seeking contraceptive care.

Health plans expressed that MCOs are adept at care coordination, including face-to-face visits, targeted education, and the regular review of claims to address reimbursement problems. These plans also identified several areas where there are barriers in how family planning services are billed and reimbursed, particularly post-partum LARC, as well as the way they are measured for purposes of quality reporting. In addition, the

frequency of churn for low-income women presents a financial disincentive for plans to provide comprehensive, long-term contraceptive care. Religious institutions and providers may also serve as an obstacle in the path of women seeking family planning services. Plan members may not be aware of the religious restrictions their health care providers place on their family planning care, and it is left to enrollees to seek help from their plan to find those services elsewhere.

Health plans also identified policies they believed would help to overcome the barriers to quality family planning services and supplies in the Medicaid managed care system. They emphasized the need for state Medicaid programs to unbundle payments for pregnancy care, and in particular, to reimburse post-partum LARC devices and insertions separately in order to more effectively promote their use post-partum. Innovative policies to aid providers in the stocking of IUDs and implants are also essential to the timely provision of the full-range of contraceptive care. Furthermore, this study has highlighted the lack of data collected on the provision of family planning services to Medicaid populations in order to measure and evaluate quality and access in the managed care setting, in most cases because of the lack of valid and reliable measures. This may change with the new family planning quality measures recently endorsed by the National Quality Forum.

This survey sought to understand better how Medicaid MCOs are providing family planning services to their members. We sought to understand the challenges that plans have identified as well as uncover innovative strategies used to address them. As federal and state policymakers explore opportunities to restructure the Medicaid program, consider changes to benefits and eligibility, and potentially reduce the pool of available family planning providers such as Planned Parenthood®, Medicaid MCOs will likely have a growing role and greater responsibility to assure that their members have access to the full range of high quality family planning services.

Endnotes

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THE HENRY J. KAISER FAMILY FOUNDATION

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270

www.kff.org

This publication (#9018) is available on the Kaiser Family Foundation's website at www.kff.org.

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