

# Family Planning and Medicaid Managed Care: Improving Access and Quality Through Integration

## Phase One Report

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# Executive Summary

State agencies, managed care plans, and public health experts are increasingly focused on how Medicaid managed care — a foundational part of most state Medicaid programs — can address whole-person health needs. Given its documented impact on patient and population health, high-quality family planning is essential to a comprehensive managed care strategy.

For a half-century, family planning has been a mandatory Medicaid service. Furthermore, family planning has been deemed so essential that since 1981, federal law has contained a family planning out-of-network safeguard. This safeguard guarantees that members of Medicaid plans can continue to receive family planning services from their Medicaid-qualified provider of choice regardless of whether their provider is part of their plan's network.

At the same time, however, integration of family planning and managed care is a desirable aim. Good managed care practice means that members should be able to look to their health plans for comprehensive preventive care delivered by a high-performing provider network. Furthermore, family planning visits uncover previously undisclosed physical and mental health conditions requiring follow-up care from other providers. This type of integrated care approach presumably works best when all providers and care managers involved are members of the patient's network.

This study was undertaken to understand the current status of family planning and managed care integration 40 years after enactment of the "freedom of choice" safeguard, when managed care now enrolls nearly 70 percent of the Medicaid population. The study's goal is to identify practical, actionable opportunities for greater integration and how managed care

purchasing might be used to strengthen family planning while preserving the "freedom of choice" safeguard.

This report shares findings from the first phase of the study, which consisted of a review of state purchasing documents related to comprehensive managed care, and in-depth interviews with senior Medicaid officials in 10 states. During Phase Two, we will conduct similar in-depth interviews with managed care plans and family planning providers.

Key findings include:

- All states using comprehensive managed care treat family planning as a fundamental system feature. State officials emphasized their expectations that contractors will fully meet members' family planning needs.
- State purchasing documents codify the "freedom of choice" safeguard to some degree, but relatively few explicitly require contractors to inform members regarding the existence of their access safeguard.
- No state viewed the "freedom of choice" safeguard as imposing any real policy or operational burden; indeed, nearly all agreements address their obligation through provisions requiring contractors to cover and pay for family planning services regardless of a provider's network status.
- States can do more to promote family planning and managed care integration. Areas of priority focus include: clarifying the scope of family planning services to which the "freedom of choice" safeguard should apply, more detailed specifications regarding contraceptive coverage, emphasis on building strong family planning provider networks to minimize reliance on out-of-

network care when possible, policies that encourage contractor use of evidence-based family planning practice guidelines to guide network performance and value-based payments that attract and reward strong network providers, and ongoing work to develop patient and population performance measures.

- More comprehensive federal guidance regarding managed care and family planning integration is of enormous importance, in particular, guidance regarding the scope of family planning services that should be covered by “freedom of choice” safeguard — including sexually transmitted infection (STI) diagnostic and treatment services, HIV assessment and counseling, and immunizations to reduce cancer risk. Classifying these services as part of the family planning bundle for freedom of choice purposes would promote greater consistency between Medicaid and commercial sector practices, where it is common and standard for providers that offer basic family planning services to provide, bill, and receive payment for services such as STI treatment and testing. Such a change in Medicaid managed care practice would also help promote access to treatment for STIs, which have reached public health crisis proportions.
- In addition to clarifying the scope of the “freedom of choice” safeguard, the Centers for Medicare and Medicaid Services (CMS) could spearhead efforts to develop best practice approaches for family planning and managed care integration, including service coverage, network design, access enhancement, team-based care management, and performance measurement and improvement. These efforts can build on landmark Centers for Disease Control (CDC) and HHS Office of Population Affairs (OPA) family planning

standards of care by translating these standards into managed care operational terms. This comprehensive effort could be carried out in collaboration with state agencies, experts in managed care performance and financing, clinical and family planning practice experts, and experts in public health and population-based health improvement. Of great value would be the inclusion of experts from the CDC and OPA, who led the development of the family planning practice standards. Such an effort would come at a crucial time, as federal agencies simultaneously move to restore the nationwide Title X family planning network, and whose providers play such a crucial access role for the Medicaid population.

## Introduction

This report presents initial findings and recommendations from a two-phase study of family planning and Medicaid managed care. The purpose of the study is to identify strategies and options for strengthening access to high-quality, comprehensive family planning services as a core Medicaid managed care service while at the same time preserving key family planning direct access safeguards that are a longstanding hallmark of federal Medicaid policy.

Over the past 40 years, Medicaid managed care has grown in scope and sophistication, and enrollment in comprehensive managed care plans now accounts for nearly 70 percent of all Medicaid beneficiaries.<sup>1</sup> In the modern managed care era, state purchasers, managed care plans, public health and health management experts, providers, and consumers are increasingly focused on putting purchasing strategies to work to address the whole-person health needs of plan members. Given the profound relationship between overall physical and mental health on one hand and reproductive health on the other, family planning emerges as an essential part of such a strategy.

Furthermore, in the U.S. — which has the highest infant and maternal mortality rates among wealthy nations, and in which nearly half of all pregnancies are unintended<sup>2</sup> — planned pregnancies become a vital tool for ensuring that women enter and go through pregnancy and the postpartum period in optimal health. The argument for a greater focus on high-quality family planning as an explicit, integrated feature of Medicaid managed care is also supported by research showing the large proportion of patients in publicly funded family planning settings — a patient group disproportionately enrolled in Medicaid — whose exams reveal previously unidentified physical and mental health conditions requiring referral and follow-up care.<sup>3</sup>

For historic reasons explored further below, the

term “family planning” as used in Medicaid is a broad one that has evolved over time to encompass not only routine counseling, exams, contraceptive services, and related follow-up care, but also certain diagnostic and treatment procedures aimed at preventing and treating health conditions that can affect reproductive and overall health. As a result, this report uses the term “family planning” to encompass the full scope of services as this scope has evolved under federal law in response to public health and health care expert recommendations.<sup>4</sup>

Three major findings emerge from this initial study phase.

- First, states treat family planning as a fundamental element of Medicaid managed care and expect their health plans to fully meet their members’ needs in this regard. In doing so, states have absorbed Medicaid’s special family planning “freedom of choice” access safeguard into basic managed care operations as a core feature of their purchasing systems.
- Second, despite this embrace of family planning as a basic feature of Medicaid managed care, significant ambiguities emerge in how states define and operationalize family planning services in a managed care context. These ambiguities begin with a lack of clarity about what is covered by the “freedom of choice” safeguard. Ambiguities also exist concerning other key aspects of integrating family planning into Medicaid managed care, including strong network and access standards, expectations regarding the level and quality of family planning practice, quality improvement and performance measurement, strategies for follow-up care for family planning patients with additional physical and mental health conditions, and the use of value-based payments to encourage a high-performing network that can reduce reliance on out-of-network care.

- Third, the federal government similarly has a critical opportunity to clarify and strengthen the policy framework that guides the integration of family planning, Medicaid managed care, and states' and plans' efforts to improve quality and accessibility. Of particular importance is the need for greater clarity regarding which family planning services should be classified as family planning for purposes of Medicaid's special "freedom of choice" safeguard, and guidance on strategies to strengthen managed care performance where family planning is concerned. An initiative to strengthen the bonds between managed care and family planning would come at a crucial time, as the administration works to restore the Title X family planning program and the provider network on which so many Medicaid beneficiaries depend.

A full study methodology, including all of the tables that present the information presented in this report in detailed form, can be found in the Appendix, along with a list of advisors and the states we interviewed.

## Overview: Medicaid Managed Care and Family Planning

The starting point for this initial project phase — an in-depth examination of Medicaid managed care purchasing agreements — reflects the evolution of both Medicaid managed care and family planning policy over the decades, virtually from Medicaid's enactment.

### Medicaid managed care

The origins of what we know today as Medicaid managed care date to the original 1965 law, which authorized state agencies to purchase private health insurance as a form of medical assistance benefit.<sup>5</sup> Widespread adoption of managed care began in earnest in the early 1980s with the passage of the Omnibus Budget Reconciliation Act of 1981 (OBRA-81).<sup>6</sup>

Over the ensuing decades, managed care became the Medicaid program's operational norm, particularly for children and adults whose eligibility

is tied to low income alone. Enrollment grew significantly in the 1990s as a result of a series of federal Medicaid demonstrations carried out by the Clinton administration under Section 1115 of the Social Security Act. The Clinton demonstrations initially coupled expanded eligibility for low-income working-age adults (a precursor to the 2010 ACA Medicaid expansion) with compulsory enrollment into managed care plans.<sup>7</sup> The Balanced Budget Act of 1997 codified mandatory Medicaid managed care as a state option that eliminated the need for special demonstration authority, with enrollment required as a condition of eligibility for most beneficiaries.<sup>8</sup>

Because of who enrolls in Medicaid — and therefore, who is enrolled in Medicaid managed care — any discussion of Medicaid managed care policy also automatically becomes a discussion of Medicaid and reproductive health policy. Seventy-seven percent of women who are of reproductive age and entitled to comprehensive Medicaid coverage are also enrolled in Medicaid managed care. This group includes women eligible under a traditional eligibility category (very low-income parents or caretakers of minor children, people with disabilities, children and adolescents, and women whose eligibility is tied to pregnancy). It also includes women eligible as low-income adults under the ACA Medicaid expansion.<sup>9</sup> (As discussed below, certain Medicaid beneficiaries are entitled only to limited family planning benefits and services and generally are not enrolled in Medicaid managed care).

The relevance of Medicaid managed care to reproductive health is not limited to women, of course. Millions of sexually active males — teens, young adults, and, especially in Medicaid expansion states, working-age men who are fathers and sexual partners — depend on Medicaid managed care for a full range of health needs.

In many design and operational aspects, Medicaid managed care parallels private health plans that tie coverage to care through participating provider networks. At the same time, Medicaid managed care is distinct in the degree to which coverage is

restricted to in-network care. In a typical private insurance plan, an insurer incentivizes in-network care through lower patient cost-sharing and protections against balance billing; members can, if they choose, seek out-of-network care, with coverage at a higher cost-sharing rate. But cost-sharing financial incentives of any magnitude cannot work for impoverished populations whose access to care is so sensitive to more than nominal cost-sharing.<sup>10</sup> For this reason, Medicaid managed care systems utilize closed provider networks subject to strict cost controls.

At the same time, federal law recognizes three exceptions to Medicaid's tightly controlled network and coverage model:

- *Emergency care.* Like the Affordable Care Act protections that govern the private insurance and health plan markets,<sup>11</sup> federal Medicaid law allows an exception for hospital emergency care using a "prudent layperson standard."<sup>12</sup>
- *Services exempted from a state's managed care contract.* Most states either partially or wholly exempt certain services from their managed care purchasing agreements, especially benefits related to high cost, high-need health care and care furnished in settings that may not easily fit within a managed care model, such as homeless shelters or schools. Managed care plans may, in some cases, help manage access to these services and perform third-party claims administration functions. However, provider network restrictions would not apply, and members would continue to have access to any qualified Medicaid provider without regard to network status. By law, managed care organizations must inform members about services covered under the state plan but are not included in the service agreement.<sup>12</sup>
- *"Freedom of choice" for family planning services and supplies.* As part of OBRA-81, Congress included a special family planning exemption to normal managed care network and access rules. The family planning exemption covers "family planning services and supplies" and guarantees that plan members

can continue to receive these services from their Medicaid-qualified provider of choice, regardless of network status. This special exemption, required by federal law, reflects both a Congressional desire to promote access to care and to accommodate managed care participation by religiously-affiliated health plans whose contracts might limit or exclude covered family planning services. The OBRA-81 "freedom of choice" guarantee, a key focus of this study, is distinct from a separate protection added to Medicaid in 1997, which guarantees direct access to *in-network* women's health care providers without the need for a referral from their primary care provider. This later protection (discussed further below) would subsequently be extended to insurance plans more generally.

## Medicaid family planning benefits

Family planning has been a mandatory Medicaid service for 50 years. In the context of this study, two aspects of the benefit are notable.

First, under federal Medicaid law, the definition of what constitutes "family planning services and supplies" is quite broad. Under longstanding law dating to the original 1972 family planning amendments,<sup>14</sup> certain family planning services (examinations and related tests, contraceptives, and counseling) qualify for enhanced federal funding at a 90 percent federal payment rate. But the Affordable Care Act extended and broadened the definition of family planning also to encompass "medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting."<sup>15</sup>

In implementing this expanded definition of family planning, the Centers for Medicare and Medicaid Services (CMS) has elected to divide the benefit into two clusters: family planning services and "family planning-related services." Under CMS guidelines, "family planning services" qualify for 90 percent federal funding, while "related" services are paid at the regular federal medical assistance rate (between 50 percent and 77 percent in 2021). Both types of benefits can be covered for people

entitled to limited Medicaid benefits for family planning under the ACA's special Medicaid family planning eligibility option. As of 2021, 26 states provide coverage for this limited benefit group.<sup>16</sup>

Second, in the case of beneficiaries entitled to full Medicaid benefits, the definition of family planning benefits also can vary. For the traditional population entitled to Medicaid prior to the ACA, the required scope of family planning benefits includes contraceptives whose scope would be governed by Medicaid's basic test of coverage reasonableness.<sup>17</sup> For the ACA adult expansion group, however, contraceptive coverage explicitly includes all FDA-approved contraceptive methods.<sup>18</sup> Furthermore, the ACA Medicaid expansion group is entitled to "essential health benefits" under "alternative benefit plans." The essential health benefit standard also explicitly includes a bundle of services classified as "women's preventive health services" that includes both benefits considered to be family planning services and supplies as well as other benefits such as screening for interpersonal and domestic violence, preventive exams, and diabetes screening, as

shown in **Figure 1** below.

**Figure 2** shows the three basic Medicaid eligibility pathways and how family planning benefits can vary by pathway depending on how states implement the family planning coverage requirement.

Regardless of the basis of eligibility, however, it is important to stress that the federal definition of family planning is potentially very broad. CMS provides guidance on which family planning benefits qualify for 90 percent federal funding and which are "related" and qualify for federal payments at the regular FMAP rate and are potentially available to the limited family planning eligibility group. But the guidance is silent on which family planning benefits are covered by Medicaid's "freedom of choice" safeguard. The assumption appears that the safeguard extends to those benefits recognized as such in 1981 (counseling, contraceptives, exams). The guidance does not consider the interaction between the "freedom of choice" safeguard and the subsequent 2010 amendment that fundamentally altered the

### Figure 1. Women's Preventive Health Services

Source: Health Resources and Services Administration (HRSA)

- Screening for anxiety
- Breastfeeding services and supplies
- Cervical cancer screening
- Screening for cervical cancer
- Contraception care including counseling, initiation of contraceptive use, counseling (all FDA-approved contraceptive methods)
- Screening for diabetes both during and after pregnancy
- Screening for HIV
- Screening for interpersonal and domestic violence
- Counseling for sexually transmitted infections
- Well women preventive visits
- Screening for urinary incontinence



Figure 2. Principal Medicaid Eligibility Pathways and Family Planning Coverage Variation

Eligibility Pathways	Family Planning Coverage
<p><b>“Traditional” beneficiaries:</b></p> <ul style="list-style-type: none"> <li>• Low-income children</li> <li>• Very poor parents and caretaker relatives</li> <li>• Children and adults with disabilities</li> <li>• Pregnant/postpartum women</li> </ul>	<p>Family planning services and supplies. Federal guidelines that identify which services qualify for 90 percent federal funding define the term as consisting of counseling services and patient education; examination and treatment; laboratory examinations and tests; medically approved methods, procedures, and devices to prevent conception; and certain infertility services. Medically necessary diagnosis and treatment services for conditions found in a family planning visit typically would be covered under the state plan rather than as a family planning service.</p>
<p><b>ACA expansion beneficiaries:</b></p> <ul style="list-style-type: none"> <li>• Low-income, non-elderly adults with household incomes up to 138% FPL</li> </ul>	<p>All essential health benefits, including all FDA-approved contraceptive methods, as well as a broad package of women’s preventive health services — which may extend beyond the Medicaid definition of family planning and related services both in scope and the range of services furnished in a family planning setting (e.g., screening for anxiety and depression).</p>
<p><b>Beneficiaries eligible for family planning and family planning-related coverage:</b></p> <ul style="list-style-type: none"> <li>• Incomes between 138% FPL and states’ upper-income limit for pregnant women</li> </ul>	<p>Family planning services and supplies — defined as including not only contraceptives, tests, and counseling, but medically necessary diagnosis and treatment for conditions disclosed during a family planning visit and furnished in a family planning setting.</p>

definition of family planning services.

### Medicaid care and family planning integration

The breadth of family planning services and supplies are foundational to preventive care and can act as a key entry point into health care more generally. This underscores the value and desirability of integrating family planning into comprehensive managed care systems as part of a

“whole person” health strategy improvement strategy. A strong orientation toward integration would emphasize a wide choice of family planning network providers and a comprehensive range of family planning services to encourage early detection of conditions affecting overall reproductive health. Inclusiveness also would emphasize performance standards that include special accessibility efforts reaching all qualified providers in medically underserved communities,

especially those that offer special programs for hard-to-reach populations such as immigrants, adolescents, or patients with disabilities or underlying behavioral health conditions. In other words, effectively integrating family planning into Medicaid managed care raises a host of important considerations when designing effective systems for a diverse and vulnerable population that go beyond simply covering and paying for family planning services but orienting managed care systems to reach members with complex needs, and to focus special attention on issues such as confidentiality and patient supports. Integration also means incorporating evidence-based practice standards as a network expectation, adopting value-based payment strategies to attract and retain a high-performing network, and developing performance measures that can capture certain outcomes, as well as evidence of basic procedures such as cervical cancer screening for adults<sup>19</sup> and

chlamydia screening for adolescent women ages 16-20.<sup>20</sup>

*Models of managed care/family planning integration.* The complexity of integration means that managed care and family planning integration can be thought of as happening along a spectrum, from limited integration to comprehensive integration and prioritization. Under limited integration that mainly relies on the “freedom of choice” safeguard to promote access to care, family planning might be covered. Still, only a modest focus would be given to aspects of managed care such as networks, access, performance standards, payment incentives, links between family planning network providers and social services, and quality measurement and performance improvement. Plans essentially would emphasize their role as claims managers, and members would seek care from their provider of choice. Family planning would exist as a covered

**Figure 3. Models of Family Planning/Managed Care Integration**

Limited	Comprehensive
<ul style="list-style-type: none"> <li>• Family planning benefits are covered but broadly defined</li> <li>• Services covered by the “freedom of choice” exemptions are not defined</li> <li>• Contract does not specify family planning-focused access or network specifications</li> <li>• Contract does not specify specific expectations regarding referrals between out-of-network family planning providers and in-network care</li> <li>• Contract does not incorporate social determinants expectations specifically into family planning services</li> <li>• Contract does not specify family planning-related performance expectations or quality improvement goals</li> </ul>	<ul style="list-style-type: none"> <li>• Family planning is specified in detail with coverage spanning the full range of federally-permissible services</li> <li>• Services covered by the “freedom of choice” exemption are defined</li> <li>• Contract specifies detailed access and network expectations</li> <li>• Contract specifies referral arrangements for follow-up care</li> <li>• Contract specifies a focus on family planning patients with social determinants needs</li> <li>• Contract specifies family planning performance expectations and quality improvement goals</li> </ul>

benefit but not one subject to robust coverage, access, or performance specifications.

In a more robust integration model, the contract would lay out more detailed specifications governing coverage and performance to elevate the importance of family planning access, quality, and performance as a major focus of managed care patient and population health improvement. The contract would be more specific regarding networks, coverage, performance expectation, referral systems, linkages between family planning and social services, and other matters. Payment incentives would be in place for plans and provider networks that achieve high performance as defined by evidence-based practice standards, such as providing same-day walk-in care, the “quick start” family planning method, and other strategies designed to make family planning simple and easy to access.

The basic features of what might be thought of as two distinct models for approaching managed care and family planning are shown above in **Figure 3**.

## Study Aims and Assumptions

This two-phase study has been designed to better understand the issues in family planning and Medicaid managed care integration and how states currently approach these issues. The first study phase, whose results are presented here, offers a baseline assessment of issues and state approaches through an in-depth review of managed care purchasing agreements coupled with in-depth discussions with state Medicaid leaders.

As with our previous work in the field of managed care policy and practice, we assume that there is no correct answer to the question of “how much” or “to what extent” to integrate managed care and family planning — and how robustly and with what level of focus. On-the-ground health care conditions, public health, and policy priorities, consumer preferences, other considerations strongly influence how states shape and design their managed care systems and the priorities they choose.

At the same time, we also believe that much is to be gained from a focus on greater managed care and family planning integration in terms of quality, efficiency, and the promotion of reproductive and overall patient and population health. Furthermore, because real-world considerations play such an important role in Medicaid managed care design and operationalization, the 1981 “freedom of choice” exemption remains as important today as it was when it was originally enacted, since the exemption assures that states and health plans can adjust their activities and areas of emphasis without compromising access to this essential benefit.

Finally, we assume that because an understanding of, and experience with, both family planning practice and the field of Medicaid managed care has changed dramatically over the past four decades; we believe that a deep dive into the family planning/managed care integration question will add value to health care practice and policy.

## Study Overview

This study phase presents findings from our baseline study, which involved a detailed analysis of state Medicaid managed care purchasing agreements coupled with discussions with senior Medicaid officials in ten states. This baseline is intended to help illuminate what can be thought of as the managed care “blueprint” in all states: the major purchasing agreements on which all Medicaid managed care systems sit.<sup>21</sup>

Medicaid managed care contracting is challenging for an impoverished, high-need population because the act of purchasing goes far beyond the concerns involved in purchasing typical private health plans. In light of the concentration of Medicaid beneficiaries with complex needs in poor rural and urban communities with extensive medical underservice problems, network sufficiency and capability considerations rise to the forefront, as do access concerns. Coverage must be well-defined to capture the full range of covered services included in the contract. Utilization management approaches must be tailored to a

member population with elevated health and social needs. Relationships with social service and other providers must be in place. Quality improvement priorities must be tailored to a member population with complex needs. Federal managed care requirements must be satisfied along with state laws governing large-scale procurements.

Thus, managed care can vary enormously from state to state depending on population need, on-the-ground health care conditions, legal considerations, policy priorities among state lawmakers, advocates, and health professionals, procurement laws, and the customs and practices of the managed care industry itself. Along with this variation in approaches to Medicaid managed care comes variation in state purchasing agreements. Some states may broadly word their agreements and supplement general agreements with more detailed guidance documents, while other states might take a granular approach to their agreements, filling them with detail. Some states may use a procurement approach that begins with a procurement announcement and then incorporates acceptance of plan responses to a standard set of terms and conditions, meaning that the contractor's response guides the detail.

Despite these differences, federal law treats Medicaid contracts as the foundation of state systems, and our studies of Medicaid managed care contracts over nearly three decades underscore the degree to which all states use purchasing agreements to signal areas of high-priority interest and focus. A state's priorities might result from the on-the-ground public health conditions or health care realities (particularly, the concentration of Medicaid beneficiaries in low-income urban and rural communities at risk for health and social risks coupled with a shortage of primary care services). State priorities might also reflect gubernatorial or legislative initiatives. Moreover, because the purchase of health care is so complex, any managed care contract is a mix of the specific and the general. That is, in any state, the contract will reflect areas of high specificity where a state desires a specific approach or a specific result, and the other issues are left

substantially to contractor discretion in accordance with prevailing industry practice.

In sum, despite certain limitations, Medicaid managed care purchasing documents play a central role in state systems and offer a means of gaining an overall picture of states' health system approaches and priorities.

**Appendix 2** provides a fuller explanation of our methods. In brief, this study involved collecting public purchasing documents from the 39 states and the District of Columbia in which comprehensive managed care was in use in 2020. These documents were reviewed using an instrument designed to capture each document's framework in detail through a series of six domains, each with numerous sub-topics (shown in **Figure 4**). Each domain and sub-topic are relevant in assessing the extent to which state purchasing agreements contain express specifications aimed at translating family planning practice and policy for medically underserved populations into their managed care purchasing blueprints. In developing these domains and sub-topics, we were guided by comprehensive family planning guidelines developed by the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA), federal Medicaid policy considerations, and project advisors (listed in **Appendix 3**) whose expertise spans Medicaid policy, family planning policy and practice, managed care, and primary care practice and policy.

Once the domains and sub-topics were finalized and converted into a review instrument, a team trained and experienced in analyzing Medicaid managed care purchasing documents reviewed all state agreements and prepared the detailed master tables found in **Appendix 1**. These tables provide two levels of information: 1) an overview of the degree to which documents do or do not contain family planning-specific provisions addressing a particular domain or subtopic; and 2) the actual language contained in each state document relevant to that domain or subtopic, which gives users the ability to compare precisely

Figure 4. Managed Care and Family Planning: Study Domains and Sub-Topics

**Domain 1. Coverage**

- Identifies family planning as a covered benefit
- Coverage is explicit on coverage of all FDA-approved family planning methods
- Coverage of family planning services and supplies is coextensive with the coverage provided by the state Medicaid plan
- Coverage of family planning as a postpartum benefit is required
- Family planning-related services are defined
- Quick start contraception<sup>1</sup> is required as a contract service

**Domain 2. Access and Provider Networks**

- Coverage of out-of-network family planning services regardless of network status
- Coverage of family planning-related services regardless of network status and without prior authorization
- Network contracts offered to all Medicaid-qualified family planning providers in the plan service area
- Bars against the use of prior authorization or other utilization management methods for family planning services
- Incentives for same day walk-in care
- Maximum wait times for family planning visits
- Maximum travel time for family planning visits
- Family planning provider/patient ratios
- Telehealth family planning visits
- Non-emergency transportation for family planning

**Domain 3. Information for Plan Members**

- Contractors required to inform members of free choice of family planning providers
- Contractors required to inform female members of their right to direct access to in-network women's health specialists without prior authorization
- Contractors required to inform members of any family planning services covered under the state plan but not include in the contract
- Contractors required to inform members about relevant family planning confidentiality considerations
- Contractors barred from disclosing family planning visit information in members explanation of benefits

**Domain 4. Payment Incentives**

- Requirement for payment add-on or incentives for family planning drugs and devices furnished incident to a family planning visit
- Separate payment for postpartum long-acting reversible contraceptives (LARCs; i.e., IUDs, contraceptive implants)
- Value-based payments for family planning services

**Domain 5. Social Determinants of Health**

- Family planning patients identified as a prioritized population for social risk health screening
- Referral arrangements required between family planning providers and social service agencies

**Domain 6. Quality Improvement and Performance Measurement**

- Family planning and family planning-related-specific performance measures
- Family planning performance measures as part of maternity care
- Specifies one or more family planning health outcome measures
- Adolescent performance measures for family planning specified

<sup>1</sup> "Quick starting" is the term used to describe immediate initiation of a contraceptive method at the time a woman requests it, rather than waiting for the start of the next natural menstrual period.

how different states may address a topic. In the context of purchasing agreements, these details matter in framing the scope of state expectations and the degree of discretion afforded to plan contractors.

## Findings

Our review of state Medicaid plans — the foundation on which managed care contracts rest — results in two key findings.

First, our review suggests that in contracting for managed care, while all states view family planning as a foundational service, states tend not to elevate family planning as a major area of focus in terms of coverage and performance specificity. Indeed, contract documents tend to leave plans with broad discretion to define the full scope of what constitutes family planning coverage itself, including the types of coverage that should be covered by the “freedom of choice” exemption. Of course, there are notable exceptions, but overall, family planning is a basic expectation but not one that merits extensive specification or emphasis as a performance priority.

Second, while the selection of key areas of focus is principally a matter of state leadership and choices, the federal government’s silence on managed care and family planning is also quite notable. For example, the federal government has been a leader in the development and publication of landmark guidelines on high-quality family planning services. CMS has launched an effort to develop more robust measures of managed care family planning performance. But in other critical respects, CMS activities have been limited. For example, CMS has never developed detailed guidance on how states might translate the CDC/OPA guidelines into a managed care operating environment. Nor does CMS maintain guidelines regarding the range of considerations that go into Medicaid managed care and family planning integration or how to align managed care coverage and performance with the “freedom of choice” exemption.

Indeed, even basic CMS documents — such as the preprinted document states use to describe their

state plan coverage — are ambiguous and unclear. As a result, it is not possible from the preprints to know the full scope of state coverage of family planning, including which benefits and services identified in federal law are classified as a family planning benefit and which benefits are covered by the “freedom of choice exemption.”<sup>22</sup> Two states plans specify unequivocally (Ohio and New Jersey) that as a basic state plan matter, all comprehensive coverage beneficiaries are entitled to all FDA-approved contraceptive methods regardless of their basis of eligibility. Other state plans are ambiguous, and this ambiguity carries through to the purchasing itself.

In sum, an important consideration in most states’ decisions to elevate family planning as a focus of managed care priority may be that except for an effort to develop more refined quality measures, managed care and family planning are not a focus for CMS either.

## Summary findings from the Medicaid managed care contract review

Figures 5 through 10 present summary findings from our contract review of public purchasing documents from the 39 states and the District of Columbia utilizing comprehensive managed care in 2020. The tables referred to in each of these figures can be found in **Appendix 1**.

### Coverage

As **Figure 5** shows, family planning is a basic offering of all state managed care agreements. In other words, no states, in response to the “freedom of choice” guarantee, has elected to simply exempt family planning services and supplies from its managed care system. States assume (confirmed by our discussions with state officials) that family planning is a basic feature of their managed care systems. Eight states explicitly include language on coverage of all FDA-approved family planning methods. Figure 5 also shows that 12 state agreements specify that contractor coverage of family planning services must be coextensive with the state plan, presumably eliminating contractor discretion to define coverage scope.

Nine states specify family planning as a pregnancy-related postpartum service. No states specify what is meant by coverage of family planning-related services. No states specify coverage of quick-start contraception, which permits coverage in the absence of an initial exam.

### ***Access to coverage and provider networks***

**Figure 6A** shows that 18 states specify that contractors must pay for all family planning services when furnished by a qualified Medicaid provider, regardless of the provider's network status. Twenty-six states bar use of prior authorization or other utilization management techniques in the case of family planning services. Figure 6A also shows that although states do not specify what constitutes family planning-related services in a coverage context, four states specify that contractors must pay for family planning-related services when furnished by a Medicaid provider, regardless of network status and without prior authorization. Six states specify that contractors must offer network contracts to all qualified Medicaid providers in their plan service area.

**Figure 6B** reports on family planning-specific versions of general access measures such as travel times, wait times, and provider/patient ratios. With respect to rapid access, six states require or specify incentives to create same-day walk-in access. Six states reference maximum wait times for in-network family planning services, 19 reference travel times, four reference provider/patient ratios, six specify the use of telehealth services, and 31 states specify non-emergency transportation for family planning visits.

### ***Information for plan members***

As seen in **Figure 7**, 11 states specify that contractors must inform members of their right to family planning services from the qualified provider of their choice and without regard to network status or prior authorization. Fifteen states expressly require that contractors inform members of their right to directly access any in-network women's health specialist for routine preventive care, a specific information guarantee under

federal law.

Fourteen states require plans to inform members regarding the full scope of family planning coverage under the state plan (which may differ from what the contractor offers) and where and how to obtain services not covered under the contract. Among these 14 states, five states specifically stipulate that enrollees must be informed about how to access covered services that the contractor has objected to on moral or religious grounds. However, no contract appeared to require contractors to identify religiously affiliated providers within their network.

No states specifies that contractors are required to inform members about their rights regarding family planning and provider-patient confidentiality. One state bars contractors from including identifiable information about a family planning visit in the explanation of benefits (EOB) sent to members.

### ***Payment and payment incentives***

As **Figure 8** shows, one state specifies additional payment to providers for drugs and devices furnished during an office-based family planning visit. In contrast, two states require contractors to make separate payments for hospital-inserted LARCs. Five states encourage the use of value-based payment models for either office-based or hospital-based family planning services.

### ***Social determinants of health***

**Figure 9** reports that no state identifies family planning patients as a specific priority population for social and health risk screening, while one state requires contractors to maintain referral relationships between their in-network providers and social service agencies.

### ***Quality improvement and performance measurement***

Last, **Figure 10** shows that 23 states specify performance measures for family planning or family planning-related services. In many cases, state measures focus on family planning-related services, such as cervical cancer screening or chlamydia screening. Seven states specify family

planning as a pregnancy-related performance measure, and seven states specify family planning performance as a measure of adolescent health. No states specifies a family planning health outcome measure.

## State variation in contract terms: a closer look

These summary findings provide a high-level overview of the extent to which state purchasing documents, as a group, contain coverage, access, network, quality, payment, and performance provisions specific to family planning. But within these high-level patterns, important differences can be seen in the precise approach that any two or more states might take to the same topic or focus area. As we have noted in our previous Medicaid managed care research,<sup>23</sup> empirical evidence does not exist that would suggest that one approach to drafting achieves better outcomes; contracts that vest plans with discretion as to whether to cover and furnish certain services and, if so, to what extent, may achieve results that do not differ from contracting approaches that are more directive.

But for standard setting and accountability reasons, states and plans typically agree to specific performance expectations regarding coverage, care, payment, quality improvement, consumer safeguards, and other matters. Indeed, one of the most important decisions states and plans make is how to balance deference against clarity. Many considerations may enter into this equation, such as whether on-the-ground conditions make the realization of the standard feasible, and considerations of cost and efficiency. For this reason, this variation in coverage and deference is a signature characteristic of state contracting practices around any particular topic. For example, a specification that defines contractor coverage obligations as “appropriate family planning services” would signal to contractors the flexibility to set parameters on coverage that may differ from all FDA-approved contraceptive methods or even the level of coverage afforded by the underlying state Medicaid plan.

Silence on a particular matter signals a policy judgment in its own right. For example, a contract may be silent on the use of telehealth services. This does not mean that telehealth services might not be available under plans’ operating standards, but instead that whether to use telehealth services and under which conditions is left to contractor discretion.

Drawing from the tables in **Appendix 1**, we offer several comparisons to illustrate this basic point about how contracts are drafted.

### I. Coverage of Family Planning Services

As discussed, federal law gives states considerable discretion to define the term “family planning services and supplies.” A state’s definition would be relevant not only as an expression of the state’s policy regarding what a high-quality family planning service should encompass but also because the definition would play a key role in defining the scope of the state’s “freedom of choice guarantee.”

Nevada uses a succinct definition:

*Vendor Covered Services ... At a minimum, the Vendor must provide directly, or by subcontract, all covered medically necessary services, which shall include, but may not be limited to, the following:*  
*4.2.2.13 Family Planning Services.*

South Carolina uses a more extensive definition:

*4.2.12. Family Planning Services—Family Planning Services include traditional contraceptive drugs, supplies, and preventive contraceptive methods. These include, but are not limited to the following: (1) examinations, (2) assessments, (3) diagnostic procedures, and (4) health education, prevention and counseling services related to alternative birth control and prevention as prescribed and rendered by various Providers.*

Under both state definitions, contractors presumably would have the latitude to determine when certain services are furnished in a family planning setting and pursuant to a family planning visit (such as the HPV vaccine or diagnosis).



Figure 5. Summary Findings from Table 1: Coverage

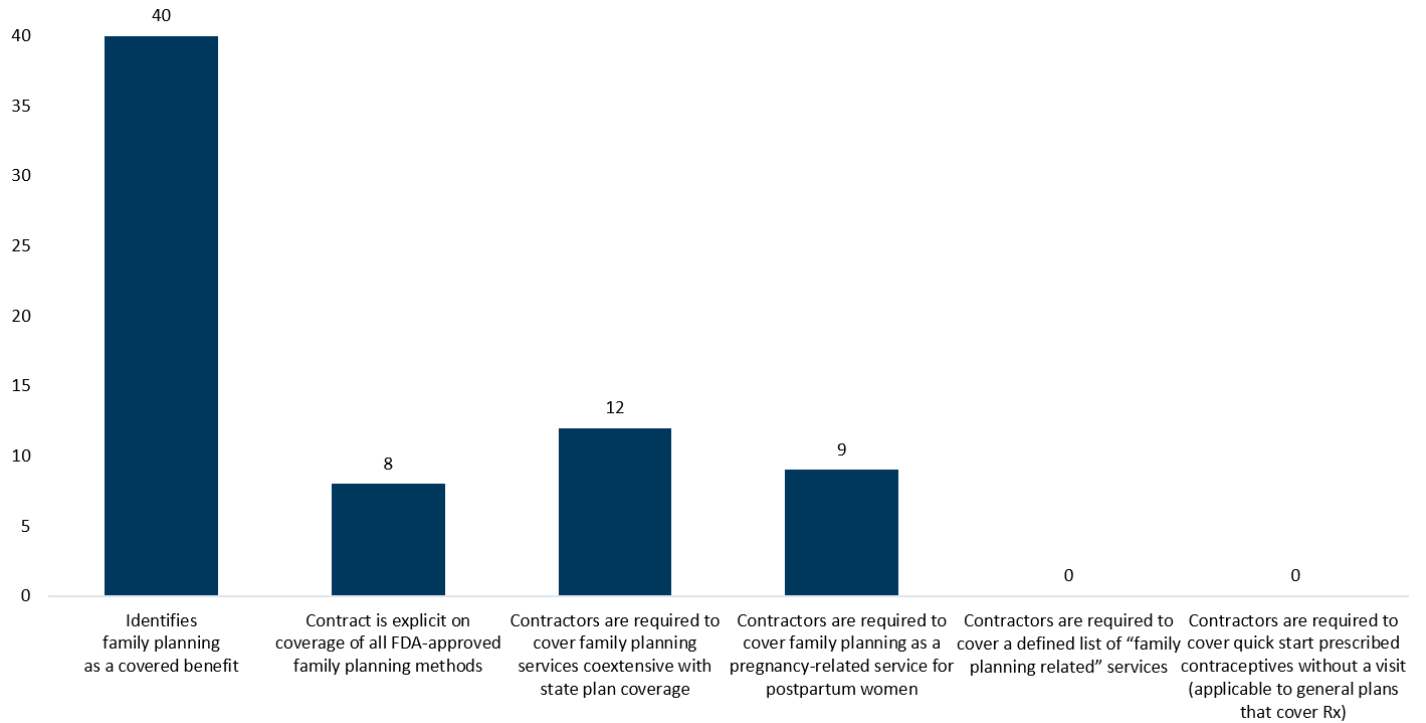


Figure 6A. Summary Findings from Table 2: Access to Coverage and Provider Networks

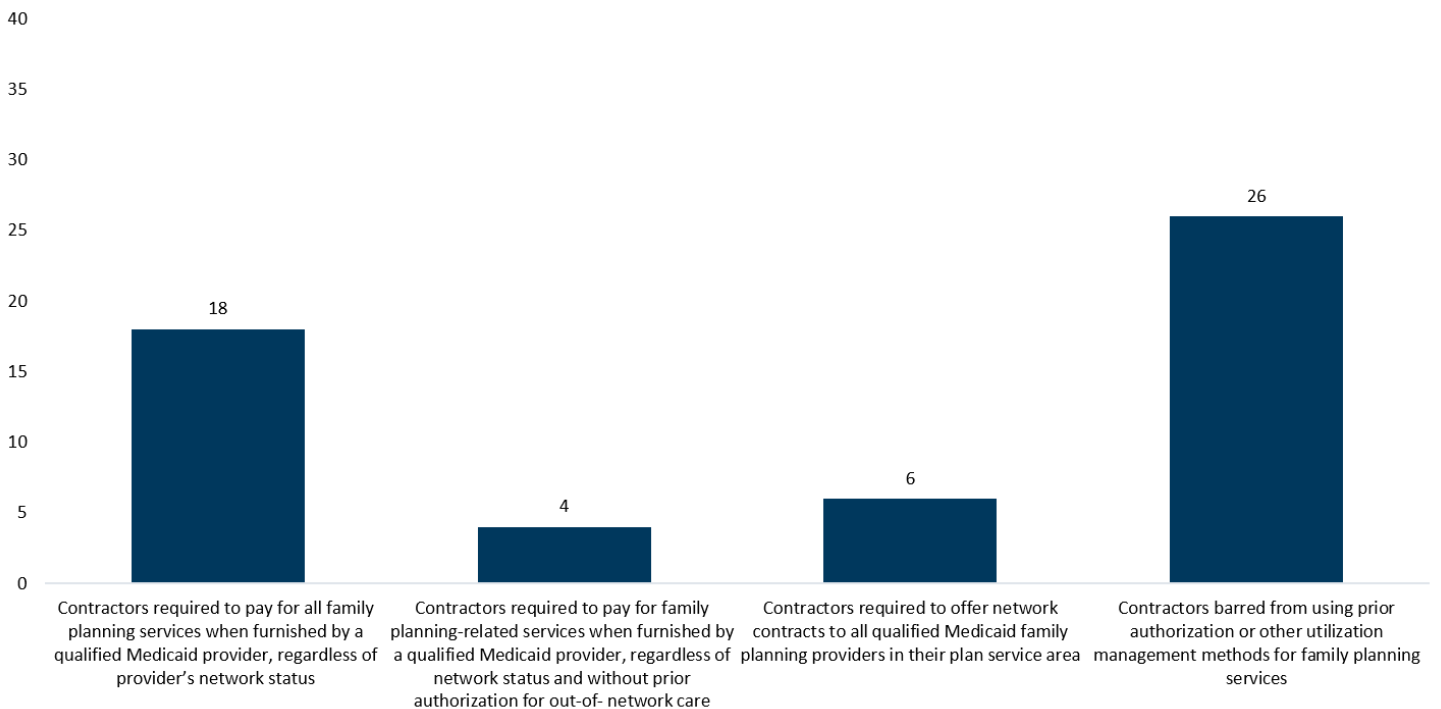


Figure 6B. Summary Findings: Access to Coverage and Provider Networks

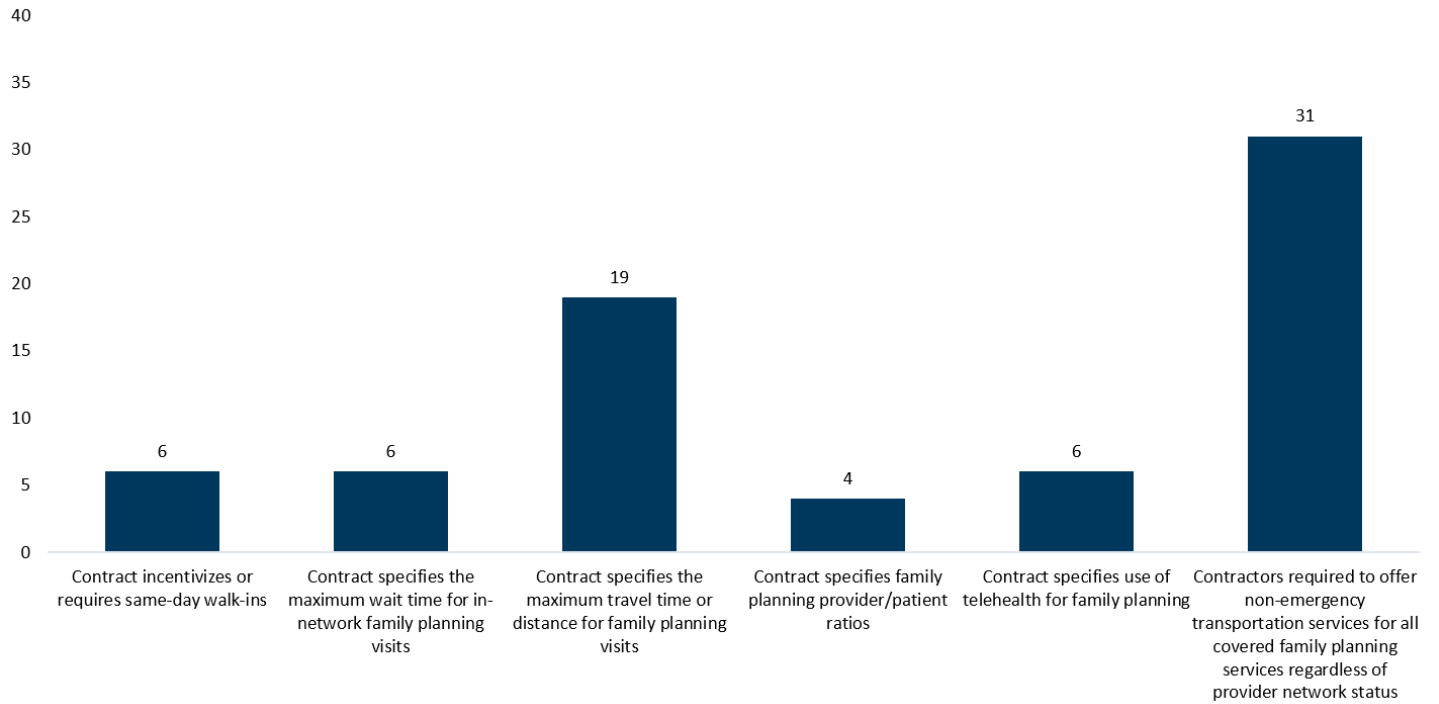


Figure 7. Summary Findings from Table 3: Information for Plan Members

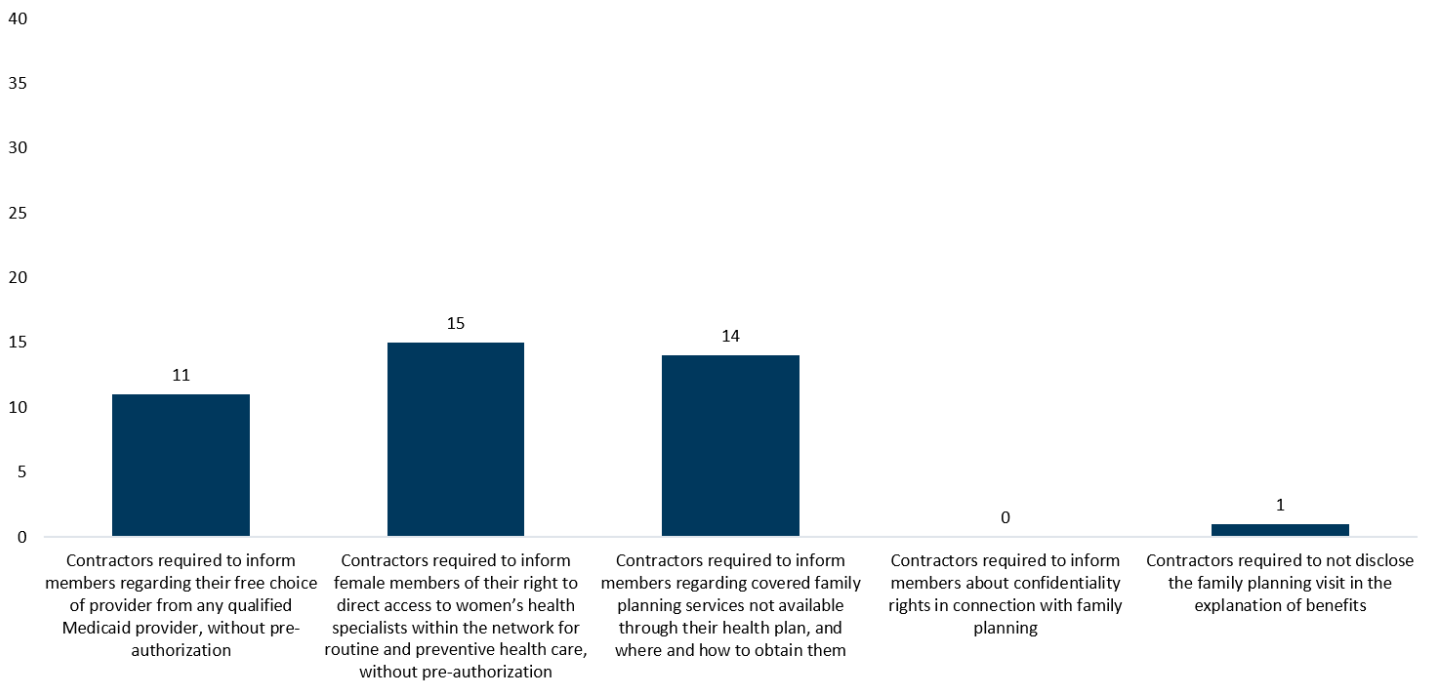


Figure 8. Summary Findings from Table 4: Payment Incentives

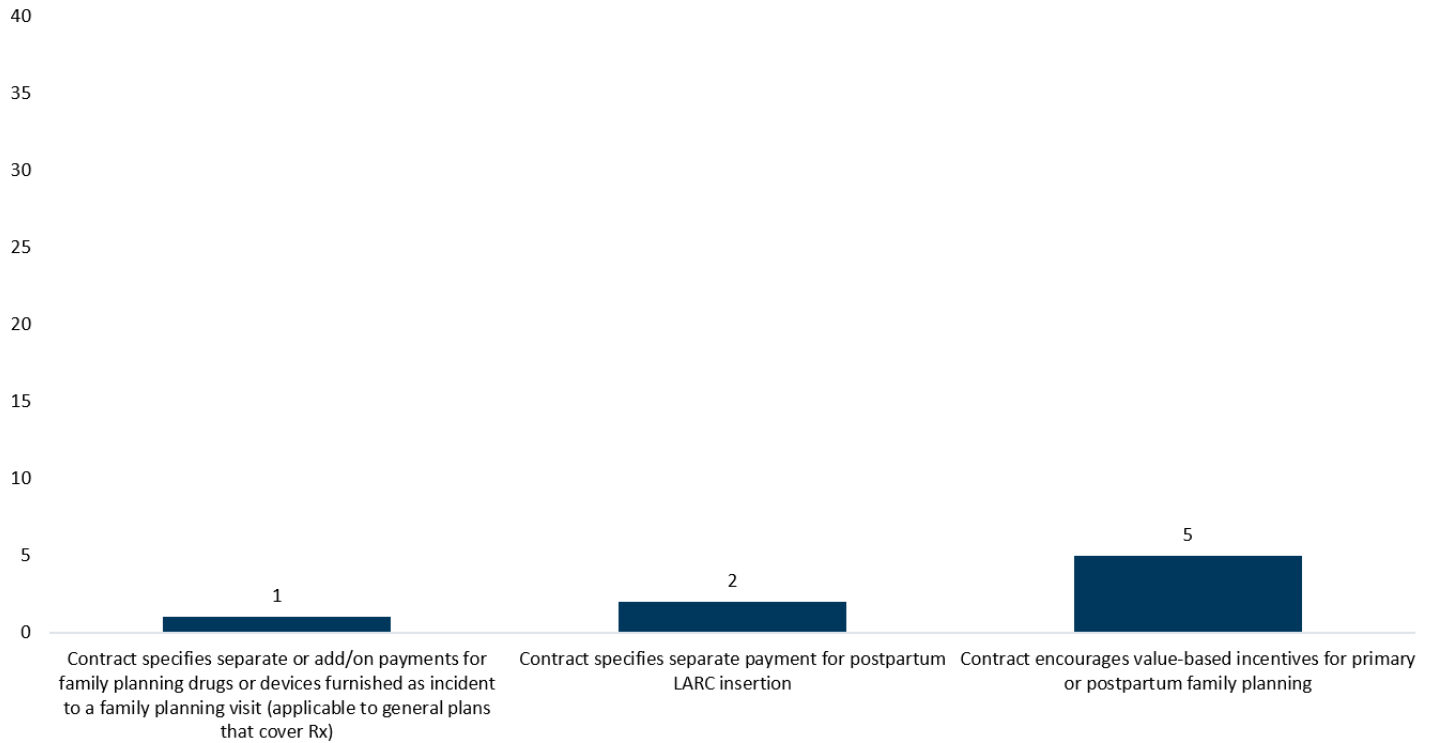


Figure 9. Summary Findings from Table 5: Social Determinants of Health

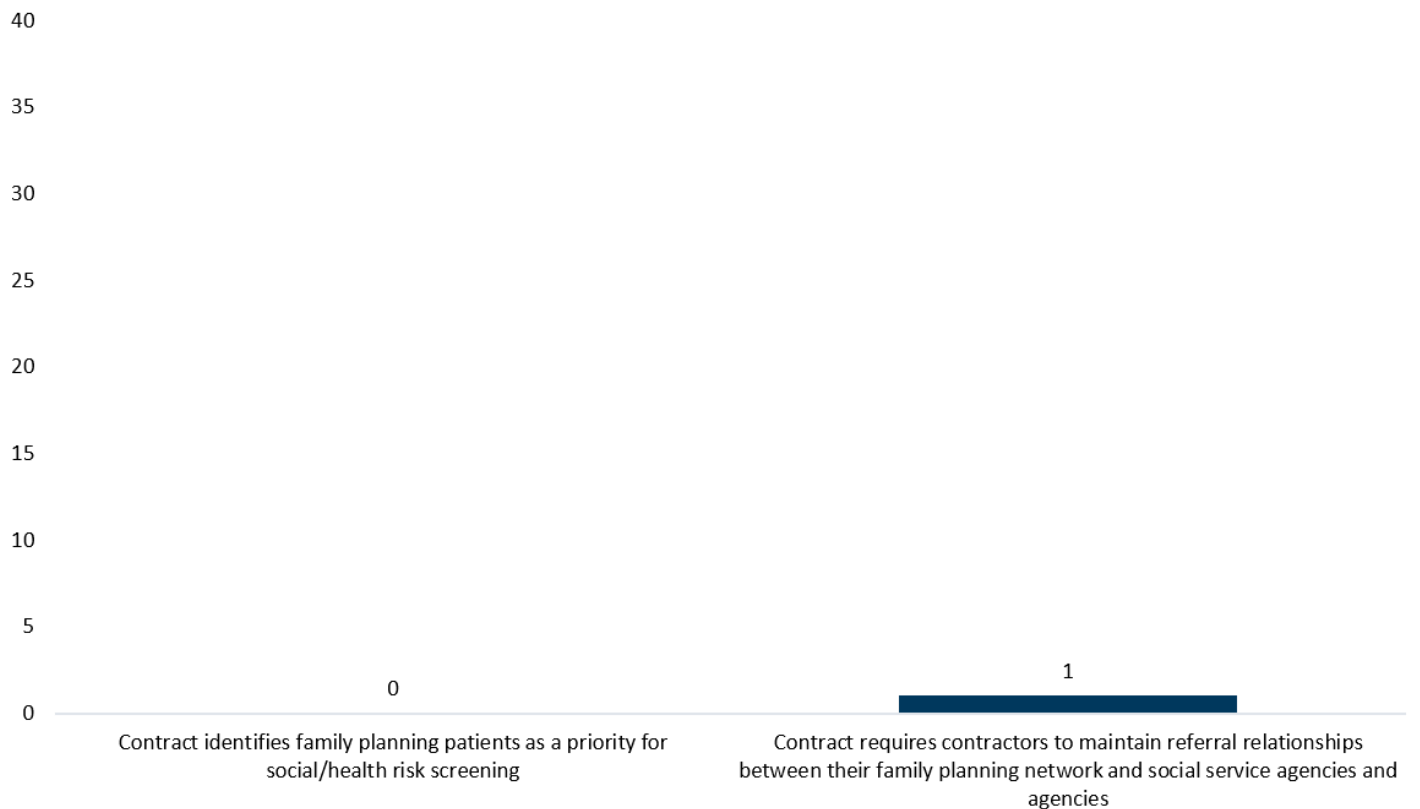
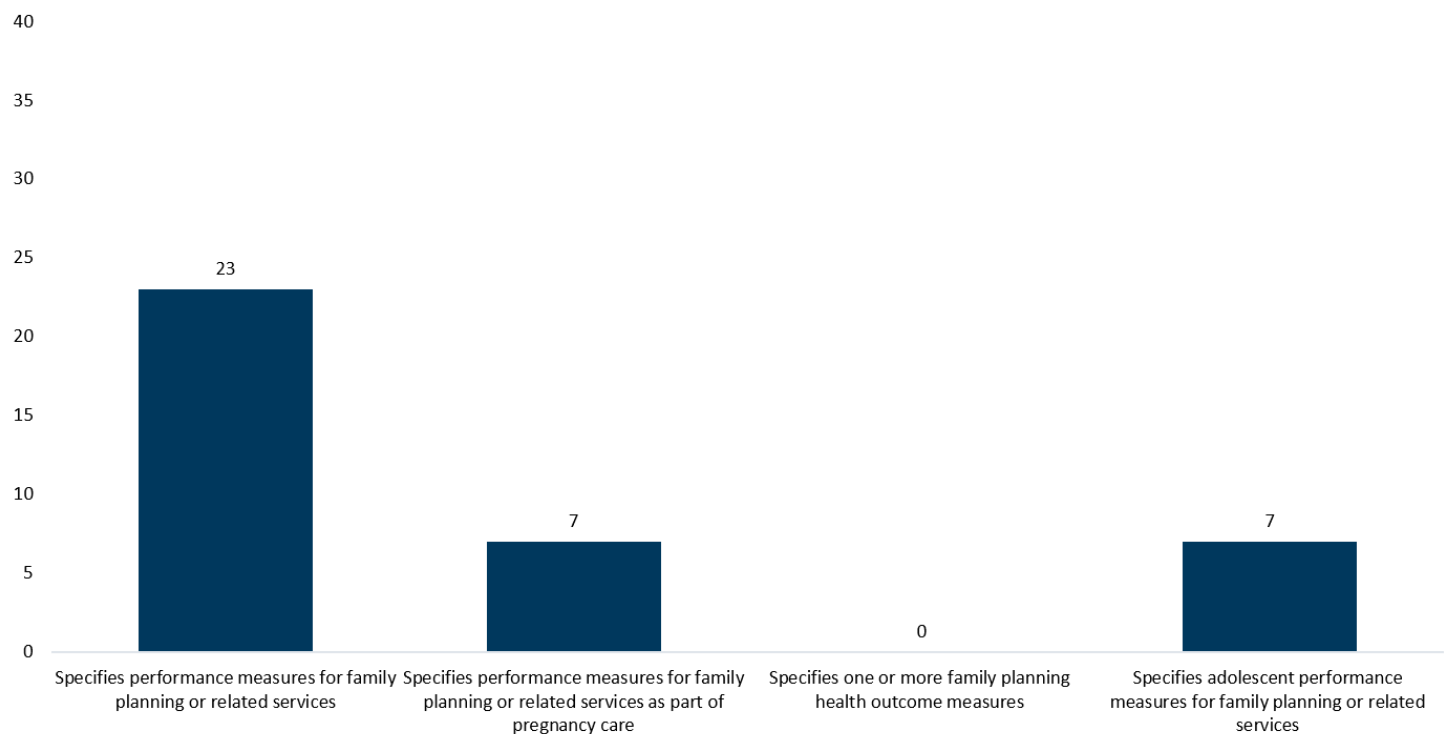


Figure 10: Summary Findings from Table 6: Quality Improvement & Performance



Arizona’s contract defines the postpartum family planning duty as follows:

*The Contractor must monitor rates and implement interventions to improve or sustain rates for low/very low birth weight deliveries, utilization of long acting reversible contraceptives (LARC), prenatal and postpartum visit.*

Louisiana defines the postpartum coverage obligation as follows:

*The MCO shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning services for pregnant women.*

Arizona’s contract is drafted in a way that approaches postpartum family planning as an intervention that arises out of patient monitoring post-delivery, with the intervention seemingly required if monitoring suggests the need for such an intervention. Louisiana, by contrast, specifies family planning as part of the pregnancy bundle,

not conditioned on the results of member or patient monitoring. Arizona’s drafting would support contractor accountability in terms of provision of the intervention in the wake of evidence, as defined by the contractor, that is gained from monitoring. Louisiana sets a performance expectation of family planning as a basic element of postpartum coverage.

## II. Access to Family Planning-Related Services from Out-of-Network Providers

Although the contracts lack specific coverage terms regarding what must be covered out-of-network, four states set standards in terms of access. California addresses the issue of out-of-network coverage in some depth, while Pennsylvania offers a general minimum and thus would rely on contractor discretion.

California’s contract providers as follows:

*Out of network family planning services. Members of childbearing age may access the following services from out-of-network family planning providers to temporarily or permanently delay pregnancy: (a) health education and counseling. . . ;*

b) limited history and physical examination. . . . c) laboratory tests if medically indicated. Contractor shall not be required to use out of network provider for pap smears if contractor has provided pap smears to meet U.S. Preventive Services Task Force guidelines. . . . d) diagnosis and treatment of a sexually transmitted disease episode . . . . e) screening testing and counseling of at risk individuals for HIV and referral for treatment. . . . f) follow-up care for complications associated with contraceptive methods. . . . g) provision of contraceptive pills, devices and supplies . . . . h) tubal ligation. . . . i) vasectomies; j) pregnancy testing and counseling.

Compare this language with an excerpt from Pennsylvania:

*The PHO-MCO may not use either the referral process or Prior Authorization to manage the utilization of family planning services. . . . Members may access **at a minimum**, health education and counseling. . . ., pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures. [Bold emphasis added.]*

Whereas California presents contractors with a defined list, Pennsylvania gives contractors the discretion to add to the minimum list or elect to not do so.

### III. Performance Measurement

Performance measures are not without controversy; nevertheless, the development of more robust family planning performance measures has been a recent focus within CMS. As of 2018, four contraceptive measures were available in the CMS Maternal and Perinatal Health Measures Core Set for voluntary reporting by state Medicaid agencies. These measures include 1) Contraceptive Care among Postpartum Women Ages 15 to 20, 2) Contraceptive Care among Postpartum Women Ages 21 to 44, 3) Contraceptive Care among All Women Ages 15 to 20, and 4) Contraceptive Care among All Women

Ages 21 to 44.<sup>24</sup> This set seeks to measure the percent of women at risk of unintended pregnancy who were provided with a “most effective or moderately effective” FDA-approved method of contraception, such as LARCs.<sup>25</sup>

Seven states currently include at least one of these CMS contraceptive core measures in their Medicaid managed care contracts: Arizona, Florida, New Jersey, Louisiana, New Mexico, and Oklahoma. Louisiana, for example, has included the two CMS Contraceptive Care among Postpartum Women core measures — making the state one that establishes a clear link between a specific expectation of postpartum family planning coverage and a specific measure of performance:

*Contraceptive Care-Postpartum (ages 15-20) Measure Description: The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported. Contraceptive Care-Postpartum (ages 21-44) Measure Description: The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported.*

A few states included contraceptive measures which were distinct from the CMS contraceptive core set. For example, Georgia has attempted to capture the outcomes of its Planning 4 Healthy Babies Program, a special demonstration embedded in its managed care system:

*Planning 4 Healthy Babies Program Objectives [...] Improve access to family planning services by extending eligibility for family planning services to all women aged 18 – 44 years who are at or below 200% of the federal poverty level (FPL) during the three year term of the Demonstration. Achievement of this objective will be measured by: Total family planning visits pre and post the Demonstration; Use of contraceptive services/ supplies pre and post the Demonstration; Provide access to inter-pregnancy primary care health services for eligible women who have previously delivered a very low birth weight infant. Achievement of this objective will be measured by:*

*Use of inter-pregnancy care services (primary care and Resource Mothers Outreach) by women with a very low birth weight delivery; Decrease unintended and high-risk pregnancies among Medicaid eligible women and increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women. Achievement of this objective will be measured by: Average inter-pregnancy intervals for women pre and post the Demonstration; Average inter-pregnancy intervals for women with a very low birth weight delivery pre and post the Demonstration; Decrease in late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women. Achievement of this objective will be documented by: The number of repeat teen births assessed annually; Decrease the number of Medicaid-paid deliveries beginning in the second year of the Demonstration, thereby reducing annual pregnancy-related expenditures. Achievement of this objective will be measured by: The number of Medicaid paid deliveries assessed annually; Increase consistent use of contraceptive methods by incorporating Care Coordination and patient-directed counseling into family planning visits. Achievement of this objective will be measured by: Utilization statistics for family planning methods or Number of Deliveries to P4HB participants.*

## Discussions with state Medicaid officials

Upon completion of our contract review, we held a series of 10 discussions with senior Medicaid officials to learn more about their thinking regarding the relationship between Medicaid managed care and family planning generally and their approaches to family planning through managed care purchasing. See **Appendix 4** for a full list of the 10 states with whom discussions were held. (Note: Interviews with plans and providers will take place during Phase 2 of this study.) From these discussions, several key themes emerged:

*Family planning is part of the “routine operation,” “basic general care,” and “integrated care” that managed care plans are expected to provide.* All

discussants viewed family planning as part of their state’s core Medicaid managed care operation, not one that stands apart. While the “freedom of choice” provision stands as a key access safeguard, the existence of this provision did not cause agencies to either think about or treat family planning as somehow separate from their overall health care purchasing strategy. Indeed, officials in one state view the safeguard as the basis for a requirement that their contractors not only pay providers for out-of-network care but have working two-way referral arrangements with all Medicaid participating family planning programs in their service areas. In other words, the presence of out-of-network coverage protection is in and of itself the basis for an operational expectation.

*In states that have prioritized family planning as a service to receive a higher level of attention, this prioritization can be traced to individual leadership.*

All agencies recognize the importance of family planning as a matter of both patient and population health. The decision to elevate family planning contractually — through greater clarity and specificity of expectations — is the result, officials say, of deliberate leadership decisions by agency officials, public health officials, and other state leaders concerned about both individual and population health and its link to the timing and spacing of pregnancy. In one state, this decision to move more aggressively on family planning came from the realization that the state’s unintended pregnancy rates were too high. Another state decided to make performance improvement in its hospitals (in the case of postpartum family planning) and community health centers a policy and strategic planning priority and intends to use its comprehensive health system reform demonstration renewal as a tool for focusing on this issue. Other states indicated that the focus on family planning was part of a broader initiative — for example, an effort to make well-woman’s health care a major priority in Medicaid managed care or to bring a family planning focus into initiatives around pregnancy care.

Agencies view family planning and the “freedom of choice” exemption as an issue that has been operationalized with relative ease. All Medicaid agencies, health plans, and providers face challenges in operationalizing aspects of health system delivery reform. The agency officials we spoke with viewed family planning operations as smooth and with few hiccups. Those officials who were familiar with problems noted that they were manageable (e.g., payment rate adjustments, additional payment for postpartum LARC unbundled from the hospital delivery rate, ensuring that MCOs fully understand and embrace family planning as a focus of state interest, limited member take-up of certain types of long-acting contraceptives). From the agencies’ perspective, issues in family planning are considered readily identifiable, and their resolution has clear answers. Whatever problems arise are ones that can be addressed. Although contracts may not specify coverage of all family planning methods, no state has heard from providers that a method is being denied coverage.

Agencies struggle with which issues to prioritize and when to translate priorities into clear contractual expectations. All agencies focused to a greater or lesser degree on the tension between the scope of the undertaking they face (that is, buying health care for entire populations), when to make a particular population or service a major priority, and when to set clear expectations that effectively are intended to move all contractors in the same direction on a matter of overarching importance. In other words, the question of when to set general directions and allow contractors to exercise judgment and innovation, and when to choose a strategy or a standard and expect uniform adaptation, is one of the most difficult questions that agencies confront — whether in the area of primary and preventive care or care for complex health conditions. Indeed, as one agency told us, the point of managed care is to get the benefit of contractor expertise and the flexibility that comes with capitation and allows contractors to test approaches that are not possible in a fee-for-service context. This uncertainty over when to add or strengthen priorities also carries over into

decisions about updating and adding performance expectations. Contracts are often for multi-year terms, and states may frequently update or alter terms and payment structures. In other words, whether to modify expectations or requirements for contractors does not arise only when new contracts are established but is a continuous matter.

Agencies are varied on the issue of networks. The in-network/out-of-network dichotomy appears to play out differently for different states. Some reported a deliberate strategy aimed at enlarging their managed care family planning networks as a means of bolstering the role of their health plans as comprehensive systems of care and ensuring network adequacy. Other states did not perceive networks as an issue, expressing the sense that the “freedom of choice” provision eases this concern and effectively allows both providers and member to make their own decisions. This view was perhaps best expressed by one state official who indicated the sense that “most state family planning providers have in-network contracts with at least one plan.” Still, for the agencies, the issue of in-network or out-of-network did not raise concerns. While states indicated their desire that plans make a reasonable effort to enroll family planning providers, it was evident in the discussions that ensuring in-network access did not register as a matter of urgency. Thus, there was no pressure in their view to “dictate” network design to their plans, as one agency official put it.

States are relatively split on their plans as claims administrators for out-of-network providers. Some use plans as claims administrators for all family planning services regardless of network status, while others do not. Those who do not use plans as claims administrators noted minimal problems, and if problems did arise (e.g., confusion over the payer), they were resolved with relative ease. However, one state was concerned that requiring family planning providers to bill multiple plans may be placing too much of a burden on them.

States are split on the use of some level of utilization management for family planning services. Several states prohibit pre-approval or

other forms of utilization management, while others do not. Those whose contracts do not bar utilization management varied in their approaches. One state actively supported utilization management as an activity it hopes its contractors do as appropriate for all services. Other officials required that the use of utilization management for family planning services would need to be “run by” the state agency, indicating a process of informal oversight of utilization control policies in this area.

Family planning-specific access requirements are not perceived as necessary. In keeping with agencies’ relatively relaxed attitudes about network composition and adequacy, officials also indicated that they do not perceive the need for family planning-specific access measures because they do not perceive access to family planning services as a problem. It is worth noting that during the period in which these interviews were conducted, the 2019 Title X Family Planning Rule was in full effect. Studies suggest that the rule had a notable impact on family planning program participation.<sup>26</sup> To the extent that patients and members were experiencing access problems as capacity dropped, this development did not appear to translate into an area of concern for agency officials. It is conceivable, of course, that because of the “freedom of choice” guarantee, the need to ensure strong provider networks is simply far less in the view of Medicaid officials because managed care does not act as an interrupter of care patterns of pre-existing service accessibility. Simply put, the “freedom of choice” guarantee acts as a braking mechanism, alleviating the network adequacy pressures state Medicaid programs and plans face for other contract services that lack an out-of-network exemption. Put another way; the out-of-network safeguard lessens the need to “own” the issue.

At least some agencies are focused on the rise of religious providers that may resist family planning as a priority activity. Several agencies noted the increase in religiously affiliated plans and providers, which underscores the importance of the “freedom of choice” guarantee. It is also an issue that may, in some communities, complicate

comprehensive efforts to focus on elevating family planning improvements as a managed care priority. At least one state also noted the difficulty in elevating these issues in legislative policy and suggested that the most effective approach was to incorporate family planning into larger initiatives.

Despite the absence of perceived pressing problems, agencies recognize the importance of family planning and express strong interest in strategies for performance improvement. Although family planning emerged as an area relatively free of pressing problems for state officials, all states appreciated the importance of strong and effective family planning services and appreciated the significance and value of high-performance systems where family planning is concerned, and understood clearly that managed care offers a major tool for improving family planning. Of particular interest, generally, was overall plan performance improvement. One state was particularly focused on increasing the quality of performance by key in-network providers such as hospitals and community health centers that play such a major role in delivering care to members but whose family planning performance may need strengthening. Indirectly, at least, this interest in plan performance improvement despite the absence of evidence of major problems underscores that states are interested in improving managed care not only in response to a “house-on-fire” emergency but as a general matter. In other words, the absence of critical problems in the experience of state officials is a matter separate and apart from the question of how to improve and strengthen the quality and accessibility of a service so fundamental to patient and population health.

## Discussion

The interim findings from this project suggest two key areas of focus ongoing forward.

**1) The need for greater federal policy clarity regarding family planning and managed care integration and how to align the family planning “freedom of choice” exemption with managed care principles and practice.**



One of the most striking aspects of this research has to do with the confusing nature of federal policy guidance and the uncertainty about what falls within the definition of family planning services and supplies. Some may posit that the distinction of what is or is not a family planning service carries little meaning for beneficiaries entitled to comprehensive benefits since Medicaid permits providers, plans, and states to report diagnostic and treatment services under any number of separate benefit categories (e.g., as a physician service, a hospital outpatient service, a federally qualified health center or rural health clinic service, and so forth). It is only in the case of beneficiaries whose coverage is limited to family planning and family planning-related care that what does or does not fall into this particular benefit category takes on significance as a basic matter of coverage.

However, the “freedom of choice” provision of federal law makes this distinction enormously important since the definition so highly influences the issue of out-of-network payment and access. At a time when sexually transmitted infections have reached epidemic proportions<sup>27</sup>, for example, public health considerations argue for ensuring that the family planning “freedom of choice” provision encompasses not only those services funded at 90 percent federal funding but also those that are fully fundable but at a lesser rate under CMS guidance, such as STI treatment along with other essential services such as HIV screening and HPV vaccinations. Public health considerations warrant identifying all of these services contractually as covered by the “freedom of choice” safeguard.

While the goal of in-network care to ensure maximum care coordination and plan accountability is extremely important and worthy of a long-term effort, the problem of controlling preventable sexually transmitted infections is so urgent that clarifying coverage ambiguities rises to a high level of importance to remove any potential barrier to care or delay in care. Furthermore, this recommendation is consistent with how private insurers treat STI treatments. Data from Fair Health,

the largest repository of private insurance claims data in the U.S., show that 69 percent of providers that furnish basic family planning services also provide, bill, and receive payment for STI testing, while 76 percent furnish and receive payment for STI treatment services.<sup>28</sup> These figures suggest that it is standard practice for insurers to pay family planning providers for STI treatment as well. By including STI treatment within the bundle of family planning services covered by the “freedom of choice” safeguard, Medicaid programs would align their practices with those followed in the commercial insurance market.

We are convinced that the ambiguities and uncertainties in state contracts regarding the extent of family planning coverage are the result, in large part, of the absence of clear guidance from CMS on this matter. What we believe would help enormously is policy guidance, developed by CMS in consultation with experts from the Office of Population Affairs and the CDC, that describes best practice approaches to family planning coverage both generally and in a managed care context, including parity in coverage between traditional and ACA expansion populations for all FDA-approved contraceptives and the extent to which “well-woman’s health services” as an essential health benefit could be classified as family planning benefits and covered for all women as such. In addition, federal guidelines could clarify state options regarding the ability to classify certain diagnostic and treatment services as family planning benefits, particularly STI diagnosis and treatment, HPV vaccines, HIV testing and counseling, because of their integral relationship with family planning. Furthermore, these benefits should be payable at the 90 percent rate and available from any Medicaid qualified provider as a family planning benefit, at state option.

***2) The value of a collaborative state effort to identify best practices and model purchasing language related to managed care and family planning.***

As noted, as a strict matter of law and policy, the “freedom of choice” safeguard has the effect of lessening the direct pressure on states to ensure

strong provider networks, effective access, and high performance from their plans. This somewhat lessened legal accountability pressure is reflected in the contract documents themselves, containing relatively few family planning-specific performance measures or purchasing specifications. This is true even in the case of matters in which specifications presumably play a critical role. One such area is the definition of what is covered as a family planning benefit for both in and out-of-network care. Another is the obligation of managed care plans to fully inform members about their ability to obtain family planning services (as defined) from their provider of choice. A third — given the fact that out-of-network access is a matter of federal policy — is the need for two-way referral arrangements between plans and all family planning providers in their service areas, regardless of network status, to ensure that members who need help finding a family planning provider can get it and those whose family planning visits reveal other serious health conditions can be quickly and smoothly referred back to their plans for in-network care.

Beyond making sure that plans effectuate the federal out-of-network policy in a manner that fosters strong performance, our findings confirm considerable state interest in building strong in-network family planning services as a basic feature of high-performing health plans. Areas to target in a state collaborative effort around family planning and managed care would be coverage and utilization management, the use of payment incentives and community outreach to develop provider networks that include all highly-valued providers, and above all, perhaps, the development of performance measures. This review suggests that states are beginning to seriously address the need for outcome measures beyond cervical cancer screening. In the case of adolescents, the one measure in the CMS quality measures that does exist (chlamydia screening) appears to have gained minimal traction, at least as a matter of formal purchasing policy. States uniformly recognize the challenge of attempting to upgrade managed care performance in the absence of performance standards. For this reason, performance standards development emerges as a key priority across the

range of preventive, diagnostic, and treatment services that would fall within a full and robust definition of family planning.

States are beginning to devote time and energy to family planning in a postpartum context. This focus offers an excellent starting point for a more expansive effort to achieve more robust performance on family planning as a basic preventive service and the role of integration to improve overall patient and population health.

Perhaps the most important finding in this study is the great importance that family planning appears to play in the minds of state Medicaid programs. Indeed, agencies do not consider family planning to be an area where they face immediate and urgent problems. But uniformly, the officials we spoke with — and the contracts we reviewed — underscored the view of family planning as a central feature of managed care system. Despite the existence of a “freedom of choice” policy might—at least in theory—lead agencies to believe that high-quality family planning is not a managed care front-burner issue. This is not the case. Officials’ appreciation for the foundational role of family planning and their interest in using managed care tools to improve access and quality point to the value of a longer-term effort to strengthen managed care performance. The fact that several states have focused on family planning access by expanding the populations covered for this service underscores the timeliness of an initiative to broaden this focus to include managed care performance for full benefit populations.

Family planning represents one of the nation’s most important and effective preventive services. With 70 percent of Medicaid beneficiaries enrolled in comprehensive managed care, it is time to create robust guidance that helps states tackle family planning as not only a basic aspect of Medicaid managed care but as a major opportunity to improve health and value.

## Appendices

[Appendix 1: Medicaid Managed Care Contract Review Tables](#)

[Appendix 2: Study Methods](#)

[Appendix 3: Advisory Committee](#)

[Appendix 4: Case Study States](#)

## References

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<sup>13</sup> 42 U.S.C. 1396u-2 (b)

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